

A Dissertation
Entitled
A Narrative Analysis of Familial, Collegiate, and Professional Experiences
that Enhance the Formation of Civic Engagement and
Mission Commitment among Catholic Health Care Nurses

by
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Submitted to the Graduate Faculty as partial fulfillment of the
requirements for The Doctor of Philosophy Degree in Higher Education

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Educating for citizenship has pervaded the mission of higher education from classical Greece up to the present day. Colleges and universities increasingly encourage service learning and other curricular approaches that promote social responsibility and civic involvement. Other mission-oriented institutions, such as Catholic health care, grapple with issues of social responsibility and civic involvement as they discern their role in the community and face the challenges of a changing workforce.

This dissertation examines, through narrative analysis, how mission commitment in a specific industry—Catholic health care—is influenced by higher education, and how higher education might learn from mission commitment development in that industry. The study explores how nurses understand their personal development of mission commitment with a specific focus on the way in which life experiences—familial, collegiate, and professional—have enhanced or driven their mission formation. Because higher education is an integral part of the process of nurturing and sustaining responsible civic engagement, this study first seeks to understand that process as a pedagogical endeavor. It next narrows this broad discussion of responsible and engaged citizenry to a

more focused study of the specific discipline of nursing: first, its theoretical and practical curricular and co-curricular approaches to education, and then the expectations of a specific corresponding industry—Catholic health care— for its newly hired professionals.

The Backward Design process frames the discovery of common ground shared by higher education and Catholic Health care in mission commitment formation.

Participants in this study comprise a purposeful sampling of 13 nurses employed by a large Catholic health care system in the Midwest. These nurses are front-line, baccalaureate-prepared, and institutionally recognized, cited, or awarded for their mission commitment. Their collected narratives, analyzed through the lens of a model created by Labov and enhanced by the work of others such as Riessman, Coffey, and Atkinson, lead to recommendations for more effective mission formation practice in both Catholic health care and higher education.

The academy should “make for less misery among the poor, less ignorance in the schools, less suffering in the hospital, less fraud in business, [and] less folly in politics”
~Daniel Coit Gilman

For Luke, Alma, Joseph, and Ruth—my grandparents. You made for less misery among the poor, less fraud in business, and less folly in politics through your work and through your lives. Your commitment toward education in the service of others lives on in your children, grandchildren, great grandchildren and great-great grandchildren.

For Mom and Dad. Thank you for valuing education enough to make it a priority. You have recognized, encouraged, and modeled for us the mandate to use our gifts and talents in service of those in our families, our communities, our nation, and our world who are in need. Remember: “Just one more...”

Table of Contents

Abstract.....	iii
Table of Contents.....	vi
List of Tables.....	x
I. Introduction	1
A. Purpose Statement.....	6
B. Working Hypotheses and Significance of Study.....	7
C. Theoretical and Conceptual Framework.....	8
D. Scholarly Context.....	9
E. Research Questions.....	10
F. Research Site and Participant Selection.....	11
G. Methodology.....	12
H. Data Collection, Management, and Analysis.....	12
I. Delimitations.....	14
J. Limitations.....	14
K. Definitions.....	16
II. Literature Review.....	19
A. Backward Design.....	20
B. Social Theory of Education.....	21
a. History of Higher Education and Civic Engagement.....	24
b. Professional Education and the Liberal Arts.....	32
c. Student Learning, Outcomes, and Development.....	34
d. Narrative Learning.....	46

e. Nursing Education.....	50
C. Catholic Health Care.....	55
a. Continuation of Mission and Sponsorship.....	63
b. Engaging a Diverse Workforce.....	69
c. Mission-Minded Behaviors and Characteristics.....	73
D. Conclusion.....	77
III. Methodology.....	79
A. Strategy, Genre, and Rationale.....	80
B. Research Site and Participants.....	81
a. Site Selection and Access.....	82
b. Participant Selection.....	83
C. Researcher's Role and Ethical Considerations.....	87
D. Data Collection, Management, and Analysis.....	90
a. Data Collection.....	91
b. Data Management.....	92
c. Data Analysis.....	93
E. Trustworthiness.....	98
IV. Analysis.....	103
A. Participant Demographics.....	104
B. Analysis.....	105
a. Understanding Mission.....	110
b. Familial Influences.....	123
c. Becoming a Nurse.....	131

d. Collegiate Experience.....	145
e. Civic Engagement and the Public Face of Nursing.....	163
C. Conclusions.....	170
V. Findings.....	172
A. Summary and Backward Design.....	173
B. Research Questions.....	174
C. Narrative Methodology and Learning.....	179
D. Discoveries in Light of the Literature Review.....	182
a. Social Role of Education.....	182
b. Liberal and Professional Education in Nursing Education.....	185
c. Student Learning, Outcomes, and Development.....	189
d. Intellectual and Moral Conversion.....	196
e. Mission-Minded Behaviors and Characteristics in Catholic Health Care.....	197
E. Recommendations for Practice.....	200
a. Programmatic Evaluations.....	201
b. Evaluative Considerations.....	203
c. Environmental/Cultural Considerations.....	204
F. Implications for Further Research.....	207
a. Legacy of Nursing in Families.....	207
b. Quantitative and Qualitative Research.....	207
c. Undergraduate Program Development and Frameworks.....	209
d. Organizational Culture and Structures.....	210

G. Final Thoughts.....	212
Afterword.....	213
References.....	215
Appendices	
A. Sample Intake Form.....	235
B. Sample Interview Questions and Probes.....	236
C. Labov’s Elements of Narrative Analysis.....	237
D. Participant Demographics.....	238
E. Mission Commitment Narratives.....	239
F. Familial Influences.....	249
G. Becoming a Nurse Narratives.....	250
H. Collegiate Narratives.....	259
I. Civic Engagement and Public Face of Nursing Narratives.....	265

List of Tables

Table 1. Amanda’s Mission Commitment Narrative.....	110
Table 2. Kim’s Mission Commitment Narrative.....	114
Table 3. James’s Mission Commitment Narrative.....	119
Table 4. Terri’s Familial Influences Narrative.....	123
Table 5. Sarah’s Familial Influences Narrative.....	128
Table 6. Craig’s Becoming a Nurse Narrative.....	132
Table 7. Maria’s Becoming a Nurse Narrative.....	136
Table 8. Lyn’s Becoming a Nurse Narrative.....	141
Table 9. Amanda’s Collegiate Experience Narrative.....	146
Table 10. Kristi’s Collegiate Experience Narrative.....	149
Table 11. Sarah’s Collegiate Experience Narrative.....	156
Table 12. Ann’s Civic Engagement Narrative.....	164
Table 13. Lyn’s Civic Engagement Narrative.....	165
Table 14. Bob’s Civic Engagement Narrative.....	168
Table 15. Recommendations for Practice.....	206
Table E1. Craig’s Mission Commitment Narrative.....	239
Table E2. Kristi’s Mission Commitment Narrative.....	241
Table E3. Lyn’s Mission Commitment Narrative.....	243
Table E4. Maria’s Mission Commitment Narrative.....	244
Table E5. Sarah’s Mission Commitment Narrative.....	246
Table E6. Bob’s Mission Commitment Narrative.....	248
Table F1. Jackie’s Familial Influences Narrative.....	249

Table G1. Amanda’s Becoming a Nurse Narrative.....	250
Table G2. Kim’s Becoming a Nurse Narrative.....	251
Table G3. Jackie’s Becoming a Nurse Narrative.....	252
Table G4. Kristi’s Becoming a Nurse Narrative.....	254
Table G5. Terri’s Becoming a Nurse Narrative.....	255
Table G6. James’ Becoming a Nurse Narrative.....	256
Table G7. Sarah’s Becoming a Nurse Narrative.....	257
Table H1. Kim’s Collegiate Experience Narrative	259
Table H2. Jackie’s Collegiate Experience Narrative.....	261
Table H3. Maria’s Collegiate Experience Narrative.....	263
Table I1. Amanda’s Civic Engagement Narrative.....	265
Table I2. Kim’s Civic Engagement Narrative.....	266
Table I3. Jackie’s Civic Engagement Narrative.....	268
Table I4. Kristi’s Civic Engagement Narrative.....	269
Table I5. Maria’s Civic Engagement Narrative.....	271
Table I6. James’ Civic Engagement Narrative	272
Table I7. Sarah’s Civic Engagement Narrative.....	273

Chapter One

Introduction

Educating for citizenship has been a perennial goal of society for much of recorded history. The Code of Hammurabi is the earliest known written attempt at codifying education for a safe society and responsible citizenry, however coercive it seems to modern eyes. Texts from most faith traditions speak to believers about how to be in right relationship with God or the gods by living well within the community. Socrates insists he is neither an Athenian nor a Greek, but a citizen of the world; Plato exhorts each citizen to play a part in the community according to individual gifts. Education for citizenship has been a central task of the greatest minds of the Western tradition.

While “civic virtue” and “democracy” are not synonymous terms, the broader discussion of American education often links the two. As noted below in Chapter Two, the American grand narrative promotes democracy as chief among the civic virtues. The Center for Civic Education, for example, states that the ultimate goal of its curriculum is “to enable students equipped with the requisite civic knowledge and the skills of civic participation to make their own commitment, carried to adulthood, to the civic values deemed necessary for the nurture and strengthening of the ideals of American democracy. This goal,” maintains the Center, “is summarized in the term ‘civic virtue’” (The Center for Civic Education, 2009). The Center recalls the spirit of John Dewey when, earlier in the century, he promoted democratic citizenship as an end product of American education. “Democracy has to be born anew every generation, and education is its midwife” (1915, p. 15). At the same time, Dewey does not see education as an incubator,

separate from the civic duties of adult life: “education is not a means to living, but is identical with the operation of living a life which is fruitful and inherently significant” (1916, p. 239). Daniel Coit Gilman, the president of the first research university in the United States—Johns Hopkins University— states that the academy should “make for less misery among the poor, less ignorance in the schools, less suffering in the hospital, less fraud in business, [and] less folly in politics” (Fleming & Brabeck, 2002, p. 82). Educating for citizenship thus continues to undergird the mission of American higher education, both public and private. The relevance and effectiveness of institutions of higher education depends upon the creation of meaningful curricular and co-curricular learning experiences, developmentally appropriate opportunities for responsible citizenship in undergraduate education, and awareness of what an adult understanding of, and commitment to, civic engagement looks like.

Because higher education is an integral part of the process of nurturing and sustaining responsible civic engagement, the task of this study is first to understand that process as a pedagogical endeavor. The next task is to narrow this broad discussion of responsible and engaged citizenry to a more focused study of the specific discipline of nursing: first, its theoretical and practical curricular and co-curricular approaches to education, and then the expectations of a specific corresponding industry—Catholic health care— for its newly hired professionals.

Religious institutions sponsored many hospitals from the earliest days of American health care. By the end of the 20th century, many of these hospitals had developed into large health care organizations. Some chose the path of secularization, eventually associated with their founding religious congregations in name only, if at all.

However, a large number of these institutions continue their religious sponsorship.

Among Catholic health care systems, the practice of maintaining awareness of religious sponsorship and its relevance to the daily practice of health care and education is known as “mission integration.”

Catholic health care finds itself at a watershed moment in the early 21st century. In earlier sponsorship models, the religious orders supplied much of the administration and labor within the hospital. Additionally, Catholic colleges, universities, and schools of nursing and allied health provided a framework to transmit Catholic culture and its underlying/foundational mission into educational practices and workplace preparedness. However, the number of Roman Catholic vowed women religious in health care is rapidly diminishing and the number of employees and constituents with an awareness of the founding religious mission of these institutions is likewise in decline. This makes “mission integration” at once all the more urgent and all the more difficult. “The distance from the founding stories and the declining number of religious sisters,” states one health care system, “present challenges requiring explicit attention to the development of lay leaders who integrate the Mission into their lives and demonstrate it in word and deed” (Catholic Healthcare Partners, December 2008, p. 1).

Although other health care providers are also socially conscious, Catholic health care has a unique institutional imperative to concentrate on medical ethics and moral agency. This imperative directs the focus and quality of end-of-life care, community benefit, and advocacy: “Catholic organizations—because of institutional guidance from their founding congregations, the *Ethical and Religious Directives*, and mission and vision statements—have become leaders in the provision of care to the dying” (Cochran

& White, 2002, p. 5). Furthermore, Catholic health care has an explicit mission to provide excellent patient care to those who are poor and under-served. Catholic Health Association, the umbrella organization for Catholic health care in the United States, defines the mission of Catholic health care as “a ministry continuing Jesus' mission of love and healing today. As provider, employer, advocate, citizen — we bring together people of diverse faiths and backgrounds. Our ministry is rooted in our belief that every person is a treasure, every life a sacred gift, every human being a unity of body, mind, and spirit” (Catholic Health Association, Mission, 2009).

A Georgetown University study found that “Catholic health care facilities are often the provider of last resort for millions of Americans. They often provide necessary medical services that other hospitals won't provide because they are not profitable—such as burn units, neonatal intensive care units, mental health facilities, etc. They continually reassess local needs and create services to benefit the community they serve. Catholic health care is a valuable national resource” (Catholic Health Association, 2009).

“Mission integration” is one of the factors that sustain this resource. Without conscious “mission integration,” these foci can be lost. Vulnerable populations are at risk of falling through the cracks in the U.S. health care system as a result. Even so, mission integration is in danger due to “a declining and aging population of sisters, changing church dynamics...payment constraints, regulatory requirements, not-always-favorable public perceptions of Catholic health care, and the need for partnerships with other-than-Catholic organizations” (Sullivan Clark, 2005, p. 32). Those who value the social mission role that has been filled by Catholic health care institutions must be concerned about how to educate the individuals who comprise the institution into this mission-

mindedness. As Thoreau observes, “It is truly enough said that a corporation has no conscience; but a corporation of [the] conscientious... is a corporation with a conscience” (Thoreau, 1993, p. 5).

This study addresses the following problem of Catholic corporate conscience: “mission integration” is seen as becoming more difficult because fewer and fewer people are connected with, and invested in, the religious institutions that sponsor Catholic health care—that is, fewer and fewer employees are women religious or have been educated within Catholic school systems. Catholic education and employee socialization no longer go hand in hand. When employees were sisters or graduates of Catholic schools, administrators could assume familiarity with, if not belief in, the Catholic faith teachings and lessons promoted in Catholic intuitions such as those put forth by Catholic Health Association:

- providing compassionate, high-quality care for bodies, minds and spirits;
- promoting health and well-being for all persons and communities;
- paying special attention to those who are poor, underserved and most vulnerable;
- acting to end poverty, injustice and discrimination ;
- using our resources responsibly; and
- acting in harmony with the Catholic Church. (Catholic Health Association, Mission, 2009).

These teachings have traditionally resulted in a mission-mindedness, or at least a mission-consciousness, that can no longer be taken for granted as part of an individual’s prior life experience. Catholic health care is presented with the challenge of

compensating for this type of education through means such as family, other religious or spiritual educational experiences, and collegiate experiences.

College experience, while not designed to foster particular religious beliefs and practices, has often had a strong philosophical basis regarding the purposes of citizenship, democracy, and the improvement of society. At the same time that Catholic health care is experiencing a decline in a workforce that grew up Catholic, emergent pedagogies such as “service learning” have surfaced. It therefore makes sense to examine college experience and its implications for preparing a socially engaged or mission-minded workforce.

Purpose Statement

The original purpose of this study was to explore the following hypothesis: as Catholic health care experiences the aforementioned gap in mission-minded education, curricular and co-curricular aspects of the college experience can lead to the development of mission-minded, socially responsible, civically engaged professionals. As the research progressed, the participant narratives broadened the perspective of the study. The hypothesis was disregarded as too narrow, and the broader purpose of the study became to identify, through narrative, how Catholic health care nurses understand their personal development of mission commitment with a specific focus on the way in which life experiences—familial, collegiate, and professional—have enhanced or driven their mission formation. Once identified, what then are the implications for undergraduate education within the university system and for “mission integration,” recruitment, development, and retention initiatives within Catholic health care? Many Catholic health care systems have programs in place to build mission capacity through board, senior

leader, and management formation. However, little work has been done to identify those experiences that lead to mission-committed employees, how to build mission capacity, and how to engage front-line employees in mission integration. Such understanding can not only enhance professional development within the Catholic health care industry, but can also inform the development of social responsibility and mission mindedness within higher education system, both secular and faith-based.

Working Hypotheses and Significance of Study

Life experience – family, faith, collegiate, and professional – shapes openness to mission commitment. The influences of family and faith are not necessarily susceptible to change through curricular and co-curricular experiences in college. However, collegiate experiences can significantly shape, even deepen, professional mission integration.

As commonalities emerged throughout participant narratives that describe understanding of mission-commitment, the implications of this study and its findings are at least twofold. First, the study generated a list of experiences and processes that need to be a part of an undergraduate experience if it is to lead to mission commitment in all its aspects: social, philosophical, spiritual, et al. and therefore must be funded, developed, and offered in the undergraduate setting. If the significant experience happened outside of the collegiate setting, there need to be ways that the experience can be translated into the collegiate experience in a meaningful way.

Secondly, as a result, this list provides Human Resources professionals with criteria for successful mission-based hiring practices, whatever the orientation of the orientation might be.

Theoretical and Conceptual Framework

The structure of this study draws on the educational philosophy of Social Reconstruction as well as the conceptual framework of “Backward Design” as described by Wiggins and McTighe in *Understanding by Design*. These two approaches “inform both the methodological and the substantive aspects” of the study and offer a framework out of which to examine “data from different perspectives” (Glesne & Peshkin, 1992, p. 21).

The sociological theory of Social Reconstruction substantiates both the historical impetus and the contemporary need to create learning environments that prepare an engaged citizenry who will address “critical problems to promote equality, justice, and democracy in the social environment” (Oakes & Lipton, 2003, p.107). Social reconstructionism begins with the assumption that society is structurally based on inequities and injustices, and that scholars should develop research agendas and pedagogical methods that will expose inequities and will influence the “reconstruction” of a more equitable and just society. Backward Design is an educational and curriculum development model that begins with the end in mind. Any given research question – for example, “What am I expecting Catholic health care nurses to be predisposed to do, and to be able to do, in terms of mission?” – can have many legitimate answers. Accordingly, although employee behaviors might correspond to a list of desired mission-based behavioral outcomes, mission commitment will naturally manifest differently in different people. Because “investigators do not have direct access to another’s experience” (Riessman, 1993, p. 8), the task of this research is to understand the formative

experience—the narrative behind *how* and *why* a given employee either presents or self-identifies as mission-committed.

Backward Design, as adapted in the Backward Design Process put forth by the consortium Digital Literacy (n.d.), begins with a series of questions in three areas: identifying desired results, determining acceptable evidence, and planning learning experiences. Mission commitment—the desired result of education, in this study—is largely intuitive and can be therefore somewhat difficult to articulate. Backward Design clarifies how we know when someone is mission-committed. Employees are the best authorities on the origins of their own formation as they relate the experiences that provided fertile ground for mission commitment. Their stories show the experiences—undergraduate, familial, professional, and others—that promoted this formation, and can suggest learning experiences that should be provided for future students as part of their collegiate experience.

Scholarly Context

The literature review consists of three primary research areas: Backward Design, the social role of higher education, and Catholic health care. Backward Design, as described earlier, helps to structure the research process with guiding questions and an overarching goal of answering the question: How do how Catholic health care nurses understand their personal development of mission commitment with a specific focus on the way in which life experiences—familial, collegiate, and professional—have enhanced or driven their mission formation.

Next, the review of the literature contextualizes education within the social role of higher education. Drawing on the history of higher education and its curricular and

theoretical developments, the review surveys higher education's role in civic engagement and democracy building (including social reconstructionist approaches), student learning, evaluation of outcomes, and theories of student development, and the preparation of practitioners within the discipline of nursing. This foundation of education—focusing on the education and development of mission-minded, socially responsible, civically engaged professionals—then leads to the discussion of the particular industry of Catholic health care. The literature on Catholic health care reveals that it is essential to continue the mission through sponsorship models, the reality of diversity within the workforce, and the preparation of mission-minded behaviors and characteristics of its workforce.

Research Questions

The primary research question of this study is “How do Catholic health care nurses understand their personal development of mission commitment with a specific focus on the way in which life experiences—familial, collegiate, and professional—have enhanced or driven their mission formation?” The formulation of this research question reveals a secondary set of questions that may be answered either through the review of relevant literature or through the actual process of data collection and analysis.

Thus the study is further shaped by several secondary questions:

1. How do Catholic health care employees understand mission commitment and mission alignment?
2. What characteristics do leaders point to when describing mission-commitment/infusion or mission-alignment?
3. What life experiences contribute to (or lead to) mission commitment in Catholic health care employees?

4. Is it reasonable to expect that employees, Catholic and non-Catholic, should understand, respect, and contribute to the Catholic character and mission of Catholic health care?
5. How do the mission statements of institutions of higher education articulate a goal of educating for citizenship?
6. What curricular and co-curricular theories and experiences do graduates of higher education point to as integral to fulfilling a goal of educating for citizenship?
7. What curricular and co-curricular theories and experiences do health care/nursing educators point to as integral to fulfilling a goal of educating for citizenship?
8. What are the implications for institutions of higher education?
9. Is there a difference in how Catholic health care employees articulate mission based on the type of undergraduate institution they attended?
10. What are the implications for “mission integration,” recruitment, development, and retention initiatives within Catholic health care?

Research Site and Participant Selection

The research site for this project is a large Catholic health care system in the Midwest. A study of the origins and evolution of Catholic health care reveals a common and strong mission-mindedness that pervades every level of its institutions from leadership to employee base.

To date, there are approximately 900,000 workers in Catholic health care across the United States. The target population in this study was a purposeful sampling of 13 nurses from the above regional Catholic health care system. The nurses selected were all

front-line, baccalaureate-prepared, and institutionally recognized, cited, or awarded for their mission commitment.

Methodology

The research questions above are addressed through qualitative methodology in the form of narrative analysis. Narrative analysis is an approach to interpreting qualitative data that uses the structural elements of story to preserve the meaning of the narrator's experience. This is accomplished through an organic process and not imposed by any artificial, pseudo-objective classification; the narrator's perspective, rather than the perspective of the researcher, drives the process. As Connelly and Clandinin (1990) describe it, "at the heart of narrative analysis lie the ways humans experience the world" (p. 2). Narrative research is, then, the most appropriate methodology to address the questions posed by this study, as they all concern how participants interpreted their experiences to become mission-minded.

Data Collection, Management, and Analysis

A brief overview of the collection, management, and analysis of the data includes the process of interviewing participants, organizing data from the interviews, and then interpreting this data through the lens of narrative analysis. The primary unit of analysis consists of the narratives of the individuals identified as "mission-minded." Once the participant pool was established, I conducted prearranged individual interviews with identified participants. The interview process was "semi-structured," i.e., the questions were "more flexibly worded, or the interview [was] a mix of more or less structured questions" (Merriam, 1998, p. 74).

To ensure the integrity of the collected data, I designated two binders for my research. One binder holds all identifying documents and information and is kept in a locked drawer of my file cabinet. The other binder is divided into one section per participant. Each section includes copies of the verbatim transcription of the interview, using the participant's choice of name, interview notes and descriptive notes (again with participant's choice of name), structural analysis notes, other materials the participant submitted, and the audio tapes of the actual interviews. This binder is stored in my library with my educational books and materials.

In the process of data collection, through reflection on observations, notes, and a close study of verbatim transcriptions of interviews, I utilized a structural framework based on Labov's work, as well as the work of Coffey, Atkinson, and Riessman, to analyze the collected narratives. All narratives follow a structure, though it is not always readily apparent to the casual listener. By attending to how narrators structure their narratives, however, one is able to identify the points that the narrator is making, rather than risk focusing on some detail of the narrative that is only incidental. When analyzed, the resulting structure includes six elements: abstract, orientation, complicating action, evaluation, result or resolution, and coda (Labov & Waletzky, 1967, pp. 32-39). Although the elements I identified were the same as those identified by Labov & Waletzky, they were not always in a consistent order. Coffey and Atkinson (1996) insist that stories have certain structural properties that enable social actors to tell their stories with a specific purpose. Analysis of these stories provides, in the words of Cohen et al. (2000), "a conduit to closing the loop between the research question and raw findings/answers and the task of relaying the researcher's present understanding and interpretation of the data

to all other readers” (p. 71). When the structural properties of the narratives are properly analyzed, the participants’ intent is more accurately articulated to a wider audience.

Delimitations

There are intentional boundaries to the scope of this study, delimited by unit of analysis and by methodology. My research focuses on individual narratives of mission commitment in Catholic health care nurses rather than on the broader organizational culture of Catholic health care. This leaves the organizational study of Catholic health care to another project, and precludes mission commitment stories of nurses in other health care settings. The choice to use purposeful sampling methods instead of a random sample also means that the narratives of those nurses who may self-identify as mission-minded, or who graduated with a baccalaureate preparation prior to the 1989, will be excluded as well.

The methodology employed in any research process is driven by the research question, which in the instance of this study demands a qualitative approach. This decision foregoes statistical descriptions and correlations, as well as generalized findings, in favor of the richness of narrative and individual expression.

Limitations

Physical limitations situate research in a particular place, time, and circumstance. The limitations and potential weaknesses in my research are primarily connected to site and sample selection and to the procedures of interviewing, including the practice of self-reporting and the perspective of the researcher.

The site encompasses four Midwestern states, and the site selection may therefore have produced geographically idiosyncratic understandings of mission commitment. The

identified sample also tended to be homogeneous in terms of faith background. It was difficult to find non-Catholic participants who fit the selection criteria. This could be attributed to a bias toward Catholics in the mission award protocol or it could be a reflection of the rather Catholic-saturated area in which the hospitals are situated.

The procedures of interviewing are impacted by both researcher and participant. There is much discussion among qualitative researchers regarding issues of memory, meaning-making and truth-telling in interview narratives. Atkinson, Coffey, and Delamont (2003) remind researchers that “the encounter” of the interview “becomes a collaborative act of mutual identity construction,” and that “through these discursive acts, the participants can create public selves, characters, moral categories, and varieties of experience” (p. 112). Although this quest “to explore the authenticity of personal or private experiences...explores the interiority of experience,” it must always be placed in social context; “there is no place to [take] an un-social view of the person...the expression of the ‘experience’ never escapes the shared cultural frameworks, register, and genre”(p. 140). In this study, the interior world and public construct are balanced by the very identification of a mission-committed employee’s reception of a mission or service award. In this same vein, the role of researcher in qualitative research is prominent, and thus his or her own subjectivities come into play. In this particular study, I, as the researcher, have a role within the system, and unless I frame my questions correctly, it is possible that participants might tell me what they think I want to hear rather than their personal truth.

It is not possible to eliminate every influence a narrative researcher might have on a subject. However, I took steps to minimize such influence by raising awareness and

articulating limits, and then put safeguards in place to produce the most accurate and trustworthy findings possible.

Definitions

Below, I provide general definitions of key concepts within the study:

Backward Design: Backward Design is an educational and curriculum development model that begins with the end in mind. It follows a series of questions in three areas: identifying desired results, determining acceptable evidence, and planning learning experiences (Digital Literacy, n.d.).

Social Role of Education: Substantiates both the historical impetus and current need to create learning environments that can prepare and engaged citizenry who will address “critical problems to promote equality, justice, and democracy in the social environment” (Oakes & Lipton, 2003, p.107).

Social Reconstructionism: A philosophy that emphasizes the addressing of social questions and a quest to create a better society and worldwide democracy. According to Theodore Brameld, the goals of social reconstructionism include democratic socialism, global order, cooperative power, self-transformation” and an encouragement of “students, teachers, and all members of the community not merely to study knowledge and problems crucial to our period of culture, but also to make up their minds about the most promising solutions and then to act concertedly” (Kridel, 2006, p. 74). See also Freire (1990) and Oakes and Lipton (2003).

Civic engagement: Philosophical basis regarding the purposes of citizenship, democracy, and the improvement of society.

Service Learning: Arguably, the most promulgated and adopted pedagogy for the educational outcome of civic engagement. The National and Community Service Trust Act of 1993 defines service learning as a method under which students or participants learn and develop through active participation in thoughtfully organized service. Additionally, several goals of service learning programs include the development of citizenship and preparation of students for participation in an active civic life; the moral and religious development of students; the preparation of students for careers through engagement in real-world activity; and the partnering of the university and the community in ways that enhance both student learning and the intellectual, economic, and social resources of the community (Kenny & Gallagher, 2002, p. 15-16).

Front-Line Nurse: Staff-level nursing professionals of various clinical ladder levels and experience, as well as such varied nursing specialties as intensive care, medical-surgical, telemetry, obstetrics, and pediatrics.

Baccalaureate-Prepared: Registered nurses who have completed a baccalaureate degree from an institution of higher education.

Catholic Health Care: A system of health care facilities and services that consciously and explicitly identify themselves as Catholic in keeping with the Catholic Church's stated mission to deliver medical services. In 2010 there were 561 hospitals listed in *The Official Catholic Directory* (2010) that identify themselves in this way.

Sponsorship: An unofficial but commonly used term referring to the overarching roles, responsibilities, and influence of congregations in independently incorporated institutional ministries (Morey, 2002, p. 292).

Mission: A mission statement tells outsiders ‘who we are,’ and guides the actions and decisions of those within. “An institution’s public statements of mission and vision should reflect its particular history, context, and realities” (Diamond, 2002, p.17).

Mission Integration: The practice of maintaining awareness of religious sponsorship and its relevance to the daily practice of health care and education.

Mission Commitment (also referred to as mission infusion; mission minded): The sincere intention and proven ability to act according to the explicit agenda of an institution as expressed in its mission and or vision statements.

Narrative Analysis: A methodology that examines the stories people tell, the language they use, and elements of narrative structure to interpret qualitative data that preserves the meaning that participants ascribe to their experiences. Key researchers: Labov (1967; 1972), Coffey and Atkinson (1996), and Riessman (1989).

Chapter Two

Literature Review

This study addresses the questions of how Catholic health care nurses understand their personal development of mission commitment, and in particular, what familial, collegiate, and professional experiences lead to the development of mission-minded, socially responsible, civically engaged professionals. The research identifies college-related activities and undergraduate experiences, as well as aspects of family, faith, and profession that contribute to the formation of mission-mindedness in nursing professionals working within Catholic health care institutions. This is of interest to colleges and universities as they increasingly encourage service learning and other curricular approaches that promote social responsibility and civic involvement. It is also of import to traditionally mission-oriented institutions, such as Catholic health care, which increasingly grapple with their role in the community and challenges of a changing workforce. The literature review is thus divided into three sections: first, an explanation of “Backward Design,” which is the framework for the study; second, an examination of the social role of higher education; and third, material relevant to the case study of Catholic health care and its mission.

This study contextualizes education within the framework of social theory. Drawing on the history of higher education and its curricular and theoretical developments, it then will survey higher education’s role in civic engagement and democracy building, student learning, evaluation of outcomes, and theories of student development, and the preparation of practitioners within the discipline of nursing. This foundation of education—focusing on the education and development of mission-minded,

socially responsible, civically engaged professionals—will lead to the discussion of the particular industry of Catholic health care and the preparation of its workforce.

Catholic health care is a uniquely situated case study of how a mission-minded, socially responsible, civically engaged professional imbues these values into a workplace environment. Catholic health care has a unique and systemic cultural presence. There is a high awareness of the importance of mission-mindedness within this industry; it is not unusual for employees to be able to articulate how mission engagement is evidenced through organizational behaviors, vocational expectations, and assessment of their conduct, actions, and performance. Thus, it is vital to understand the origins of mission-mindedness, which is the subject of this study.

Backward Design

The framework for this study is the concept of “Backward Design” as described by Wiggins and McTighe (2005). Backward design is a model for educational and curriculum development that begins with the end in mind. Once again, the question addressed in the following pages is: How do how Catholic health care nurses understand their personal development of mission commitment with a specific focus on the way in which life experiences—familial, collegiate, and professional—have enhanced or driven their mission formation? From the perspective of Backward Design, the “end in mind” is expressed by the question, “How should effective, competent nursing professionals in Catholic health care be predisposed in terms of mission?”

The question can have many legitimate answers. Mission-mindedness will naturally manifest itself differently in different people. The spectrum of expression of successful mission infusion will be varied rather than uniform. Therefore, it is essential to

understand formative experience, the story behind *how* and *why* someone presents as mission-committed as the result of their familial, undergraduate, and professional experiences.

As noted in Chapter One, “Backward Design”—as adapted in the process articulated by the Digital Literacy consortium (n.d.)—begins with a series of questions in three areas: identifying desired results, determining acceptable evidence, and planning learning experiences. Mission commitment—the desired result of education, in this study—is largely intuitive and can be therefore somewhat difficult to articulate. Backward Design addresses this challenge by affirming that employees are the best authorities on the origins of their own formation, as they relate to the interviewer the experiences that provided fertile ground for formation toward mission commitment. Their stories indicate which, if any, undergraduate learning experiences promoted this formation, and for future students, can suggest what learning experiences should be provided. The Backward Design approach will “inform both the methodological and the substantive aspects” of the study and offer a framework in which to examine “data from different perspectives” (Glesne & Peshkin, 1992, p. 21).

Social Theory of Education

The social demand for institutions of education to prepare an engaged citizenry has been illustrated throughout the history of education. Oakes and Lipton’s educational philosophy of Social Reconstruction speaks of education’s purpose: to solve “critical problems to promote equality, justice, and democracy in the social environment” (Oakes & Lipton, 2003, p.107). In *Teaching to Change the World*, they note that “since the Republic’s founding, Americans have placed their hopes for democracy on public

schools,” and that, “only a century ago...five years was considered enough time to prepare children to learn the knowledge and habits necessary for social harmony” (pp. 5-6). Through their research of the foundations, practice, and profession of teaching, Oakes and Lipton articulate the broad outcomes needed to prepare students for participation in society: “at the present, schools must preserve the culture, support economic stability, ensure national security, solve social problems, [and] boost international competitiveness” (Oakes & Lipton, 2003, pp. 5-6).

In “Becoming Good American Schools,” Oakes et al. (2000) focus on K-12 education, but their observations are applicable to higher levels. Their contribution to the Carnegie Council on Adolescent Development's middle-grades reform effort, outlined in “Turning Points: Preparing American Youth for the 21st Century,” points toward the relevance to higher education of the general goal to “foster meaningful engagement with ideas, as well as with caring people, diverse environments, and democratic processes” (p.568). The authors address the tension “between an American culture that embraces democratic ends for its schools but resists the democratic means necessary to achieve them” (Oakes, Quartz, Ryan, & Lipton, April 2000, p. 569).

This tension is idiosyncratic. Melchin (1998), in his work *Living With Others*, points to how some organizations can take on a personality of their own and have an impact further-reaching than the individual subjects and components that make up the whole. “These social structures can harness the inputs of vast numbers of people towards the achievement of goods that none could have envisaged on their own, so too can they become agents of evil that far surpass the malice if individual people” (p. 93) – the whole, in other words, is greater than the sum of its parts. However, if we also believe

that the whole *is reflected in* each of its parts, we need to study, evaluate, and direct energy toward these vital components. Energy needs to be invested in developing and improving the structure, human resource and capital, political, cultural, symbolic frames of organizations—educational organizations included.

Melchin (1998), from his Catholic orientation, writes on four themes or points of access for improvement and doing good: God’s justice, the dignity of persons, the common good, and the preferential option for the poor. These points of analysis bring Melchin to the conclusion that those “social structures [that] must command our support will be those that build up the dignity of persons and nurture them as responsible agents for social meaning” (p.114), which will ensure a paradigm in which civic virtue can flourish.

Again and again, authorities write of creating a learning environment oriented toward *civic virtue*, “that is, in the direction of policies and practices that characterize the public good as embodied in a citizenry that can come together across differences and solve common problems in a democratic sphere” (Oakes et al., 2000, p.569). A civic virtue orientation requires a common understanding and agreed-upon definition of the common, public good.

We recall from Chapter One that the American grand narrative often links civic virtue and democratic values. Oakes and Lipton find that the search for such a common understanding plays itself out in a struggle for social justice, a struggle to care, and a struggle to participate. Inevitably, it also results in resistance from the inside out. “Reminiscent of John Dewey’s thinking about schools, [there is a] strong sense that democratic principles must guide the reform process as well as its ends” (Oakes et al.,

2000), and the democratic approach to such a process is neither easy nor simple. Conflicts around these struggles may even impede genuine participation and are influenced negatively by the larger context of institutions and reform. Fortunately, prominent voices continue to point to the historical roots and contemporary relevance of civic engagement as a desirable outcome in higher education.

History of higher education and civic engagement.

In her commencement address to the University of Michigan's class of 2010, President Dr. Mary Sue Coleman proposed an over-reaching goal of higher education: civic engagement for the strengthening of democracy. She noted that four out of five 2010 University of Michigan graduates participated in service-oriented activities, and observed that "civic engagement is the foundation for a vibrant, prosperous society." She went on to quote President Barak Obama: "service is how we will meet the challenges of our time...answering this call to serve makes us stronger, more productive, and more compassionate" (Coleman, May 2010).

The University of Michigan pioneered research, publication, and promotion of service learning as a modern pedagogy for citizenship education. However, education for civic engagement harkens back to the discipline of rhetoric in ancient Greece, and has remained a constant through the rise of the Medieval universities into Colonial-era and contemporary American higher education. Surveying the history of the Western ideal of citizenship, Derek Heater (2004) observes that the role "requires the capacity for a certain abstraction and sophistication of thought," and "entails a status, a sense of loyalty, the discharge of duties and the enjoyment of rights not primarily in relation to another human being, but in relation to an abstract concept, the state" (p. 2).

The Athenian notion of ἀρετή (“arête”), or “virtue,” nuanced an earlier militaristic Spartan concept toward civil excellence and political wisdom. “But we must not forget,” writes Heater (2002), “the informal means of acquiring understanding of public affairs, through oral tradition, songs and theatre: how much more fun to attend a performance of an Aristophanes play than to learn the rules of rhetoric from a Sophist” (p. 458)! In the fourth century BCE, Aristotle (350 BCE/1984) states in his *Politics* that the “good man” – for, of course, no woman held citizenship in Greek culture – is the one who finds happiness in living a virtuous life. Good citizens, Aristotle reasons, will likewise use their virtue to support the civic endeavor. Although citizens are dissimilar in character or preferences, they share the common goal of the preservation of civic partnership.

Moving forward in history, Heater (2002) notes that the power wielded by the Roman *paterfamilias* dictated that “citizenship education was the responsibility of the family. The father discharged that duty for his sons aged seven to sixteen, female members of the family educating the younger boys and the girls. The core task was to instruct the new generation in ‘the customs of the ancestors’ (*mos maiorum*) and the ancient laws of the Twelve Tables” (p. 458). Republican Rome further separated citizenship from moral development in preference of military heroism on behalf of the state; the extension of this idea into Imperial Rome moved Church father Augustine (354-430 CE) to draw a sharp distinction between the duties of the Roman citizen and the virtues expected of Christians as citizens of the “City of God.” Even so, Augustine (1467/1972) insists that such citizens have as their goal “the attainment of that peace in view in every good action [they perform] in relation to God, and in relation to a neighbor” (p. 878). The development of the classical Western attitude can be summed up

in Augustine's (1467/1972) aphorism: "the life of a city is inevitably a social life" (p. 878).

The rise of universities in early Medieval Europe was accompanied by a rediscovery of these earlier classical writings on citizenship. In Bologna (1088), Paris (c. 1150), Oxford (1167), Palencia (1208), Cambridge (1209), Salamanca (1218), Montpellier (1220), Padua (1222), Naples (1224), and Toulouse (1229), universities provided training in the "seven liberal arts" to "associations of students and teachers with collective legal rights usually guaranteed by charters issued by princes, prelates, or the towns in which they were located" (Colish, 1997, p. 267). While the sciences of the *quadrivium* were also emphasized, it was the *trivium* (grammar, rhetoric, logic) that made possible the transmission of citizenship values. "Aristotle's *Politics* was expounded by the Dominican friars in Italian city-states, notably Florence, so that students and congregations learned about his concept of citizenship," observes Heater (July 2002). "Moreover, when secular teachers replaced clerics, they took the opportunity of informing their pupils about citizenship as practiced in Sparta, Athens and Republican Rome" (p. 460).

Thelin notes in *A History of American Higher Education* that higher education reflects the tenor of its time. In the late 18th and early 19th centuries, innovation and consumerism were its hallmarks (2004). Half a century later, the legislation collectively known as the Morrill Acts emphasized "the teaching of trades as well as the application of scholarship to the practical needs of the community," note Bloom, Hartley, and Rosovsky (2006, p. 294). This philosophy, which "focused academic resources on improving the lives of farmers and citizens across the entire state, came to be known as a

combination of ‘soil and seminar’ [and] exemplified the ideal of the institution of higher learning as a solver of local problems and a servant of the people” (Bloom, Hartley, & Rosovsky, 2006, p. 294).

This historical perspective reminds us that student achievement solely for the sake of individual advancement is insufficient and unsustainable. “Educational benefits cannot be measured solely on the basis of monetary returns to the individual or to society” writes Kern Alexander (1976) in his influential article “The Value of Education.” He purports “education benefits many people other than the student, including the student’s children who receive positive intergenerational transfers of knowledge, neighbors who are affected by favorable social values developed by schooling, and employers who are seeking a trained labor force” (p. 90). The 21st-century higher education described by Mary Sue Coleman builds on this scope of benefit by upholding education for citizenship, which exemplifies the connection between education and work through 1) contributing new ways to educate our workforce, 2) creating jobs to get that done, and 3) utilizing the structures of education to help solve societal issues or to better the American and global standard of living. As Kenny, Simon, Kilye-Brabeck, and Lerner (2002) argue, “the major challenge facing contemporary higher education is to enhance its relevance and connectedness to the issues and problems faced by the broader society—as these problems are defined by community members” (p. 3).

Kenny et al. (2002) further observe that many institutions of higher education have responded to this challenge by “attempting to weave civic engagement into the core educational experiences of students.” They offer several examples of strategies used by

colleges and universities: “service learning, experiential learning, participatory action research experiences, or practicum placements...make student civic engagement and university outreach an integrated part of their educational curricula and a value-added feature of the outreach role of the college or university in the life of its community” (p. 2).

At the root of each of these strategies is the perennial goal of civic engagement. These strategies have become more pronounced within the last two generations of educators. One of the earlier among these is service learning, a term “first coined in 1967, in reference to an internship program that was sponsored by the Southern Regional Education Board” (Kenny & Gallagher., 2002, p. 15). Service-learning is arguably the most promulgated and adopted pedagogy for the educational outcome of civic engagement. Kenny and Gallagher (2002) list several goals of service learning programs: the development of citizenship and preparation of students for participation in an active civic life; the moral and religious development of students; the preparation of students for careers through engagement in real-world activity; and the partnering of the university and the community in ways that enhance both student learning and the intellectual, economic, and social resources of the community (p. 15-16).

Public policy reinforces the need for civic engagement pedagogy and the outcomes it seeks. The National and Community Service Trust Act of 1993 promotes citizenship initiatives through student learning in a way that improves both the student and the community. This legislation defines the term “service learning” in the following way: a method under which students or participants learn and develop through active participation in thoughtfully organized service. This service has the following attributes.

First, it is conducted in, and meets the needs of, a given community. Secondly, the service is coordinated with an elementary school, secondary school, institution of higher education, or community service program, and in cooperation with the community. Finally, the service helps foster civic responsibility. According to the law, the method of service learning has two additional features. It is integrated into, and enhances the academic curriculum of the students, or the educational components of the community service program in which the participants are enrolled. The method also provides structured time for the students or participants to reflect on the service experience (P. Law 103-82, 1993).

The Corporation on National and Community Service (CNCS), created as an independent agency of the United States government by the National and Community Service Trust Act of 1993 provides a widely accepted definition of service learning that includes the following components:

- the need for active participation;
- thoughtful organization;
- the meeting of actual community needs;
- collaboration between school and community;
- integration with the students' academic curriculum;
- structured time for reflection;
- opportunities to use newly acquired skills in real-life situations;
- extension of learning beyond the classroom; and
- the fostering a sense of caring for others (Hallmarks of Effective Service-Learning Programs, 2003).

The mission of the CNCS is to support the American culture of citizenship, service, and responsibility in order “to improve lives, strengthen communities, and foster civic engagement through service and volunteering. The CNCS currently delivers several programs designed to help communities address poverty, the environment, education, and

other areas of unmet human need (The Corporation for National and Community Service, Our mission and guiding principles, para. 1).

One of the more frequently cited definitions of service learning currently in circulation first appeared in a 1996 article by Bringle and Hatcher, who stated,

We view service learning as a credit bearing educational experience in which students participate in an organized service activity that meets identified community needs and reflect on the service activity in such a way as to gain further understanding of the course content, a broader appreciation of the discipline, and an enhanced sense of civic responsibility. Unlike extracurricular voluntary service, service learning is a course based service experience that produces the best outcomes when meaningful service activities are related to course material through reflection activities such as directed writings, small group discussions, and class presentations. Unlike practica and internships, the experiential activity in a service learning course is not necessarily skill based within the context of professional education (p. 222).

These characteristics—credit bearing, organized, meeting identified community needs, reflective, promoting an appreciation of the discipline, enhancing civic responsibility—continue to pervade service learning pedagogy.

Another foundational definition of service learning is offered by Howard (1998). Howard identifies service learning as a counternormative pedagogy, characterized by four essential components. He insists that service learning is primarily a teaching methodology. It is also, according to his definition, an intentional effort to bring together community and campus. It integrates experiential and academic learning in a mutually strengthening manner. In addition, true service learning is relevant to the academic course of study. Zlotkowski (1996) agrees with this focus on learning, and describes it as the work of "socially, morally, and pedagogically concerned academicians" rather than that of "socially and morally concerned activists operating from an academic base" (p. 25).

Eyler and Giles (2001) have documented the academic outcomes of service learning in measurable terms. They summarize their findings on personal, social, learning, and career development outcomes as the result of service learning. The effects they observe are significant and include the following:

- a positive effect on student personal development such as sense of personal efficacy, personal identity, spiritual growth, and moral development;
- a positive effect on interpersonal development and the ability to work well with others, leadership and communication skills;
- a positive effect on reducing stereotypes and facilitating cultural & racial understanding;
- a positive effect on sense of social responsibility and citizenship skills;
- a positive effect on commitment to service;
- a positive impact on students' academic learning by improving students' ability to apply what they have learned in “the real world” and the demonstrated complexity of understanding, problem analysis, critical thinking, and cognitive development;
- contributes to career development and stronger faculty relationships;
- improves student satisfaction with college and thus more likely to graduate; and
- a positive impact on outcomes such as identity development & cultural understanding (Eyler & Giles, 2001).

The meaningful integration into an academic curriculum requires an articulated philosophical base. This places service learning squarely in the middle of one of the most profound tensions in higher education; the tension between professional training and the liberal arts.

Professional education and the liberal arts.

The current debate over the role, the values, and the scope of American education can be analyzed through macro-level tension between professional education and the liberal arts. There is a tension between proponents of focused workforce training and those who defend their fundamental belief that the education of individuals outside the limitation of vocational training is a common good. Unfortunately, this tension is often framed as irreconcilable rather than creative. Service learning is pulled in both directions by this tension. The way in which individuals are educated—through professional or liberal arts pedagogy directly effects civic engagement and mission-mindedness.

Pragmatic programs of study, which lead to employment in practical fields such as education and health care, bring financial benefit to many graduates, their families, their neighborhoods, and employers. Environments where concepts, theories, and abstract thought are welcomed also benefit graduates, their families, their neighborhoods, and employers through the development of critical thinking and expression of humanist values. Each model of education fills a need, and both approaches are important. However, their relationship is most effective when it is symbiotic. Whichever model prevails in a specific learning environment needs to be informed by the other; either model, professional training or the liberal arts, is weakened without the influence of its counterpart. The vision of a university or college is weakened if it is unable to identify—and subsequently balance—its bias toward one or the other.

One goal in the history of higher education in the United States, although elitist in hindsight, was to create an intelligentsia who could participate in a democratic nation. An educated person was defined as someone who could, through polished rhetoric, lead

and transform common culture. Education was envisioned as an experience to encompass the whole person. Altbach (2001) writes that the American university was shaped by a tradition of liberal arts inherited from Europe, such as “the English liberal arts tradition, the German research concept, and the idea of service to the state” (p.15).

In an effort to make higher education accessible to a broader population, focus shifted from the liberal arts—traditionally a refuge of the intelligentsia—to a focus on professional training. “Changes in occupational status in American life placed new demands upon higher education institutions,” Sheridan (1998) notes, and this realigned social hierarchies: “any occupation and any subculture of American life achieved recognition and status when it became deserving of study as a professional and academic science with its distinct theory and intellectual requirements” (pp. 29-30). Freeland (2004) notes that this realignment is perpetually underway. “Slowly, but surely, higher education is evolving a new paradigm for undergraduate study,” he writes, one that “encourages students to include both liberal arts and professional coursework” (p. 142). The new paradigm taking shape, Freeland says, is neither exclusively based in the liberal arts nor oriented toward professional training. Rather, it “is a curricular ‘third way’ that systematically integrates liberal education, professional education, and off-campus experience to produce college graduates who are both well educated and well prepared for the workplace” (2004, p.142).

This integrative approach, Freeland’s “curricular third way,” is particularly appropriate for health care and nursing. “While nursing conceptualizes the person as multi-dimensional with each part having its own unique characteristics, it recognizes that all parts function together as a whole,” write Wilt and Smucker (2001). “Science and

technology are especially limited in answering questions about meaning, value, and existence” (p. 3) and so need to be informed by the liberal arts. Wilt and Smucker conclude that “nursing as a fine art requires nurses to give care with creativity, sensitivity, and intelligence, not just mechanically” (p. 14).

The aforementioned observation of Wilt and Smucker—that all parts of nursing education function as a whole—highlights the fact that the tension between the liberal arts and professional training is, at its root, a creative tension. It is more about forging an integrative relationship than perpetuating an adversarial stance. It provides a “liminal space” for decision-making in higher education instead of a course charted on unexamined assumptions. Schools considering major investments in developmental education, accessibility, funding and finance – addressing, for example, the consumer mentality, student programming, or distance learning – must first have a significant conversation about where they stand on the continuum between professional training and the liberal arts.

Student learning, outcomes, and development.

Civic engagement is a valued, even assumed, outcome of effective higher education. This is confirmed by a multidisciplinary review of the literature pertinent to this study, including the fields of educational social theory, the history of higher education, the foundations of professional and liberal arts education. According to Wiggins and McTigue (2005), once a desired outcome such as civic engagement or mission commitment has been identified, the next step articulated by the Backward Design process is to determine “acceptable evidence” (p. 18) and how that evidence will be assessed.

Such evidence is contingent on discovery of how students develop and learn. Learning, for Piaget (1954), begins with the “accommodation of mental structures to reality [that] implies the existence of assimilatory schemata apart from which any structure would be impossible” (p. 352). Paulo Freire (1998) further states that “to teach is not to transfer knowledge but to create the possibilities for the production or construction of knowledge” (p. 30). Benjamin Bloom (1956), through his foundational taxonomy of cognitive learning, notes that “what we are classifying is the intended behavior of students—the ways in which individuals are to act, think, or feel as the result of participating in some unit of instruction” (p. 12). Wiggins and McTigue (2005) define understanding as “an insight into ideas, people, situations, and processes manifested in various appropriate performances...to make sense of what one knows, to be able to know why it’s so, and to have the ability to use it in various situations and contexts” (p. 353). In other words, effective higher education empowers students to apply life-changing cognitive structures which incline their behaviors in such constructive directions as civic engagement.

New frameworks of knowledge are the outcomes of quality learning programs, outcomes that share the goal of what Howard Gardner calls “education for understanding—a sufficient grasp of concepts, principles, or skills so that one can bring them to bear on new problems and situations, deciding in which ways one's present competencies can suffice and in which ways one may require new skills or knowledge” (as cited in Barr & Tagg, 1995, p. 22). Barr and Tagg (1995) propose that “a college's purpose is to create environments and experiences that bring students to discover and

construct knowledge for themselves...to make students members of communities of learners that make discoveries and solve problems” (p. 13).

Employing learning as a process of community-building is a collective task: “Talent is not something to be found in the few; it is to be developed in the many” (Anderson, 2003, p. 384). Astin (1985) concurs in his talent development model: “the major purpose of any institution of higher education is to develop the talents of its faculty and students to their maximum potential” (p. 16). “True excellence,” Astin concludes, “lies in the institution’s ability to affect its students and faculty favorably, to enhance their intellectual and scholarly development, and to make a positive difference in their lives” (p. 61).

Institutions of higher education are therefore called to “to make value-added contributions to communities, to foster civil society, and to contribute to the holistic education of the person” (Kenny et al., 2002, p. 5). Institutions nurture “the traditional core values of what it means to be an educated person” when they provide contexts for excellent student learning. Such contexts include “the traditional core values of what it means to be an educated person. Having an education may mean (again) being able to translate one’s academic knowledge into information of value to one’s own life and to those of one’s family, community, and society.” (Kenny et al., 2002, p. 7-8).

Excellent student learning contexts are safe places for students to explore, experiment, attempt new things, and realize their full potential – places in which it is possible to experiment, fail, try again, and ultimately succeed. Love and Guthrie (2005) “specifically recognize one of the primary functions of the environment [is] its function to hold securely by confirming and supporting as opposed to keeping or confining” (p.

66). Effective education pays careful attention to the *process* of learning to achieve a quality *outcome*, and the optimal environment employs holistic attention to spiritual, intellectual, and psychological being.

Proper attention to this kind of holistic student development prepares students for academic success, enabling them to realize their potential and mature into civically engaged citizens. Piaget, Kohlberg, and Erikson all write of critical developmental stages in the lives of maturing students, stages that “define the life cycle and involve the formation of new attitudes, skills, and roles, [as] the convergence of social expectations and physiological maturation occurs” (White & Porterfield, 1993, p. 66). “At each stage of development,” writes Piaget, a given student advances so as to become “capable of certain [new] forms of thought, of specific concepts” (Ginsburg & Oppen, 1979, p. 232). This developmental need of students to place themselves in a context increasingly bigger than themselves is a need that pervades the work of scholars such as Marcia Baxter Magolda, Arthur Chickering, Linda Reisser, Patricia King, Ivor Goodson, Norma Adair, Kenneth Melchin, and Alexander Astin.

Baxter Magolda (2000) encourages “inclusive and effective learning environments...in which opportunities for complex cognitive, intrapersonal, and interpersonal development exist for all students” (p. 94). She asserts that there are three dimensions of development: “how we know or decide what to believe, how we view ourselves, and how we construct relationships with others—intertwined to contribute to self-authorship” (2001, p. xix) which she defines as student awareness that they are at once both individuals and members of a community. Therefore, to meet the outcome of civic engagement in professional life—life after college—Baxter Magolda (2001)

suggests framing academic advising and career services to promote self-authorship. This begins with “immersing students in the complexity of various career options...which can be achieved through internships, shadowing professionals, [and] information interviews” (p. 311). Throughout these experiences, she proposes that “students must be challenged to explore their reactions to this information, assess their skills relevant to these roles, and reflect on how their values compare” (p. 311).

Baxter Magolda (2008) conducted a 21-year longitudinal study of young adults age 18-39. Her primary interest in self-authorship is grounded in the work of Robert Kegan and how students “build complex belief systems and a coherent sense of identity” (p. 269). Here is her most recent articulation of the elements of meaning-making in self-authorship.

Trusting the Internal Voice, Building an Internal Foundation, and Securing Internal Commitments...each reflects a distinct focus yet all three are based on the same underlying organizing principle—internally determining one’s beliefs, identity and social relations. The initial element involves developing the internal voice to use in these decisions. The intermediate element involves using the internal voice actively to build one’s internal belief system and solidifying that internal system. The advance element involves refining and strengthening the internal system as it becomes the core of one’s existence (p. 281).

Chickering and Reisser coined the term *vectors* to describe the stages in the process Baxter Magolda (2001) refers to as the “awareness that students are both individuals and members of a community” (p. xix). Chickering and Reisser (2005) describe vectors as “the major highways for journeying toward individuation” (p. 181). These are the developmental tasks and processes young adults must inevitably move through. To make their model organic and accurate, they recorded “student perceptions of their experience” and “excerpts from student self-assessments, short reflections exercises,

and papers...where autobiographical examples were included” (p. 185). Chickering and Reisser’s list of vectors is numbered, and vectors six and seven in the model deal with developing purpose and integrity, the “discovery and refinement of one’s unique way of being and toward communion with other individuals and groups, including the larger national and global society” (p. 181). Vectors six and seven orient learning opportunities toward “clear vocational goals, sustained and rewarding activities, strong interpersonal and family connections, humanizing values, social responsibility, congruence, and responsibility” (p. 183). In short, Baxter Magolda’s work explores how we decide what to believe; Chickering and Reisser describe how the process of decision develops.

Sociologists Goodson and Adair are members of the *Learning Lives* team—a collaborative effort in the United Kingdom between the university of Exeter, the University of Brighton, the University of Leeds and the University of Stirling. According to the group’s website, the main focus of *Learning Lives* is on

the interrelationships between learning, identity and agency in the lifecourse. On the one hand, we seek to understand how identity (including one’s identity as a learner) and agency (the ability to exert control over one’s life) impact upon learning dispositions, practices and achievements. On the other hand, we seek to understand how different forms and practices of learning and different learning achievements impact upon individual identities (including learner identities), on individuals’ senses of agency, and on their actual capacity to exert control over their lives (Teaching and Learning Research Programme, 2008).

Goodson and Adair (2007) describe what they call “primal learners”: individuals whose learning is self-motivated rather than directed by exterior forces; who are naturally inquisitive; and who are compelled by what they can learn in a situation rather than by the immediate rewards the situation might provide. “Primal learning comes from the inside out, rather than the outside in. The commands are not coming from ‘socially

determined scripts' but from a personally generated symbolic construct or life theme," Goodson and Adair write. "The sequence of learning and identity constructions moves then from the personal interior out into the social world." (p. 6) Primal learners enjoy learning for its own sake and are energized by acquiring new skills. One way in which "primal learners" gain insight about themselves is through the work of weaving the interior, exterior and interpersonal together by an ongoing storying or narrative learning. This "pursuit of personal meaning," Goodson and Adair observe, "is evident in nearly all lives. What is different [in primal learners] is the balance and sequence between the personal, the external-social and the interpersonal." (p. 7)

In a similar vein, Patricia King's (2000) Reflective Judgment Model describes the "developmental progression that occurs between childhood and adulthood in the ways people understand the process of knowing and the certainty of knowledge claims and in the corresponding ways that they justify their beliefs" (p.16). King outlines three categories and seven stages of thinking styles in her model. They include *pre-reflective thinking*, in which "knowledge is gained through the word of an authority figure and is absolutely correct" (p.17), *quasi-reflective thinking*, in which one begins to recognize that "knowledge claims contain elements of uncertainty due to missing information or errors in data-gathering methods...but appear confused about how to reach a conclusion" (p.18). Finally, in *reflective thinking*, one comes to "believe knowledge claims must be evaluated in relation to the context in which they were generated to determine their validity; that any claim should be reevaluated in light of new data, new methodologies, and new perspectives on the question; and that they must actively construct their own decisions" (p.19). King's Reflective Judgment Model, writes Baxter Magolda (2000),

“appears to be related to other dimensions of development, including moral reasoning and reasoning about diversity issues” (p. 22).

Moral reasoning is a function of ethical development. In the introduction to his book *Living with Others*, Kenneth Melchin (1998) reflects on the ethical dimension of student development. “Ethical understanding and action have a profound impact, not only on our lives, but on those of others,” Melchin insists; where other aspects of development are more straightforward, “ethics seems to go to the heart of persons in quite a different way” (p. 7). Moreover, Melchin points out that ethical development does not exist in a vacuum. “The objective content of moral knowledge will be shown to be quite real and irreducibly social,” he insists; “the primary concern of ethics is living with other people” (p. 9). As Baxter Magolda (2005) points out, grappling with basic questions of identity in relationship to others—“How do I know?” “Who am I?” “What relationships do I want with others?” (p. 81), as well as the process of meaning-making—underpins much of moral development. The transitions between stages of moral development are times of intense growth, creativity and community building. Students in these transitional times are ripe for conversion.

According to Melchin (1998), conversion (*Metanoia, μετάνοια*) is the “fundamental reorientation of one’s whole life...a process of shifting and expanding our frame of reference or horizons” (p. 30). This radical reordering and shift in worldview rarely occurs as a sudden, dramatic, one-time event. Rather, conversion is a *process*—more spiral in nature than linear. Within the conversion process, one usually experiences various stages or periods of awakening and understanding coming back around to revisit certain periods at new depths as information continues to enter into the process or as

other conversion processes occur simultaneously. Anthony Garascia (1989) names these stages as periods of incongruence, heightened awareness, re-ordering, commitment to lasting consequences, energy, disenchantment, examining and choosing again.

Canadian philosopher and theologian Bernard Lonergan (1992) writes that this fundamental reorientation of life occurs in various areas of development— intellectual, moral, affective, sociopolitical, or religious— and expresses itself on three levels of human knowing: experience, understanding, and judgment. Because each category of conversion impacts the human person, and because the categories “mutually condition” one another, it is somewhat artificial to delineate conversion into types. However, for reasons evident in the topic of this section, the category I will highlight is intellectual conversion.

According to Don Gelpi (1993), intellectual conversion “heals the mind of blindness, rigidity, dogmatism, and prejudice” (p. 193). As a consequence, “intellectual conversion teaches the human mind to think clearly about any reality whatever, including human consciousness itself. Intellectual conversion, therefore, facilitates affective, personal moral, socio-political, and religious conversion by teaching the covert to understand clearly the conditions and consequences of conversion in each of these realms of experiences” (Gelpi, 1998, p. 48). A person who has begun to undergo the experience of intellectual conversion will begin to rethink the moral decision-making process, or at least enter into it more intentionally. Melchin (1998), building on Lonergan’s work, claims there are three levels of moral good, each consisting of dominant values, motives or manner of social participation, limits, and fundamental moral obligations. Optimally, individuals experience movement, tension, and integration between levels.

The aforementioned authors and their theories all point to the significance of understanding how knowledge and values are internalized in student cognitive development. Astin (1997) is even more focused: some of his more historically-based research documents specific types of student involvement within the college environment that can impact social activism. Astin's more recent research, completed with Helen Astin and Jennifer Lindholm (2011), studies spirituality and the inner lives of students.

The regression analysis of Astin's (1997) longitudinal and multi-institutional "National Data Set: 86-90, "Social Activism," is defined by the importance that students assign to four life-goal items: 1. participating in community action programs; 2. helping others in difficulty, 3. influencing social values; 4. influencing the political structure. The data set (freshman survey and follow-up survey), built on the IEO model, consists of 600 + variables including institutional data/characteristics and 4405 cases. Astin's data base is multi-faceted; it takes into account institutional characteristics, curricular measures, faculty environment, the peer group, clusters of environmental measures, measures of student involvement, analyses of environmental effects, intermediate outcomes and then describes the process, response rate, etc. of the survey (pp. 22-23). "Outcome data for the study come from three different sources: the CIRP follow-up questionnaire administered during 1989-90 to samples of students who originally entered college as freshmen in the fall of 1985; retention information on these same students, provided by the registrars of their institutions; and various national testing organizations [SAT, ACT, LSAT, MCAT, NTE] taken by these same students four years later (p. 13).

Astin (1997) based "Measuring Social Activism" on six particular value items from the data set: becoming involved in programs to clean up the environment,

developing a meaningful philosophy of life, helping to promote racial understanding, raising a family, making a theoretical contribution to science, and being very well off financially. “When the student’s outcome performance can be compared with input performance four years earlier, we can develop a measure of *growth* or *change*” (p. 13). The study notes that after completing their undergraduate studies, students became much more interested in involving themselves in programs to clean up the environment and their commitment to developing a meaningful philosophy of life increased. At the same time, their commitment to being very well off financially decreased.

Astin also found a modest increase in students’ commitment to promoting racial understanding. In particular, social activism had a strong positive relationship with student-faculty interactions and student-student interactions. Although neither maturation nor social chance appear to have contributed to the increase in social activism, involvement measures with significant correlations to social activism include: discussing racial or ethnic issues with other students, taking ethnic studies courses, socializing with students from different ethnic or racial groups, attending racial or cultural awareness workshops, participating in campus demonstrations, hours per week spent in volunteer work, and the number of history or writing-skills courses a student takes. It is significant that all of these involve social interaction. It is also significant that measures with a significant negative relationship involve withdrawal from social interaction, such as the number of mathematics courses taken and hours per week watching television.

More recently, Alexander and Helen Astin, along with Jennifer Lindholm (2011), published the results of their current research on “how students change spiritually and religiously during the college years, and to identify ways in which colleges can contribute

to this developmental process” (p. 9). The new research notes an increase in participation in community action programs, which seems to echo their previous findings regarding social activism.

This new data on how college can enhance students’ inner lives was produced through the development and dissemination of a “four-page questionnaire called the College Students’ Beliefs and Values (CSBV) Survey. [The survey was] completed by 3,680 college juniors attending a diverse sample of forty-six baccalaureate colleges and university” (Astin, Astin, & Lindholm, 2011, p. 17). The survey’s measurements included spirituality (spiritual quest, equanimity, ethic of caring, charitable involvement, and ecumenical worldview) and religiousness (religious commitment, religious engagement, religious/social conservatism, religious skepticism, and religious struggle).

In short, the research confirmed what is commonly understood in terms of religious engagement during college—that it declines. However, the study is breaking ground in spirituality among college students. The study found that during college, students’ “spirituality shows substantial growth. Students become more caring, more tolerant, more connected with others, and more actively engaged in a spiritual quest. We have also found that spiritual growth enhances other college outcomes, such as academic performance, psychological well-being, leadership development, and satisfaction with college” (Astin, et al., 2011, p. 10).

Astin, et al. (2011) note that these changes can be attributed to more than just maturation. They claim that the data provides evidence that points “to specific experiences during college that can contribute to students’ spiritual growth. Some of these experiences, such as study abroad, interdisciplinary studies, and service learning,

appear to be effective because they expose students to new and diverse people, cultures, and ideas” (p. 10). Additionally, the data maintains that “spiritual development is also enhanced if students engage in what we refer to as ‘inner work’ through activities such as meditation or self-reflection, or if their professors actively encourage them to explore questions of meaning and purpose” (p. 10). This quantitative research on spirituality and college students is bridging a gap in the current student development literature, even as it supports the earlier conclusions of theorists such as Baxter Magolda, Chickering and Reisser, Goodson and Adair, and King.

In addition to providing access to such experiences, the construction and delivery of curriculum that integrates these earlier findings is also important. Understanding how students learn—about themselves and about the world—will help to support and disseminate curriculum opportunities in ways that will best facilitate developmental learning. Ultimately, this will facilitate the desired outcome of civically engaged graduates.

Narrative learning.

Pedagogical theorists over the past generation have increasingly recognized storytelling, or “narrative,” as a valuable learning tool for students and other adult learners engaged in making sense of their lives. Humans are constantly in the process of making narratives. “We live by stories,” Rita Charon (2002) affirms, “and they’re what give sense to our lives” (p. 3). Storytelling, literature, and narratives are best-practice tools used by caregiving professionals to reflect on the moral life and ethics in their complex field. Narrative is a different epistemology – another way of knowing – distinct from scientific inquiry. “Whatever specialized job you do,” says psychologist Jerome

Bruner of narrative knowledge's place in medicine, "there's some kind of underlying thing that gives a kind of unity and sympathy and possibility for the human condition continuing" (Charon & Montello, 2002, pg. 3). It is narrative that frames human experience and thereby makes it comprehensible.

Anne Hunsaker Hawkins uses literature and drama as part of her work at the Pennsylvania State University College of Medicine. She maintains that plays from classical Greece give guidance for medical ethics and practice. "The moral life cannot be conceived apart from one's relationships with others – a claim that contrasts to modern notions of the self as an isolated unit . . . An individual's 'character' in Greek tragedy is a function of relationships with immediate others" (Charon & Montello, 2002, p. 73). The stories we live by are stories we tell these "immediate others," narratives we present to the listeners in our lives. To use a dramatic analogy, we are the actors; the word "audience" (i.e. our "immediate others") is derived from the Latin verb for listening.

This ongoing human drama is precisely the process of making sense of experience – this, indeed, is a basic premise of the hermeneutic phenomenological method. Cohen, Kahn, and Steeves (2000) insist that people come to an understanding of their lives "by treating them as narratives that are unfolding. In other words, the understanding people have of their world and life situation and the meaning they have made of this is usually contained in the narratives or stories they tell, first to themselves to make sense of their own experience; then to family, friends, and other social actors in their lives; and finally to any social scientists who come asking" (pp. 59-60). Coffey and Atkinson (1996) concur: "As social actors, we are all involved in retelling our experiences and lives. In doing so, we chronicle our lives in terms of a series of events, happenings, influences,

and decisions. Narrative, as autobiography, describes the way in which people articulate how the past is related to the present” (p. 68). This kind of autobiographical narrative, which provides continuity in human experience, will prove valuable in this study.

People articulate this relation through the narrative properties of chronicle, performance, and ethnopoetics, which lend structure to the enterprise. “Time is placed into a personal history, where the past is given meaning in the present,” Coffey and Atkinson write (1996). Social actors make sense of their lives by organizing their experiences through stories. “This chronicling of a life, or part of a life, often starts from a point of ‘how it all happened’ or ‘how I came to be where I am today’” (p. 68). Moreover, such chronicling is universal: “All of us have stories about our careers, as students, or teachers, or parents, or academics” (p. 68). The working life is fundamental material for narrative chronicling.

Coffey and Atkinson (1996) go so far as to speak of narrative in terms of performance – the *ethnopoetics* of everyday life. “Thinking about how stories are performed enables us to think about analysis in terms of how social actors self-present to a public or an audience, and how that presentation is achieved” (p. 76). Ethnopoetics has to do with the beauty of language, the descriptive part of narrative. It is “my” story, “my” people, “my” background, “my” heritage, “my” class, “my” culture. In this way, people generalize their personal scripts into a life theme which often becomes their life work. They proceed to structure their vocational identity around this life theme (Csikszentmihalyi & Beattie, 1979). Baxter Magolda (2008) refers to this in her description of the developmental tasks of building internal voice and internal foundation. Weaving one’s scripts and episodic stories into an evolving narrative is an ongoing task

that asks pertinent framing questions: What is my story about? What is my dream, mission, or purpose? These scripts and episodic stories are shaped by three interdependent forces: externally learned scripts; interior constructions of personal and primal identity work; and interactive and interpersonal encounters (Goodson & Adair, 2007).

The work of weaving the interior, exterior, and interpersonal together is undertaken by an ongoing “storying,” a narrative learning. Baxter Magolda calls this process securing internal commitment; McAdams refers to as “selfing.” To “self,” as a verb, is to apprehend one’s actions, thoughts, feelings and so on as ‘mine’; grasp phenomenal experience as one’s own, as belonging to me; locate the source of the experience as oneself. Selfing therefore engenders feelings of agency (McAdams, 1996, p. 302); the more thoroughly “selfed” we are, the better situated we are to think of ourselves as enabling the dramatic narrative of our own lives. Finding our identity is “an evolving narrative quest,” McAdams writes; “the story is created and revised across the adult years as the changing person and the person’s changing world negotiate niches, places, opportunities, and positions within which the person can live, and live meaningfully” (McAdams, 1994, pp. 306-307). It is this continuously evolving, creative process which, properly channeled, creates personal mastery of professional formation.

Nursing education.

For the present study, let us reframe the contemporary confrontation between the liberal arts and professional education as a creative tension from which nursing pedagogy and professional development can draw energy and focus. Student learning, outcomes, and development benefit from such focus and energy; nursing as a field of study requires,

as in most professions, this kind of attention to both theory and praxis as one learns about the profession's competencies and skill sets, and how these are best delivered and learned. "Expert preparation of nurses...is imperative, for in addition to patient care, nurses conduct research, serve as administrators and educators, sit on trans-disciplinary teams and engage in the ethical dilemmas of health care on a daily basis" (Curry, 2010, p. 25). Civic engagement and mission-mindedness are among the everyday tools of nursing. What must nursing professionals in Catholic health care be predisposed to do, and be able to do, to advance its stated mission?

Nursing is a high-touch vocation. Florence Nightingale (1972), who revolutionized patient care, is credited as saying to her probationers and nurses that "nursing is an art: and if it is to be made an art, it requires an exclusive devotion as hard a preparation, as any painter's or sculptor's work; for what is the having to do with dead canvas or dead marble, compared with having to do with the living body, the temple of God's spirit? It is [. . .]the finest of Fine Arts" (p. xix). Because nursing is centered on health and well-being, it demands high ethical standards. The American Nurses Association's *Nursing Code of Ethics* includes the following tenets:

- The nurse, in all professional relationships, practices with compassion and respect for the inherent dignity, work, and uniqueness of every individual, unrestricted by considerations of social or economic status, personal attributes, or the nature of health problems.
- The nurse's primary commitment is to the patient, whether an individual, family, group, or community.
- The nurse promotes, advocates for, and strives to protect the health, safety, and rights of the patient.
- The nurse is responsible and accountable for individual nursing practice and determines the appropriate delegation of tasks consistent with the nurse's obligation to provide optimum patient care.

- The nurse owes the same duties to self as to others, including the responsibility to preserve integrity and safety, to maintain competence, and to continue personal and professional growth.
- The nurse participates in establishing, maintaining, and improving health care environments and conditions of employment conducive to the provision of quality health care and consistent with the valued of the profession through individual and collective action.
- The nurse participates in the advancement of the profession through contributions to practice, education, administration, and knowledge development.
- The nurse collaborates with other health professionals and the public in promoting community, national, and international efforts to meet health needs.
- The profession of nursing, as represented by associations and their members, is responsible for articulating nursing values, for maintaining the integrity of the profession and its practice, and for shaping social policy (Nursing Code of Ethics, 2001).

Standards of nursing are thus clear and universal. The Joint Commission (2009) dictates that care, treatment, and services are to be provided in a way that respects and fosters dignity, autonomy, positive self regard, civil rights, and involvement of patients. Moreover, a hospital's adherence to ethical care and business practices significantly affects the patient's experience of and response to care, treatment, and services. Finally, patients deserve care, treatment, and services that safeguard their personal dignity and respect their cultural, psychosocial, and spiritual values.

Programs of nursing within institutions of higher education are obliged to give attention to skill and character development, critical thinking, and ethical decision-making. Accreditation guidelines and the mandate of professional board preparation focus this attention through the organization of nursing programs of study. This is especially important in what Panicola, Belde, Slosar, and Repenshek (2007) describe as "the social endeavor of health care and how human people and communities are affected

by medicine, medical technologies, and the decisions we make in health care of various levels...[that] health care is a basic need [that encompasses] physical health and mental well-being...the vulnerability of patients in relation to care givers” (p. 11).

Accrediting bodies require congruence between the mission of an institution and the mission of the specific programs it conducts. The Commission on Collegiate Nursing Education (CCNE) articulates “Standards for Accreditation of Baccalaureate and Graduate Degree Nursing Programs” intended to “hold nursing programs accountable to the community of interest—the nursing profession, consumers, employers, higher education, students and their families, nurse residents—and to one another by ensuring that these programs have mission statements, goals, and outcomes that are appropriate to prepare individuals to fulfill their expected roles” (2008, p. 2). Board-ready student nurses are educated in content areas that include quality and legal ethical issues, leadership and management principles, delegation and prioritization, and resource management. One outcome measure of these knowledge bases is the NCLEX exam. Regulating bodies such as The Joint Commission (an independent organization that evaluates and accredits hospitals), Health Care Acquisition Performance System (HCAPS) reporting, and Centers for Medicare & Medicaid Services (CMS) measure performance with attention to ethical decision making, moral frameworks, and critical thinking.

From the beginning of modern nursing education, Nightingale’s emphasis on approaching the profession as an art rather than collection of skills has been important. The body of literature on nursing skills education and its history reveals a continued

tension between theory and practice, between focus on skill development and cutting-edge technology or on communication and interpersonal skills development.

Nightingale's creative understanding of nurse education as the refinement of practical skills toward the art of taking care of the patient was thrown out of balance during the 1950 and 60's, when "the concept of art in nursing was narrowed down...to motor skills characterized in terms of technique and manipulations, that is strength, reaction time, speed, precision, consideration, and flexibility (Björk, 1999, p. 54). Björk argues that these skills must be expanded to include other dimensions. He states that "skills are shaped by nurses' intentions. Intentions are formed on the basis of procedural knowledge as well as personal knowledge of the patient. Skills are also shaped by knowledge specific to the nursing discipline such as ethical, practical, and theoretical knowledge that directs us in helping beings sustain and promote activities of daily living" (Björk, 1999, p. 57). In this way, the balance is restored, and the tension between art and skill becomes creative rather than combative.

Educating students in the necessary leadership skills, public health knowledge, compassion, and concern toward cultural competencies might better be achieved through a constructivist than through a positivist paradigm. In the past, a positivist approach dominated nursing pedagogy. Newman (2004) describes the positivist paradigm as a "received view" from traditional science, ontological focus on the belief that a definable reality exists and causal relationships can always be objectively identified and verified. On the other hand, constructivism takes a "perceived view" or human science approach, which treats observation as relative, perceptual and interpretive. Conclusions are drawn

from the interaction between the individual and the environment. Constructivist ontology is drawn from multiple views, fostering new insights.

To facilitate this kind of constructivist learning, Carper (1978) introduced a framework consisting of four fundamental patterns of knowing: empirics, aesthetics, personal knowing, and ethics. Through coursework, skills development, and clinical placements, student nurses are introduced to these four patterns and learn to use them as lenses to reflect on their education. Recently, the pedagogy of service learning has surfaced as a means to develop “cultural sensitivity, caring for people in different cultures, learning/knowing more, and the potential impact on practice” (Casey & Murphy, 2008, p. 307). Previously, Poirreir (2001) has noted in his writing that nursing, a service-oriented profession, easily lends itself to collaborating with health care professional in all settings and connecting with individuals, families, and groups in the community. Casey and Murphy (2008) likewise point out that “the central elements of service learning that differentiate it from traditional clinical education include meaningful service, reflection, development of leadership, and reciprocity” (p. 306). As this study suggests, the constructivist model lends itself to a more mission-committed and civically engaged understanding of nursing.

This review of the foundations of higher education literature, study will contextualize education within the framework of social theory. Drawing on the history of higher education and its curricular and theoretical developments, it then will survey higher education’s role in civic engagement and democracy building, student learning, evaluation of outcomes, and theories of student development, and the preparation of practitioners within the discipline of nursing.

The foundation of education leads to this next discussion of the particular industry of Catholic health care and the preparation of its workforce. Catholic health care is uniquely suited to be a case study of how a mission-minded, socially responsible, civically engaged professional translates these values into a workplace environment.

Catholic Health Care

Catholic health care has a unique systemic cultural presence that includes a rich history of care giving, a commitment to excellence, and a high awareness of mission-mindedness. Employees therefore tend to be able to articulate how mission engagement is evidenced through organizational behaviors, career and vocational expectations, employee conduct, actions, and performance.

History tells us, writes Steinfels (2003), that organized Catholic health care began as “a response to the plagues that swept over medieval Europe...where heroic groups of religious men and women risked their lives to provide the victims with some modicum of care...Not only did they minister to the sick and bury the dead when the plague swept their communities; they also founded hospitals...as refuges for society’s outcasts—the indigent, abandoned, helpless, deranged, and dying” (pp. 114-115). This same impetus is found in the early history of Catholic health care in the United States. “Selfless women nursed victims of cholera and yellow fever, cared for soldiers during the Civil War, and brought medical care to the frontier...[where] the common task was tending without stint to the bodily needs and the psychological states of those without family or resources until either change in circumstance, natural recuperative powers, or death itself relieved the situation (Steinfels, 2003, p. 115).

Wilt and Smucker (2001) confirm professional nursing's roots in the time-honored European tradition of Roman Catholic men and women in religious orders "living out their faith by providing both physical care and spiritual comfort to their own and to travelers passing through" (p. 21). They also point out that this tradition has its Protestant parallel: "Much of Florence Nightengale's nursing knowledge and skill came out of her own religious heritage, training at the Deaconess Instititue at Kaiserwerth, Germany, and having an upper-class woman's knowledge of health, healing, and home management" (p. 21). In addition, it is thought that "it was from Irish Sisters of Mercy...that Florence Nightingale, despite her suspicions of their Catholic loyalties, learned important lessons about nursing during the mid-nineteenth-century Crimean War" (Steinfels, 2003, p. 115).

For the church, health and the healing apostolate take on special significance because of the church's long tradition of involvement in this area, and because the church considers health care to be "a basic human right which flows from the sanctity of human life" (National Conference of Catholic Bishops, 1981, para. 3). Over the course of time, the practice of referring to health care as an apostolic work evolved into the conviction that health care is a ministry of the church (Place, 2000). Pope John Paul II (1987), in his address to the leaders in Catholic health care, recognized that the work of health care is not tangential to the Church, but rather an essential ministry. "Your health care ministry, pioneered and developed by congregations of women religious and by congregations of brothers, is one of the most vital apostolates of the ecclesial community and one of the most significant services which the Catholic Church offers to society (para. 1).

This declaration that marks Catholic health care as a ministry of the Church both underscores the importance of Catholic health care and complicates the matter of the authority that guides its direction. In the past, religious orders enjoyed a sense of autonomy over the expression of their specific “charism” or gifts. As an official ministry of the Church, Catholic health care is now answerable to the authority of the bishop of the local church and to the United States Conference of Bishops. Fr. Charles Bouchard, OP (2008) writes that “the use of the term ‘ministry’ to describe Catholic health care began only a short time ago, but it has now become common parlance.” He goes on to say however, that “there are challenges and questions “surrounding the use of ‘ministry’ and the challenges we face if it is to be applied in any meaningful way to Catholic health care” (p. 26). Some of these challenges include lay ministry to corporate ministry, money and ministry, formation for ministry, sponsorship and governance, collaboration, and joint ventures (Bouchard, 2008). One area that Bouchard (2008) points to is the Church’s underdeveloped theology of lay ministry, and thus, an underdeveloped understanding of how an institution can be a ministry. He reminds us of the practice of ‘juridic person’ or ‘moral persons,’ a canonical term that recognizes that organizations that act on behalf of the Church “have the same kinds of responsibilities, accountability and agency as individual persons” (p. 27).

Canons 113-123 in the *Code of Canon Law* explain the statutes concerning “juridic persons.” In particular, Canon 113 §2 states that “In the Church, besides physical persons, there are also juridic persons, that is, subject in canon law of obligations and rights which correspond to their nature” (Canon Law Society of America, 1998, p. 32). Canon 114 §1 and §2 elaborate: “Juridic persons are...ordered for a

purpose which is in keeping with the mission of the Church and which transcends the purpose of the individuals. ..The purposes...are understood as those which pertain to works of piety, of the apostolate, or of charity, whether spiritual or temporal” (Canon Law Society of America, 1998, p. 32). Robert Kennedy (2000), in the *New Commentary of the Code of Canon Law* explains that “A juridic person, on the other hand, is an artificial person, distinct from all natural persons or material goods, constituted by competent ecclesiastical authority for an apostolic purpose with a capacity for continuous existence and with canonical rights and duties like those of a natural person (e.g., to own property, enter into contracts, sue or be sued) conferred upon it by law or by the authority which constitutes it” (p. 155). Kennedy goes on to give examples of juridic entities in the Church: “colleges, universities, hospitals, and other apostolically oriented institutions can also serve as the substrata of juridic persons” (p. 157).

Sponsorship and mission-minded organizational behaviors will be addressed in later sections of this dissertation. It is nonetheless important to stress at the outset that any organization with the agency of a juridic person has a responsibility to oversee the formation of its employees as part of its mandate to help the mission prosper. Church governance of Catholic health care likewise influences the direction of organizational and biomedical ethics, research, and the practice of employed physicians. In practice, these activities are already aligned with the U.S. Bishops’ *Ethical and Religious Directives*. Should a system therefore take on the “juridic person” model, these expectations would change only with the addition of an annual report to Rome. In either case, Catholic health care has a formal accountability, in canonical law, to ecclesiastical authority.

Not all Catholic health care facilities or systems have sought the designation of public juridic persons. However, many systems are in search of different models to sustain the ministries of the Church as the number of women religious continues to decline. In the past, the sponsoring congregations (religious sisters or brothers) of Catholic health systems have held public juridic person status with its attendant responsibility to report annually to the Vatican. This is now changing; systems, rather than their sponsoring organizations, can choose to operate, through bylaws, under both civil law and canon law. Becoming a public juridic person “allows religious and laypeople to better share sponsorship responsible...and [will] help assure that [Catholic] health will be sustained and strengthened over time” (Catholic Health Association, 2011, p. 1). Covenant Health System, based in Massachusetts, was the first Catholic health system to apply for lay public juridic person status (J. Ketterer, personal communication, August 10, 2011). Recently, Ascension Health, the “largest Catholic and nonprofit health system in the U.S. transitioned to a public juridic person sponsorship model” (Catholic Health Association, 2011, p. 1).

Catholic health care continues to flourish in the United States. According to *The Official Catholic Directory*, there are 561 Catholic hospitals serving 86,525,713 patients annually (2010). Not only is Catholic health care strong in terms of the sheer number of institutions and patients served, it is also a leader in health care excellence. In a recent study on the 100 top hospital health systems, a Thompson Reuters survey found that Catholic and other church-owned health systems had significantly better quality performance than investor-owned systems. Catholic health systems are also found to provide significantly higher quality performance to the communities served than secular

non-for-profit health systems (Foster, D., 2010). This assertion is based on the following benchmarks or measures that center on quality of care, efficiency, and consumer satisfaction:

- Risk-adjusted mortality index (in-hospital);
- Risk-adjusted complications index;
- Risk-adjusted patient safety index;
- Core measures mean percent;
- 30-day risk-adjusted mortality rate for heart attack, heart failure, and pneumonia;
- 30-day risk-adjusted Readmission rate for heart for heart attack, heart failure, and pneumonia;
- Severity-adjusted average length of stay;
- Hospital Consumer Assessment of Healthcare Providers and Systems (HCAPS); and
- score of patient rating of overall hospital performance (Foster, 2010, p. 4)

Such a reputation of excellent patient care might be reason enough to draw well-trained, committed, civically engaged, and mission minded health care professionals into becoming providers within Catholic health care. However, as Porter (2000) notes in his article “The Essence of Catholic Health Care,” characteristics of Catholic health care also provide meaningful and professionally satisfying places of employment. Some of the characteristics of Catholic identity that Porter describes include adhering to the Gospel values set forth in Catholic social teaching, bringing spirituality to healing, demonstrating respect for the person, focusing on the common good, providing for the most needy, collaborating, stewardship, serving as instruments of God’s work in the healing ministry

and the willingness to take risks, to act as an agent of change within society and within the ministry.

Porter (2000) states that these characteristics “set us apart from the for-profit sector. Their primary responsibility is to the shareholder; ours, on the other hand, is to the community” (p. 17). He goes on to write that “by definition, our [Catholic health care] work is a call to serve. Ask your coworkers about what drew them to their jobs. They sought more than a paycheck; they want to care, they want to serve, they want to help people” (p. 20). However, putting this desire to serve into action is proving complicated in the 21st century. At the same time that a willing workforce desires to deliver care aligned with the characteristics of Catholic health care, mission integration—instilling mission mindedness—is becoming more difficult. Fewer and fewer people are connected with and invested in the religious institutions that have traditionally sponsored Catholic health care—that is, fewer and fewer employees are women religious or have been educated within Catholic school systems. Catholic education and employee socialization no longer go hand in hand.

When employees were sisters or graduates of Catholic schools, administrators could assume familiarity with, if not belief in, the Catholic faith teachings and lessons promoted in Catholic intuitions such as those put forth both by Porter and by the Catholic Health Association:

- providing compassionate, high-quality care for bodies, minds and spirits;
- promoting health and well-being for all persons and communities;
- paying special attention to those who are poor, underserved and most vulnerable;

- acting to end poverty, injustice and discrimination ;
- using our resources responsibly; and
- acting in harmony with the Catholic Church. (Catholic Health Association, Mission, 2009).

The impetus behind these teachings is to produce a mission-mindedness, or at least a mission-consciousness, that can no longer be taken for granted as part of an individual's prior life experience. The resulting gap must therefore be compensated for by other means. These means might be family, other religious or spiritual educational experiences, or collegiate experience.

In the course of the 20th century, college experience became disengaged from particular religious beliefs and practices, but has always had a strong philosophical basis regarding the purposes of citizenship, democracy, and the improvement of society. At the same time that Catholic health care is experiencing a decline in an intentionally Catholic-culture-educated workforce, emergent pedagogies such as “service learning” have surfaced. It therefore makes sense to examine college experience and its implications for preparing a socially engaged or mission minded workforce.

Continuation of mission and sponsorship.

The future of Catholic health care depends on mobilizing willing and prepared health care professionals. This entails the mutual discovery of methods that call forth the gifts of aspiring professionals, especially those gifts that resonate with the core commitments of Catholic identity. In the last few centuries, the question of who would continue the mission of Catholic health care was not on the horizon. No thought was given to the possibility that the workforce, which was largely comprised of religious

sisters and Catholic nurses trained in Catholic schools of nursing, was not sustainable. As the number of sisters began to decline, strategic placement of the “few but mighty” remaining sisters helped to ensure that the mission of Catholic health care remained vital through board membership and other senior leadership positions. In recent years, however, it has become apparent that this merely forestalled an inevitable decline.

In his article “The Essence of Catholic Healthcare,” Porter (2000) offers a summary of the issues concerning mission and identity: “The questions we face together are, How can we create an organization that in every dimension of its activities embodies the core commitments of Catholic health care? How do we capture the power that resides within our people and collaborate with each other so that our collective efforts transform our community?” If we were to create a vision of an organization, a community that fully lived these commitments, what would it look like? What would it feel like to work there? To receive service there? To collaborate with it? What do we need to do to make that vision a reality? How can we build systems and processes that compel us to challenge and transform our world?

These questions lead to a discussion of the history of sponsorship and the growth of new models of sponsorship. While most writing that addresses questions of Catholic sponsorship has dealt with higher education, the same issues apply to health care. From the beginnings of both health care and higher education in the United States, many hospitals, colleges, and universities have been sponsored by, or affiliated with, religious institutions. Some of the earliest of these institutions have chosen the path of secularization or are, at most, associated in name only with their founding congregations. However, a large number of the early hospitals, colleges, and universities, as well as

many of those founded in the nineteenth and twentieth centuries, continue to be governed by, or at least connected with, sponsoring religious organizations. Presidencies, trustee membership, finances, community services, and curricula perpetuate these ties. The sponsored hospitals, colleges, and universities, and the religious congregations that sponsor them, face the same dilemma: dwindling numbers within the sponsoring congregations, and the desire to continue delivery of mission-based health care and education.

Questions arise as to how the sponsor-relationship can best be continued. There are almost as many models of sponsorship as there are sponsored institutions. One way to assess the viability of various models or frameworks of sponsorship includes identifying the core motivations, biases, strengths, and weaknesses of the given approach. Both sponsor and institution must communicate clearly to determine the direction in which they wish to head. In this context, it is important to define sponsorship, mission and charism.

Sponsorship can be interpreted and implemented in an array of relationships. Melanie DiPietro, in *Catholic Women's Colleges in America* (as quoted in Morey, 2002) describes it as “an unofficial but commonly used term referring to the overarching roles, responsibilities, and influence of congregations in independently incorporated institutional ministries” (p. 292). In the case of hospitals, colleges, and universities, sponsorship can be expressed through mission and vision statements, presence, community services, curriculum, governance, and financial relationship. Holtschneider is more specific still: “The sponsorship relationship in [experienced] in three ways: through the influence of the members of the congregation present at the [institution], through the

congregation's structural governance control, and through the commingling of resources" (Holtschneider and Morey, 2000, p. 3).

Mission can have a religious or secular connotation depending on the structure of the organization. A mission statement tells outsiders 'who we are,' and guides the actions and decisions of those within. "An institution's public statements of mission and vision should reflect its particular history, context, and realities" (Diamond, 2002, p.17). Although straightforward in a singular institution, this identifying statement can become more complex when the characteristics of both the sponsored institution and the sponsoring congregation need to be included. These characteristics are sometimes referred to as *charisms* (from the Greek for "gift," the particular expression of purpose in terms of a group's identity). As described earlier, due to shrinking numbers of members within the sponsoring institutions, there is a need to change and/or redefine the sponsor relationship. In light of how to best nurture and sustain the role of mission integration through governance and administrative structures, Melanie Morey (2005) offers four approaches to sponsorship from the perspective of the sponsoring institution: preservation, reclamation, adaptation, and liberation. Although these approaches are based in the reality of Catholic colleges and universities, they are applicable to other sponsored situations such as Catholic health care.

In a *preservation* approach, the sponsoring congregation is in power and there is a reliance on the congregation by the hospital, college, or university. Assets of this approach include the visibility of the sponsoring community and continuity in terms of knowledge of history, charism, and identity. Liabilities include a paternalistic leadership style and a lack of opportunity for evolving lay leadership. Although preservation

provides stability in changing times, this approach resists change, tends to keep things as they are, confuses stagnation with stability and is many times motivated by fear and a sense of loss (Morey, 2005, p.7).

Reclamation, in contrast to preservation, redistributes and reinvigorates authority. Although it may encourage a revitalization of congregational involvement and interest, reclamation may turn out to be an “ill-conceived attempt to compensate for waning influence” (Morey, 2005, p. 8). Reclamation is rooted in the charism of the sponsoring congregation, but it tends to be a project-based, departmentalized mission approach. Although concrete and focused, reclamation tends not to infuse mission into the life and culture of the sponsored institution.

A third model, *adaptation*, is “attentive to changing circumstances and makes ongoing adjustments” (Morey, 2005, p.10). An adaptation model takes a path different from either preservation or reclamation. If keeping the sponsorship ties is a goal, this more flexible approach is strategically wise. However, Morey (2005) points out, adaptation can also backfire; the confusion of the sponsoring institution can be made manifest in an “overly reactive response to real or imagined shifts and pressures” (p. 10)

The three approaches described above all assume an ongoing relationship between the sponsor and the sponsored. If it is determined that, for the good and growth of the sponsored institution, the relationship should be severed, a fourth approach, *liberation*, approach allows for mission responsibility to be passed to a new entity. This can be a “practical step to codify [an] existing reality,” but only if it is a “mutually agreed upon strategic response” (Morey, 2005, p. 12). Otherwise, liberation might be perceived as abandonment.

From the perspective of the sponsored institution, there is a multitude of methods designed to promote the values and mission of the sponsoring body. For example, some institutions self-identify as “the” Catholic, “the” Christian Reformed, “the” Baptist, “the” Methodist, or “the” Seventh Day Adventist hospital or hospital system. Their board members, presidents, key leaders, and workforce might heavily lean toward denominational membership. These institutions might act as monitors, enforcers of orthodoxy, and producers of leaders in their traditions. Yet they must, in order to submit to the intellectual tradition, provide forums for discussion to help educate employees and leaders who do not espouse the specific tradition of their employing institution. Acculturation must be intentional if such employees are to learn how to live with the tension of the sometimes gray areas in the context of the organization.

On the other end of the spectrum, are institutions that broadly interpret their mission and work to include everyone (i.e.: James Joyce’s here come the Catholics, here comes everyone). Their work is marked by a humanistic, positive, “for the good of the world” approach in which hospitality, justice, common good, and the option-for-the-poor abound. These institutions, by loosening the bonds of relationship with the sponsoring group, may risk mission ambiguity.

Thelin (2004) has observed that, in the past, denominational beliefs were often more important to an institution’s founders and factions than was mere institutional survival (pp. 61-62). It is a premise of this study that the very survival of Catholic health care, along with its sponsoring institutions, depends on its willingness to invest in determining exactly what it is, what it wants to be, and how it plans to get there. This will entail intensive self-assessment as well as difficult and honest conversations among the

institutions, sponsors, and Church leadership. Although there is no litmus test to check for “right sponsorship,” promising places to begin might include benchmarking budget expenditures, business initiatives, and behavioral standards to identity and values, hiring, mentoring, and retention for mission.

In order to research and evaluate the effectiveness of the sponsor relationship, it is necessary to determine the areas of focus (goals and objectives), characteristic activities, key allies, and challenges. One way to clarify relevant issues would be to ask and answer crucial questions. What are we trying to accomplish when we are trying to inculcate a “Catholic culture?” Who or What should be the target of our efforts? What type of professional do we wish to hire and retain? Who is charged with mission? Who needs to be enlisted to help these efforts? What will these people need from us to be successful? What are the obstacles and how will we get around them? How will we structure accountability? The answers to these questions will help articulate the vision, motivate the personnel, and give momentum to the sponsorship discussion.

Engaging a diverse workforce.

Catholic health care expects its Catholic employees to understand, support, participate in, and contribute to its ministry and mission. By the same token, non-Catholic employees in Catholic health care are expected to perform at a level of support, participation, and ministry/mission contribution appropriate to their relationship to Catholicism, yet still deeply enough invested for mission success. This expectation is the result of premises derived from the global mission of the church; from the role of reason and natural law in Catholic thought; from the conviction that dialogue with the modern

world is fruitful and necessary; and from the recognition that health care is a basic human need, and therefore a necessary mission of the Church.

The Second Vatican Council document *Gaudium et Spes* (1965) opens with the title “Solidarity of the Church with the Whole Human Family.” The gathered community of the Catholic Church much be responsive to the surrounding world: “Nothing that is genuinely human fails to find an echo in their hearts” (no. 1). The document addresses “not only the daughters and sons of the church...but the whole of humanity as well. The world which the council has in mind is the world of women and men, the entire human family seen in its total environment” (nos. 2). Although Catholicism regards Catholic health care as a ministry of the Church, that care is not exclusive: it provides excellent care and an excellent work environment to patients and staffs of all backgrounds. The Church universal does not discriminate among various sects of Christianity in its responsibility to serve others and address social concerns.

Because the Church shares these problems, it is experiencing the same clash among paradigms as its surrounding culture. As an institution, the Church tends to work out of a model of hierarchy, bureaucracy, and legalism. However, the Vatican II documents point to the fact that the present age is increasingly pluralistic, dialogic, and ecumenical. There is thus a tension between Vatican II theory and institutional praxis. Gaillardetz (2006) notes that the work of the council was grounded less in a common theology of the church than in a shared commitment to seek ecclesial reform and renewal. However, there were at least two responses or two impulses to this shared commitment. “One is captured by the French term *ressourcement*, a ‘return to the sources.’ This term referred to a commitment to recover the theological vision of the early church that had

been eclipsed by the static neo-scholastic view dominant on the eve of the council...The second impulse for renewal is captured in the Italian word *aggiornamento*, which can be translated as ‘bring up to date.’ The work of *aggiornamento* demanded a policy of active and respectful engagement with the world out of a confident expectation that the hand of God was at work in the world” (p.xvii). These two responses, although both valid in and of themselves, can contribute in perpetuating the underlying tension of how one “conceives the role of innovation and discontinuity in the preservation of the living tradition of the Church” (Rush, 2004, p.25). Gaillardetz (2006) maintains that Ormond Rush “has provided the most balanced hermeneutical framework to date for interpreting council documents, one which avoids a false absolutizing of either continuity or discontinuity” (p.xvi). When the historical and theological stances of the Catholic church are balanced they synergize *both* a return to biblical and patristic sources *and* a contemporary reading of the “signs of the times.” Out of this synergy of *resourcement* and *aggiornamento*, Catholicism can reclaim the root meaning of the word catholic: universal. In the mission of the Catholic Church, the improvement of the human condition, anyone can participate; a diverse workforce can contribute.

This Catholic appeal to universality grows out of the theological relationship between natural law and reason exemplified by the work of Thomas Aquinas (1225-1274/1963). “The rule and measure of human acts is the reason, which is the first principle of human acts,” writes Aquinas (I-II, Q.90, A.I; see also Porter, 1999, pp. 85-98). This view, later expanded in the 1870 Vatican I document *Dei Filius* (1990, no. 7), presumes that moral impulses are shared by Catholics and non-Catholics alike – that “the Christian revelation contains in its moral teaching no substantial element over and above

what is accessible to human reason without such revelation” (Mahoney, 1987, p. 107). All humans have the innate capacity to reason, and the resulting moral good through right reasoning allows for mutuality among persons of all traditions and provides a basis for collaboration (Gaudium et Spes, 1996, no. 16). As all humans can reason, even people who do not follow Catholic doctrine can still reason together.

This voice of reason also recognizes that health care is a basic and universal right. Pope John XXIII (date), in his encyclical *Pacem In Terris*, points to the human rights of “life...bodily integrity, and...the means which are suitable for the proper development of life; these are primarily food, clothing, shelter, rest, medical care, and finally the necessary social services” (no. 11). In the *Ethical and Religious Directives for Catholic Health Care Services*, The United States Bishops (2009) concur, “Catholic health care ministry is rooted in a commitment to promote and defend human dignity...the first right of the human person, the right to life, entails a right to the means for the proper development of life, such as adequate health care” (p. 8). The complexity of health care demands that knowledge and resources be obtained from a broad, and therefore rich and informative, spectrum of participants. *Gaudium et Spes* recognizes the value of collaboration. The Church, declares the document, “profits from the experience of past ages, from the progress of the sciences, and from the riches hidden in various cultures, through which greater light is thrown on human nature and new avenues to truth are opened up.”

Nowadays when things change so rapidly and thought patterns differ so widely, the church needs to step up this exchange by calling upon the help of people who are living in the world, who are expert in its organizations and its forms of training, and who

understand its mentality, in the case of believers and non believers alike. “Whoever contributes to the development of the human community on the level of family, culture, economic and social life, and national and international politics, according to the plan of God, is also contributing in no small way to the community of the church insofar as it depends on things outside itself” (Gaudium et Spes, 1996, no. 44). John Courtney Murray, SJ (1966), concurs that, if Catholics are to arrive at new truths about God, they will have to do so in conversation on a footing of equality with non-Catholics and atheists.

This pressing need for such an egalitarian conversation was recognized during the Second Vatican Council in 1965. The document on Interreligious Dialogue *Nostra Aetate* insists that the “church rejects nothing of what is true and holy” in other religions; “the Church, therefore, urges its sons and daughters to enter with prudence and charity into discussion and collaboration with members of other religions” (Nostra Aetate, 1996, no. 2).

To provide the best patient care possible, it is therefore not only legitimate and appropriate but essential to draw all committed employees – not just Catholic employees – into an understanding, respectful, and supportive participation in creating and sustaining the character and mission of Catholic health care.

Mission-minded behaviors and characteristics.

The healthcare industry is one of the few growing industries in the United States. As the “Baby Boomer” generation reaches critical mass, in ever-greater need of healthcare services, insurance reimbursement levels continue to plummet; technology costs multiply as rapidly as technological advances, and the complexity of the healthcare

industry increases. Organizations with a mandate rooted in historical mission are challenged to meet these changing demands. As described earlier, Catholic health care offers excellent, mission-based services. However, in order to continue to deliver these services in a way that differentiates it from other healthcare providers, it is vital to build on Thoreau's (1993) idea that conscientious people make for a "corporation with a conscience"; it is paramount to engage mission-minded associates. Just as vital is the mandate that the culture of the organization likewise exhibit the stated desired mission-minded behaviors.

These sentiments are echoed in Charles Bouchard's (2008) challenge: if Catholic health care is designated as a ministry—that is, if it is to have the same kinds of responsibilities, accountability, and agency as individual persons—the organization should give attention to the formation of its members (employees) so as to help the mission prosper (p. 27). From a systems perspective, a health care business strategy must include providing quality services coupled with the responsible management of resources.

Human capital is the most precious of these resources. A strategic approach to human resources assures an organization's success through the productive and efficient management of work design and hiring. Conversely, human resources should also advocate for the interests of employees in matters of compensation, recognition, and reward. The best interests of both the organization and the individual are brought together when a wide range of opportunities and activities are used to advance the abilities and careers of personnel, which in turn serve to improve the organization. An industry's literature conventionally gives attention to formation of board-level and senior

leadership. However, substantial formation of frontline clinicians—those employees who are the face of Catholic health care, those most publically expected to exhibit mission behaviors and characteristics—are only recently becoming the topic of discussion and writing.

An organization with a strong commitment to its mission faces the enormous task of ensuring that a tremendously diverse, multi-level workforce is well-informed and committed to the core values that are expressed in its mission statement. In a health care organization, which operates around the clock, it is crucial to keep all staff members connected to assure that their work is aligned to explicit goals in order to maintain the integrity of the organization. In creating policies and designing regulations in concert with core values, organizations must be committed to the development of a diverse work force that benefits from the assurances of just wages, benefits, and working conditions.

Hiring for organizational fit, as explained by Brian O'Toole (2006), is an absolute imperative. "New hires in Catholic health care...are assessed not only for their skills and 'job fit' but also for their personal values and integrity, their ways of making decisions, and their personal character (as revealed by their general behavior), all of which must be taken into consideration in assessments of 'organizational fit' (p. 36). This entails, at the most basic level, hiring a skilled workforce that encompasses the breadth and depth of subspecialists combined with a facility for new technologies – most recently, those such as tomo-radiation, robotic-enhanced surgery, electronic health recording, an affinity for operational excellence, and the patient-centered service as derived from such experts as Quint Studer. This forms a solid base for quality care, which must then be a catalyst for organizations committed to the crucial next step—hiring for mission. "Both medicine and

nursing are beginning to recognize that health and healing involve more than science can tell us and that the value of our technology may have limits. Science and technology are especially limited in answering questions about meaning, value, and existence” (Wilt and Smucker, 2001, p. 3).

These areas concerned with common human experience are made manifest in Catholic health care through a commitment to bioethics, community benefit, advocacy, charity care, community outreach, healthcare education, and disease prevention and management. The *Ethical and Religious Directives for Health Care Services* state:

Catholic health care should distinguish itself by service to and advocacy for those people whose social condition puts them at the margins of our society and makes them particularly vulnerable to discrimination: the poor; the uninsured and the underinsured; children and the unborn; single parents; the elderly; those with incurable diseases and chemical dependencies; racial minorities; immigrants and refugees. In particular, the person with mental or physical disabilities, regardless of the cause or severity, must be treated as a unique person of incomparable worth, with the same right to life and to adequate health care as all other persons (National Conference of Catholic Bishops, 2009, p. 4).

The ongoing development of the talents and skills of “people who are vital to transforming care delivery through excellence” (Catholic Health Partners, p. 2, 2005) is a commitment that needs to coexist with hiring practices. In an interview with employees of the Sisters of Mercy Health System in St. Louis, the mission department, in collaboration with human resources, has attempted to create hiring screens to assess through behavioral and values-based interviewing, potential for fit, training and organizational development opportunities, spirituality in the workplace initiatives, and accountability checks that undergird the service standards reflected in their mission (Jones, J. & Ballard, L., January 18, 2010, Personal communication). The Alexian Brothers Medical Center in Elk Grove, Illinois, has created a performance evaluation that

has as the base, the core values of the institution (Prunty, 2007). Most Catholic health care systems articulate core values that encompass such values as compassion, service, justice, excellence, stewardship, care of the poor, human dignity, sacredness of life or some manifestation of these. The stated values and mission set the standards for the hiring, formation, and retention of mission-minded employees.

As noted, Catholic health care has a unique, systemic cultural presence that includes a rich history of care giving, a commitment to excellence, and a high awareness of mission-mindedness. Employees therefore tend to be able to articulate mission engagement and identify it in organizational behaviors, career and vocational expectations, employee conduct, actions, and performance.

Retention of these civically engaged and mission-committed employees is significant. One area reviewed for Magnet status—those hospitals which, according to the American Nurses Association Credentialing Center, satisfy a set of criteria designed to measure the strength and quality of their nursing—is indication of workforce resilience. A Magnet hospital is stated to be one “where nursing delivers excellent patient outcomes, where nurses have a high level of job satisfaction, and where there is a low staff nurse turnover rate and appropriate grievance resolution. Magnet status is also said to indicate nursing involvement in data collection and decision-making in patient care delivery” (The Center for Nursing Advocacy, 2008). The wealth of experience made possible by the retention of high- and middle-performing employees creates stability in the midst of a rapidly changing industry.

This type of professional commitment speaks to the foundational role of nursing in advocacy and the active support of patient rights, patient choices, interests, values,

patient/human flourishing, accountability in terms of professional, patient, societal, colleague, and employer relationships, cooperation and a movement toward common good through participation with others, reciprocity, and collaborative engagement, and a caring: relationality through presence, respect, empathy, and relating.

Conclusion

The above thematic review of the relevant literature for my study guides the ongoing development of my research to identify what college-related activities and undergraduate experiences contribute to the formation of mission-mindedness in nursing professionals working within Catholic health care institutions. My overall thinking about this research has been informed and broadened by expert voices. Although I found a richness of resources in each area of the literature review, there is a gap in the literature regarding mission commitment formation in front-line Catholic healthcare nurses.

Therefore, I have used the major themes and contributions from the reviewed body of knowledge as the foundation to my research approach. Significant concepts that build this foundation include the Backward Design process; examining the social role of higher education (including the history of higher education and its curricular and theoretical developments, higher education's role in civic engagement and democracy building, student learning, evaluation of outcomes, theories of student development, narrative, and the preparation of practitioners within the discipline of nursing); and comprehending the culture of Catholic health care, its drive to continue its mission through sponsorship models, the reality of diversity within its workforce, and the preparation of mission-minded behaviors and characteristics of its workforce. These insights will help me to articulate how a mission-minded, socially responsible, civically

engaged professional translates these values into a workplace environment. In particular, these insights will help me to understand the origins of mission-mindedness, the subject of this study.

Chapter Three

Methodology

In order to tie together the worlds of higher education and healthcare, to see how the curricular features of the former contribute to the enactment of the latter, this study's original purpose was to explore the hypothesis that curricular and co-curricular aspects of the college experience can lead to the development of mission-minded, socially responsible, civically engaged professionals. As the research progressed, the participant narratives broadened the perspective of the study. The purpose, then, became to identify, through narrative, how Catholic health care nurses understand their personal development of mission commitment with a specific focus on the way in which life experiences—familial, collegiate, and professional—have enhanced or driven their mission formation. Access to these understandings was best gained through narrative analysis.

The following discussion of the project's strategy, genre, and rationale establishes the relevance of the research question and the approach that best answered it. A description of the research site and participants will follow, as well as an explanation of the criteria that determined participant selection. The discussion will include an explanation of the researcher's role, the importance of this role as a primary research tool, and the ethical considerations that accompany the role. Attention is given to the details of data collection, management, and analysis that guided the research process and ensured the continuity and integrity of the data. Finally, the discussion addresses the trustworthiness of the findings and the accountability of the researcher.

Strategy, Genre, and Rationale

As discussed in Chapters One and Two, Backward Design is a model for research in education and curriculum development that begins with the end in mind. Any given research question can have many legitimate answers. Accordingly, although employee behaviors might correspond to a list of desired mission-based behavioral outcomes, mission commitment will naturally manifest differently in different people. Because “investigators do not have direct access to another’s experience” (Riessman, 1993, p. 8), the task of this research is to understand the formative experience, the narrative behind *how* and *why* a given employee either presents or self-identifies as mission-committed. In other words, in the employee’s understanding, what were the formative factors that led to the behaviors that correspond with the institution’s list of mission-based behaviors?

Qualitative methodology, in the form of narrative analysis, is the best vehicle for this research. It reflects my own interest in human motivation for service. I am intrigued, as Marshall and Rossman (2006) write in *Designing Qualitative Research*, “by the complexity of social interactions expressed in daily life and by the meanings that participants themselves attribute to these interactions” (p. 2). The questions and answers generated in this study are “grounded in the lived experiences of people” (p. 2), in the storied lives of Catholic health care nurses who are identified as front-line, baccalaureate prepared, and mission-committed. The study relates the rich “meaning-making” of these Catholic health care employees as they tell their stories.

Cohen, Kahn, & Steeves (2000) state that a “driving force of human consciousness is to make sense of experience” (p. 59). Narrative analysis, an approach to interpreting qualitative data, preserves the meaning that participants ascribe to their experiences by examining the stories

they tell, rather than chopping their experiences into thematically-identified pieces. “Individuals construct past events and actions in personal narratives, observes Riessman (1993), “to claim identities and to construct lives” (p. 2). Narrative research is, then, the most appropriate methodology to address the questions posed by this study because narrative research uses individual stories and the evaluation offered by the narrators as the raw material for the data.

Mission commitment—a desired result of education, in this study— is largely intuitive and can therefore be difficult to articulate. This is where Backward Design is most useful, because employees are the best authorities on the origins of their own formation: they relate the experiences that provided fertile ground for formation toward mission commitment. Their stories identify the faith, family, professional, and undergraduate learning experiences that promoted this formation, and suggest which learning experiences will be most helpful for future students. Once identified, these learning experiences can be planned, created, and funded, with the goal of producing behavioral outcomes to serve as acceptable evidence of mission-mindedness. To measure this evidence, the design model also makes use of consensus definitions from various constituencies, including senior leadership, managers, employees, and patients. Organizational and human resource standards also articulate this measurement.

Research Site and Participants

Through personal interviews that draw upon lived experience (personal background, educational experiences, and current context), I explored critical influences in the mission-committed behaviors of 13 front-line, baccalaureate prepared, and mission-committed Catholic health care nurses. The study identified patterns of influence regarding the personal backgrounds (faith and family), experiences in

undergraduate education, and current work environments among front-line Catholic health care employees who have been identified as mission-committed. The participants also related their understanding of mission, vocational call, interconnectedness with others, and service.

Site selection and access.

This research is not a case study of any particular institution, or of Catholic health care at large. Even so, Catholic health care is an ideal vantage point from which to observe how a mission-minded, socially responsible, civically engaged professional transmits these values in a workplace environment. Catholic health care has a unique systemic cultural presence that includes a rich history of care giving, a commitment to excellence, and a high awareness of mission-mindedness. Employees therefore tend to be able to articulate how mission engagement is evidenced through organizational behaviors, career and vocational expectations, employee conduct, actions, and performance. More importantly, facility with mission language and understanding allow Catholic health care employees to focus on their experience of service, mission, and engagement.

The particular site for this research was a regional system of Catholic health care located in four Midwestern states. The system, the largest in its region, consists of three divisions. The system's 38,388 associates make it the fourth largest employer in its primary state and with \$348.2 million in community services benefits annually, it is the number one provider of Medicaid services in its primary state. With 34 hospitals and 14 long-term care facilities, this system is the eighth largest non-profit health care system in

United States. When ranked by revenue, 4.17 billion dollars, it is the seventh largest Catholic health care system (M. Shay, personal communication, November 22, 2010).

Access to the site was granted by the system's Senior Vice President of Mission as well as the regional Vice Presidents of Mission for individual systems and/or hospitals within the larger system. In addition to completing the mandatory Institutional Review Board (IRB) processes of the University of Toledo and The Sisters of Mercy (my home system), the IRB process of each institution within the system was followed. All regions waived their rights to further review, giving rights to review and monitor to either to the Sisters of Mercy IRB or the IRB of the University of Toledo.

Participant selection.

"Once the general problem has been identified," advises Merriam (1998), "the task becomes to select the unit of analysis, the sample" (p. 60). The sample in this study is comprised of 13 individuals identified as mission-minded, Catholic health care nursing professionals from one regional Catholic health care system. This method of selection was quite deliberate; per Cohen, Kahn, & Steeves (2000), random sampling is not in keeping with qualitative research methods and is not a reliable method of gaining in-depth information (p. 50). Merriam (1998) augments this insight: "sample selection in qualitative research is usually (but not always) nonrandom, purposeful, and small, as opposed to the larger, more random sampling of quantitative research" (p. 8). Thus, in this study, purposive sampling methods identified participants from diverse institutions, e.g. acute care settings such as trauma hospitals and community hospitals, diverse faith backgrounds, as well as a deliberate cross-section of graduates from institutions of higher

education who meet the stated criteria: front-line, baccalaureate prepared, and mission-committed.

Because “how you select your sample is directly linked to the questions you ask, and to how you have constructed the problem of your study” (Merriam, 1998, p. 2), the target population or sample included front-line, baccalaureate-prepared, acute-care Catholic health care nurses who were identified through award selection as mission-committed. One criterion of selection is historical: it is only within the last twenty years that civic engagement has established pedagogies that are overt, recognized, and purposefully planned (e.g. service learning). Therefore, participants in the research sample will have graduated from college with a bachelor’s degree sometime between 1989 and the present. Additionally, because part of my argument is that non-Catholic employees can advance the mission of Catholic health care, six of the participants are from denominational backgrounds other than Catholic and eight participants earned baccalaureate degrees from non-Catholic institutions of higher education.

Participants described as “front-line” included staff-level nursing professionals of various clinical ladder levels and experience, as well as such varied nursing specialties as intensive care, medical-surgical, telemetry, behavioral, and pediatrics. “Baccalaureate-prepared” nurses are likely to have experienced a broad range of undergraduate experiences, participated in coursework that developed both practical skills and an attitude toward caring for others, and many times point to a vocational call or desire to be of service. Additionally, the field of nursing is undergoing a culture change because the role of the nurse continues to become more complex. It is recognized that nurses are key

in the delivery of quality health care and there is some discussion on just what educational degree level best prepares future nursing professionals for this work.

In the past, most registered nurses were either diploma certified or associate degreed nurses. However, according to two seminal studies often referred to by hospitals designated as Magnet hospitals (those hospitals that according to the American Nurses Association Credentialing Center satisfy a set of criteria designed to measure the strength and quality of their nursing), the effect of nursing practice environments—including educational preparation of registered nurses—has a favorable impact on patient outcomes and achieving high quality of care (see Aikens, L. H, S. P. Clarke, D. M. Sloane, E. T. Lake & T. Cheney, May 2008 and C. R. Friese, E. T. Lake, L. H. Aiken, J. H. Silber, & J. Sochalski, August 2008). The educational level associated with favorable outcomes is that of baccalaureate preparation. At any rate, these practicing professionals can tell us something about their experiences in higher education and their development of mission-mindedness within the discipline of health care education, which can then be translated back into the more general higher education goal of educating for citizenship.

Mission commitment was determined through a system-wide list of employees recognized for mission and service excellence. Utilizing the Backward Design process of identifying desired characteristics and outcomes (in this case mission-mindedness), one determinant that distinguishes an employee as mission-committed is recognition by senior leadership, management, physicians, patients, and other employees through mission and service awards.

I began to identify subjects by obtaining the system publication that highlights the names and brief biographical statement of the regional front-line, acute-care nurses who

were nominated for the Excellence in Mission Award. This particular award, according to the *2007 Clinical Quality and Patient Care and Business Innovation Awards Brochure* is “a powerful indicator of an organization’s culture is what it affirms and celebrates. The basic bond that holds together the multiple community partners that make up [the system] is a common mission. That mission is and should be the driving force within the day-to-day operations of each...organization... [The] Excellence in Mission Award recognizes an individual whose performance in his or her work is a particularly evident reflection of [the organization’s] mission [and core values]” (Catholic Health Care Partners, 2007, p. 4). Because there were limited numbers of bachelor-prepared nurses within this category, I then needed to look to regional and divisional nominations of mission awards from such programs as *Keys to Excellence*, *Cameos of Caring*, and *Mission and Community Outreach Awards*. This again allowed for participants who were publically recognized by multiple constituencies for behaviors consistent with the system’s mission, core values, and standards of behavior. Because the names of these nurses are public record, there was no potential breach of confidentiality.

Again, this method did not surface enough participants with baccalaureate degrees to offer a necessary balance between Catholic and non-Catholic nurses. Therefore I asked those identified as possible participants to use networking or “snowballing” methods to gain names of other mission-minded co-workers. “Snowball, chain, or network sampling is perhaps the most common form of purposeful sampling. This strategy involves asking each participant or group of participants to refer you to other participants” (Merriam, 1998, p. 63). I then checked these names with managers and human resources to create a multi-faceted nomination process.

I contacted each potential participant by phone to discuss the goals of my research and to confirm their willingness to participate. I then emailed them a lay summary and letter of consent and ask them to complete a short demographic survey (see Appendix A) so that a match to the criteria can be made (i.e. front-line, baccalaureate-prepared, with a degree conferred after 1989). In this survey, I asked whether or not they would be open to participating further in the research through face-to-face interviews. Finally, I verified the background of each nurse to see if he or she met the criteria, per Merriam (1998): “The criteria you establish for purposeful sampling directly reflect the purpose of the study and guide in the identification of information-rich cases” (p. 62).

Although absolute confidentiality is precluded by the public nature of the awards process, I kept confidential the list of who was actually contacted and who chose to participate. Participants had the option to use pseudonyms to protect their identity. Because “most people who agree to be interviewed enjoy sharing their knowledge, opinions, or experiences” (Merriam, 1998, p. 214), I was not surprised to find that those identified to participate in this research readily gave their consent.

Researcher's role and ethical considerations.

In the field of health care, the “Health Insurance Portability and Accountability Act (HIPAA) of 1996 (P.L.104-191), provides federal protections for personal health information held by covered entities and gives patients an array of rights with respect to that information. This protection gives health care workers a concrete understanding of protecting the private information of others which can easily be translated into the realm of ethical research. With specific regard to Catholic health care, the United States Bishop’s (2009) document entitled *The Ethical and Religious Directives* states the

professional-patient relationship is mutual in nature. “A person in need of health care and the professional health care provider who accepts that person as a patient enter into a relationship that requires, among other things, mutual respect, trust, honesty, and appropriate confidentiality. The resulting free exchange of information must avoid manipulation, intimidation, or condescension” (p. 18). The relationship between researcher and participant requires the same free exchange. In both instances, effective care is made possible through mutual relationships that allow both parties to participate in identified processes, both in healing and in research.

“Because the primary instrument in qualitative research is human,” states Merriam (1998), “all observations and analyses are filtered through that human being’s world view, values, and perspective” (p. 22). Transparency requires me, as the researcher, to name my social location and any biases or subjectivities I may bring to the project. I am a higher education researcher, teacher, faith-based health care industry manager, service-learning proponent and participant, and mission-minded employee; the topic of civically engaged and mission-minded professionals chose me more than I chose it. My work as an educator, campus minister, and coordinator of service learning has given me vital firsthand experience. I have witnessed young adults learning how to engage with the world, with their communities, and with their chosen profession for the good of others. I have also witnessed them learning to make connections between their social concern, theories on how to manifest it, and the real-world complexities of its impact. As a mission-minded employee and an employee charged with mission infusion, I interact with employees on a daily basis and am in awe of their level of commitment to mission and civic engagement.

As a researcher, I believed that the subjectivities listed above placed me in a fortunate position to investigate collegiate experiences that enhance the formation of civically engaged and mission committed Catholic health care nurses in a sensitive, comprehensive, and relevant manner. At the same time, I recognized the need to employ meta-cognition strategies to ensure that my perspective did not unduly influence my study—that I was aware of my own preconceived notions, that I chose participants properly, and that I proceeded professionally in the collection, analysis, and dissemination of my data. One way I ensured that I was not projecting my own subjective understanding onto the research was through the examination of every narrative that was told (although not all are presented in the body of the dissertation) in order to avoid picking only those that match my preconceived ideas. In actuality, most of the narratives deviated from my hypotheses that curricular and co-curricular experiences were primary in forming mission commitment. Another was to triangulate my understanding of the narratives with that of the narrative and with that of my advisor.

I had, and continue to have, support from the system I accessed. Hope has been expressed that my findings might provide insight into the formative experiences that encourage mission commitment. There is, however, no pressure from the system to publish my findings or to put forth any insights other than what the research shows, and so this project is free from conflicts of interest. Additionally there is no expectation that I share data from particular participants with supervisors, vice presidents, or others.

The underlying research concept of educating for citizenship demands an adherence to the research principles of “mutual respect, of noncoercion and nonmanipulation, and of support for democratic values and institutions” (House, 1990, p. 158). I presented my research goals and

objectives at the start of the conversation with each participant. I assured participants through the lay summary and the letter of consent that they were not required, in any way, to participate in the research as a condition of their award status and/or employment status. And, once they agreed to participate, they could opt out at any time.

Narrative analysis is all about understanding the world view of the narrator. “The key philosophical assumption . . . upon which all types of qualitative research are based, is the view that reality is constructed by individuals interacting with their social worlds. Qualitative researchers *are interested in understanding the meaning people have constructed*, that is, how they make sense of their world and the experiences they have in the world” (Merriam, 1998, p. 6). As participants share their experiences, their narratives, it is essential that the research honor and respect that which is disclosed. Merriam (1998) reminds us that for those who conduct qualitative research, it is essential for the researcher to demonstrate a tolerance of ambiguity, sensitivity, and good communication. In all interactions, I acted with the knowledge that “qualitative researchers are guests in the private spaces of the world. Their manners should be good and their code of ethics strict” (Stake, 1994, p. 244). I was careful, therefore, to create a safe and hospitable environment for the participant interviews.

Data Collection, Management, and Analysis

Now it is critical to explore the manner in which the data were collected, managed, and analyzed. “There is simply no ethical alternative to being as non-biased, accurate, honest as is humanly possible in all phases of research. In planning, conducting, analyzing, and reporting his [*sic*] work, the scientist should strive for accuracy” (Diener, E. & Crandall, R., 1978, p. 164).

Data collection.

As stated earlier, the primary unit of analysis consists of discrete/separate narratives from individuals identified as mission-minded. Once the participant pool was established, I conducted prearranged individual interviews with identified participants. Because I was working to understand the subject's formative experiences, the narrative behind *how* and *why* someone presents as mission-committed, I focused on the narratives participants shared with me during the interview process. "We interview people to find out from them those things we cannot directly observe," writes Patton (1990); "We cannot observe feelings, thoughts, and intentions. We cannot observe behaviors that took place at some previous point in time. We cannot observe situations that preclude the presence of an observer. We cannot observe how people have organized the world and the meanings they attach to what goes on in the world. We have to ask people questions about those things. The purpose of interviewing, then, is to allow us to enter into the other person's perspective" (p. 196).

I included the following elements within the interview process as suggested by Taylor and Bogdan (1984):

1. the investigator's motives and intentions, and the inquiry's purpose
2. the protection of respondents through the choice to use a pseudonym
3. decided who has final say over the study's content
4. payment (if any)
5. logistics with regard to time, place, number of interviews to be scheduled (pp. 87-88)

Because it was important that participants understood the process they were entering into, the above elements were expressed in various forms including during the inquiry phone call, within the letter of consent, and at the introduction of the first formal interview. The interview process could be considered “semi-structured”: an interview process in which the questions are “more flexibly worded, or the interview is a mix of more or less structured questions” (Merriam, 1998, p. 74). Questions and discussion starters for interviews began at a general level and move toward the specific—following the parallel between narrative structure and interview questions offered by Coffey and Atkinson (1996) as included in Appendix B.

I audio-taped each interview and took notes. After each interview, I documented observations and reflections through more descriptive notes on behavior (both verbal and non-verbal), recorded insights, formulated follow-up questions, and began to draw connections among common ideas. The data analyzed thus consisted of a verbatim transcription (completed by a trained transcriptionist) of each recorded interview as well as drafts of the descriptive notes I gathered. I reviewed each transcription at least twice, listening to the audio-recording while reading the transcript, to ensure accuracy.

Data management.

Ethical handling, storage, and review of collected data is a priority. Because “qualitative research is not a linear, step-by-step process” (Merriam, 1998, p. 151), planning how the data were organized aided in the accuracy and cleanliness of data as well as the protection of identifying information. The sample size in a qualitative study tends to be small, yet the depth of data collected will merit what social scientists call “thick observation.” The sheer amount of information on each participant and his or her

narrative will, when analyzed using the Labov model, yielded a great deal of information. Therefore, I designated one binder section per participant for the collection of data. Each section included copies of the verbatim transcription of the interview, using the participant's choice of name, interview notes and descriptive notes (again with participant's choice of name), structural analysis notes, other materials the participant submitted, and the audio tapes of the actual interviews. This binder is stored in my library with my educational books and materials. I kept a separate binder locked in my file cabinet that included all identifying documents and information. This includes the list of award winners, letters of consent, introductory survey with contact information as well as choice of name to be used in the study, list of dates contacted and agreements to when and where the interviews took place, and a code list for specific sites and place names.

Data analysis.

To analyze the collected data, I used the structural framework first outlined by Labov and Waletzky (1967, pp. 32-39) and further articulated by Labov (1972, pp. 363-370):

1. Abstract
2. Orientation
3. Complicating action
4. Evaluation
5. Result or resolution
6. Coda

It is important to note that the above structure was abstracted by Labov from a particular genre and corpus of stories (third grade fight stories; Labov, 1972). Thus, narratives collected by other researchers, such as the collection of adult divorce narratives by Riessman (1989) or nurses' career and education narratives as analyzed here, may or may not have similar structures. According to Coffey and Atkinson (1996), the interest is in "how the identification of such structural units can help us think about our data, in order to facilitate...analysis (p. 58). They develop this argument by using the structures to identify how people tell stories the way that they do: how they give the events they recount shape; how they make a point; how they "package" the narrated events and their reactions to them, and how they articulate their narratives with the audience or audiences that hear them (p. 58). The structure of the stories of mission development proved to follow rather closely to Labov's; thus his structure provided a useful starting point.

In discussing different approaches to narrative analysis, Riessman (1993) writes about the work of Susan Bell, a sociologist who studied the narratives of DES daughters. "Bell revealed a logic that links the stories, how when analyzed together the stories show individuals changing their consciousness" (p. 34). She goes on to state "the purpose is to see how respondents in interviews impose order on the flow of experience to make sense of events and actions in their lives. [Narrative analysis] examines the informant's story and analyzes how it is put together, the linguistic and cultural resources it draws on, and how it persuades a listener of authenticity. Analysis in narrative studies opens up the forms of telling about experience, not simply the content to which language refers. We ask, why was the story told *that way*" (p. 2)? There is a reason stories are told in a particular way—the way in which the narrator's perspective has shaped *this* version of

the story, *this* change in consciousness. In this study, there is a reason why nurse participants told their stories of becoming mission committed. This is precisely what I wanted to discover.

Another variation of narrative structure is that of compound narratives. Hamer (1999) writes that individuals engage in storytelling to mediate “between their private and public spheres, i.e., reconciling their personal beliefs and experiences with their professional responsibilities (p. 365). She continues, “more interesting than identifying simple genres [or narratives] is examining how complex genres [or narratives] are created in performance. When a person performs a story she or he uses primary generic forms i.e., known stories and known types of stories, as building blocks in order to construct a new, complex story... One genre provides context for, and therefore shapes the meaning of, another genre” (p. 366). This combining of discrete narratives into a complex narrative occurred in the nurses’ narratives. Similarly, Bloom (1998) draws on theorist Jean Paul Sartre’s forward-backward method of reading through an individual’s corpus of narratives to allow one narrative to inform understanding of another.

In the narratives presented, many include more than one narrative block. These blocks then, are told as a pair. These pairs can be read against or off each other and tend to enrich each other’s meaning. “If we can continue to think of these stories as having certain structural properties...[and that] social actors tell their story with a purpose” (Coffey and Atkinson, 1996, p. 67), Labov’s framework, as well as the work of Coffey and Atkinson, Riessman, Bell, Bloom, and Hamer will provide, in the words of Cohen et al. (2000), “a conduit to closing the loop between the research question and raw findings/answers and the task of relaying the researcher’s present understanding and

interpretation of the data to all other readers” (p. 71). This, along with an opportunity for participants to check the accuracy of my analysis, allowed me to find commonalities among the narratives and, in Taylor and Bodgan’s (1984) words, to undercover “categories or themes that capture a recurring pattern that cuts across ‘the preponderance of the data’ (p. 139).

Analytical stages and use of conventions.

There were three stages of analysis in the work on the narratives. First, as I began a closer analysis of the narratives, I listened again to the interviews, both to ensure accuracy in the verbatim transcriptions and to begin to identify the narratives within the interview. I highlighted areas, blocks, key insights on the verbatim transcriptions in order to identify the separate narratives told within a single interview. Then, following the processes, stages, and influences of mission-commitment that surfaced while examining the transcripts, I engaged in a structural analysis of those elements for all the narratives in each transcript. I found it helpful in this level of analysis to put these elements into a table format for further review and analysis. These tables were then shared with participants for feedback around accuracy and the choice to exclude information shared in the interviewing process. Third, I compared the parts of the narrative and analyzed how they worked together. That is, for example, I considered how the orientation of the narrative (the who, where and when) related to the complications (what happened), by which means I determined whether it was familial, collegiate, or professional experiences that were having the impact on mission formation. Similarly, the evaluation (so what?) within a narrative was of paramount importance because it was there that the narrator summed up what the impact had been on her/his mission formation. In all, I analyzed the

65 narratives found within the 13 transcripts (narratives within each transcript ranged from three to seven). Included in Chapter Four are exemplars of this closer structural analysis. The remaining narrative tables are found in Appendices E, F, G, H, and I.

I put in place a few transcription and analytic conventions in order to present the narratives as powerfully in print as they were in person. These conventions included the use of pseudonyms for persons, institutions, and locales recounted in the narratives, standardization of grammar, and the addition or deletion of information in service of clarity.

Another example of an analytic convention I implemented pertained to grammar. In general, people do not use perfect grammar when speaking. Because the interviews were recorded and listened to in an oral/aural format, incorrect grammar was not noticeable to either speaker or listener: examination of any oral communication will reveal that no one speaks in the Standard American English that is taught in schools. However, when writing, most people who have been educated through dominant culture institutions use the standard grammar which they were taught. This issue surfaced when I shared the structural blocks with participants in order to check accuracy. Many participants asked if they could ‘polish’ up their responses. Thus, I decided that when transcribing from spoken word to written word, I would maintain the quality of the communication by doing some editing, particularly in the case where grammatical mistakes proved to be distracting. Edited words are marked with brackets.

Finally, there are some challenges in representing oral speech in printed form. For example, what is clear in the spoken word is sometimes unclear when translated into the written word. When meaning seemed ambiguous in the verbatim transcript, I added

information that I was privy to, having been present at the interview, in brackets for clarification. Additionally, as I presented the narratives for analysis in the structural element format, I deleted extraneous phrases and sentences where the narrator digressed from the narrative, perhaps distracted by something happening in the room or a phone call. I also deleted questions that I, as the interviewer asked, in order to maintain the flow of the narrator's speech, although I was mindful that sometimes my question(s) did in fact provide the abstract of the narrative, i.e., what the narrative was about ("How would you define mission-commitment" for instance set up the narrative that was told in answer as being about the definition of mission-commitment. Usually the participant would not repeat, "This is a story about mission-commitment," but that abstract was understood in the context of the interview.) These omissions are indicated either by a gap in the line numbering or by the use of ellipses.

These conventions were put in place so that the data presented in this dissertation best represent the intentions of the participants. These issues of interpreting and representing the data lead into the discussion of how accurate and how trustworthy the conclusions are.

Trustworthiness

As with any research, standards of quality legitimize a study. In quantitative research, reliability and validity are the frameworks used to establish quality. Qualitative researchers prefer to "argue for use of words such as trustworthiness and accuracy to convey these ideas...[such as] quality" (Cohen, Kahn, & Steeves, 2000, p. 12). Most qualitative researchers agree that if "qualitative studies cannot consistently produce valid [or trustworthy and accurate] results, then policies, programs, or predictions based on

these studies cannot be relied on” (Maxwell, 1992, p. 279). One of the goals of this research project is to determine best practices and policies for both higher education and Catholic health care. These best practices and policies are only going to be as useful as my narrative analysis is accurate.

Bringberg and McGrath (1985) point out that “validity is not a commodity that can be purchased with techniques...rather, validity is like integrity, character, and quality, to be assessed relative to purposes and circumstances” (p. 13). The purpose of undertaking research is to best understand an experience or certain set of experiences and/or observations. Validity, trustworthiness, and accuracy are all tied to the fullest and richest understanding of “an account...in its relationship to those things that it is intended to be an account of” (Maxwell, 1992, p. 281). Maxwell (1992), in his article “Understanding and Validity in Qualitative Research” describes five broad categories of understanding that are relevant to qualitative research, three of which I will focus on: descriptive, interpretative, and theoretical.

According to Maxwell (1992), in narrative analysis, descriptive validity has to do with the “factual accuracy of their account” (p. 285); or rather the understanding that the narratives shared and observations noted are “valid descriptions of the physical objects, events, and behaviors in the settings” studied (p. 288). The procedures of interviewing are further impacted by both the researcher and the participant and there is much discussion among qualitative researchers regarding issues of memory, meaning making and truth telling when sharing ones’ experiences. Atkinson, Coffey, and Delamont (2003) remind researchers that “the encounter...becomes a collaborative act of mutual identity construction...[that] through these discursive acts, the participants can create

public selves, characters, moral categories, and varieties of experience” (p. 112). The interviews for this study were collaborative acts of exactly this kind. The participants described in detail their mission formation—with its characters, moral categories, and varieties of experience—and how it shaped the public performance of their nursing.

Interpretative validity is concerned with whether or not the researcher is obtaining (collecting) and representing the participant’s interpretation of the data. The use of narrative analysis and the identification of the participant’s evaluation permits the primary interpretation of what the narrative was about to be that of the participant, not the researcher’s interpretation. Maxwell (1992) asks of the researcher, “is there mutuality in “what these objects, events, and behaviors mean to the people engaged in and with them” and, “Has the researcher ensured the rigor necessary to interpret authentically that which has been shared and understood by the participant (p. 288)? Interpretive validity in this study begins with my choice to present the participants’ actual words, in narratives, so that the meaning intended by the narrator is transparent to the reader. After several levels of analysis (going over the narratives time and again) rooted in Labov’s model, I sent each participant the structural analysis of his or her narrative. I asked each participant to review the structural analysis of their narratives. I received no objections and some clarifying comments. Those who did respond, confirmed the interpretive validity of their respective narrative—that I had actually heard, perceived, or inferred, what the narrator intended.

And finally, theoretical validity “explicitly addresses the theoretical constructions that the researcher brings to, or develops during, the study and the [reasonableness] of the postulated relationship among the concepts” (Maxwell, 1992, p. 291). That is, the

theories and ideas I bring to the study, such as mission-commitment and backward design, allow for a valid claim that the events recounted and the narratives told relate to the outcome of mission-committedness. According to Maxwell, there are two types of theoretical validity: one is whether or Merriam (1998) postulates that “data collection and analysis is a *simultaneous* activity in qualitative research” (p. 151). Thus, she reminds the researcher and the reader that “emerging insights, hunches, and tentative hypotheses direct the next phase of data collection, which in turn leads to the refinement or reformulation of questions, and so on. It is an interactive process throughout that allows the investigator to produce believable and trustworthy findings” (p. 151).

Maxwell (1992) concludes his discussion on validity by stating that “the applicability of the concept of validity does not depend on the existence of some absolute truth or reality to which an account can be compared, but only on the fact that there exist ways of assessing accounts that do not depend entirely on features of the account itself, but in some way relate to those things that the account claims to be about” (p. 283).

To ensure the legitimacy of this particular research study and to account for claims of accuracy and trustworthiness, the intent and methods of the study will attend to Maxwell’s (1992) categories of understanding—including the five broad categories of understanding descriptive, interpretative, and theoretical.

Again, this narrative analysis research study seeks to understand, through narrative, how Catholic health care nurses understand their personal development of mission commitment and addresses the following question: What college-related activities and undergraduate experiences, as well as what faith, family, and professional experiences, contribute to the formation of mission-mindedness in nurses working within

Catholic health care institutions. The formulation of this project's methodology, including the project's strategy, genre and rationale, a description of the research site and explanation of the criteria that determine participant selection, a discussion of the researcher's role and the ethical considerations that accompany the role, as well as attention to the details of data collection, management, and analysis and an accountability toward the accuracy and trustworthiness of the findings have grounded the integrity of the research and the research process.

Chapter Four

Analysis

This study seeks to understand, through narrative analysis, how Catholic health care nurses understand their personal development of mission commitment. A specific focus is the way in which life experiences—familial, collegiate, and professional—have enhanced or driven their mission formation. The study’s original purpose was to explore the hypothesis that curricular and co-curricular aspects of the college experience that can lead to the development of mission-minded, socially responsible, civically engaged professionals. However, during the course of this research, as I interviewed the 13 Catholic health care nurses who met the participant selection criteria outlined in Chapter Three, this purpose shifted. I learned from the participants that collegiate experiences, although important, has less impact than family and professional experiences on their mission commitment. The purpose of the study as it evolved, therefore widened to include various facets of experience: family, faith, collegiate, and professional. The participants themselves identified such elements as formative in the development of their mission commitment.

The 13 participants explored their personal understandings of mission commitment and how it developed in their lives through a variety of experiences and individual motivations. The study analyzes these core narratives through the lens of the Labov model: abstract, orientation, complication, evaluation, resolution, and coda (see Appendix C). Coffey and Atkinson (1996) explain that “Labov developed a sociolinguistic approach to narratives and stories [whereby] narratives have formal, structural properties in relation to their social function. These formal structured

properties have recurrent patterns that can be identified and used to interpret each segment of narrative” (p. 57). In Riessman’s words, the core narratives “provide a skeleton plot, a generalizable structure” that can be used “to compare the plots of individuals who share a common life event” (1993, pp. 60-61). By comparing the plots of narrated accounts of life events that shaped mission-commitment, the researcher has a structured method for identifying the individuals, points in life, and settings (announced in the orientation), the key events or activities (told in the complication), the meaning in terms of mission-formation (the evaluation), and perhaps ongoing effects (the resolution) that mission-committed individuals recall as key to their mission formation. Once identified and compared, these elements can inform the kinds of life experiences that higher education provides for undergraduates through service learning and other pedagogies, and the kinds of life experiences mission-committed institutions might look for in their potential employees.

Participant Demographics

As outlined in the methodology section, the sample in this study is comprised of 13 individuals identified as mission-minded, Catholic health care nursing professionals from one regional Catholic health care system. They come from diverse, acute care institutions, including trauma hospitals, critical access hospitals, teaching hospitals, and community hospitals. The participants’ faith backgrounds, although all Christian, are denominationally diverse. Additionally, participants represent a deliberate cross-section of graduates from institutions of higher education. All met the stated criteria: front-line, baccalaureate prepared, and mission-committed.

The 13 participants, three males and 10 females, ranged in age from 25 years to 61 years with a mean age of 38 years. The average year of baccalaureate degree completion was 2001. One participant graduated from a private institution of higher education, five graduated from public institutions, and seven completed baccalaureate degrees from faith-based institutions. Additionally, one participant completed a Master's degree in nursing and one is in process of completing a Master's program in nursing. Three participants work in small critical access hospitals, six work in larger community hospitals, and four work in teaching and level I trauma centers. Among the participants, specialties ranged from cardiac and critical care to renal care, from oncology to general medical surgical, and from neurology to behavioral and intensive care. Additionally, all participants self-identify as Christian; seven claim a Catholic faith tradition; one identifies as a Methodist; one is a member of the Christian Missionary Alliance church; one is a member of the Church of Christ; two describe themselves as Christian Non-Denominational; and one identifies as "non-practicing" (see Table C1 in Appendix C).

Analysis

Examining the orientation, complication, evaluation, and resolution of a narrative provides a structural foundation to study how each participant became mission-minded, or rather, how each participant understands the development of his or her mission-mindedness. "Narrative analysis," writes Bell, "shows how structure, content, and interpretation are interwoven" (1999, p. 348). It is especially important "to avoid the tendency to read a narrative simply for content, and the equally dangerous tendency to read it as evidence for a prior theory," Riessman (1993) states and then suggests,

Beginning with the structure of the narrative: How is it organized? Why does an informant develop her tale this way in conversation with this listener? To the

fullest extent possible...start from the inside, from the meanings encoded in the form of the talk, and expand outward, identifying, for example, underlying propositions that make the talk sensible, including what is taken for granted by speaker and listener. The strategy privileges the teller's experience, but interpretation cannot be avoided. Individuals' narratives are situated in particular interactions but also in social, cultural, and intuitional discourses, which must be brought to bear to interpret them (p. 61).

Of primary interest in this study was the nurses' understanding of mission commitment and how they came to be that way. Richardson (1990) reminds us that as social actors, we are all involved in retelling our experiences and lives. The task of this study, then, is to interpret the meaning of this "common life event" (Riessman, 1993, p. 60)—mission commitment—by observing how participants structured their narratives in order to make sense of their experiences.

Each participant responded to a common set of questions regarding their mission-commitment (see Appendix B). Maria, Terri, Lyn, Kristi, Bob, Sarah, Craig, Rich, Kim, Rose, Amanda, Ann, and Jackie (the names participants chose to have used in this study) each related their stories, describing the salient points of their motivations for doing the work they do, including how they started, why they started, and what keeps them going. Their accounts of their development into mission-minded nurses provided a rich reservoir of experiences in which to search for commonalities. "We chronicle our lives in terms of a series of events, happenings, influences, and decisions. Narrative, as autobiography, describes the way in which people articulate how the past is related to the present" (Coffey & Atkinson, 1996, p. 68). The search for commonalities within the group of narratives required a focus on the narratives as the units of analysis rather than the individual nurses. Thus, in the analyses that follow, narratives have been analyzed in terms of the parts of a narrative: the orientation, complication, evaluation, and resolution

given the research question: “How do familial, collegiate, and professional experiences enhance the formation of mission-committed Catholic health care nurses?”

I will walk the reader through each structural element of the featured narratives: abstract, orientation, complication, evaluation, and resolution. In the analysis, I am interested in the evaluation, or rather the words that reveal the attitude of the narrator and emphasize the importance of the narrative units. “This or that contributed to my commitment,” or “To me, this or that was a model of mission-mindedness.” Equally important is the complication section: What exactly was the nature of the experience that led to this commitment? What was the context of the experiences, barriers, and encounters that led to this commitment? In short, what happened? Finally, since I am interested particularly with collegiate experiences that contribute to mission-mindedness, I will give attention to the orientation, the given circumstances of situation in terms of person(s), place, and time: Was the experience curricular or co-curricular in nature? Was the setting a Catholic, public, or other faith-based institution? Were the key players faculty, peers, staff, outsiders? If the experience happened outside of the collegiate setting, are there ways that the experience can be translated into the collegiate experience in a meaningful way?

The following arrangement of narrative and analysis flows from several close reads of the verbatim transcriptions. During these first perusals, various experiences, processes, stages, and influences of mission-commitment surfaced: mission-commitment, being a nurse, familial influences, collegiate experiences, and civic engagement and the public face of nursing. As I began to examine the transcripts through a process of the structural analysis of Labov’s elements (orientation, complication, evaluation, and

resolution), I found it helpful to arrange these elements into a table format for deeper review. Once in the table format, it became clear that several of the narratives were actually comprised of more than one narrative block. As described in Chapter Three, the reality of compound narratives that are either parallel in nature or can be read against or off each other tend to enrich each other's meaning and point to the complexity of storytelling.

Identifying narrative segments for analysis is a slow and painstaking process. Sometimes a segment is clear cut; the participant signals that a story is coming and indicates when it is over with entrance and exit talk. At other times, segments are less clearly delineated, and there seems to be a negotiation between teller and listener about placement and relevance. These can be analyzed with transcriptions that include paralinguistic utterances (“uhms”), false starts, interruptions, and other subtle features of interaction. Deciding which segments to analyze and putting boundaries around them is an interpretive decision, framed in this study by my theoretical interests. Deciding beginnings and endings of narratives is often a complex interpretive task that requires attention to subtlety, nuances of speech, the organization of a response, relations between researcher and subject, and social and historical contexts. Narrative analysis is not suitable for investigators who seek an easy and unobstructed view of subjects' lives, as the necessary analytic detail may seem excessive to those who view language as a transparent medium (Riessman, 2000).

In the sections below, I have included samples of the structural analysis of each narrative (the remainder of the narrative tables are found in Appendices E, F, G, H, and I). I chose the sample narratives likely to be of most use and interest to the educator who

is trying to create curricular and pedagogical experiences that lead to mission-mindedness and those that offered demographic variety. Narrative analysis is useful in this regard, because it identifies the narrative structure that is most germane to the formation of mission-mindedness. Within that structure and because of that structure, key events or insights that lead to mission-mindedness can therefore be identified by the participants themselves. These experiences, then, become the examples for the types of experiences higher education researchers and practitioners want people to have. In this chapter, I will focus on the analysis, giving little attention to interpretation—or I will at least attempt to not jump to what I think is most interesting. I will elaborate on my initial insights, comparing and contrasting the narratives through use of these selected narratives in Chapter Five.

The narratives are grouped according to the main point that the narrator makes about mission-commitment in order to facilitate further analysis of the narratives via comparing them among the individual participants. Thus the chapter is divided into sections, with basic analysis of the narratives in each section presented in a conclusion to the section. Further analysis and interpretation of the narratives will be given in Chapter Five; in this chapter, analysis stays as close as possible to the narrative itself in order to provide interpretive validity. Sections to follow include understanding of mission, familial influences, choice of nursing profession, collegiate experience, and civic engagement.

Understanding of mission.

As documented earlier, the mission of Catholic health care includes components such as compassion; high-quality care for bodies, minds and spirits; and special attention

to those who are poor, underserved and most vulnerable (Catholic Health Association, Mission, 2009). The narratives below demonstrate how Amanda, Kim, and James, in their minds and in their narratives, connect mission and practice. Narratives from other participants can be found in Appendix E; these were chosen as exemplars because they each clearly present a different aspect of connecting mission and practice.

Amanda.

Amanda, an advance practice nurse, speaks with ease about her commitment to mission. Amanda relates two narratives without pause. The first describes Amanda's daily practice at Grace Fairfield, including examples of how she applies the mission to her work and how she witnesses her colleagues doing the same. The second narrative involves her grandmother's career, which provides a comparison case—in effect, triangulating data and thereby increasing validity. The complete pair of narratives can be read in Table 1.

Table 1

Amanda's Commitment to Mission Narrative (ARMF032811/Lines 43 -101)

Narrative 1
ABSTRACT
[50-53] Just as the mission says, I really believe that we are here to help the poor and underserved...in conjunction with what Jesus felt that we should be doing. I mean we really try to provide outreach to people not only to heal them physically but mentally and spiritually as well.
ORIENTATION
[53-54] And I see that every single day what with the nursing staff, with the physicians on staff here at Grace Fairfield, the chaplains.
COMPLICATION
[54-61] We discuss care with the patient and their family. It really does take into account every aspect of them. We help them...provide them services after they discharge as far as getting their medications that they can't be afforded. There are all types of...satellite community outreach programs. We do...just this office does every year...free pulmonary function testing to screen people for COPD and emphysema. We

see that kind of stuff in the community all the time just based from this organization.

EVALUATION

[61- 63] It's really an amazing thing. We're such a big presence in the city of River Bluff what with just acquiring Methodist and...you know...all the other Graces...

RESOLUTION

[63-64] We really are the number one healthcare facility here.

Narrative 2

CODA/ORIENTATION

[64-68] So, it's really an amazing organization to work for and a very special place. My grandmother worked here. She was one of the...one of the original members of staff when Grace opened.

COMPLICATION

[68-72] She was actually a pharmacist technician and I used to help them in the pharmacy when I was a little girl and I was off school and...you know...fill things in bottles and clean. You know what I mean. I just hung around here and then I was a...you know...a volunteer and nurses' aide, a unit secretary, a nurse, and a nurse practitioner.

RESULT or RESOLUTION

[74-76] But I've really spent my whole career here. . . . Really my whole life!
(Laughter)

EVALUATION

[84-96] Gosh, there's so many people...you know...that are mission committed...that will do whatever it takes even if their shift's over...will continue to stay to be with the family or to be with the patient that needs them...that continually put their patient's need above their own. I mean, especially in the critical care arena. I mean this is the group of people I am most familiar with because I spend the most time with them...so knowledgeable and work so hard...I mean...don't take breaks...work through lunch...just committed to their wellness...whatever that may be for them. And we have a mixed medical/surgical ICU so we see all different types of critical illness whether that be a patient who has overdosed and is on a 72 hour psychiatric hold. All of our patients in holds are up in the ICU. We don't have a psychiatric facility here. Whether it be the patient that is...you know...80 years old in acute respiratory distress so he's on the ventilator or the 20-year-old that's septic and is on the ventilator...you know...and we see all kinds of things.

CODA

[96-100] So, it really takes a special kind of person to be able to look at a situation that is so grave and bring to it the best of themselves. That can be hard especially when you're doing it time and time again and for hours and hours at a time. But it's truly a family affair. They help one another...get through it and it's almost that it...I mean it makes them better and they recognize that. So, it's pretty awesome.

The interview with Amanda began with a question about mission, which

Amanda's abstract essentially defines: "We are here to help the poor and underserved."

Amanda returns to this definition, expanding on it, in the evaluation. “There’s so many people...you know...that are mission committed...that will do whatever it takes even if their shift’s over...will continue to stay to be with the family or to be with the patient that needs them.” Thus, Amanda defines mission as helping all people to the greatest extent possible, even if job description does not require it.

The orientation in Amanda’s narrative identifies both the people whom the mission is designed to serve and those who provide the service. “We really try to provide outreach to people not only to heal them physically, but mentally and spiritually as well.” Those involved in mission include, then, “we,” which is all staff “nursing staff...the physicians on staff... the chaplains,” and a generalized “people.” Explicit in Amanda’s description of what happens in her hospital is her conviction that the healing process extends beyond the physical; rather, it includes the relational. For Amanda, healing involves knowing the context of patients’ lives and which support services and resources will be best suited to a particular patient and to his or her situation. How Amanda came to this definition through experience is recounted in the complication of the narrative.

We do daily rounds with the care team. We go into the patient’s room. We discuss care with the patient and their family. It really does take into account every aspect of them. We help them...provide them services after they discharge as far as getting their medications that they can’t be afforded. There are all types of...satellite community outreach programs. We do...just this office does every year...free pulmonary function testing to screen people for COPD and emphysema. We see that kind of stuff in the community all the time just based from this organization.

The specific events or actions recounted here emphasize the daily rounds, the entry into the patient’s room, the attention to everyone (including family members), and the follow-up. In other words, the action described in the complication is daily and repeated—a ritualized practice. This holistic practice projects beyond the confines of the patient’s

room out into the community. In Amanda's words, "It's really an amazing thing. We're such a big presence in the city of River Bluff what with just acquiring Methodist and...you know...all the other Graces."

Amanda brings the first narrative to a conclusion by setting up the orientation to the next narrative—that of her grandmother's career and her own career. "It's really an amazing organization to work for and a very special place. My grandmother worked here. She was one of the...one of the original members of staff when Grace opened." In the following complication, Amanda goes on to describe how her own career unfolded as she shadowed her grandmother. "She was actually a pharmacist technician and I used to help them in the pharmacy when I was a little girl and I was off school and...you know...fill things in bottles and clean. You know what I mean. I just hung around here and then I was a...you know...a volunteer and nurses' aide, a unit secretary, a nurse, and a nurse practitioner." Amanda states, as a result, "I've really spent my whole career here. . . . Really my whole life!"

In the second of Amanda's evaluations, she reflects on the mission commitment of her co-workers. She sees in them the approach to care that she herself offers.

There [are] so many people...you know...that are mission committed...that will do whatever it takes even if their shift's over...will continue to stay to be with the family or to be with the patient that needs them...that continually put their patient's need above their own. I mean, especially in the critical care arena. I mean this is the group of people I am most familiar with because I spend the most time with them...so knowledgeable and work so hard...I mean...don't take breaks...work through lunch...just committed to their wellness...whatever that may be for them. And we have a mixed medical/surgical ICU so we see all different types of critical illness whether that be a patient who has overdosed and is on a 72 hour psychiatric hold. All of our patients in holds are up in the ICU. We don't have a psychiatric facility here. Whether it be the patient that is...you know...80 years old in acute respiratory distress so he's on the ventilator or the 20-year-old that's septic and is on the ventilator...you know...and we see all kinds of things.

In the coda—Amanda’s summary perspective on what her narrative means to her today—she realizes that it takes a tremendous disposition, as well as ability, to handle the situations she and her co-workers face each day. This shared experience creates, Amanda notes, a family-like bond.

It really takes a special kind of person to be able to look at a situation that is so grave and bring to it the best of themselves. That can be hard especially when you’re doing it time and time again and for hours and hours at a time. But it’s truly a family affair. They help one another...get through it and it’s almost that it...I mean it makes them better and they recognize that. So, it’s pretty awesome.

Kim.

Kim, a seasoned vascular and renal nurse, links patient (or customer) service and excellent clinical practice to the mission. She combines a narrative of her own understanding of service with a narrative that details the obstacles of time constraints and new technologies that constantly challenge this level of service. This tension is illustrated in the following two narratives, shown in Table 2, which were told in close succession in the interview.

Table 2

Kim’s Commitment to Mission Narrative (KCLH032111/Lines 5-58)

Narrative 1
ABSTRACT
[5-10] I think that patient-oriented service is of best interest to the patients. It [Grace] has a religious plan to it and I think that is due to it being a Catholic hospital. I do not think that it is an offensive religious plan I think it is just how it is. I think that they take the mission quite seriously, that we are here to serve, and to promote whatever the best interests are of our patients and our clients.
EVALUATION
[10-12] That is pretty well how my day would be. I do not know how it would be to work in a place that was not. I have been here for a long time but I do not have any thoughts of wanting to retire. I enjoy doing the kind of things that I get to do here.
ABSTRACT
[22-23] It is a personal ethic, like how I feel like I should take care of people and treat the people that I work with. The patients deserve professionalism and the best care.

ORIENTATION

[23- 24] We have many patients who are self-pay and [many of these patients] have no resources of any kind,

COMPLICATION

[24-28] and I do not think that they get treated any differently than the people that have everything, insurance coverage and are very demanding,

EVALUATION

but it allows me to be a better person because this is what I do. I am here to help, to service, and if you can't do the service and provide the care than you need to go to Wal-Mart.

Narrative 2

ABSTRACT

[59-62] I think that it takes a special kind of person to be a bedside nurse, I really do, they have to have compassion and they have to be empathetic to know that this person lying there is dependent on whatever care that we give them and the quality of care that we give them. . . .How sharp we are, are we assessing their real needs? that we do not let things get by and kind of triaging what is the most urgent thing that this patient needs right now?

COMPLICATION

[64-73] Around all the electronic restrictions that they have during their day, you know their meds come out of electronics, they are scanned, it is so task oriented now. . . .It is hard to provide personal hands-on care. . . The computer rolls in when you are admitted and they are looking at you asking and typing. The patient does not feel that they are the sole recipient of that nurse's interest. Then every pill, everything you do, we are scanning their arm bands – it's like going through Kroger getting your groceries.

EVALUATION

[73-74] It is kind of frustrating. They do not get the opportunity to appreciate the older side of nursing that was seeing a real person.

RESULT or RESOLUTION

[79-85]. . . some of the younger ones have not had an opportunity to have that kind of communication.

COMPLICATION

[80-84] The turnover is so fast. The patients are so acute and they have so many constrictions on their time, from the time that they get here to the time that they zoom out the door, with charting being on line, ordering on line, meds being in the [med machine], and everything is typed. The [med machine] telling them that their meds are late, highlight in red when they are not given on time...

EVALUATION

[85] ...and they do not feel like they can function as a caregiver as they are given tasks.

The pair of narratives taken together represent Kim's idea of mission commitment, which she presents as the institutional mission of patient-oriented service in tandem with special kind of person—the nurse— delivering that service.

It is useful to analyze the narratives closely in order to show how this dual-focus on the institution and the individual works. In the first narrative, Kim begins with the abstract, summarizing what the narrative is about. She states clearly that the mission is “patient-oriented service,” repeating that at the end of the abstract, and clarifying in the middle that that is “due to it being a Catholic hospital” but not “an offensive religious plan.” The abstract thus establishes a vague sense of distance from the institutional mission. This is immediately followed by an evaluation that lets the reader know the attitude of the narrator as well as the relative importance of the unit: “That’s my...day” and “I enjoy it,” which serves to establish that in her mind, the end result of the mission is good, whatever uneasiness may have arisen in its course.

Kim then offers another abstract that shifts from the institutional to the personal: “It’s a personal ethic.” This is followed by a quick orientation: the persons involved are the nurses (“we”) and patients of two types—those who can afford to pay and those who are limited to public assistance. An equally quick, very condensed complication relates a series of patients’ experiences: both receive quality care. Kim then returns abruptly to her attitude, feelings, and emphasis through the evaluation: “It allows me to be a better person.”

Kim notes in the evaluation that her mission commitment is rooted in the fact that she approaches her work in a professional manner and in her high expectations for herself and others. “It is a personal ethic, like how I feel like I should take care of people and treat the people that I work with. The patients deserve professionalism and the best care.” She continues to elaborate on mission commitment in a very personal way and insists that if a person can’t provide excellent service, then they need to change

professions. “I am here to help, to service, and if you can’t do the service and provide the care, than you need to go to Wal-Mart.” Kim is a deontological thinker—that is, her ethical mandates are duty-based.

Once again, in the evaluation, we see that the hospital where Kim works is a vital element in her ability to carry out what she considers to be mission-committed nursing. “I do not know how it would be to work in a place that was not [Catholic]. I have been here for a long time but I do not have any thoughts of wanting to retire. I enjoy doing the kind of things that I get to do here.”

Kim then offers a second narrative in response to the same question about mission commitment. In this abstract, Kim talks about the combination of skills needed to be an effective nurse—compassion and competence (“sharpness”). She moves from describing the “they” to taking on a corporate “we.”

I think that it takes a special kind of person to be a bedside nurse, I really do, they have to have compassion and they have to be empathetic to know that this person laying there is dependent on whatever care that we give them and the quality of care that we give them. How sharp we are? Are we assessing their real needs? That we do not let things get by and [a] kind of triaging [of] what is the most urgent thing that this patient needs right now?

Kim is concerned with taking the right actions on behalf of her patients. She stays aware of her patients’ needs and prides herself in her ability to assess those needs.

In further evaluation, Kim taps into the perennial struggles of nurses—balancing all aspects of patient care and the disconnect between generations of nurses. In speaking of balancing the technical demands of nursing with the human connection between nurse and patient, Kim concedes that “It is kind of frustrating.” Kim expresses nostalgia for the “the older side of nursing” and laments new nurses’ lack of awareness regarding earlier forms of praxis. “They do not get the opportunity to appreciate the older side of

nursing—that was seeing a real person...They do not feel like they can function as a caregiver as they are given tasks.” Kim is working out of the dualistic assumption that task- and technology-driven nursing precludes patient-centered care—that both cannot be done at the same time. She is also engaging in a common complaint by veteran nurses about younger or newer nurses—that they just don’t have the same level of commitment.

The nature of Kim’s experiences that impact her understanding of mission range from uninsured patients, “We have many patients who are self-pay and have no resources of any kind,” to an escalation of patient acuity, “The turnover is so fast. The patients are so acute and they have so many constrictions on their time, from the time that they get here to the time that they zoom out the door.” She also introduces the challenges of integrating technology.

You know their meds come out of electronics, they are scanned, it is so task oriented now. . . .It is hard to provide personal hands-on care. . . The computer rolls in when you are admitted and they are looking at you asking and typing. The patient does not feel that they are the sole recipient of that nurse’s interest. Then every pill, everything you do, we are scanning their arm bands – it's like going through Kroger getting your groceries.

James.

James, an ICU nurse in a community hospital, points to positive attitude and being relational as his preferred ways to express mission. Although less distinct than Amanda and Kim, James also offers two narratives within the same block—the narrative of his personal experience with health care through the illness and death of his mother, and the narrative of how he experiences a family approach in the work of his unit. Both of these can be read in Table 3.

Table 3

James's Commitment to Mission Narrative (ROSA030411/Lines 3-57; 129-155)

ABSTRACT
[6] We are here to serve the community no matter what, if rich or poor or underserved.
ORIENTATION
[12-17] [W]orking in ICU we deal a lot with very critical patients, even life and death. Really enveloping maybe a little bit of religious background, support no matter what their beliefs are, making sure there is support for the family. Sometimes they bring in their own chaplain or we bring in our own. Every day I think we see a chaplain and we try to get them in and involved with the patients. Doing living wills, things like that, making sure that their wishes are met.
EVALUATION
[23-25] I think [our unit is] very supportive, making sure the patient is taken care of. I just lost my mom in July and I think that dealing with that, and being in the hospital with her, and knowing how you want to be treated is a big thing.
COMPLICATION
[25-31] It was like years ago. . . it was the same thing in long term, you know, Hospice care for about 1½ years. It is just knowing that it hits home and you kind of see that other side of the patient. Know how you want to be treated, and this is how I try to treat others. Sometimes it is difficult and they do not see it the same way that you are seeing things, but providing the information and then going from there sometimes. Keeping people updated. Last week I dealt with 2 families that were both with code status.
[35-44] [. . .] One was in the terminal wing and expired one day after that, dealing with that code status and actually another one, I think that they are in Hospice today. Trying to teach them about code status, what it means, how and what do you want done. Family wishes, patient wishes. [. . .] One of the family members actually came around yesterday, she wanted to see us and thank us.
EVALUATION
[52-56] [I think our department is j]ust very caring, up front, kind of like even a family member, like, you know, I think that we work as a family sometimes. Very caring and very committed to their work and some really intelligent co-workers that really know how to care for the patient and applying that to care for the patient. I think meeting the spiritual needs too. The person that I am thinking of goes in every morning with a bright smile and a great attitude.
COMPLICATION
[139-145] [T]hey moved a patient back for a procedure, he had a cardioversion done, he just came back for that and then was transferred back out again, but I had to watch him for an hour after we gave sedation. You pretty much have to stay in the room the hour after, so we did a lot of talking, you get to know them and they get to know you as they ask the questions back. They were a very nice couple. Certain people are not that sociable or sit in the corner, like “okay, I can watch the patient from over here,” instead of getting involved and talk.

[150-153] One patient said I have only been here for like 20 hours or something, but I just loved his experience because he felt that everybody got along here, you know everybody was kind of committed in taking care of him, and they knew their stuff, and he felt very comfortable.

EVALUATION

[127-129] I think a lot about that, just the attitude, you know, you are not just here to do a little job and get through the hours, you are really here to be committed.

CODA

[129-130] What I really like about St. Mary's is it is on a smaller scale and it seems more family-oriented. A lot of the people treat the patients like family.

James' abstract summarizes how he defines the mission of Catholic health care, "We are here to serve the community no matter what, if rich or poor or underserved." He quickly moves to orient that definition in terms of who makes this definition come alive (critical patients, the family, the care team) and in what context (the ICU).

Working in ICU we deal a lot with very critical patients, even life and death. Really enveloping maybe a little bit of religious background, support no matter what their beliefs are, making sure there is support for the family. Sometimes they bring in their own chaplain or we bring in our own. Every day I think we see a chaplain and we try to get them in and involved with the patients. Doing living wills, things like that, making sure that their wishes are met.

James' experience of his particular unit's team approach orients his mission-committed behaviors. He asserts that care giving, including education and support for decision-making, is offered in the physical, emotional, and spiritual realms.

James' familial and professional contexts have given him experiences in which his understanding of mission is rooted, from working with critical patients in the ICU to the profound experience of losing both his parents. In this particular narrative he speaks to his mother's time in hospice. In the narrative block about becoming a nurse, James shares how the childhood experience of his father's illness shaped his views regarding health care and hospitals and increased his desire to be a nurse. These are so integrated in

James that he vacillates between the two (familial and professional) settings unconsciously; one set of experiences informs the other.

It was like years ago. . . you know, Hospice care for about 1½ years. It is just knowing that it hits home and you kind of see that other side of the patient. [You] know how you want to be treated, and this is how I try to treat others. Sometimes it is difficult and they do not see it the same way that you are seeing things, but providing the information and then going from there sometimes. Keeping people updated. Last week I dealt with 2 families that were both with code status.

James' understanding of the importance of "being" with people, of providing care in a more contemplative fashion, allows him to balance the high demand for action-oriented care necessary in the ICU with the patient's need for personal connection and the trust that is built within a well-functioning care giving relationship.

They moved a patient back for a procedure, he had a cardioversion done, he just came back for that and then was transferred back out again, but I had to watch him for an hour after we gave sedation. You pretty much have to stay in the room the hour after, so we did a lot of talking, you get to know them and they get to know you as they ask the questions back.

James' evaluation on mission-commitment is relational. He speaks of providing supportive care that helps to facilitate healing, education, and decision-making to patients and receiving such attention in his own family experience. He uses a family model to provide care. "I think [our unit is] very supportive, making sure the patient is taken care of. I just lost my mom in July and I think that dealing with that, and being in the hospital with her, and knowing how you want to be treated is a big thing. [I think our department is] just very caring, up front, kind of like even a family member, like, you know, I think that we work as a family sometimes."

Although supportive, relational care drives James' understanding of mission, he also points to commitment, ability, and attitude. He describes others in his unit as "Very caring and very committed to their work and some really intelligent co-workers that

really know how to care for the patient and applying that to care for the patient...the person that I am thinking of goes in every morning with a bright smile and a great attitude.” In contrast to Kim, James is not duty-driven but virtue-based; a good attitude, commitment, and skill are the desired qualities in a good nurse. “I think a lot about that, just the attitude, you know, you are not just here to do a little job and get through the hours, you are really here to be committed.”

The result then, for James, is that he has a sense of family in his work environment and that this comes across in the patient experience. He states, “What I really like about St. Mary's is it is on a smaller scale and it seems more family-oriented. A lot of the people treat the patients like family.” An example James gives is the feedback from a patient who enthused, “I have only been here for like 20 hours or something, but I just loved [this] experience.” The patient explained this was “because he felt that everybody got along here, you know everybody was kind of committed in taking care of him, and they knew their stuff, and he felt very comfortable.”

Conclusion regarding understanding of mission.

In almost all of the above narratives, there is an analogous value system between personhood and vocation. Additionally, the presence of a basic desire to treat others with respect and compassion allows these nurses to provide empathetic care that takes into consideration the needs of patients as well as commitment to do what is best for them. This is equally true for the six additional narratives contained in Appendix E. A desire for integration and integrity surfaces, as does the skill of taking into account the needs of patients when considering and implementing a plan of care. Regard for ‘presence,’

awareness, relationship, and the so-called “Golden Rule” also becomes clear as participants speak about their work with patients.

Familial influences.

Throughout the narratives above, as well as those in Appendix F, family experiences were as influential as work environment in forming participants’ understanding of mission. In this section we will look at narratives told by Terri and Sarah as presenting different ways in which families influenced mission-committed nurses’ delivery of care.

Terri.

Terri is a cardiac nurse in a research and level I trauma center. Her narrative in Table 4 reveals how her approach to work parallels the way in which she learned to work in her family context.

Table 4

Terri’s Familial Influences Narrative (RJSV012011/Lines 153-217; 308-327)

ABSTRACT

[308-311]

I think my religion and the fact that I came up in a family that my mother was very strongly family oriented with good morals, good values, respect for people. My mother's theory was be nice to people no matter how they treat you. Turn the other cheek kind of thing from religion. I think my commitment like my work ethic came from my family.

ORIENTATION

[153-160] I actually have an aunt who I never really met; she died younger. I always heard about aunt Margie; she was a nurse, she was an RN, she actually lived here in Riverside as well. I really did not know her, she passed away when I was really young, and then I had another aunt who was actually an LPN and she was a nurses aide but then she got grandfathered in to be an LPN when they changed all of that and she worked at St. Andrew. She of course was retired by that time. I did have a first cousin who I was not real close with. She went to Charity and she probably graduated in the early 80's and was a nurse.

[165-175] I am the youngest of 7 [. . .] I grew up on a dairy farm. I have one sister and my other siblings are all brothers, so I have 5 brothers. My mother is a very family-

oriented person. She is kind of the youngest of a “yours, mine, and ours” family. She was a stay-at-home mom. My dad provided – so, basically, one income. I spent a majority of my summers working in the garden, bailing hay, bailing straw. We did stuff together as a family. We sat down and we would eat breakfast, lunch, and dinner together[. . .] We always prayed before each meal. We go to church every week on Sunday as a family, it was always 9:30 mass, we sat in the same spot.

[183-191] My parents were always together; when I came home from school every day, my mom and dad were there. Mom was always there. I had older siblings, a very good older sister. She is 4 years older; she always kind of included me, she always took me along, even with her friends. So she is also kind of symbolic in the way that my mother is. Family oriented. We would do things together as a family, go to the lake, go to the park and have a picnic, make homemade ice cream growing up. We still do that and get together like a couple of weekends ago we all went bowling together. Now we have included the nieces and nephews, and they are the ones saying "Hey, let's all go bowling." Next weekend we are all going to a hockey game.

COMPLICATION

[196- We worked hard as kids. When we look back and we think, "oh my gosh, you could not get any kids to do this anymore". . . We were taught to do things thoroughly and complete. I remember one time probably in my teenage years I did not do something quite right and my mom would say "okay do it again, and again, and one more time so that the next time you will know how to do it. Now she kind of says that I am so picky, and I say, "but you did that to me". We were also made to hold our commitment; if you say you would do this or that you did it. An example was when I was in high school, I got a part-time job after school my junior and senior year to make money to go to school. They had called in the daytime while I was at school, and my mom told them that I would be there. When I came home I said "I can't, I have a date." My dad said, "you wanted a job, so now you are going to work this job." So, I went to work. When I worked at Grace in Fordson I worked nights, so I would sleep during the day. They would call and say, "can Terri come in at 7:00 and work till 7:00?", and my mom would say "yes, she will be there," and my mom would wake me up and say "hey, they called you and want you to come in early." So I would get up and go to work. The girls that I work with were stunned that my mom said that I would be there for me, and I was there.

EVALUATION

[215-217; 308-324] I think that sometimes some of our younger people their choice of entertainment is more important than their commitment to their job sometimes. They do not think anything of it to call off to go to a game, whereas I do not do that.

I think my religion and the fact that I came up in a family that my mother was very strongly family oriented with good morals, good values, respect for people. My mother's theory was, “be nice to people, no matter how they treat you.” Turn-the-other-cheek kind of thing from religion. I think my commitment, like my work ethic, came from my family. My parents also making me maintain that as a teenager, you know, they kind of forced "you wanted a job, now here is your chance." I think that part of it is self-driven a little bit in that I do not want to look dumb in front of my patients, I do not want to look dumb in front of a doctor. There is not anything worse than the doctor coming in and saying "Oh, was the echo done? or what is this? what is that?", or “they had positive

blood cultures, well, what are they showing?” – “I don’t know.” That sort of thing just is not me. I want to know, “is it positive?” Are we on the right antibiotic? Is this covering this organism? Maybe this person is running a temperature, do [they] need this and this? Sometimes they are busy too, and they are passing through for a short interval, so part of it is self-driven. I just want to do a good job, be well liked, but I think it is totally the whole upbringing, religion, and it is your family values and your morals, and just doing the right thing.

RESULT or RESOLUTION

[324-327] It is being committed, this is my job, I need to be here because first of all I need money. Second of all if I am going to be here, I am going to follow policy and procedure. I am not going to be a bad employee and I am not going to do something just part way, I am going to do it all, and I am going to do it completely and thorough.

EVALUATION

[195-196] I think belonging, getting along, going with the flow, things pop up that you do not expect, just learn to deal with them.

[213-214] It is like commitment: follow through, this kind of builds who you are. It also make you learn where your priorities are.

Terri’s abstract summarizes her belief that religious values and morals— particularly the way in which her mother modeled those values and morals— created the work ethic that is the foundation of Terri’s mission commitment.

I think my religion and the fact that I came up in a family [where] my mother was very strongly family-oriented with good morals, good values, respect for people [shaped my mission commitment]. My mother’s theory was “be nice to people no matter how they treat you.” [It is the] “turn the other cheek” kind of thing from religion. I think my commitment, like my work ethic, came from my family.

Given circumstances—the people and places in Terri’s life—loom large in her memory. In the orientation she recalls RN relatives with a mythic tone, the identity and reality of belonging to a large family, and the modeling of her parents and siblings—in particular her older sister. “I always heard about aunt Margie; she was a nurse, she was an RN...I really did not know her...then I had another aunt who was actually an LPN and she was a nurses’ aid...I did have a first cousin who I was not real close with.”

These aunts and a cousin, although professional nurses, were on the periphery. It was shared experience with siblings and parental dynamics that left the strongest mark on

Terri's imagination. These experiences include household chores, meal times, worship, and socializing.

I grew up on a dairy farm. I have one sister and my other siblings are all brothers, so I have 5 brothers. My mother is a very family-oriented person. She is kind of the youngest of a "yours, mine, and ours" family. She was a stay-at-home mom. My dad provided – so, basically, one income. I spent a majority of my summers working in the garden, bailing hay, bailing straw. We did stuff together as a family. We sat down and we would eat breakfast, lunch, and dinner together[. . .] We always prayed before each meal. We go to church every week on Sunday as a family, it was always 9:30 mass, we sat in the same spot.

This family cohesion, particularly with her mother and sister, exemplifies care giving and belonging for Terri. Her family's "team approach" continues into the present day.

My parents were always together; when I came home from school every day, my mom and dad were there. Mom was always there. I had older siblings, a very good older sister. She is 4 years older; she always kind of included me, she always took me along, even with her friends. So she is also kind of symbolic in the way that my mother is. Family oriented. We would do things together as a family, go to the lake, go to the park and have a picnic, make homemade ice cream growing up. We still do that and get together like a couple of weekends ago we all went bowling together. Now we have included the nieces and nephews, and they are the ones saying "Hey, let's all go bowling." Next weekend we are all going to a hockey game.

Terri's understanding of familial influences on her nursing has a very different feel than James' narrative in Table 4.3. In the evaluation, Terri reflects on parental influence in her upbringing and projects the role of parent onto the institution, and on physicians in particular.

I think my commitment, like my work ethic, came from my family. My parents also ma[de] me maintain that as a teenager, you know, they kind of forced "you wanted a job, now here is your chance." I think that part of it is self-driven a little bit, in that I do not want to look dumb in front of my patients, I do not want to look dumb in front of a doctor. There is not anything worse than the doctor coming in and saying "Oh, was the echo done? or What is this? What is that?" or "They had positive blood cultures, well, what are they showing?" – "I don't know." That sort of thing just is not me."

Additionally, Terri's impetus to do what is asked of her, to follow through on that to which she has committed herself, is an expectation she also holds for others. She is vocal when others do not live up to this expectation. "I think that sometimes [for] some of our younger people, their choice of entertainment is more important than their commitment to their job sometimes. They do not think anything of it to call off to go to a game, whereas I do not do that."

It is clear in Terri's evaluation that she sees successful patient assessment, interventions, and outcomes recording as an objective measurement not only of her own abilities, but also of best practices; it is in "doing the right thing" that she becomes the best nurse she can be. Although she has a sense of internal motivation, much of how she executes her work and measures her success is dictated by external approval. "I just want to do a good job, be well liked, but I think it is totally the whole upbringing, religion, and it is your family values and your morals, and just doing the right thing. "

In the larger evaluation block above, we get a sense of Terri's priorities within the context of her work environment. This approach toward work parallels the experience she had with work through her childhood and adolescent years.

We worked hard as kids. When we look back and we think, "oh my gosh, you could not get any kids to do this anymore". . . We were taught to do things thoroughly and complete. I remember one time probably in my teenage years I did not do something quite right and my mom would say "okay do it again, and again, and one more time so that the next time you will know how to do it. Now she kind of says that I am so picky, and I say, "but you did that to me". We were also made to hold our commitment; if you say you would do this or that you did it. An example was when I was in high school, I got a part- time job after school my junior and senior year to make money to go to school. They had called in the daytime while I was at school, and my mom told them that I would be there. When I came home I said "I can't, I have a date." My dad said, "you wanted a job, so now you are going to work this job." So, I went to work. When I worked at Grace in Fordson I worked nights, so I would sleep during the day. They would call and say, "can Terri come in at 7:00 and work till 7:00?", and my mom would

say "yes, she will be there," and my mom would wake me up and say "hey, they called you and want you to come in early." So I would get up and go to work. The girls that I work with were stunned that my mom said that I would be there for me, and I was there.

Terri’s childhood is ever-present in her vocational self-talk. However, as Terri evaluates her insights regarding mission commitment and nursing, she gradually exhibits more flexibility. “I think belonging, getting along, going with the flow, things pop up that you do not expect, just learn to deal with them...It is like commitment [and] follow through, this kind of builds who you are. It also makes you learn where your priorities are.”

Sarah.

Sarah is a recent college graduate. She works on a neurological and palliative unit in a level I trauma hospital. Sarah’s narrative features a pronounced bias toward action in consideration of others, fostered by her grandfather—a physician who has become an archetype in her life story—and maintained in her immediate family. In Table 5, Sarah unites her strong work ethic with her understanding of faith.

Table 5

Sarah’s Familial Influences Narrative (SSSV012811/Lines 94-126)

ABSTRACT/ORIENTATION
[97-101] [. . . M]y grandpa was a physician and he was one of those physicians that when you came to his office he saw you, he saw your children, and anybody that you brought with you. He was a physician with Grace and he lived the mission. [My grandpa] kind of set an example for me and growing up my family was not one that was Bible-thumpers. We did go to church on Sundays and were active in youth group.
COMPLICATION
[101-103] Actually it was one of those things when I first started college and I got away from that I did not realize what was missing until I started going back to church and I realized that faith is very important.
EVALUATION
[103-113] As I have gone through college and progressed in the nursing field I see that everybody has different faith, and everybody expresses their faith differently, but it

really does have an impact on who you are, how you see other people, and understanding that. One of biggest I was taught growing up is "God has a reason for everything". Sometimes it is hard to impose your religion on other people but a lot of times when you tell that to a family "there is a reason for everything" it seems to give them some peace. I think that seeing how my parents raised us to be conscience of your faith, be conscience of others. They were really good about teaching us the chivalry and respect, I think that helps. It hurts these days when you drive around, or even patients sometimes, they do not have the respect for others.

RESULT or RESOLUTION

[117-118] I think that [work ethic] also comes from family values. I was raised to work hard, put everything that you have into it.

CODA

[118-121] Some days are harder then others, but everybody has good days and everybody has bad days. I think that one of the things that was stressed to me as well is the harder that you work the more appreciated you will be, people will notice it, and the more it will pay off.

From the opening orientation, Sarah points out “who” was formative in her understanding of mission commitment—her grandfather. “Grandpa was a physician and he was one of those physicians that when you came to his office he saw you, he saw your children, and anybody that you brought with you. He was a physician with Grace and he lived the mission.” Like Terri, Sarah points to religion as part of her family experiences. [My grandpa] “set an example for me and growing up my family was not one that was Bible-thumpers. We did go to church on Sundays and were active in youth group.” Sarah reflects, “As I have gone through college and progressed in the nursing field, I see that everybody has different faith, and everybody expresses their faith differently, but it really does have an impact on who you are, how you see other people, and understanding that.” Sarah relates an instance in which something that she was taught about God has proven helpful for her patients and their families. “One of biggest [things] I was taught growing up is ‘God has a reason for everything.’ Sometimes it is hard to impose your

religion on other people, but a lot of times when you tell that to a family, [that] ‘there is a reason for everything.’ it seems to give them some peace.”

Sarah recognizes that her faith education came from her parents and grandfather, rather than from an institution, and that her understanding of faith takes into consideration “the other.” “They were really good about teaching us the chivalry and respect, I think that helps. It hurts these days when you drive around, or even patients sometimes, they do not have the respect for others.”

The way in which Sarah describes her grandfather, who looms large in the orientation, highlights her understanding of the difference between religiosity and spirituality. She relates how a person approaches work and interacts with people to how a person understands his or her faith. Sarah learned, from a young age, that it’s not necessarily participation in organized religion that makes a person spiritual, but rather how a person behaves toward others.

My grandpa was a physician and he was one of those physicians that when you came to his office he saw you, he saw your children, and anybody that you brought with you. He was a physician with Grace and he lived the mission. [My grandpa] kind of set an example for me...growing up, my family was not one that was Bible-thumpers. We did go to church on Sundays and were active in youth group.

The result, for Sarah, is that she also ties her work ethic to the use of her gifts and talents for the benefit of others. “I think that [work ethic] also comes from family values. I was raised to work hard, put everything that you have into it.”

Sarah is a young professional. She is growing into and expanding upon her strong spiritual foundation through participation in a faith community. As she relates in the complicating action of her narrative, this sometimes produces obstacles. “Actually it was one of those things when I first started college and I got away from that I did not realize

what was missing until I started going back to church and I realized that faith is very important.” At this point in her life, Sarah is still working toward internalizing her motivations. On one level, she knows the internal reward for doing the right thing. On the other, she still desires affirmation from others. “Some days are harder than others,” Sarah states toward the end of her narrative, “but everybody has good days and everybody has bad days. I think that one of the things that was stressed to me as well, is the harder that you work the more appreciated you will be, people will notice it, and the more it will pay off.”

Conclusion regarding familial influences.

As noted, familial influences come through strong in the narratives about understanding mission, and include mythic role models, shared experiences of health care professions across generations, family illness, and transcendent values. In this section comprised of two narratives by individuals who spoke at great length about their families, and in the additional narrative about familial influences located in Appendix F, we hear several other ways in which families influenced the development of work ethic, resiliency, and vocation.

Becoming a nurse.

Familial influences, experiences within the profession, and collegiate experiences shaped participants’ interest in health care careers and decisions to enter the nursing profession. Choosing the vocation of nursing is many times, in and of itself, a mission-driven decision. In many of the narratives, participants recount that their aspirations to nursing began very early in life. Their interest in the profession was encouraged by family members, teachers, and healthcare professionals as a match to each individual’s

talents and/or because it was considered to be a reliable way to make a living.

Participants, in general, pointed to the substantial “face time” with patients—inherent in nursing not only, as something that drew them to the field, but as a reward that keeps them in it. Narratives told by Craig, Maria, and Lyn identify the different influences on their decision to pursue careers in health care.

Craig.

Unlike many of the other narratives, it was Craig’s experience in college that first set the tone for his future career in nursing. His work study placement—originally simply the means to pay for his college tuition—quickly became a way to try out skills that would eventually open an avenue toward his life’s work. As his narrative about becoming a nurse unfolds, other sources of encouragement surface—support from his wife, his connection with family, and spiritual growth. These expanding narratives can be found in Table 6.

Table 6

Craig’s Becoming a Nurse Narrative (CSSV020711/Lines 69-117)

ABSTRACT

[76-81] I lived in a dorm where there was all these people who were disabled. Prior to coming in I was just like, there would be no way, but something about itI needed a little income and what I found is that I was good at it and I liked it. Over the next couple of years I continued to do it. I ended up working with the disability services office. I did all the training—I was a consultant, so everything kind of built on that. So then it was brought to my attention like, well, why don't you go into nursing [. . .]

ORIENTATION

[71-80] It actually started back when I was in college I took a little...to get my first degree, but when I started I did not know really what I wanted to do. It was kind of you know, I need to go to school, I need to fill it out, so I ended up getting into dorm personal care for students who were disabled and that included like because of injury they were quadriplegic, paraplegic, people with MS, muscular dystrophy, cerebral palsy, Spina Bifida did care. I lived in a dorm where there was all these people who were disabled. Prior to coming in I was just like, there would be no way, but something about itI needed a little income, and what I found is that I was good at it and I liked it. Over the next

couple of years I continued to do it. I ended up working with the disability services office. I did all the training—I was a consultant, so everything kind of built on that.

COMPLICATION

[80-101] So then it was brought to my attention like well why don't you go into nursing and at that time I was like.....well I don't know, I just was not sure about it. I ended up talking to an advisor who told me that I probably was not smart enough to be a nurse at that time and that maybe I better look into something else. That kind of stuck with me. I spoke with the director of disability services and he mentioned the program that I wanted to get into which is vocational rehab counseling. I said okay I will try it.

RESULT or RESOLUTION

I started school full time and then I went down to part time and ended up working some more, so I kind of fluctuated a little bit and so it took me a little longer to get through school.

ABSTRACT

I got my degree in vocational rehab counseling and then I ended up working with the community in mental health centers down in Centralia and I found out that I liked it.

ORIENTATION

I stayed there, it was more of a social work field, and I ended up doing an internship up here at Collegeville, that is how I got to Riverside, I did an intern and ended up staying and working in a community mental health center here for a while. Then I got married and my wife and I were just talking one day, we were married probably for about 1 year, and we talked about where our jobs were and what we were doing. At that time I was a hospital liaison for the community mental health center where I worked. The majority of my day I was in one of the private hospitals. I was getting information, I was doing tracking.

COMPLICATION

I then took a position as a mental health professional. In talking to my wife she said "what do you want to do" and I said "well I could either get a masters in social work and just carry on what I am doing...and she said "what is an interest"?, I said "you know I have always thought about nursing but I told her the story and she said that I should do it. I told what if I invest the money and it does not work? She said you are not going to know unless you try. I got approved for nursing school and I ended up working full time at a nursing home, went to school full time, continued to work at St. Andrew, and then I took my board, I passed my exams, and I ended up getting hired at St. Andrew. That is how I got into nursing.

EVALUATION

[102-105; 112-116] I have a family that is in nursing, I have 3 or 4 cousins that are all nurses. I have always been able to talk about how they like their jobs and everything. Then faith-wise I was kind of at a low, kind of in and out of churches and trying to find myself. As I started getting further and further into the nursing program then I found myself becoming more and more part of the church and attending church more, so my faith started growing as I started growing.

CODA

[117] It did kind of led me to where I am today.

In both narratives, Craig's experiences and other voices in his life inform his career discernment. In the abstract and orientation of Craig's first narrative, he recalls the special set of skills he discovered through a work study placement in the public university he was attending. "I lived in a dorm where there were all these people who were disabled. Prior to coming in I was just like, there would be no way, but [there was] something about it. I needed a little income and what I found [was] that I was good at it and I liked it."

Although Craig had little or no vocational direction when he started college, this experience called on his natural abilities and gave him a trajectory toward health care. "Over the next couple of years I continued to do it. I ended up working with the disability services office. I did all the training—I was a consultant, so everything kind of built on that. So then it was brought to my attention like, well, why don't you go into nursing?"

Through the complicating action of the first narrative, Craig is thrown a curve when he is advised that he doesn't have the capacity to become a nurse. That advice sends him down another career path, albeit in health care.

I ended up talking to an advisor who told me that I probably was not smart enough to be a nurse at that time and that maybe I better look into something else. That kind of stuck with me. I spoke with the director of disability services and he mentioned the program that I wanted to get into which is vocational rehab counseling. I said okay I will try it.

Craig "ended up staying and working in a community mental health center for a while." As time went on, Craig's administrative responsibilities combine with a new voice in his life, his wife's, challenge him to take another look at nursing. As Craig states in the orientation of the second narrative, "The majority of my day I was in one of the

private hospitals. I was getting information, I was doing tracking. Then I got married and my wife and I were just talking one day.” As the complicating action unfolds, Craig recounts this conversation with his wife.

In talking to my wife she said "what do you want to do?" And I said "well, I could either get a masters in social work and just carry on what I am doing...and she said "what is an interest?" I said "you know, I have always thought about nursing." But I told her the story [about the advisor saying he wasn't smart enough] and she said that I should do it. I told her, "what if I invest the money and it does not work?" She said, "you are not going to know unless you try."

This new voice, the voice of Craig's life partner, gives him the nudge he needs to pursue what he wants. "I got approved for nursing school and I ended up working full time at a nursing home, went to school full time, continued to work at St. Andrew, and then I took my board, I passed my exams, and I ended up getting hired at St. Andrew. That is how I got into nursing."

Craig's evaluation of this second narrative provides a transition into a third, which concerns family and faith connections to his chosen profession.

I have a family that is in nursing, I have 3 or 4 cousins that are all nurses. I have always been able to talk about how they like their jobs and everything. Then [before going back for my nursing degree], faith-wise I was kind of at a low, kind of in and out of churches and trying to find myself. As I started getting further and further into the nursing program, then I found myself becoming more and more part of the church and attending church more, so my faith started growing as I started growing.

Maria.

Maria's response to how she became a nurse is comprised of three narratives: one that recounts her early desire to be a nurse, a second that speaks to family experiences related to this desire, and a third that explains how her cultural background (including faith) impacts her nursing. These narratives can be found in Table 7.

Table 7

Maria's Becoming a Nurse Narrative (RESC011311/Lines 57-183)

ABSTRACT

[66-70] [My choice to become a nurse] has always kind of been in the plan I guess. I never knew what else to be I guess, I never knew anything else that I wanted to be, you know. I have a lot of other interests but I always knew that I wanted to be a nurse. I do not know why sometimes, it is very stressful at times, but I never knew what else to be I guess.

ORIENTATION

[59-66] I did not realize this until.....I guess I kind of forgot that I always wanted to be a nurse. My friend from Kindergarten she reminded me as she said "Oh I am so happy for you. I had this friend from Kindergarten on through 8th grade, we were best friends forever. In high school we kind of lost touch you know, then you get married and kind of move on, you have separate lives. Then her mom died and I went to her mom's funeral, I was like 8 months pregnant or something, and we got to talking again and she said "I remember you always said that you wanted to be a nurse, ever since kindergarten, and I said "Oh yeah, I forgot I did say that."

COMPLICATION

[73-88] I guess, just because I did not know anything other than that I was going to be a nurse, that's it. Even in the program when I went to nursing school, it was rough; I worked 2-3 jobs. I lived on my own, I lived with my sister, I had to pay rent, I had my own car, a junk car, pay car insurance and I am only 18 years old. I graduated from high school and 3 days later I started Mason. In the summer program.

EVALUATION

[78-80] So I guess that has always been part of the plan. Even when it was the toughest point, and I wanted to quit, and I was going to fail everything, in the back of my mind I still just did it. This is what I am going to do.

ABSTRACT

[87-90] [. . .] just from growing up in a big family, there were 8 of us and my mom and dad who would be married 43 years. I have 4 brothers and 3 sisters, I have a lot of nieces and nephews, I have great nieces and nephews. We grew up catholic and my dad and mom they lived in the city in south Riverside.

COMPLICATION

[90-109] Eventually my oldest sister became age 16 and they could not afford to put everyone in catholic school. My dad always had a dream of moving out to the country. That is when he picked up and moved everyone out to Reno, which was fine. We grew up in a home that was kind of like a duplex but underneath was a restaurant building, and then we lived up top which was actually an old onion barn over 100 years old. It was a gas station at one point and then it was a barn, so we lived there and my dad started a pizza business there and that was his dream to move into the country. So he opened up a pizza place, which we are Mexican, but it was really a good time, we were very poor. My dad would work his other job which was a tree cutting service, then my mom had to stay home and raise the kids and run the restaurant. My older sisters worked the restaurant and then the little kids, we kind of watched ourselves or each other, all the little

ducks you know, all lined up. From there like on Sunday we would all pack into the station wagon and go to church. I went to Mt. Sinai Church, a Catholic church, growing up and that is how we learned some of our values. Like I said my sisters went to Catholic schools up until the point where they really could not afford it anymore. They went to St. Peter, they were married there.

[109-114] EVALUATION

We always had our catholic background. Since we were a Mexican American family we still have likeI mean back to the mission first started coming voyaging over and they tried to convert everybody to Catholicism you know you still have your tribes. You know the Spanish, the Mexican, the different groups, I have learned about it over the years but this is how I came to be here I guess, over the past 500 years, this is where I am right now. I know that a lot of the traditions stay the same and I know there are pagans and they have their different ways of worshipping, they mix. We were a very catholic based family.

ABSTRACT

[114-118] My grandmother, my mom's mom is very, very catholic you know she goes to church every Sunday and prays the rosary and does all of this and that. Whereas my other grandmother she knows all the prayers, she never learned to read any English or write, but she knows all of the prayers. She knows them by heart. You know she knows the traditions, more of her thing is spirituality, praying, saying prayers over people when they are sick.

ORIENTATION

[125-129] So it is just the traditions like Aloe and just the cultural—I guess you know like all of your ailments. You kind of learn what would work and my grandmother used Aloe for everything off an Aloe plant. You know she would say like " Use this for your cuts, and for your zits, and use this for everything, it will work.

EVALUATION

[152-154] I'm at a little loss for words right now. There is a bit of a barrier that I have seen from other nurses I would say just because they do not talk the way that you talk.

COMPLICATION

[154-156] They are from a certain part of town and you know you automatically make stereotypes about a person because of that or even mental illness or detox patients.

EVALUATION

[156-158] It kind of comes and goes, I have seen it with nurses and you might make a little comment here and there, but I just kind of learn to not even listen to it, and just go on about my work.

RESULT or RESOLUTION

[159-162] [I] try to do the best that I can for them, and give them the information that they would need, if it is a new diagnosis give them the education. Just talk to them and treat them like people the way that they want to be treated. Just listen to what they might need, they are not from where you came from.

CODA

[163] I guess you just have to be non-judgmental and keep doing what you are doing.

EVALUATION

[167- 179] It is hard to say exactly how I treat people because I do not really think about the way that I treat people, I just go about it and do it, so it is really hard for me to put

into words how to act, I guess or how to treat people because everyone is so different. I don't treat everyone the same, honestly, I don't. Because sometimes you might go into a patient's room and you have your 89-year-old patient and they are a farmer and are from maybe Venice or Washington, and they had their farm for many, many years, and they grew up German-Catholic or German Protestant or whatever it is and they are stoic. Then you go across to another room and you take care of someone who might be African American from Detroit and from the city, you know they are not going to talk the way that you talk. Maybe their mom was from the south and they have come up here. Maybe even taking care of different Mexican families and get to know them from the inner city a lot of them started off in the fields in the areas and they moved to the inner city and so through time you get to know all the different families.

RESULT or RESOLUTION

[179-181] You have to know how to be like a chameleon and kind of make yourself be around, and just listen to them, and realize that they are not who you are.

CODA

[181-183] You are there to help them and give them the information that they need or treat them the way that they need to be treated. We can't cater to ourselves when we are nurses.

Maria states in the first abstract that she has known that she wanted to be a nurse for as long as she can remember, a choice that “has always kind of been in the plan I guess. I never knew what else to be I guess, I never knew anything else that I wanted to be, you know. I have a lot of other interests but I always knew that I wanted to be a nurse. I do not know why sometimes, it is very stressful at times, but I never knew what else to be I guess.” She recalls in the orientation a recent interaction with a childhood friend who reminded her of this desire.

I had this friend from Kindergarten on through eighth grade, we were best friends forever. In high school we kind of lost touch you know, then you get married and kind of move on, you have separate lives. Then her mom died and I went to her mom's funeral, I was like 8 months pregnant or something, and we got to talking again and she said "I remember you always said that you wanted to be a nurse, ever since kindergarten," and I said "Oh yeah, I forgot I did say that."

In the first set of complicating actions, Maria describes some of the hardships she has encountered. “Even in the program when I went to nursing school, it was rough; I worked two to three jobs. I lived on my own. I lived with my sister. I had to pay rent. I

had my own car, a junk car. [I had to] pay car insurance and I am only 18 years old.”

However, Maria evaluates these potential obstacles as “part of the plan”: “Even when it was the toughest point, and I wanted to quit, and I was going to fail everything, in the back of my mind I still just did it. This is what I am going to do.”

Maria’s belief in “the plan,” in her “knowing,” undergirds her persistence toward her goal. This persistence seemed to be learned within the context of her family and cultural background, which she describes in great detail in the second narrative.

Although Maria did not have nurses or other health care professionals in her immediate family, she recalls taking on the role of caretaker throughout her early and later adolescent years.

Eventually my oldest sister became age 16 and they could not afford to put everyone in catholic school. My dad always had a dream of moving out to the country. That is when he picked up and moved everyone out to Reno, which was fine. We grew up in a home that was kind of like a duplex but underneath was a restaurant building, and then we lived up top which was actually an old onion barn over 100 years old. It was a gas station at one point and then it was a barn, so we lived there and my dad started a pizza business there and that was his dream to move into the country. So he opened up a pizza place, which we are Mexican, but it was really a good time, we were very poor. My dad would work his other job which was a tree cutting service, then my mom had to stay home and raise the kids and run the restaurant. My older sisters worked the restaurant and then the little kids, we kind of watched ourselves or each other, all the little ducks you know, all lined up. From there like on Sunday we would all pack into the station wagon and go to church. I went to Mt. Carmel Church a catholic church growing up and that is how we learned some of our values. Like I said my sisters went to catholic schools up until the point where they really could not afford it anymore. They went to St. Peter, they were married there.

Maria’s evaluation of her family context is rooted in a sense of providence in the face of hardship. This leads to the abstract of the next narrative, in which Maria combines her identity as an immigrant with her cultural and religious background.

We always had our catholic background. Since we were a Mexican American family we still have like...I mean back to the mission first started coming

voyaging over and they tried to convert everybody to Catholicism you know you still have your tribes. You know the Spanish, the Mexican, the different groups, I have learned about it over the years. But this is how I came to be here I guess, over the past 500 years, this is where I am right now. I know that a lot of the traditions stay the same and I know there are pagans and they have their different ways of worshiping, they mix. We were a very catholic based family.

In the orientation, Maria speaks of her grandmothers and various ways in which traditions were handed down.

My grandmother, my mom's mom is very, very catholic you know she goes to church every Sunday and prays the rosary and does all of this and that. Whereas my other grandmother she knows all the prayers, she never learned to read any English or write, but she knows all of the prayers. She knows them by heart. You know she knows the traditions, more of her thing is spirituality, praying, saying prayers over people when they are sick.

In a series of complications and evaluations, Maria discusses the reality of cultural insensitivity found among some of her co-workers.

There is a bit of a barrier that I have seen from other nurses I would say, just because [patients] do not talk the way that you talk. [Patients] are from a certain part of town, and you know, you automatically make stereotypes about a person because of that or even mental illness or detox patients.

This type of behavior, in Maria's eyes, does not reflect the best in patient care. Maria does not confront the behavior, but rather holds herself to a different standard. "I have seen it with nurses and you might make a little comment here and there, but I just kind of learn to not even listen to it, and just go on about my work." In her evaluation, we see that Maria's personal ethic of caring for a diverse patient population is to see each patient as an individual and to create a plan of care that addresses their needs.

[I] try to do the best that I can for them, and give them the information that they would need. If it is a new diagnosis, give them the education. Just talk to them and treat them like people the way that they want to be treated. Just listen to what they might need, they are not from where you came from.

Maria's approach is so much a part of her identity that she does not give it much attention. "It is hard to say exactly how I treat people because I do not really think about the way that I treat people, I just go about it and do it, so it is really hard for me to put into words how to act, I guess or how to treat people because everyone is so different." Maria goes on to reflect a sophisticated understanding that equal treatment does not mean identical treatment.

I don't treat everyone the same, honestly, I don't. Because sometimes you might go into a patient's room and you have your 89-year-old patient and they are a farmer and are from maybe Venice or Washington, and they had their farm for many, many years, and they grew up German-Catholic or German Protestant or whatever it is and they are stoic. Then you go across to another room and you take care of someone who might be African American from Detroit and from the city, you know they are not going to talk the way that you talk. Maybe their mom was from the south and they have come up here. Maybe even taking care of different Mexican families and get to know them from the inner city a lot of them started off in the fields in the areas and they moved to the inner city and so through time you get to know all the different families.

Lyn.

Lyn is another example of a participant who knew from a very young age that she wanted to be a nurse. Lyn undertook a stepped approach to nursing education. She earned her Licensed Practical Nursing certification first. Then, learning that she not only enjoyed nursing, but that she was good at it, Lyn went on to complete a diploma program, and later a bachelor's degree. Table 8 presents two narratives that describe Lyn's entrance into the path of nursing and her experience of different educational settings.

Table 8

Lyn's Becoming a Nurse Narrative (MZSC011811/Lines 177-240)

Narrative 1
<p>ABSTRACT</p> <p>[181-184] I think RN was above me at that time. I did the LPN for about 15 years and then I went back to school. I think maybe my mom or dad never said "Oh don't be an</p>

LPN be an RN". They never did any of that. They supported me. I don't think that I ever wanted to do anything else at that young age. [. . .] it was never pushed on me. My mom did not work while we were growing up.

ORIENTATION

[177-179] I was a Clara Jane in high school. My dad was a doctor and my mom was an RN. One of my girlfriends down the street when we were in grade school she became an LPN. She kind of talked me into the LPN part.

EVALUATION

[179] I think that I needed to start there as I was extremely shy and timid and I think that was where I needed to start.

Narrative 2

ORIENTATION

[180] I had catholic [school] all the way through. I went to St. Brendans, Our Lady of Fatima...went to St. Catherine's High School, then Grace.

EVALUATION

[195] It always felt like a closer knit, you are part of the group I think.

COMPLICATION

[196-105] I had to take some of my classes at UR and Mason. A couple of the classes I was never on the roster until halfway through. They were like "don't worry your on it" and then you are shaking in your boots and then finally you end up on the roster. But UR they were just not as organized. I went to Loretto too for a couple. At Loretto, I went in there, and the little nun took my hand....."OK honey come over here and she would walk me over to pay my fee, then she took me to get my books, she was delightful. [. . .] you're not just another person sitting on that chair. When I took chemistry at Loretto the nun at the end she knitted us Little pot holders and she put on each one what she thought our personalities were. [. . .]

EVALUATION

[105-108] I feel she [the nun] had mine down to a T. "You take care of people especially you lab partner" who was never on time. You know, this young thing—I figured, "oh well I will help her." I did not care. I think that she [the nun] had us down to a T. We were individuals to her. Not just a person sitting in her class.

RESULT or RESOLUTION

[204] [At Loretto I had the feeling that] you're not just another person sitting on that chair.

[212] We were individuals to her. Not just a person sitting in her class.

ORIENTATION

[108-110] At Grace for my R.N., I think those instructors were very strong, they were very rigid in their rules, which I was very appreciative of. I knew what I was dealing with...

COMPLICATION

[110-224]...you know working full time and going through Grace full time, with Grace being one of the harder schools, then 3 kids age 7, 8, and 9 and over 40...Okay now this assignment is due on this day and if you don't have it done then you are knocked down two grades, or whatever. I would always get mine in on time. The kids that lived in the dorms I though okay you are here and you do not have to work. I was watching to see if they got theirs in on time too, there was one that did not and she got the lower grade.

EVALUATION

[224-227] I think that [Grace's rigidity] was very important and the Grace instructors were very strong on that, on the floor they were very strong, they were knowledgeable. To this day I think that the Grace graduates have the better bedside manner, clinical know-how, smarts, because of those instructors.

CODA

[238-240] Top notch [instructors are] tough, but necessarily so, I truly feel that we have to be that way with the new grads.

In the first of the three narratives, Lyn relates her early desire to become a nurse, the support of her mother and father, the path of LPN training, and her need to start in an entry level program. In the abstract and orientation, Lyn speaks about her parents support and the encouragement of a neighborhood friend.

I think RN was above me at that time. I did the LPN for about 15 years and then I went back to school. I think maybe my mom or dad never said "Oh don't be an LPN be an RN". They never did any of that. They supported me. I don't think that I ever wanted to do anything else at that young age. [. . .] it was never pushed on me. My mom did not work while we were growing up. I was a Clara Jane in high school. My dad was a doctor and my mom was an RN. One of my girlfriends down the street when we were in grade school she became an LPN. She kind of talked me into the LPN part.

Although she remembers being "talked into" the LPN path toward nursing, Lyn evaluates that decision positively: "I was extremely shy and timid and I think that was where I needed to start."

Lyn begins a second narrative orientation when she contrasts her experience in Catholic schools and with her experience in a public community college. "I had Catholic [school] all the way through. I went to St. Brendan's, Our Lady of Fatima...went to St. Catherine's High School, then Grace. It always felt like a closer knit, you are part of the group I think." She goes on to describe the context of this narrative in the complication.

I had to take some of my classes at UT and Mason. A couple of the classes I was never on the roster until halfway through. They were like "don't worry your on it" and then you are shaking in your boots and then finally you end up on the roster.

But UT they were just not as organized. I went to Loretto too for a couple. At Loretto, I went in there, and the little nun took my hand..."OK honey, come over here" and she would walk me over to pay my fee, then she took me to get my books, she was delightful. [. . .] you're not just another person sitting on that chair. When I took chemistry at Loretto, the nun, at the end, she knitted us little pot holders and she put on each one what she thought our personalities were...

Lyn evaluates the importance of personalized affirmation: "I think that she [the nun] had us down to a T. We were individuals to her...not just a person sitting in her class."

Although Lyn attaches importance to this kind of student-centered, personal touch in the classroom, the orientation to her next narrative piece describes how she also values high expectations and performance standards. "At Grace for my R.N., I think those instructors were very strong, they were very rigid in their rules, which I was very appreciative of."

In the complication, Lyn describes some of her own hurdles. "You know working full time and going through Grace full time, with Grace being one of the harder schools, then three kids age seven, eight, eight, nine, and over 40." Just as she found a way to complete assignments on time in the midst of other commitments, Lyn watched to see that others were held to the same standard.

Okay, now this assignment is due on this day and if you don't have it done then you are knocked down two grades, or whatever. I would always get mine in on time. The kids that lived in the dorms, I thought, "okay you are here and you do not have to work." I was watching to see if they got theirs in on time too. There was one that did not, and she got the lower grade.

As Lyn reflects, she notes the importance of stringent standards not only in her own educational experience, but for current nursing pre-professionals. She feels this type of approach to nursing education makes for better nurses.

I think that [Grace's rigidity] was very important and the Grace instructors were very strong on that, on the floor they were very strong, they were knowledgeable. To this day I think that the Grace graduates have the better bedside manner, clinical know-how, smarts, because of those instructors. Top notch [instructors

are] tough, but necessarily so, I truly feel that we have to be that way with the new grads.

Conclusion to becoming a nurse.

In summary, most of the participants referred to an early interest in health care. In addition, it seems that the “high-touch” nature of nursing is what drew them toward this specific career. Face-to-face contact provides both the professional and personal gratification that makes it possible for nurses not only to persevere in this demanding occupation, but to uphold the human dignity of the patients they meet day in and day out.

The seven additional narratives in Appendix G emphasize the point that, although many participants had an early desire for a career related to health care, many did not reflect on the “why” of this choice until later in life, if at all. Those who have wondered “why health care?” or “why nursing?” seem to be moved by the human contact involved in health care careers. A few others began their journey toward nursing by considering, or actually completing, degrees in related fields such as respiratory therapy or medicine.

Collegiate experience.

In the following narratives told by Amanda, Lyn, and Kristi it will become clear that, although each participant has earned at least a bachelor’s degree, contiguous collegiate attendance (i.e. the traditional four-consecutive-year baccalaureate track) was the exception among the participants. Instead, “segmented” education was the norm. All but four participants earned an associate’s degree or diploma in nursing first; then, after a significant number of years of clinical practice, they sought further education at the baccalaureate and/or master’s level. The pragmatic nature of nursing professionals surface in participants’ accounts of how and why they chose to attend particular institutions of higher education. As participants recall their collegiate experiences, most

identify a clinical placement, faculty member, or mentor that confirmed their vocation as nurses.

Amanda.

Amanda's narrative of her collegiate experience begins with two parallel blocks describing how her choice of university, at every degree level, was based primarily on financial considerations. Those blocks are followed by a description of how her financial struggles impacted her performance and how encouragement from a professor helped her gain confidence and prioritize her studies. These narratives can be found in Table 9.

Table 9

Amanda's Collegiate Experience Narrative (ARMF032811/Lines 156-204)

Narrative 1
ABSTRACT
[159-160] [How I chose to attend Manhattan University for my ABN] is actually a very simple story. They gave me the most money. I got a scholarship. I actually got a full scholarship and everything.
EVALUATION
[162-164] So...that seemed reasonable to me. You know, if they were going to pay for my education, then that's where I was going to go. It was close to home, it paid for what I needed, and I didn't have to do sports to get the money.
COMPLICATION
[164-165] So, I had gotten a couple of opportunities...I ran track and cross country...couple of opportunities to run.
EVALUATION/RESULT or RESOLUTION
[165-167] I knew that nursing was going to be intense and I didn't think that I would have time for both. So, this was the opportunity that I felt was the best. So...It was a fairly easy decision.
Narrative 2
ORIENTATION
[169-170] [My decision to attend the University of River Bluff for my Bachelor's and my Master's] also had to do with money. I went to URB for my Bachelor's because it was going to be less costly and quicker than it would be through Manhattan.
COMPLICATION
[170-172] Also, I knew at that point that I wanted to be a nurse practitioner. So, URB has a Master's program and Manhattan does not.

EVALUATION

[172-173] So, I figured I should get my foot in the door and build my reputation with the staff there.

Narrative 3

ORIENTATION

[178-180] I think that when I was in my ADN at Manhattan, I actually didn't do that well mostly because I was struggling financially.

COMPLICATION

[180-190] I mean I'm trying to feed myself and work. I worked almost entirely full time while I was going to nursing school which didn't leave a whole lot of time for studying. So, I had a professor...anatomy and physiology professor at Manhattan who saw that I was struggling. I mean you have to get really good grades to be a nurse. So, to have borderline grades, which was something that I have never had happen to me in my entire life, he pulled me aside one day and instead of acting like I wasn't...you know...trying or I didn't care or anything, he said, "I know how smart you are. I cannot see you fail this. Come and talk to me after class. This is what we can do. You are going to be a great nurse." You know what I mean...and he said, "Most of the people that get A's in my class aren't necessarily the best nurses. I know a good nurse when I see one. You cannot fail this class."

EVALUATION

[190-193] So, I mean it was really...you know to have someone have faith in me even when I was sort of at my worst...helps me all the time in my work because we see people at their worst, usually, and to help reassure them that they can do better; that's it's within them.

RESULT or RESOLUTION/CODA

[193-194] That experience helps me all the time even in my personal life.

As we learned from an earlier narrative, Amanda knew at a young age that she wanted to be a nurse. However, Amanda was responsible for financing her own college education. As she summarizes how and why she chose to attend Manhattan University, a public university, she simply states, "They gave me the most money. I got a scholarship. I actually got a full scholarship and everything." She evaluates that choice in a pragmatic manner. "So...that seemed reasonable to me. You know, if they were going to pay for my education, then that's where I was going to go. It was close to home, it paid for what I needed, and I didn't have to do sports to get the money."

In the complication, Amanda tells of a few offers to participate in collegiate athletics. "I had gotten a couple of opportunities...I ran track and cross country...couple

of opportunities to run.” Yet, again, as Amanda evaluated her situation, her sense of the practical prevailed. “I knew that nursing was going to be intense and I didn’t think that I would have time for both. So, this was the opportunity that I felt was the best. So...It was a fairly easy decision.”

The circumstances around Amanda’s enrollment in her bachelor’s and master’s programs follow a similar pattern. She again chose a public institution, the University of River Bluff, for these two degrees, and again the choice “also had to do with money. I went to URB for my bachelor’s [and master’s] because it was going to be less costly and quicker than it would be through Manhattan.” Amanda also relates in the complication she had further educational plans. “Also, I knew at that point that I wanted to be a nurse practitioner. So, URB has a Master’s program and Manhattan does not.” As she evaluated that factor, Amanda displayed her ability to think ahead. “I figured I should get my foot in the door and build my reputation with the staff there.”

Thinking back to her ADN program, Amanda recalls a bit of academic challenge in her given circumstances in the orientation. In the complication, she reveals how the intervention of a professor proved to be a turning point.

I think that when I was in my ADN at Manhattan, I actually didn’t do that well mostly because I was struggling financially. I mean I’m trying to feed myself and work. I worked almost entirely full time while I was going to nursing school which didn’t leave a whole lot of time for studying. So, I had a professor...[an] anatomy and physiology professor at Manhattan who saw that I was struggling. I mean you have to get really good grades to be a nurse. So, to have borderline grades, which was something that I have never had happen to me in my entire life... he pulled me aside one day and instead of acting like I wasn’t...you know...trying, or [that] I didn’t care or anything, he said, “I know how smart you are. I cannot see you fail this. Come and talk to me after class. This is what we can do. You are going to be a great nurse.” You know what I mean...and he said, “Most of the people that get A’s in my class aren’t necessarily the best nurses. I know a good nurse when I see one. You cannot fail this class.

Although bright enough to receive a tremendous amount of scholarship money, according to Amanda, she had to learn, with the guidance of a professor, to balance the practicalities of working her way through college with the academic demands of her nursing program. She recalls through her evaluation how important it was “to have someone have faith in me even when I was sort of at my worst...helps me all the time in my work because we see people at their worst, usually, and to help reassure them that they can do better; that’s it’s within them.” She ends by affirming, “that experience helps me all the time even in my personal life.”

Kristi.

Kristi entered baccalaureate culture early when she enrolled in a large state university. Although on a political science and history track, she moved toward independent studies as a major and ended up transferring and completing that degree, as well as a nursing degree, at a small, faith-based institution. We can trace her transfer process, structural or system obstacles, and the effect of environment on her experience in the first narrative. She then offers a lengthy second narrative that highlights the impact of a children’s literature class on her perspective, and its influence on her current practice and interactions with patients. Both narratives unfold in Table 10.

Table 10

Kristi’s Collegiate Experience Narrative (KKSA012711/Lines 94-231)

Narrative 1

ABSTRACT

[96-98] I was at RU at the time and I was like, "well I am going to finish what I am doing here you know as far as studies" I have to finish what I start. So I finished and I decided if I switched it and went towards a more independent study they would allow me to finish with a curriculum that I wanted, but at the same time I knew that I had to be around people more.

ORIENTATION

[113-119] When I was at UR they were restructuring a few of their class loads, I only needed three classes to graduate with my independent studies. The way they did their classes it was actually going to take me two more years because of the way they offered in the calendar year—which just ticked me off because it did not make sense to me. I could not grasp that, so I had my advisor pull all my transcripts and I left and went to Loretto. My mom had told me go to Loretto, go to Loretto. She was a nurse manager and a lot of her nurses were going there and enjoyed it, liked it, and I finally went over there and I really liked it.

COMPLICATION

[119-121] I talked to the lady [at Loretto] and within a day she showed me okay we can do this for you as far as independent studies. Everything will transfer except for two classes, which did not meet their criteria.

EVALUATION

[121-126] I figured if I stay at UR I am going to be here two more years regardless. If I go to Loretto I am going to be here two years regardless but I am going to finish my independent studies as well as my nursing. So it was kind of a no brainer even as far as the logistics of classes, even parking. When I had kids, when they were younger, it just made it so much easier. I could get [to campus] and park. I did not have to leave an hour early to get to class.

COMPLICATION

[126-128] When I went there the very first day I spoke with one of the advisers. He even said that it was their goal to educate spiritually, emotionally, physically, and they really did not have intramural sports like they do now when I went there.

EVALUATION

[128-144]

It was interesting to me because I could go to RU [where] I could play Racquetball, or I could go to the sports complex, or I could do any of that stuff. I never did. I did not use one thing there and I am an athletic person. I could not stand it. It just was not for me. I would [then] go to Loretto and they did not have any of that. And the fact that I could take a class and have an hour in between and actually walk the entire campus, and walk past the graveyards, and walk through the gardens behind the grotto that was there. I did that every day. I don't know—even though they offered...and they said...you know as far as the spirituality and the emotional and the health—they offer all of that and they talked about it the very first day I was there. I did not even think twice about it [when I first transferred]. It did not even influence me one way or the other, but yet I did it.

COMPLICATION

[144-147] I enjoyed sports but I spent that time on the grounds and just mentally, I was able to get it together in between class or I would bring my notes with me and walk around for that hour. I was doing it without even realizing it.

EVALUATION

[147-149] Looking back now I know that they are very sports active. I always tell people go there, if anything you will save your mind. There is a spirituality there that you don't get at RU.

ORIENTATION

[149-156] [The campus] is gorgeous. It was interesting I had a young daughter at the

time, so I had other things that were occupying my time. There were people in my classes that would do the same thing that I would. They had all the time in the world. They could go down the street to the bar if they wanted to between class, to the Village Inn or do whatever, but it was spiritual for people whether they knew it or not.

CODA

[156 -160] To this day I will go over there sometimes because I have a friend that lives by there and I will still walk the campus. It is gorgeous; I was doing it at the time without realizing it, absolutely.

Narrative 2

ORIENTATION

[172-174] I am trying to remember her name [. . .] I can see her crazy red hair. She was an English instructor and I took multiple classes of hers. I would look her classes out and actually end up taking them as electives.

COMPLICATION

[174-180]

The one class that I loved, she was a British lit teacher, but yet she would cross over and do different classes. She did a children's literature class that was amazing, because she pointed out in children's literature from 6th to 8th grade level, and the books that she picked they were all Caldecott winners, and we were required to study them but the focus was on basically the reflection. They were not written by children they were written for children.

EVALUATION

[180-192] I think that awareness that I have, English and literature was always my favorites as well. I have a minor in English too. It is just an education thing, I love to learn. The children's literature class we had so many books that we looked at and a lot of them were from WWII. Having an adult reading a children's literature book...you look at it in a whole different perspective. There is an awareness that comes, and the influence, as you are an adult looking at it...forces you to look at things through a kids eyes. I guess I still do that. I kind of look at what is going on with a patient or I look at what is going on whether they are adults or children, and I try to always look at it through their eyes. That was the class that really kind of (it had nothing to do with nursing what so ever)...turned a switch on for me. Like, okay, you can take this book—even though it is supposed to be a kids book. What adult is really going to pick it up and read it? Maybe not many, but maybe they should. Maybe they should learn to look at something through a different perspective. I think that really brings a huge awareness.

[208-222] Like *The Diary of Anne Frank*, they want you to read that in 8th grade, you don't care, you know you are reading it and it is like yea that war happened, yea whatever, but to go back and to really look at something through someone else's eyes and also the influence. Like if a kid is reading this book how are they looking at it? How is it influencing them and is it? Maybe it is not. Like you said you know they are reading this book and it does not mean anything to them they are just reading it because they have to. But to go back as an adult and look at that, the same thing with patients. What I am saying to a patient when I am discharging them or educating the on something, does it go in one ear and out the other? Yes. They are not paying attention to me it is not making a difference for them because they are usually focused on something

else. You know if they sat in the ER for three hours and they got a gastro thing and they are dehydrated and there is all these important things that I have to tell them, but those three hours ran past the time that their kid got out of school, so now they are so focused on getting home to get their kids that they are not really listening to what I am telling them and chances are that they are going to come back.

RESULT or RESOLUTION

[192-196] When I look at a cancer patient or something. I have no idea of why I pinpointed that class, since you asked me that I think that is the one. It does not have anything to do with nursing but it does. I think that class really forced me to look at something from a different perspective. Maybe it is the fact that I have always done that but that just really triggered it for me.

[222-231] If you realize that [patients are not really paying attention] and are aware of that as a nurse, you can pinpoint these things and make [discharge information] very distinct and tight-form. Re-write it in one word phrase [. . .] instead of just going “here are your discharge instructions” and they run out of there. In two days they are back in because they did not do anything that was on those instructions; because you were not aware of the fact that they have so much other crap going on that you need to make it distinct. And so, that class did maybe point that out.

CODA

[201-202] I still think about that [English] class and maybe it brought more of awareness.

Kristi sets up the narrative about her collegiate experience by summarizing her desire both to finish what she started, and to undertake a new course of study. “I was at RU at the time and I was like, ‘well, I am going to finish what I am doing here, you know, as far as studies’ I have to finish what I start. So I finished and I decided if I switched [my major] and went towards a more independent study, they would allow me to finish with a curriculum that I wanted. At the same time, I knew that I had to be around people more.” Kristi then recounts the challenges of the institution’s structure and coursework availability. She speaks of those she approached for help, including an advisor, the action she took to handle her frustration, and the role her mother played in suggesting an alternative.

When I was at UR they were restructuring a few of their class loads, I only needed three classes to graduate with my independent studies. The way they did their classes it was actually going to take me two more years because of the way

they offered in the calendar year—which just ticked me off because it did not make sense to me. I could not grasp that, so I had my advisor pull all my transcripts and I left and went to Loretto. My mom had told me “go to Loretto, go to Loretto.” She was a nurse manager and a lot of her nurses were going there and enjoyed it, liked it, and I finally went over there and I really liked it.

Kristi’s choice to transfer from a large public university to a small, faith-based institution proved to be a good choice for her, a better fit. At this small, faith-based institution, convenience and easy access to parking, registration, and other advantages proved significant.

I talked to the lady [at Loretto] and within a day she showed me okay we can do this for you as far as independent studies. Everything will transfer except for two classes, which did not meet their criteria. I figured if I stay at UR I am going to be here two more years regardless. If I go to Loretto I am going to be here two years regardless but I am going to finish my independent studies as well as my nursing. So it was kind of a no brainer even as far as the logistics of classes, even parking. When I had kids, when they were younger, it just made it so much easier. I could get [to campus] and park. I did not have to leave an hour early to get to class.

Kristi reflects on how surprising she found it that the beautiful setting and surroundings of the campus provided good space for studying as well as for clearing her head and enhancing her spirituality. “When I went there the very first day, I spoke with one of the advisers. He even said that it was their goal to educate spiritually, emotionally, physically, and they really did not have intramural sports like they do now when I went there.”

Kristi evaluates how differently she took advantage of various offerings on each campus—RU, the large public university and Loretto, the small Catholic college.

It was interesting to me because I could go to RU [where] I could play Racquetball, or I could go to the sports complex, or I could do any of that stuff. I never did. I did not use one thing there and I am an athletic person. I could not stand it. It just was not for me. I would [then] go to Loretto and they did not have any of that. And the fact that I could take a class and have an hour in between and actually walk the entire campus, and walk past the graveyards, and walk through the gardens behind the grotto that was there. I did that every day. I don’t know—

even though they offered...and they said..you know as far as the spirituality and the emotional and the health—they offer all of that and they talked about it the very first day I was there. I did not even think twice about it [when I first transferred]. It did not even influence me one way or the other, but yet I did it.

Complication

The beauty of the campus added to the learning environment for Kristi. “I spent that time on the grounds and just mentally, I was able to get it together in between class or I would bring my notes with me and walk around for that hour. I was doing it without even realizing it.” It also seems to have given her an experience of how spirituality can add balance to life. “I always tell people go there, if anything you will save your mind. There is a spirituality there that you don't get at RU.”

In the second narrative, Kristi conveys a classroom experience that continues to influence her care giving as nurse by challenging her to observe events from perspectives other than her own. She orients the lengthy narrative by describing the person she holds responsible for this learning. “I am trying to remember her name [. . .] I can see her crazy red hair. She was an English instructor and I took multiple classes of hers. I would look her classes out and actually end up taking them as electives.” Kristi’s experience broadens through what happened in these classes.

The one class that I loved, she was a British lit teacher, but yet she would cross over and do different classes. She did a children's literature class that was amazing, because she pointed out in children's literature from 6th to 8th grade level, and the books that she picked they were all Caldecott winners, and we were required to study them but the focus was on basically the reflection. They were not written by children they were written for children.

The reflection that was required of Kristi in these literature classes has proven to be a skill that helps her be a better nurse.

Having an adult reading a children's literature book...you look at it in a whole different perspective. There is an awareness that comes, and the influence, as you are an adult looking at it...forces you to look at things through a kids eyes. I

guess I still do that. I kind of look at what is going on with a patient or I look at what is going on whether they are adults or children, and I try to always look at it through their eyes. That was the class that really kind of (it had nothing to do with nursing what so ever)...turned a switch on for me. Like, okay, you can take this book—even though it is supposed to be a kids book. What adult is really going to pick it up and read it? Maybe not many, but maybe they should. Maybe they should learn to look at something through a different perspective. I think that really brings a huge awareness.

Kristi's concludes that this changed her perspective on delivery of healthcare.

When I look at a cancer patient or something. I have no idea of why I pinpointed that class, since you asked me that I think that is the one. It does not have anything to do with nursing but it does. I think that class really forced me to look at something from a different perspective. Maybe it is the fact that I have always done that but that just really triggered it for me.

If you realize that [patients are not really paying attention] and are aware of that as a nurse, you can pinpoint these things and make [discharge information] very distinct and tight-form. Re-write it in one word phrase [. . .] instead of just going “here are your discharge instructions” and they run out of there. In two days they are back in because they did not do anything that was on those instructions; because you were not aware of the fact that they have so much other crap going on that you need to make it distinct. And so, that class did maybe point that out.

Sarah.

Sarah's plunge into her collegiate experience also follows the trajectory of what is often referred to as a “trad” or traditional student. She enrolled in a baccalaureate course of study at one small, Catholic college. Unlike Kristi, Sarah immersed herself in the curricular and co-curricular programs of the college. Although Sarah ended up transferring to another institution (another small, Catholic college), she continued to engage in the full college experience, including clinical rotations and service trips. Sarah's account develops as a narrative within a narrative within a narrative. As Table 11 shows, Sarah comingles her experiences as student, nurse extern, and nurse.

Table 11

Sarah's Collegiate Experience Narrative (SSSV012811/Lines 132-268)

ABSTRACT

[132-137] I knew that I wanted to go the Grace when I graduated from high school. My grandpa was a physician for Grace, I was born at Grace, it just seemed like Grace was the place to go. Everything was wonderful. I think that I got wrapped up in other things where I did not necessarily have my priorities straight. I was not studying as hard as I could have and I ended up not finishing the program at Grace. Therefore, I was looking for a new program and I found Loretto.

ORIENTATION

[137-142] I did not even know [Loretto] existed until I started looking for a new program. Once I got to Loretto, it was an opportunity to reset my priorities. Go back to those family values. Live by what I was taught you know. Hard work pays off. I think that leaving Grace also had something to do with that. I saw people, and I saw what they had made of themselves, how hard work paid off for them and I wanted that too. I am going to start over, I want that.

COMPLICATION

[142-148] So I when I started at Loretto, I set my mind to it that I was going to work hard; I was going to achieve everything that I could. At Loretto, the staff was very wonderful. They felt like family. It is not very professional, but we did call our teachers by their first name. We had their cell phone numbers and you could call them whenever you needed help. It did feel like a family. When I graduated, it was like where did my family go? The teachers were willing to bend over backwards and would do anything for you. If you wanted help, they would give up their time and their energy to help you.

[163-180] I think that the biggest [experience] that stands out is I did a peds [pediatrics] clinical and I always thought that I wanted to do peds or OB because I love babies. When I did my OB orientation, and [I] actually ended up repeating it from Grace and Loretto, I thought "this is so mundane, like, I need a little bit more excitement." Also working in the hospital and seeing how things can change [turned out to be] one of those "Okay this is not for me" [moments]. People come here with the expectation of having a baby and they are healthy people. So I kind of figured that OB was not for me. I did the peds clinical and there was an 11-month-old baby who was having difficulty urinating. This was the family's second child, [and] they noticed that the child was not urinating much. They brought the baby back in. I know that as a clinical student you do not have as many patients [as] you would as a nurse. So this was my only patient and I got a chance to kind of go in and talk with the parents. they were overwhelmed by the number of people that kept coming into the room. The first thing that we did was put [up] a sign to check at the nurses' station [in order] to limit the number of people going into the room. [As] part of the clinical rotations you are supposed to give your patient a bath. I was like "Oh, I get to give this baby a bath and I was really excited about it." I took the little baby boy from his mom and I said that I was going to give him a bath. She sat down on the couch to have some breakfast with her husband. She said "oh my gosh,

this is the first time in seven days I have gotten to sit down to eat breakfast.” She was just so grateful.

EVALUATION

[181] It was that kind of moment that made me think "this is why I am a nurse."

ORIENTATION

[152-154] Grace college was very similar to the [regional] mission in that they kind of run side by side and one program kind of feeds into the system. The Loretto mission was very similar as well, being that it is also a catholic institution.

EVALUATION

[154-156] I do not think that I would have been able to go to another [type of] institution. I think that is part of what made the experience so nice—because their missions were so rooted in faith. I would not have been able to do the university.

COMPLICATION

[186-188] There have been several times where I had the opportunity to sit down with patients and just talk to them. They seemed to like that fact that there was someone to just listen and who is not rushed. I could really see them open up.

EVALUATION

[188-192] It was really nice to see them when you walk into the room. They are so overwhelmed by everything that is going on. You get a chance to talk to them and they let so much off their shoulders. You walk out of the room and you can see that you made their day. Again, it goes back to knowing that you made some sort of impact or difference.

RESULT or RESOLUTION

[199-201] I think encouraging people to be involved outside a classroom [is important to education]. The classroom is never going to teach you everything. The classroom cannot prepare you for life.

EVALUATION

[201-249] I think that was one of the things that I really enjoyed about Loretto. At Grace college they were associated with Grace facilities so the majority of the clinicals were with the Grace facilities. Not that there is anything wrong with that, but because Loretto had to fight for spots, there was such a variety you know—"go do your clinicals here." You got the opportunity to see schools in a different light as a nurse versus a student. Going to a factory and realizing there are nurses at factories. Seeing things in a different light really brings out the whole picture. It is not just a classroom. You can't learn everything from a textbook and you can't learn everything from a lecture. [. . .] Clinicals [. . .] Outside involvement, I think that it varies based on curriculum as far as nursing, and going out and seeing different forms of nursing—more than just the hospital setting. Seeing home health. Other curriculums, like say business, like going out seeing a tax professional or somebody that deals with inner city.

[. . .] Here in the United States we are split, that is putting it plainly, we are split. When you go to other countries that are less fortunate and you get the opportunity to help them it first of all makes you appreciate what you have. You can learn so much from somebody who finds joy in the littlest things and is so thankful for everything that you do for them. Seeing a different way of life and experiencing life outside of what you are used to. Being put outside of your comfort zone can really broaden your horizon if you

appreciate what you have. It kind of keeps you in check as well when you come back from a trip like that. It makes you keep things in check as far as how you do things. You tend to be a little more resourceful. You focus on the little things, the things that make a difference. You know "we are going to take you down for a CT scan" or "we are going to take you to surgery to fix your back" or "how about I put a pillow under your legs to make you more comfortable?" Something that you can do, something resourceful, something that really makes a difference.

[. . .] Well like when I did the "mountain people"—that is stereotypical, but you know—like West Virginia and in the hills. It seemed very similar to going to Peru. You sit there and you say to yourself "this is your own country and you cannot even take care of your own people." We let people slip through the cracks. You come in a hospital and you work and everything is so sterile. You do the best that you can with what you have. Again, you are resourceful and the patient care seems to be more...because in places where people are less fortunate I think that they are intimidated by health care. They can't afford it. People ask questions when they come into hospitals, so they tend to avoid [coming in]. When you are exposed to that, and you see somebody who is less fortunate, [you realize that] they are outside their comfort zone and they are very protective of themselves. They also bring with them their family because that is their comfort. So you are not just treating them, you are treating the family.

RESULT or RESOLUTION

[254-268] You can't teach an old dog new tricks. It is the oldest saying in the book but it is so true. You can't force anything on everybody. They all have different mindsets. You can make suggestions, which tend to go over a lot better than telling somebody something. You have to really be in tune with other people's personality and their background. If you do not respect them, where they come from, their personality, their traits and all of that, it backfires on you. You become the bad person even though you are looking out for the good of the group. You appear to be dominant and close minded. [. . .] I mean, like a leader has a certain amount of dominance that they have to portray. But, I also think some of it is like a self-dominance, where you appear to be the dominant one but yet you can't give an inch or they will take a mile. You have to set some sort of boundaries, but you cannot just tell people the way that it is. I think that people respect you more when you respect them and where they come from.

In the abstract to this particular narrative, Sarah refers back to the grandfather who was so formative in her choice to become a nurse. He, again, is formative in her choice of colleges. "I knew that I wanted to go the Grace when I graduated from high school. My grandpa was a physician for Grace, I was born at Grace, it just seemed like Grace was the place to go. Everything was wonderful." However, what was a seemingly a providential option turned out to not be a good fit for Sarah. "I think that I got wrapped

up in other things where I did not necessarily have my priorities straight. I was not studying as hard as I could have and I ended up not finishing the program at Grace. Therefore, I was looking for a new program and I found Loretto.”

This is really where the narrative begins for Sarah’s reflection on her collegiate experience and a coming into her own with regard to her choice of schools. “I did not even know [Loretto] existed until I started looking for a new program. Once I got to Loretto, it was an opportunity to reset my priorities. Go back to those family values. Live by what I was taught you know. Hard work pays off. I think that leaving Grace also had something to do with that. I saw people, and I saw what they had made of themselves, how hard work paid off for them and I wanted that too. I am going to start over, I want that.”

Sarah goes on to describe, in the complication, how things were at Loretto: family-like, supportive, student-centered.

So I when I started at Loretto, I set my mind to it that I was going to work hard; I was going to achieve everything that I could. At Loretto, the staff was very wonderful. They felt like family. It is not very professional, but we did call our teachers by their first name. We had their cell phone numbers and you could call them whenever you needed help. It did feel like a family. When I graduated, it was like where did my family go? The teachers were willing to bend over backwards and would do anything for you. If you wanted help, they would give up their time and their energy to help you.

Sarah then moves on to describe an experience that both changed her mind on the nursing specialty she was interested in and confirmed her path in nursing. Her narrative moves fluidly from the first person singular into first person plural “team” language to speaking prescriptively in the second person.

I think that the biggest [experience] that stands out is I did a peds [pediatrics] clinical and I always thought that I wanted to do peds or OB because I love babies. When I did my OB orientation, and [I] actually ended up repeating it from

Grace and Loretto, I thought “this is so mundane, like, I need a little bit more excitement.”...[Then] I did the peds clinical and there was an 11-month-old baby who was having difficulty urinating. This was the family's second child, [and] they noticed that the child was not urinating much. They brought the baby back in. I know that as a clinical student you do not have as many patients [as] you would as a nurse. So this was my only patient and I got a chance to kind of go in and talk with the parents. they were overwhelmed by the number of people that kept coming into the room. The first thing that we did was put [up] a sign to check at the nurses’ station [in order] to limit the number of people going into the room. [As] part of the clinical rotations you are supposed to give your patient a bath. I was like “Oh, I get to give this baby a bath and I was really excited about it.” I took the little baby boy from his mom and I said that I was going to give him a bath. She sat down on the couch to have some breakfast with her husband. She said “oh my gosh, this is the first time in seven days I have gotten to sit down to eat breakfast.” She was just so grateful.

Sarah evaluates the situation by stating, “it was that kind of moment that made me think “this is why I am a nurse.”

Sarah then orients the reader to the quality her first college, her place of employment, and the college from which she graduated. “Grace College was very similar to the [regional] mission in that they kind of run side by side and one program kind of feeds into the system. The Loretto mission was very similar as well, being that it is also a Catholic institution.” In evaluating this mission quality, Sarah remarks on the connection and continuity she feels with all three. “I do not think that I would have been able to go to another [type of] institution. I think that is part of what made the experience so nice—because their missions were so rooted in faith. I would not have been able to do the university.”

In the complicating action, Sarah offers an example of how this mission, in action, allows her to be present to patients. “There have been several times where I had the opportunity to sit down with patients and just talk to them. They seemed to like that fact that there was someone to just listen and who is not rushed. I could really see them open

up.” She then reflects on what this lends to her role as a nurse and her desire for meaningful work.

It was really nice to see them when you walk into the room. They are so overwhelmed by everything that is going on. You get a chance to talk to them and they let so much off their shoulders. You walk out of the room and you can see that you made their day. Again, it goes back to knowing that you made some sort of impact or difference.

The result, for Sarah, is that she attributes the opportunity to learn such things to experiences outside of the formal classroom. “I think encouraging people to be involved outside a classroom [is important to education]. The classroom is never going to teach you everything. The classroom cannot prepare you for life.”

In light of this understanding, Sarah evaluates her experience at Loretto. I think that was one of the things that I really enjoyed about Loretto... Going to a factory and realizing there are nurses at factories. Seeing things in a different light really brings out the whole picture. It is not just a classroom. You can't learn everything from a textbook and you can't learn everything from a lecture. [. . .] Clinicals [. . .] Outside involvement, I think that it varies based on curriculum as far as nursing, and going out and seeing different forms of nursing—more than just the hospital setting. Seeing home health... Recalling experiences from service-learning or mission trips (one with students and faculty/staff from Grace to Appalachia and the other with students and faculty/staff at Loretto to Peru), Sarah talks about what she learned, both about the people she traveled to serve and about the situation here in the United States. Again, she moves from first person plural to second person prescriptive narration as she reflects on how what she learned influences her delivery of care. Here in the United States we are split, that is putting it plainly, we are split. When you go to other countries that are less fortunate and you get the opportunity to help them it first of all makes you appreciate what you have. You can learn so much from somebody who finds joy in the littlest things and is so thankful for everything that you do for them. Seeing a different way of life and experiencing life outside of what you are used to. Being put outside of your comfort zone can really broaden your horizon if you appreciate what you have...It makes you keep things in check as far as how you do things. You tend to be a little more resourceful. You focus on the little things, the things that make a difference. You know "we are going to take you down for a CT scan" or "we are going to take you to surgery to fix your back" or "how about I put a pillow under your legs to make you more comfortable?" Something that you can do, something resourceful, something that really makes a difference...You sit there and you say to yourself "this is your own country and you cannot even take care of your own people." We

let people slip through the cracks. You come in a hospital and you work and everything is so sterile. You do the best that you can with what you have. Again, you are resourceful and the patient care seems to be more...because in places where people are less fortunate I think that they are intimidated by health care. They can't afford it. People ask questions when they come into hospitals, so they tend to avoid [coming in]. When you are exposed to that, and you see somebody who is less fortunate, [you realize that] they are outside their comfort zone and they are very protective of themselves. They also bring with them their family because that is their comfort. So you are not just treating them, you are treating the family.

Sarah concludes her narrative about her collegiate experiences in a discourse on an insight, albeit not fully formed, that she has into the power differential between patient and caregiver.

You can't force anything on everybody. They all have different mindsets. You can make suggestions, which tend to go over a lot better than telling somebody something. You have to really be in tune with other people's personality and their background. If you do not respect them, where they come from, their personality, their traits and all of that, it backfires on you. You become the bad person even though you are looking out for the good of the group. You appear to be dominant and close minded.

Sarah grapples with knowing, on one level, the need for mutual respect and the creation of a healing environment where condescension is not the norm. Yet, in her experience, patient behavior is sometimes less than ideal, which causes her to consider a more authoritarian response from both her leaders and herself.

[. . .] I mean, like a leader [who] has a certain amount of dominance that they have to portray. But I also think some of it is like a self-dominance where you appear to be the dominant one, but yet, you can't give an inch or they will take a mile. You have to set some sort of boundaries but you cannot just tell people the way that it is. I think that people respect you more when you respect them and where they come from.

When it comes down to it, Sarah knows that a patient-professional relationship rooted in respect and empathy is the more mission-minded approach—but that approach must also have boundaries in place.

Choices having to do with education involved issues of access (financial and skill level), student-centered learning, hands-on experiences, mentoring (supportive and challenging), and location. Collegiate experiences—including content, clinical rotations, and participation in service trips, along with the need to balance the demands of family and overcoming other obstacles—have created an enormous resource from which these participants can draw to sustain their mission commitment.

Conclusion to collegiate experiences.

Choices around education involved issues of access (financial and skill level), student-centered learning, hands-on experiences, mentoring (supportive and challenging), and location. These topics, as well as the familiar occurrence of segmented education, were mirrored in the three additional narratives in Appendix H. Collegiate experiences—including content, clinical rotations, and participation in service trips, balancing the demands of family and overcoming obstacles— have created an enormous resource from which these participants can pull to sustain their mission commitment.

Civic engagement and the public face of nursing.

Participant engagement is manifest in civic life as awareness of the “public face” of nursing, the role of hospitals within the larger community, and participation in health and wellness initiatives. A handful of participants volunteered in not-for-profit organizations within their communities. What is revealed in the following narratives by Ann, Lyn, and Bob is that many participants are further involved in organizations such as their churches or in organizations associated with their children’s activities. The narratives make it clear that the time constraints inherent in working full time, raising a family, and continuing one’s education preclude significant community involvement

outside of the workplace. In this connection, many participants view their work itself as active civic involvement.

Ann.

When asked about the connection between her mission commitment at work and engagement in the community, Ann begins her narrative by separating work life and her individual volunteer commitments. However, in Table 12, Ann becomes aware of the actual integration of the two.

Table 12

Ann's Civic Engagement Narrative (CPMW033011/Lines 15-32)

ABSTRACT

[17-18] I've kind of been involved in the community but I don't associate that so much with work.

EVALUATION

[18-20] I mean, my work is work and home is home and my volunteering is that. I mean sometimes they [overlap] but...

ORIENTATION

[20-24] the last group I got involved with is called "Butterflies" and that kind of... enters into work a little bit more just because Sr. Jeanne's involved and I'm involved and some people we see might get referred to them.

EVALUATION

[25] So, that's probably the closest...

COMPLICATAION

[25-29] It's a group in Superior County that's been set up to more or less raise funds for people that have a life-controlling issue. It started in response to all the heroin in Superior County. So, their goal is to raise funds and then to screen people and then send them off to a teen challenge program. [. . .]

ORIENTATION

[29-30] I go to the MRC which is the Superior County Medical Reserve Corps.

RESULT or RESOLUTION/EVALUATION

[30-32] So, I'm a part of [those] and then through the church I started going to the Catholic Ladies of Columbia.

Ann begins by summarizing her initial response to the question of involvement in organizations outside of work in the abstract. "I've kind of been involved in the community but I don't associate that so much with work." She then clarifies: "I mean,

my work is work and home is home and my volunteering is that.” However, as she continues with the evaluation, her dualistic outlook begins to soften: “I mean, sometimes they [overlap].”

As an example of this “overlap,” Ann orients us to one of the organizations with which she works. “The last group I got involved with is called ‘Butterflies’ and that kind of...enters into work a little bit more just because Sr. Jeanne’s involved and I’m involved and some people we see might get referred to them.” Describing her work with another co-worker and potential patients in response to the critical health issue within the community, heroin addiction, triggers another involvement that Ann relates to health care. Ann quickly orients us to this other involvement, the Medical Reserves Corp. Ann wraps up this narrative with the result, “so, I’m a part of [those].” She makes a passing reference to faith-based involvement, “and then through the church I started going to the Catholic Ladies of Columbia,” but does not elaborate further.

Lyn.

Lyn’s approach to drawing connections between mission commitment at work and participation in community organizations results in two narratives, both found in Table 13. One narrative explains what organizations she is involved with and why; the other describes her involvement in Relay for Life, and in particular, reveals the explicit connection to her place of employment.

Table 13

Lyn’s Civic Engagement Narrative (MZSC011811/Lines 146-174; 263-264)

Narrative 1

ABSTRACT

[148-150] OKI am not a strong church person but I still feel very close to God...things like that, but in my own way. I help my kids all the time, I am sure all moms do that. The other thing is Relay for Life [. . .]

[173-174] I do heart walk every year, I am the team captain on that. I really get into everything.

ORIENTATION

[150-152] I come from a family of 10 kids and my sister who is 3 years younger than I am developed breast cancer when she was about age 49.

COMPLICATION

[152-154] It was a really tough struggle for her and I had to almost carry her to chemotherapy because she did not want to go, but she knew she had to, she is a nurse. I took a CTO day and I would take her and we would spend the day together.

EVALUATION/RESULT or RESOLUTION

[154-157] Just because I knew she needed someone there [. . .] I was very delighted to do it, it was not a struggle it was a pleasure to do it. That is why I started Relay for Life...to be really energetic about that.

Narrative 2

ORIENTATION

[158-162] At first I started to get all of the girls [. . .] to bake something for our bake sale. That became an annual bake sale and I bet we had 8-10 of those now, so that many years at least.

COMPLICATION

[162-171] So everybody bakes and one nurse brings in 15 Bundt cakes [. . .] We then have our bake sale on Monday. We make anywhere from \$600 to \$1000 bucks every bake sale [. . .] you know how many brownies that is? We did a cookbook and outpatient pharmacy is still selling those books.

RESULT or RESOLUTION

[171-173] After our last bake sale I put all the money that they have earned throughout the rest of this year now, I have \$500 bucks in my safe at home that is from the cook books after the bake sale.

EVALUATION/CODA

[263-264] I like to organize, you know, at both places. I have always been known for a very, very positive manner.

Lyn's narrative abstract intertwines civic engagement, her relationship with God, and her relationships with her children. "OK...I am not a strong church person but I still feel very close to God...things like that, but in my own way. I help my kids all the time, I am sure all moms do that." She then gets more specific. "The other thing is Relay for Life. . .I do heart walk every year, I am the team captain on that. I really get into everything."

Lyn orients the given circumstances in her life by recalling her family of origin. "I come from a family of 10 kids and my sister who is three years younger than I am

developed breast cancer when she was about age 49.” The importance of Lyn’s family context is apparent as the complicating action of her sister’s illness unfolds. “It was a really tough struggle for her and I had to almost carry her to chemotherapy because she did not want to go, but she knew she had to, she is a nurse. I took a CTO day and I would take her and we would spend the day together.”

As she evaluates both her sister’s bout with breast cancer and her own response to that health crisis, Lyn reports that she provided presence and transportation during her sister’s treatment and that she was motivated to action. “Just because I knew she needed someone there [. . .] I was very delighted to do it, it was not a struggle it was a pleasure to do it. That is why I started Relay for Life...to be really energetic about that.”

Involvement with Relay for Life, particularly fundraising efforts, orients the second narrative. “At first I started to get all of the girls [. . .] to bake something for our bake sale. That became an annual bake sale and I bet we had 8-10 of those now, so that many years at least.” In the complication, Lyn talks about what happens in light of the fundraising bake sales. “So everybody bakes and one nurse brings in 15 Bundt cakes...We then have our bake sale on Monday. We make anywhere from \$600 to \$1000 bucks every bake sale...you know how many brownies that is? We did a cookbook and outpatient pharmacy is still selling those books.”

As Lyn both evaluates this work and brings her thoughts back to present, she reports in the evaluation/coda that “I like to organize, you know, at both places. I have always been known for a very, very positive manner.”

Bob.

Bob's narrative on how his mission commitment impacts his civic engagement, found in Table 14, combines his awareness of community issues, economic realities, family service, and his work in health care.

Table 14

Bob's Civic Engagement Narrative (JSSA012411/Lines 126-169)

ABSTRACT

[Understanding the mission at work] makes you want to do more in the community. You want to be the best here [and out there].

ORIENTATION

You still have your family life and your life as a citizen, you get involved with different things. You still do what you want to do, [being mission committed] does mold you a little bit differently. I lived on the east side so I am east-sider, you know a bunch of rednecks. Right...we give you your water, your fuel, everything else.

EVALUATION

It helps form you to be a better person, you know, doing what I do.

COMPLICATION

I even see people in very bad situations in taking care of people. I can help the community by making sure the kids are doing what they are supposed to in school, getting involved in different things, helping out with food bank or whatever. There are a lot of things that go on, I belong to a classic car group from Point Place, we try to help out if there is something going on that there is a need.

EVALUATION

If you look at it, it does not matter what level of society you are in, you know you can get a lot out of [service] even if you're [not wealthy]. You don't have to have money, you don't have to have things like that. It is what you put into it is what you are going to get out of it.

RESULT or RESOLUTION

We try to help out if there is something going on, if there is a need. At home we have a garden, and if anybody in the neighborhood wants to come over, it is open. It is there, nobody has ever abused it. We have had a number of people that, every year they will come over. One little lady used to come over from the Jefferson homes. It is there for them if people want it. I did a lot of stuff while the kids were in school. My wife was more involved then I, but whenever I could get off and do things like that, [I]definitely[did].

In the abstract, Bob draws a parallel between who he is at work and what he does in the community. He states that understanding the mission at work “makes you want to

do more in the community. You want to be the best here [and out there].” This leads him to a particular behavioral orientation: “You still have your family life and your life as a citizen, you get involved with different things. You still do what you want to do, [but being mission committed] does mold you a little bit differently.” Bob also relates the given circumstance of the side of town he comes from. “I lived on the east side so I am east-sider, you know, a bunch of rednecks. Right...we give you your water, your fuel, everything else.”

Through a brief evaluation and through the complication, Bob reflects on being both a mission committed employee and someone from the “east side.”

It helps form you to be a better person, you know, doing what I do. I even see people in very bad situations in taking care of people. I can help the community by making sure the kids are doing what they are supposed to in school, getting involved in different things, helping out with food bank or whatever. There are a lot of things that go on, I belong to a classic car group from Point Place, we try to help out if there is something going on that there is a need.

Even with an understanding of what it is like to have experienced social and financial obstacles, Bob claims that engaging in the work of helping others can be done by anyone. “If you look at it, it does not matter what level of society you are in, you know you can get a lot out of [service] even if you’re [not wealthy]. You don’t have to have money, you don’t have to have things like that. It is what you put into it is what you are going to get out of it.”

Bob’s experience moves him to be generous with his resources, and to be generous in giving due credit to his wife for her involvement.

We try to help out if there is something going on, if there is a need. At home we have a garden, and if anybody in the neighborhood wants to come over, it is open. It is there, nobody has ever abused it. We have had a number of people that, every year they will come over. One little black lady used to come over from the Jefferson homes. It is there for them if people want it. I did a lot of stuff while the

kids were in school. My wife was more involved then I, but whenever I could get off and do things like that, [I] definitely [did].

Conclusion to the civic engagement within nursing.

The narratives above, and the seven additional narratives found in Appendix I, highlight the connection between one's role as employed nurse and one's vocation as nurse wherever one finds oneself. Participants tend to find ways to engage in civic life through organizations and activities connected to the work and school activities in which their families are already involved. Much of the civic engagement is related to health care—finding ways to provide care to specific populations, raising money for health care concerns, or teaching future health care professionals.

Conclusions

Interview after interview revealed a common understanding of the mission of Catholic health care and a remarkably similar sense of work ethic. The accounts integrated a commitment to excellence with a deep compassion for the body, mind, and spiritual care of patients. Equally noteworthy in almost every narrative is the fact that the respondents' common aspiration to become a nurse began very early in life, and that this aspiration was supported either by family values and influences, or through the modeling by relatives in health care professions, or by both. Contiguous collegiate attendance (i.e. a non-interrupted, traditional, baccalaureate path) was the exception among the participants. Instead, "segmented" education was the norm—that is, most participants earned an associate's degree or diploma in nursing first; then, after a significant number of years of clinical practice, they sought further education at the baccalaureate and/or master's level. Each participant spoke to the challenges of the nursing profession, yet each exhibited resiliency in meeting these challenges and a desire to continue in the

profession. Finally, engagement in the community manifested itself through an awareness of the “public face” of nursing, the role of hospitals within the larger community, and participation in health and wellness initiatives.

Chapter Five

Findings

...something about being able to touch somebody's life in a real way, with your own hands, with your own voice, with your own spirit, was very appealing, and still is... (Study Participant, 2011).

The place where God calls you to is the place where your deep gladness and the world's deep hunger meet (Buechner, F., 1993, p. 119).

Compassion. Excellence. Practicality. Teamwork. Resiliency. These five qualities surfaced in interviews with the study's participants. These qualities gave me new energy and deepened my belief that many employees within Catholic health care embody those articulated characteristics of mission-committed employees: compassion, service, justice, excellence, stewardship, care of the poor, human dignity, sacredness of life and the like.

Chapter One of this study introduced the Backward Design process as the conceptual framework of the research. This final chapter utilizes the Backward Design process to summarize the study, reflect on the use of narrative, tie data analysis and discoveries to the study's research questions and literature review, and explore recommendations for practice and implications for future research through the lenses of education, health care, religion, and spirituality.

Summary and Backward Design

This study sought to identify, through narrative analysis, how Catholic health care nurses understand the development of their mission commitment. A specific focus was the way in which life experiences—familial, faith, collegiate, and professional—

contributed to the formation of mission-mindedness in nurses working within Catholic health care institutions. According to Wiggins and McTigue (2005), once a desired outcome such as mission commitment has been identified through a focused question such as “How am I expecting effective, competent nursing professionals in Catholic health care to be predisposed in terms of mission?,” the next step in the Backward Design process is to determine a standard of “acceptable evidence” (p. 18) and how that evidence will be assessed.

Evidence of mission commitment in this study was garnered from baccalaureate-prepared nurses who were institutionally recognized, cited, or awarded for their mission commitment. The next step, then, was to investigate how these identified employees became mission-committed—not from an outside perspective or through hypotheses, but rather from the perspective of the participants themselves. The study then analyzed how participants structured and evaluated their mission commitment through narrative. Employees are the best authorities on the origins of their own formation as they relate the experiences that provided fertile ground for formation toward mission commitment.

The primary goal of education is not to produce workers, nor is the goal of narrative analysis to uncover pre-determined themes. Riessman (1993) insists that researchers must “avoid the tendency to read a narrative simply for content, and the equally dangerous tendency to read it as evidence for a prior theory” (p.61). Even so, by focusing on the evaluation in the structural analysis of the narratives, common key experiences and insights between the participant narratives did surface. “Narrative analysis,” writes Bell (1999), “shows how structure, content, and interpretation are interwoven” (p. 348). Following the processes, stages, and influences of mission-

commitment that surfaced while examining the narratives, these “interwoven” commonalities, it seems, are seldom programmed; rather, they are elements of the participants’ faith, family, collegiate, and professional experiences. By studying the abstract and the orientation of the narratives, the *who*, *what*, and *where* of key experiences are discerned. Such elements may, in turn, be instructive in planning learning experiences for pre-professional nurses and can highlight areas that human resource specialists might look for in applicant backgrounds when hiring for “organizational fit” (O’Toole, 2006, pg. 36). Regardless of the given circumstances of the narratives: whether the *who* were faculty, peers, staff, family members, or outsiders; if the *what* was curricular, co-curricular, familial, or professional in nature; or the *where* was a Catholic, public, or other faith-based institution; as a higher education researcher, I am interested in finding the ways that the experience can be promoted or translated into the collegiate experience in a meaningful way.

Research Questions

My goal at the outset of this research was to determine which, if any, collegiate experiences enhance the formation of civically engaged and mission-committed Catholic health care nurses. More specifically, my original research question addressed the questions of how Catholic health care nurses understand their personal development of mission commitment, and in particular, what curricular and co-curricular aspects of the college experience lead to the development of mission-minded, socially responsible, civically engaged professionals. Very early on in the interviewing process, I learned that most nurses’ educational experiences helped tremendously in their skill development and critical understanding of the health care environment and delivery of care. At the same

time, I also learned that many of their values concerning the humane care of others in health crises, as well as their comprehensive workplace skills and work ethic, were many times learned in environments other than the classroom or campus.

Thus, my original focus on collegiate experience widened to include various facets of experience: family, faith, collegiate, and professional. The participants themselves identified such elements as formative in the development of their mission commitment.

Additionally, I had hypothesized a direct connection between mission-committed nurses and their degree of civic engagement. Although advocacy in a political or democratic sense did not get a nod, mission-committed nurses did tend to define their engagement with the community and contribution to democratic values through their professional work and through a high level of commitment to advocate for and with their patients. It was instructive to learn what values and commitments were learned early in life and how the collegiate environment could sustain, and even enhance, this knowledge base.

Once the whole of each participant's narrative is analyzed, it is possible to summarize, through a focus on the abstract, evaluative, and orienting elements of each narrative, how participants organize their "lives and experiences through stories and in doing so make sense of them. This chronicling of a life, or part of a life, often starts from a point of 'how it all happened' or 'how I came to be where I am today'" (Coffey & Atkinson, 1996, p. 68). In answer to the primary research question, pertinent summaries from the sample narratives of mission awarded nurses featured in Chapter Four and those included in the appendices are provided below.

Amanda's mission commitment, as storied through two narratives, seems to have been enhanced by the combination of her life-long relationship to the organization—through her grandparents' career track and her own—and the daily work of the team in creating an environment for patients' body, mind, and spirit health. Amanda states in her abstract that helping the poor and underserved is how she interprets the work of Jesus—the work she wants to do.

Kim's pair of narratives indicate that her understanding of a personal commitment to mission is not necessarily rooted in a faith-based conviction. As a matter of fact, her abstract, orientation and evaluation suggest that it is not—and even, perhaps, that the mission works for her despite its religiosity. The institutional mission supports her individual mission and her individual quest to be a better person.

Kristi exemplifies the institutional mission through her personal integrity, through an awareness of others and what needs to be done, and her commitment to “do unto others as you'd have done unto you.” Although not an explicitly religious person, Kristi's choice to live by the so-called Golden Rule drives her behavior both in and out of work. In her evaluation, Kristi claims that she does not have a “work face” and a “home face”—she is who she is. In her orientation, Kristi points out that it is personal work ethic, not the institutional mission, that supports her mission-minded approach to health care—that she brings that ethic to whatever job she is doing.

Bob's understanding of how he developed into a mission-committed nurse, or rather, what drives Bob's mission commitment is an understanding that community issues, economic realities, family service, and his work in health care are all interrelated. Bob stated that being aware of mission at work “makes you want to do more in the

community. You want to be the best here [and out there].” His ability to connect various aspects of life was notable, “You still have your family life and your life as a citizen, you get involved with different things...I even see people in very bad situations in taking care of people. I can help the community by making sure the kids are doing what they are supposed to in school, getting involved in different things, helping out with food bank or whatever. There are a lot of things that go on.”

The study was further shaped by several secondary questions. These questions, listed in Chapter One were, for the most part, answered through the literature review. However, several questions that continued to surface through the analysis of the narratives include:

1. What are the implications for institutions of higher education?
2. Is there a difference in how Catholic health care employees articulate mission based on the type of undergraduate institution they attended?
3. What are the implications for “mission integration,” recruitment, development, and retention initiatives within Catholic health care?
4. Is it reasonable to expect that employees, Catholic and non-Catholic, should understand, respect, and contribute to the Catholic character and mission of Catholic health care?

Questions one and three are addressed specifically in the “Recommendations for Practice” section of this chapter. These recommendations are directly related to the *who* and *what* of the experiences mission-committed nurses point to when describing the way they approach their work.

The second of these additional questions considers the possible differences in how Catholic health care employees articulate mission based on the type of undergraduate institution they attended. Qualitative research, especially research with a small number of participants, foregoes statistical descriptions and correlations, as well as generalized findings. Even so, as a group, the participants do have something to tell us.

The problem statement that grounds the purpose and significance of this research points to the changing face of the employees of Catholic health care—fewer and fewer employees are women religious or have been educated within Catholic school systems. Catholic education and employee socialization no longer go hand in hand. Thus, leaders of Catholic health care cannot assume familiarity with, let alone belief in, Catholic teaching. Thus, the last of the secondary questions asks, “Is it reasonable to expect that employees, Catholic and non-Catholic, should understand, respect, and contribute to the Catholic character and mission of Catholic health care?”

The narratives reveal, in fact, very little difference in both the understanding of the mission of Catholic health care and the delivery of mission-based health care between participants who were Catholic and those who claimed other denominational faith backgrounds. Some found the environment to be formative in their mission-mindedness; whereas others depended on other experiences for their mission formation. All were committed to provide excellent and compassionate care to all who present themselves at the doors of their hospital—which a Thomist scholar would cite as the tenet of Natural Law that all humans are able to reason and thus “do good.” Interestingly enough, all participants were Christian, and although the majority of the participants alluded to their religion, faith, and/or spirituality, only a few considered themselves “practicing.”

This raises an important question for a future study of the organizational culture of Catholic health care—what does it mean to “act in harmony with the Church,” one of the characteristics promoted by the Catholic Health Association. If even the Catholic participants were more culturally Catholic than practicing, how can the transmission of the Catholic tradition occur, be measured, and suffice in the eyes of Church leadership?

Narrative Methodology and Learning

The backward design process is essential to the structure of this research project. Equally significant is the choice to utilize narrative as its methodological framework. Narrative analysis provides an organic structure that includes elements familiar in Western poetics as far back as Aristotle (inciting incident, rising action) and as recent as Labov (result, evaluation, and coda). The structure is flexible enough to embrace narrative as a tool or device and as expression of a personal, inner story that the narrator intended to relay.

The narrative lens reveals the truth that multiple bounded themes exist within each full interview. Each nested or compound narrative informs the others; the system narrative that a given participant shared informed their personal narrative, which in turn informed the more systemic pieces of their larger narrative. Narrative is distinguished by ordering and sequence; one action is consequential for the action that follows it. Participants tended to create plots from disordered experience, giving reality a unified structure not found in raw experience. Likewise, participants structured their tales temporally, spatially, thematically, and episodically; they looked back to recount lives located in particular times and places (Riessman, 2000; Cronon, 1992; Laslett, 1999; Gee, 1991; Michaels, 1981; Bamberg & McCabe, 1998; Jefferson, 1979). The familiarity of

narrative structure often prompted participants to anticipate the direction of my questions even before they were asked, yet, as stated previously, the structure helped me to keep participant interpretation at the forefront.

I learned much from the participants' stories. First and foremost, the unity of body, mind and spirit that many health professionals emphasize was reflected in the narratives; it is clearly the amalgamation of all ones' experiences that make the person. Participants systematically arranged an array of experiences and understandings in their narratives. I also observed that the values expressed in the personal narratives of each individual participant tended to reinforce the values learned from the larger socio-cultural meta-narratives, e. g. democracy, church, and health care.

As connections to the literature review are drawn in the following pages, it will become clear how personal narrative enables participants to claim ownership in these meta-narratives. For example, values storied in the meta-narrative of American democracy include those of service, work, and of improving oneself through education. Within the Christian story, suffering, healing, authentic relationships, and dignity are points of connection. Within the larger narrative of health care in general, and of nursing in particular, identification with compassion, excellence, and patient advocacy are primary.

Another clear conclusion from the narrative data is that family and professional experiences seem to have more impact on mission commitment than one's undergraduate coursework, and that specific "whos," "wheres" and "whats" influence mission commitment, e.g.:

- Who: Colleagues; Patients; Instructors; Grandparents; Parents; Siblings; Partners; Classmates; “We;” “I;” “Us”
- Where: Units; Family; Particular Hospital; Health System; Community; College/University—Short-Cycle, Community College, 4-year College, University, Classroom, Clinicals, Campus; Inner-City; Appalachia; Peru
- What: Support from Co-Workers; Mentoring; Organizational Programs; Obstacles; Discerning Skills; Technology; Courses; Alternative Spring Breaks; Work Study; Finances—Personal and Patients; Reflection; Excellence; Human Aspects of Nursing; Business versus Mission

This has clear implications for how and what institutions of higher learning can do to seek candidates for health care programs who have an inclination toward mission, and to build learning opportunities that parallel those earlier experiences. For example, it seems that the same group of indicators that signify a primal learner (self-motivated learning, naturally inquisitive, energized by acquiring new skills, etc.) also point toward mission infusion or the ability to become mission-committed. Given the improbability of ‘making’ a student a primal learner, how can colleges and universities increase awareness of primal-learner traits? How can colleges and universities enhance and/or awaken primal-learner traits so as to develop some of the best candidates for mission commitment? It is essential for such institutions to provide liminal space, space where learning and reflection occur so that people become aware of their stories, how and what they think about their stories, and how their stories are fixed to a larger narrative.

Discoveries in Light of the Literature Review

Key experiences among the participants resonated with areas discussed in the literature review. Common themes included the social role of higher education; the tension between professional education and the liberal arts, and the preparation of practitioners within the discipline of nursing; and student learning, evaluation of

outcomes, and theories of student development. Particularly noteworthy were each participant's awareness of their work within the culture of Catholic health care; the mandate to continue mission through sponsorship models; the reality of workforce diversity; and the preparation of mission-minded behaviors and characteristics of its workforce.

Social role of education.

One of the crucial principles to emerge in a discussion of education's social role was the need to create learning environments that equip people to address "critical problems to promote equality, justice, and democracy in the social environment" (Oakes & Lipton, 2003, p.107). Brameld's theory of Social Reconstructionism concurs that a democracy should encourage "students, teachers, and all members of the community not merely to study knowledge and problems crucial to our period of culture, but also to make up their minds about the most promising solutions and then to act concertedly" (Kridel, 2006, p. 74). As participants share their understanding of mission commitment, it is apparent that most make conscious and deliberate use of their gifts, knowledge, and specialties to improve the world of health care.

For the majority, the enterprise of improving the delivery of health care and civic engagement in meaningful work is focused in their workplace. Participants relate that they are either satisfied with the quality of engagement in the workplace, or that the reality of busy lives filled with full-time work and raising families limits their energies in other areas.

Amanda summarizes how professional work gives her opportunities to make a difference every day.

Some people feel like they need to volunteer...they need to do outreach projects through their work...through their church and through other means and sometimes that's great, too. I'm not diminishing that but I feel like I get to do that every day and I get to be close to God every day in what He's called me to do. That to me is amazing and it's one of the driving factors that keeps me here.

In terms of lack of time to devote to other worthy work, Maria states, "I have a five year old and a five month old. My five year old is [in] school. My daughter of course is five months old. I do not have a lot of extracurricular type activities or hobbies." Yet Maria expresses a desire to engage in the community, "That is one thing that I want to get into... maybe finding an organization or maybe a little mini-organization that I could get into and help the community more."

Rich engages in community service through activities and organizations associated with his children's involvements.

My volunteering is more with school stuff and one is volleyball club, the other one is soccer, so we do a lot of like fund-raising things like that. My son is just doing his confirmation so he has been doing service hours. He goes down to the mission just for a couple of hours to observe, I thought it was a really good experience and it opened his eyes to see what else is out there.

For a few, participation in organizations other than their primary place of employment also offers avenues to effect positive social change. In these examples, however, the participation is usually built on the particular interests and skills of health care professionals.

Lyn's choice to be involved with Relay for Life is based not only in an interest in health care, but also in the experience of her sister's battle with cancer.

I do The Heart Walk every year; I am the team captain on that. I really get into everything. The other thing is Relay for Life. [My sister's cancer] was a really tough struggle for her and I had to almost carry her to chemotherapy because she did not want to go, but she knew she had to; she is a nurse. I took a CTO day and I would take her and we would spend the day together. That is why I started Relay for Life to be really energetic about that.

Kim states her belief clearly:

If you are a nurse, you are a nurse, no matter where you are...it is just inbred no matter where you are; if you see something that needs to be done you step in, sometimes you think you are crazy saying shut up and sit down, but you do it anyway, because it is just what you do. I think that once you start in that mode of service, you do things no matter where you are. You jump up and start doing them.

Kim continues to talk about a particular way in which she has provided outreach.

“We have a clinic which is a free clinic where I have worked for several years. This clinic runs by donations and is funded by different things...health care professionals donate their time.”

Kim is also aware of how community members equate employees with their places of employment, particularly within health care. “At church [there are] like 500 people [who] feel comfortable that I am a health provider. They do not care what part that you work in; they just know that you work there.” She offers another example:

My grandmother lived 65 miles away and she would call and say “hey, so and so is down there at [your hospital]..So they associate [you with] the whole building. It does not matter what you do in the building; you are part of the organization and that means therefore you should be helpful. Even if you cannot answer their questions, you can maybe steer them some place that can.

Although at first Ann posits a separation between her work environment and her life outside of work, she goes on to describe her participation in a community organization that related to her work as a nurse.

I’ve kind of been involved in the community, but I don’t associate that so much with work,” she clarified; “I mean sometimes they interlap— the last group I got involved with...enters into work a little bit more just because Sr. D is involved and I’m involved and some people we see might get referred to our system. So, that’s probably the closest... It’s a group in the county that’s been set up to more or less raise funds for people that have a life-controlling issue. It started in response to all the [problems related to] heroin in [the] county. So, their goal is to

raise funds and then to screen people and then send them off to a teen challenge program . . . and I go to the MRC which is the County Medical Reserve Corps. Almost all of the participants looked upon nursing as community involvement.

More than half state that, between work schedules and family life, they have insufficient time to participate in organizations outside of work. Others find ways to connect with organizations in which their children participate or through church membership. Only a handful of participants are significantly involved in community organizations separate from their work and their family responsibilities.

Liberal and professional education in nursing education.

The differences between liberal arts education and professional education are prominent in the educational experiences of the participant nurses. The choice to pursue nursing, the question of where to attend school, and the movement toward, and realities of, degree completion speak to the practical nature of professional education. Added to these is the comprehensive commitment to excellence in technical skill, the development of critical thinking, and compassion in the expression of humanist values, all hallmarks of an education rooted in the liberal arts. Freeland (2004) describes this synthesis of approaches as a “curricular third way” that systematically integrates liberal education, professional education, and off-campus experience to produce college graduates who are both well educated and well prepared for the workplace” (p.142).

The history of nursing education has always included the need to approach the discipline as both art and skill. Building on this discussion, nursing education requires the combination of praxis and theory, of skill development and the well developed critical thinking skills to apply those skills. “Expert preparation of nurses...is imperative,” Curry insists, “for in addition to patient care, nurses conduct research, serve as administrators

and educators, sit on trans-disciplinary teams and engage in the ethical dilemmas of health care on a daily basis” (2010, p. 25).

As participants recalled their journey toward nursing, many were trying to discern what profession they might be either interested in, or good at doing. For Jackie, a start in a health care field helped move her toward nursing. She was, as she relates, “doing some medical assistant courses...so I knew I kind of wanted to move in that direction but I wasn’t sure I wanted to go fully into it, and I decided I wanted to be a nurse, and so that’s what I did!”

Craig was a health care professional for some time before he began the path toward his RN—the profession he had thought about for several years.

Then I got married and my wife and I were just talking one day...we talked about where our jobs were and what we’re doing. At that time I was a hospital liaison for the community mental health center where I worked. The majority of my day I was getting information, I was doing tracking. I then took a position as a mental health professional. In talking to my wife, she said, ‘what do you want to do?’ and I said ‘well, I could either get a masters in social work and just carry on what I am doing’...and she said ‘what is an interest?’, I said ‘you know, I have always thought about nursing.’ but I told her the story [about being told I wasn’t smart enough] and she said that I should do it. I told her, ‘what if I invest the money and it does not work?’ She said ‘you are not going to know unless you try.

For some, motivations were more pragmatic. In Kim’s case, it was a suggestion from her mother. “My mother thought that I needed a good job to provide me with resources, and that I would not have to be dependent on a spouse or another person to support me. She saw at that moment 30 years ago that nursing was going to be a good job for me to get into.”

The choice as to where to attend college was even more pragmatic, contingent on location (proximity) or affordability. Kim’s choice of the local community college had to do with the fact that it was “five minutes from my parents’ house. The location was

everything. I had already put in an application and had been accepted into a [baccalaureate] nursing program,” Kim says. However, Kim “had a boyfriend, and I was going to be crushed if I did not get to stay here and go to school.”

For Maria, the perceived need to be close to family trumped the dream to go away to school.

When I went to the [local community college] I was 18 years old and I always thought that I wanted to go off to school, you know I thought I could try to go to State or I could try to get a scholarship somewhere else, but you know at the same time I did not want to be away from my family. I always thought that my family needed me and I can't leave, I have to help my mom and my dad or I have to help my sister. There is always someone in need.

Cost, convenience, and familiarity were many times primary in deciding on location. For example, Rose's choice to attend the State University “was basically...because it was a state-funded school, that's where, basically, a lot of kids went...because it was more inexpensive than [other] type[s] of schools. And also my older sister was attending State at the time, too.”

Amada chose her associate, bachelor, and master's degree institutions based on financial criteria.

How I chose to attend [that University] for my ADN is actually a very simple story. They gave me the most money. I got a scholarship. I actually got a full scholarship and everything. [My decision to attend university for my Bachelor's and my Master's] also had to do with money. I went to [that university] for my Bachelor's because it was going to be less costly and quicker than it would be through [my undergraduate institution].

In the same vein, the degree a given participant chose to pursue was most often determined by how efficiently it could be obtained. Within the history of nursing education, the model of degree offerings has run the gamut from apprentice-like forms and diploma-conferring schools of nursing within hospitals to associate, baccalaureate,

master's, and doctoral degree-granting institutions of higher education—all of which culminate in board certification exam if the nurse plans on practicing.

At all levels of degree attainment, segmented or intermittent degree completion was the norm. In other words, most participants earned an associate's degree or diploma in nursing first; then, after a significant number of years of clinical practice, they sought further education at the baccalaureate and/or master's level. This provides both challenges and opportunity.

Jackie had ideas of an advance practice degree.

Initially, I wanted to be a midwife... and I thought...OK...I'll do this in two steps but there's no way I'll go back to school three times. And so I thought I'm just going to go and I'm going to get the Bachelor's and then I can get my Master's when I'm...you know... ready to do that. It took me several years to go that route because I had kids in between and you know [I was] kind of focusing on family life.

Terri's high school guidance counselor encouraged her to look at the most comprehensive program—the program that would best position her for employment.

At that time there were three major players as far as a [nursing] diploma. I knew that my guidance counselor suggested a diploma because you go to school and you get clinical experience. So when you get done you will have experience. You will have been on the floor; you have been working. That is what he really pursued and pushed.

Beginning at an entry-level position in nursing allowed Lyn to build her confidence in her nursing skills.

I think RN was above me at that time. I did the LPN for about 15 years and then I went back to school...I was a Clara Jane in high school. My dad was a doctor and my mom was an RN. One of my girlfriends down the street when we were in grade school she became an LPN. She kind of talked me into the LPN part. I think that I needed to start there as I was extremely shy and timid and I think that was where I needed to start.

There is, in the narratives, both a sense of “calling” in terms of a profession in nursing and a pragmatic understanding of what the profession can offer. In addition, decisions on where to attend college was based on location, access to degree, reputation, and affordability. Very little attention, if any, was given to the co-curricular offerings of the college. As students, these participants were focused on obtaining the skills and education needed to be the best nurses possible.

Student learning, outcomes, and development.

The work of the Center of Inquiry in the Liberal Arts at Wabash College concentrates on the synthesis of liberal arts and professional education and student learning, outcomes, and development. Just as Freeman writes about the “curricular third way,” The Center of Inquiry in the Liberal Arts at Wabash College (2009) has funded research into determining how valued liberal arts practices can be incorporated into professional education. Rather than dividing the two philosophies, the research suggests that “high-impact teaching practices and institutional conditions” can stimulate learning “and predict growth on a wide variety of student outcomes including leadership, openness to diversity and challenge, political and social involvement, and positive attitude toward literacy” (p. 1) both in traditional liberal arts colleges and in professional learning environments.

Because there is such a connection between the discoveries of this research and the area of student learning and development, I will highlight pertinent findings of the Wabash Study and cognate concepts in this study, e.g. Goodson and Adair’s primal learning, Baxter Magolda’s elements of self-authorship, and Lonergan’s intellectual conversion and moral development.

The Center of Inquiry in the Liberal Arts at Wabash College (2009) states that desired student outcomes can be predicted by certain “high-impact teaching practices” (p. 1). The first of these is “Good Teaching and High-Quality Interactions with Faculty,” which includes such practices as faculty interest in teaching and student development, prompt feedback, quality of non-classroom interactions with faculty, teaching clarity, and organization (2009, p. 1).

Amanda’s interaction with one of her teachers was a turning point in her commitment to her academics.

I had a[n] anatomy and physiology professor ...who saw that I was struggling. I mean you have to get really good grades to be a nurse. So, to have borderline grades, which was something that I have never had happen to me in my entire life. He pulled me aside one day and instead of acting like I wasn’t...you know...trying or I didn’t care or anything, he said, “I know how smart you are. I cannot see you fail this. Come and talk to me after class. This is what we can do. You are going to be a great nurse.” You know what I mean...and he said, “Most of the people that get A’s in my class aren’t necessarily the best nurses. I know a good nurse when I see one. You cannot fail this class.”

For Lyn, individual student-centered attention at the right moment during her baccalaureate studies likewise made an impression on her:

I went in there, and the little nun took my hand...‘OK, honey, come over here’ and she would walk me over to pay my fee, then she took me to get my books, she was delightful...you’re not just another person sitting on that chair. When I took chemistry...the nun at the end...she knitted us little pot holders and she put on each one what she thought our personalities were. [. . .] I feel she had mine down to a T...‘You take care of people—especially your lab partner who was never on time.’ We were individuals to her. Not just a person sitting in her class.

In Ann’s case, crucial attention came from more than once source.

When I went back for my Master’s, there were two instructors that I actually had for a couple of classes and they were just good mentors. They kind of kept me focused and telling me I was doing the right thing and that kind of stuff. And one of those instructors...she had me for the nursing leadership class and she sent me all the different places for different exposures.

Another area of high-impact practices include “Academic Challenge and High Expectations,” which includes academic challenge and effort, frequency of higher-order exams and assignments, challenging classes and high faculty expectations, and Integrating ideas, information, and experiences (p. 1). Lyn is by far the most pronounced in her appreciation of high faculty expectations.

I think those instructors were very strong, they were very rigid in their rules, which I was very appreciative of. I knew what I was dealing with, you know working full time and going through [school] full time, with [my college] being one of the harder schools. I think that [the rigidity] was very important and the instructors were very strong on that, on the floor they were very strong, they were knowledgeable. To this day I think that the graduates [from that college] have the better bedside manner, clinical know-how, smarts—because of those instructors.

Bob articulates an understanding of the importance of integrating ideas and experiences.

By the time I took my bachelor’s degree I had been a nurse for 25 years and I thought to myself, “why didn’t I do this before?” I learned so much more. It gave me a better view of the world, the way that humans act, and why do I think they are the way that they are. They were both positive and negative. Getting a degree and taking all the different courses that you need to have is very enlightening.

Sarah also integrated experiences from her undergraduate program. She articulates how immersion experiences in Peru and Appalachia continue to impact her nursing and patient care.

You do the best that you can with what you got. Again, you are resourceful and the patient care seems to be more...because in places where people are less fortunate I think that they are intimidated by health care, they can’t afford it, people ask questions when they come into hospitals so they tend to avoid it. When you are exposed to that and you see somebody who is less fortunate [in your work environment], they are outside their comfort zone and they are very protective of themselves. They also bring with them their family because that is their comfort. So you are not just treating them; you are treating the family.

Many of the participants fit the profile of Goodson and Adair’s (2007) “primal learners.” We recall that primal learners are more self-motivated than controlled by

exterior forces, naturally inquisitive, and compelled by what they can learn in a situation rather than the immediate rewards the situation might provide. Primal learners enjoy learning for its own sake and gain energy from acquiring new skills. “One way these learners learn about themselves is through the work of weaving the interior, exterior and interpersonal together by an ongoing storying or narrative learning” (Teaching and Learning Research Programme, 2008). Characteristics evident in the learning patterns and motivations of the participants include an understanding of the “interrelationships between learning, identity and agency in the life course” (Teaching and Learning Research Programme, 2008).

The connection between identity and agency is even more clearly expressed by Baxter Magolda’s (2008) work on self-authorship. In simple terms, Baxter Magolda claims that, as students develop, they tend to gain competencies as they learn to trust the internal voice, build an internal foundation, and secure internal commitments. Similarly, The Center of Inquiry in the Liberal Arts at Wabash College (2009) looks at the area they call “deep learning” which includes higher-order learning, integrative learning, and reflective learning (p.1).

Each participant narrative is richly woven with examples of interior motivation and reflection, exterior guidance, and interpersonal relationships—intuitive learning that helped participants form their identities. By making connections between sometimes seemingly unrelated learning experiences and their personal understandings of how to be a nurse, participants learned to trust their internal voice, build an internal foundation, and secure internal commitments.

Terri's confidence in her nursing, in her internal voice, commands the respect of those around her. Yet, as she monitors situations and looks for ways to meet the needs of the patients and the physicians, she vacillates between internal drive and the need for external recognition.

I want to know, 'is it positive? Are we on the right antibiotic? Is this covering this organism?' Maybe this person is running a temperature; do [they] need this and this? Sometimes [the physicians] are busy too, and they are passing through for a short interval, so part of it is self-driven. I just want to do a good job, be well liked, but I think it is totally the whole upbringing, religion, and it is your family values and your morals, and just doing the right thing. It is being committed; this is my job...I am not going to be a bad employee and I am not going to do something just part way, I am going to do it all, and I am going to do it completely and thorough.

Craig had thoughts of nursing after a college work study placement awakened in him a set of care giving skills. After being told that he might not have the academic skills to be admitted into the nursing program at his college, Craig decided on another path within health care and successfully negotiated that field for about 12 years. However, the thought of nursing stayed with him. A conversation with his life partner reconnected him with his dream. With her support, he completed his BSN and became a registered nurse. "I ended up talking to an advisor who told me that I probably was not smart enough to be a nurse at that time and that maybe I better look into something else. That kind of stuck with me. I spoke with the director of disability services and he mentioned the program that I wanted to get into which is vocational rehab counseling. I said okay I will try it. I then took a position as a mental health professional." Years later, Craig recalls the conversation with his wife that helped him trust his internal voice.

In talking to my wife she said "what do you want to do" and I said "well I could either get a masters in social work and just carry on what I am doing...and she said "what is an interest"?, I said "you know I have always thought about nursing but I told her the story and she said that I should do it. I told what if I invest the

money and it does not work? She said you are not going to know unless you try. I got approved for nursing school and I ended up working full time at a nursing home, went to school full time, continued to work at St. Andrew, and then I took my board, I passed my exams, and I ended up getting hired at St. Andrew. That is how I got into nursing.

By trusting his internal voice, Craig's life began to open up and he grew in other areas as well. "As I started getting further and further into the nursing program then I found myself becoming more and more part of the church and attending church more, so my faith started growing as I started growing."

Building an internal foundation required participants to analyze and apply knowledge that has been internally integrated. Kim had to grow into her internal leadership foundation.

Literally straight out of school heading for my 20th birthday I was a team leader, it was scary...I think people should have died, because I had no clue. On the floor that I hired in on I had worked as a tech in nursing school and so I was familiar with the floor and when we graduated three of the teams (there were four teams)...three of us took team leader positions over LPN's and Aides that had been here twice as long as we were old. It was really a tremendous eye-opening experience. It was really a tremendous eye-opening experience because my aide would tell me every day, "This is what you got to do," and I am like, "OK, who has the hat," and I decided I better do it now and I better do it her way. She knew, she was brilliant, she was absolutely a brilliant resource for me. I worked with her for another 15 years before she died. . . . she was an awesome lady.

Maria's internal foundation was strengthened as she reflected more on her daily actions.

I think that Valley Hill University definitely made me think about reflectively looking at nursing. One instructor, she was a Faith in Community instructor. That is what my focus was, faith in community and nursing. I guess she kind of helped everyone see, reflectively, throughout the day like what you are doing at that time. So instead of looking back, just like know what you are doing at the time when you are doing it, as far as being a nurse, being a person...She [the instructor] was not really focusing on the nursing, the tasks, she was focusing around the nurse as a person.

Jackie recalls the higher level learning of her baccalaureate as one way she built her internal foundation.

When we were being prepared as Bachelor's nurses, you are taught to look at the whole picture as opposed to those who go through...a diploma program or an associate's program. They're more focused on skills and disease process. [As far as liberal arts classes are concerned, I took] the theology portion and things like that. You know...looking at nursing theorists and...you know...why we do what we do...all of those in different approaches to nursing. It makes a difference, I think. [. . . it] gives you a chance to grow as a person.

Ann was surprised by the level of independence required by nursing and has built a foundation of thinking and practice skills that allow her to handle more autonomy.

I'm not quite sure what drew me to nursing originally. I suppose it would be the caring, I guess, but I can tell you when I went to nursing school the first time...it was kind of different than what I had the image of it to be. I mean, there was so much to know and...I guess...the decision making and some of the autonomy... I didn't realize [the degree of autonomy]. And the teaching was there, and I guess when I learned more about it, I [wanted] to be even better. The [decision-making and autonomy] kind of impressed me as I was going through the program.

The above excerpts from the interviews emphasize the development of participant nurses as they learned to trust their internal voice and build internal foundations. The next developmental step, according to Baxter Magolda, is for young adults to secure internal commitments. This will be best evidenced through participant observations concerning their understanding of mission commitment—manifest within their work environment— which will be discussed in the section on mission-minded behaviors.

Intellectual and moral conversion.

This movement toward self-knowing and self-authorship requires a sense of conversion and moral development. As stated in Chapter Two, although conversion can happen as a spectacular one-time event, it manifests more commonly as a process or an

accumulation of experiences that turn one's mind and heart toward a new way of knowing, thinking, and/or believing.

Although many of the narratives relate how a certain experience changed the way the participant looked at their role as nurse, Kristi's most clearly exemplifies how one experience or even a series of related experiences can turn someone's thinking in a new direction. Kristi builds an internal foundation as she analyzes and applies knowledge she has internally integrated through the process of conversion.

Kristi conveys an empathy-building classroom experience while taking a few literature courses. The reflection that was required of Kristi in these literature classes has proven to be a skill that helps her be a better nurse.

Having an adult reading a children's literature book...you look at it in a whole different perspective. There is an awareness that comes, and the influence, as you are an adult looking at it...forces you to look at things through a kids eyes. I guess I still do that. I kind of look at what is going on with a patient or I look at what is going on whether they are adults or children, and I try to always look at it through their eyes. That was the class that really kind of (it had nothing to do with nursing what so ever)...turned a switch on for me. Like, okay, you can take this book—even though it is supposed to be a kids book. What adult is really going to pick it up and read it? Maybe not many, but maybe they should. Maybe they should learn to look at something through a different perspective. I think that really brings a huge awareness.

Kristi's concludes that this changed her perspective on delivery of healthcare.

When I look at a cancer patient or something...I think that class really forced me to look at something from a different perspective...If you realize that [patients are not really paying attention] and are aware of that as a nurse, you can pinpoint these things and make [discharge information] very distinct and tight-form. Rewrite it in one word phrase [. . .] instead of just going "here are your discharge instructions" and they run out of there. In two days they are back in because they did not do anything that was on those instructions; because you were not aware of the fact that they have so much other crap going on that you need to make it distinct. And so, that class did maybe point that out.

One trait of conversion is a broadening of horizons—seeing things that you never noticed before. Kristi observed events from perspectives other than her own, and this new capacity has influenced her interactions with patients. It has sustained her in what is sometimes difficult work with difficult people. When we see from the others' perspective, we connect at the core of our human condition.

Mission-minded behaviors and characteristics in catholic health care.

The general values promoted in Catholic health care include such values as compassion, service, justice, excellence, stewardship, care of the poor, human dignity, sacredness of life, are complemented by the following list from the Catholic Health Association (2009):

- providing compassionate, high-quality care for bodies, minds and spirits;
- promoting health and well-being for all persons and communities;
- paying special attention to those who are poor, underserved and most vulnerable;
- acting to end poverty, injustice and discrimination ;
- using our resources responsibly; and
- acting in harmony with the Catholic Church.

All require employees, as Baxter Magolda suggests, to secure a commitment, both personally and professionally. A reading of the list of participant comments below will reinforce the fact that these participants truly exhibit the values promoted within Catholic health care.

- We help them...provide them services after they discharge as far as getting their medications that they can't be afforded.
- I really believe that we are here to help the poor and underserved...in conjunction with what Jesus felt that we should be doing. I mean we really try to provide

outreach to people not only to heal them physically but mentally and spiritually as well.

- So, it really takes a special kind of person to be able to look at a situation that is so grave and bring to it the best of themselves.
- We have many patients who are self-pay and [many of these patients] have no resources of any kind,] and I do not think that they get treated any differently than the people that have everything, insurance coverage...
- We are here to serve the community no matter what, if rich or poor or underserved.
- Working in ICU we deal a lot with very critical patients, even life and death. Really enveloping, maybe a little bit of religious background, support no matter what their beliefs are, making sure there is support for the family.
- So when people come in generally they are at their lowest [point] to begin with and it is our job to take care of them. It does not matter who they are, where they came from, if they have insurance or not.
- It is just so rewarding to be helping people in their time of need.
- You treat people how you would want to be treated or not want to be treated.
- The mission states that this small community hospital provides excellent service both physical and spiritual. We do not have to be like the big hospitals.
- Seeing a different way of life and experiencing life outside of what you are used to and being put outside of your comfort zone can really broaden your horizon if you appreciate what you have. It kind of keeps you in check as well, when you come back from a [service] trip like that. It makes you keep things in check as far as how you do things. You tend to be a little more resourceful.
- I see people in very bad situations in taking care of people. I can help the community by making sure the kids are doing what they are supposed to in school, getting involved in different things, helping out with food bank or whatever. There are a lot of things that go on,
- [Understanding the mission at work] makes you want to do more in the community. You want to be the best here [and out there].

As adults learn to trust their internal voices and build an internal foundation, they can commit to life work that is in service to others—that they give as much to the

organization of which they are a part as the organizations offer them. Catholic or not, participants find ways to advance the mission of Catholic health care.

Trying to understand this dynamic, I read and re-read the narratives looking for hints. I do not find a blatant desire among non-Catholics to somehow become Catholic; neither do I find Catholics who would be considered active members of congregations. Rather, I find a respect for, and connection to, the meta-narrative of Christianity—a religious community that is immersed in storytelling. The story, the narrative, is based in healing, authentic relationships, human dignity, and respecting oneself and others. This is a narrative tremendously attractive to many people who would not even consider themselves baptized Christians. Spiritual sensibility, not religiosity, is the basis of that larger story of Catholic health care. Narrative is a bridge between the confessing Catholic community and a larger secular society which Catholic health care serves.

Of the many aspects of the Christian community's narrative concomitant with Catholic health care, most prominent is Metz's idea that Christianity is a community of memory—a community that remembers and draws from the “dangerous memory” of Jesus' life. Even the so-called outsider can connect their personal narrative to the larger story—a story that discloses the universal qualities of suffering, compassion, and solidarity through the exemplary figure of Jesus.

Metz's theology can be considered under the umbrella of what he terms “political theology,” but it can also be considered a biographical theology or narrative theology. “Christianity is not really a community that interprets and gives arguments, but rather a community that remembers and tells stories, with a practical intent” (Metz, 2007, pp.197-198). Remembering and holding up the stories of those who suffer allows a community to

be moved by the authority of those who suffer (Metz, 1998). Nurses have an inner authority that compels them to be of service to those in need; compels them to engage with those who suffer; compels them toward mission with the practical intent to heal. In Metz's (2007) theology, this is to "practice a narrative-practical Christianity as opposed to a transcendental-idealist Christianity" (p. 144).

Evangelization is not the focus of Catholic health care. Its focus is, rather, sustaining "dangerous memories"—not just the memory grounded in Christ, but the dangerous world memories of the suffering that resonate on a human, organic level. In this way, participants become collaborators with God in eradicating suffering through the praxis of discipleship. "Above and beyond its regional applications, 'memory' becomes decisively important in ecclesiology in so far as it has an impact on defining the Church: a church as the public bearer of a dangerous memory in the systems of social life" (Metz, 2007, p. 169)—in this case, the system of Catholic health care.

Recommendations for Practice

Participants rarely identified any college experiences in the first several questions of each interview: "Tell me about receiving your award, and about its meaning for you. Tell me about your mission commitment at work, and outside of work. Tell me your understanding of the mission of X hospital." It wasn't until I asked a specific question about how their college experience may have influenced their ability to be mission-minded that I heard stories of professors, service trips, coursework, and clinical experiences. Any conclusions or recommendations regarding education for mission or citizenship therefore emerged out of a specific context. I analyzed the experiences, barriers, and encounters that participants thought led to their mission commitment and translate those into the language of higher education.

Recommendations for practice in Catholic health care were particularly prominent, as the narratives were filled with employee experiences within the workplace. Some recommendations affirmed current praxis. Other recommendations challenged the industry to “practice what it preaches” regarding the promotion of health in body, mind, and spirit, and upholding the dignity of all people. Many of the practices applied to both higher education and Catholic health care, and all fell into at least one of three considerations: programmatic, evaluative, or environmental/cultural (See Table 15).

Programmatic evaluations.

An institution’s tactical and strategic planning shapes programmatic recommendations and programmatic recommendations can shape an institution’s tactical and strategic planning. Some could become part of the organization’s routines, e.g. orientation, continuing education, and curriculum initiatives. These initiatives, then, influence the environment/cultural context of the organization. Other recommendations might be considered ad hoc, implemented as needed.

While the nurses I interviewed were not opposed to learning information outside their chosen discipline, it was clear that during their collegiate years, they did not have time for co-curricular activities. A pragmatic orientation should therefore be integrated into their required coursework, one that offers experiences that develop students in the liberal arts, leadership, and service—a balance of the holistic and the convenient. Emotional and spiritual support is needed to help students and employees balance home, family, work, study, and economic exigencies. Such balance creates healthier students and employees, which in turn creates a more healing care giving environment for patients.

Caregivers who learn to care for themselves are better caregivers. All of the participants in my research were considered “high performers.” The nature of their work combined with the expectations place on them from the organization, as well as self-imposed expectations, make them susceptible to burn-out and stress fatigue. Teaching strategies for self-care to both pre-professional nurses and employed nurses will result in better patient care. Minimally, mandated break times, meals away from the unit, and appropriate restroom breaks through managed coverage would also go a long way in creating a healthier atmosphere.

Another avenue to avoiding burn-out and stress fatigue is to teach and model resiliency. The nurses I interviewed were effective only insofar as they were resilient. This was reflected in how they handled obstacles, how they worked with change, and how they utilized self-talk as a way to motivate themselves.

As noted in at least one narrative, accessing education through short term programs can open doors to further degree completion. In addition, during difficult economic times where job security is at risk, short term programs can quickly enhance a person’s skill set and increase employability. Aiding students and employees with “right fit” skills and education will also help to build a more robust care environment.

Although every single participant was passionate about advocating for their patients, I found a lack of awareness of, or indeed interest in, systemic advocacy efforts among employees in health care. However, health care legislation has a real impact on these workers. The sheer number of nurses, let alone other health care workers, would allow for the creation of a formidable voting block. Nurses occupy an axis point within the realm of patient care, and their high level of commitment to advocate for their

patients therefore gives them a privileged perspective into what really works and what is really best for both patient and industry.

Evaluative considerations.

Recommendations that are evaluative in nature encompass protocols and policies, the ways and means by which value and excellence are assessed. In many of the narratives, participants indicated that they were aware of the complexity of their patients and that this helped in how they approached a plan of care. The evidence of the study tended to encourage service-learning opportunities or intentional clinical placements that place students in environments outside their comfort zones, places where the skill of “noticing” could be developed. These opportunities need to occur within the boundaries of coursework, as most pre-professional nurses do not engage in traditional co-curricular campus offerings. Guidance on how to interact and reflect on such opportunities can result in increased student awareness.

Teaching students and employees frameworks and processes to engage in reflective learning will help them integrate new information. These types of processes will empower employees to be more intentional in how they deliver care. Competent evaluation will be a crucial avenue to recruiting and retaining desirable student and employee candidates—those who either have an innate ability or have learned to reflect on their practice and to make decisions based on those reflections.

Environmental/cultural considerations.

Practices that impact the environment and culture will take into consideration the total context in which the assessment is taking place, and in which students or employees operate. In the collegiate realm, excellence in teaching must become the norm.

Participants defined excellence in terms of faculty mentoring, strong clinical placements, and a high quality of instruction. This standard of excellence will create an atmosphere to encourage and nurture primal learners.

Selection processes or applicant processes, which may be programmatic and evaluative in nature, are also elements in building a culture of vocation—an environment that allows people to do what they do best every day. Building an interdisciplinary or team approach will also enhance employee or student engagement, creating a vigorous and dynamic environment for learning and working.

An engaged health care workforce can also promote fair labor practices by encouraging healthy communication and interdependence between leadership and front-line workers. Transparency regarding actual worked hours, reporting (without retribution) those sentinel events that have (or might) cause harm, and organizational decision making within the health care industry have the potential to create a more fair and just work environment.

Because of the rapid rate of change inherent in health care, it is imperative that employees understand the dynamics of the change process as well as how they can become agents of change. An inability for people to accept and embrace change is the downfall of many initiatives. Thus, it is the responsibility of both higher education and health care not only to engage change, but to teach change as the inevitable and ultimately healthy process that it is, and to help develop so-called change agents.

In the midst of change, the goals of business and the goals of mission are sometimes at odds, thus working at cross purposes. This tension will remain unless leaders are convinced that good mission is good business. Solid business decisions can

and should be grounded in mission. In this connection, organizational studies are useful for both the undergraduate and current employees to integrate mission fully into corporate decision-making.

This research revealed many avenues to nurturing and sustaining mission commitment. I experienced the deep commitment of our nurses in the course of the interviews. As to their narratives of experiences that occurred outside the collegiate environment, I concluded that institutions of higher education must come to understand the core values that such experiences reveal, so that these values translate into effective collegiate environments both inside and outside the classroom. My findings motivate me to be public and vocal in promoting practices that will create a culture in which nurses can best incarnate their mission-committed delivery of care.

Table 15

Recommendations for Practice

Recommended Practice	Programmatic Consideration	Evaluative Consideration	Environmental/ Cultural Consideration	Impact of Practice on Higher Education	Impact of Practice on Health Care
Advocacy	X		x	x	X
Application Processes (Selection and Hiring)	X	x		x	X
Burn-Out	X		x	x	X
Business Strategies and Mission		x	x		X
Change	X		x	x	X
Employee and Student Evaluation	X	x			X
Excellence in Teaching			x	x	
Labor Issues		x	x	x	X
Primal Learners					
Pragmatic Orientation	X			x	
Reflective Learning Processes	X	x	x	x	X
Short Term Programs	X			x	
Skill of “Noticing”	X	x	x	x	X
Support	X		x	x	X
Team Approach			x	x	X

Implications for Further Research

Implications for further research were clarified through data analysis and conversations with key constituencies: participant nurses and nursing professionals outside the boundaries of my research study, the executive and administrative leadership within my current employment organization, leadership (at the president, vice president, and dean levels) at the college linked to the system in which I work, and other researchers who write on sponsorship, Catholic health care, and Catholic higher education. Kernels from these conversations led to brainstorming around the following ideas: the legacy of nursing in families; the need to triangulate quantitative research and story with qualitative research and statistical data; structured undergraduate experiences that promote the Catholic intellectual tradition, including social thought and service learning; and research on the organizational structure and culture of Catholic health care. A brief undertaking of these directions, some more developed than others, will be addressed below.

Legacy of nursing in families.

The conduit of family in the path toward health care professions proved to be prevalent in many of the participants' narratives. As I talked with other nurses about this phenomenon, they were not surprised. A qualitative study looking at the legacy of nursing in families, or more specifically, a study of the interactions, modeling, and guidance between nurse mothers and their pre-professional nurse daughters, would be fertile ground for future research.

Quantitative and qualitative research.

In the world of health care, numbers talk. Most leaders recognize the need for stories, especially in the areas of transmitting heritage, understanding patient experience,

and building employee engagement. However, when it comes to decision making about programs, strategic planning, and finances, statistical data take priority. Two promising research projects are worthy of note. First, a non-experimental study is needed to validate initial findings from this qualitative study by determining what undergraduate educational experiences are best associated with the promotion of “mission integration” and mission-commitment in newly hired, recently degreed health care professionals/employees of Catholic health care institutions across the United States. Second, a quasi-experimental study could measure the impact of a “Mission-Based Decision-Making” module on student self-assessment of decision-making attitudes in Catholic health care.

The first study would be designed to identify variables or determinants that would increase the probability of mission commitment in health care professionals. Data would be analysed primarily by means of logistic regression in order to answer the first and primary research question, “What factors in the undergraduate experience increase a probability of mission- commitment in newly hired, recently degreed Catholic health care professionals?”

The second possible study would use a pre-post control group research design. The intervention applied to the treatment group will be the “Mission-Based Decision-Making” modules. Students in the treatment group will be exposed to the content of the modules and will complete assignments that will encourage comprehension of the material throughout the semester. An analysis of variance, or a 2-Way ANOVA, would measure the main effect of time, the main effect of treatment, and the interaction of time and treatment from the data gathered in the research study.

Both of these studies would benefit institutions of higher education and Catholic health care systems. In the first, the findings could determine undergraduate experiences that promote mission-committed behavior in recent college health care majors/graduates and articulate reliable paths to the hiring of mission-committed employees. With regard to the second, critical thinking is a somewhat ambiguous skill that colleges address through coursework and co-curricular experiences. Most agree that critical thinking can be taught through a directed manner that allows students the opportunity to practice. With this study, colleges would have useful data on the impact of a critical thinking initiative—ethical decision making.

Undergraduate program development and frameworks.

There are several areas of higher education research in which I am interested. These include: professional/vocational identity, feminist approaches to care, service-learning and its impact on students from challenged socio-economic backgrounds, the move from rural to urban living and working, and activism in the healthcare profession. However, in light of a conversation with a few administrators at the Catholic college associated with the health care system in which I am employed, I have started to formulate a program précis that promotes the Catholic intellectual tradition, including social thought and civic engagement (through the use of service-learning and clinical placements). This particular précis examines issue of vocation, and more specifically, the understanding of the moral responsibility and imperatives for the health care professional including the coupling of vocation and action. The draft name of this précis is “Cultivating a Broader and Deeper Understanding of Vocation, Responsibility, and Moral Good in Healthcare Students.”

As someone who views much of life from the lens of theology, liturgy, and rituals with their inherent sense of sacramental imagination, liturgy seemed to be a natural place from which to work. Delving into the richness of liturgy, we find that our rituals and liturgies mirror the rhythm or cycle of our lives. They tap into our hopes and dreams and provide containers for our pain and sorrows. This is the story, a primordial story—our birthing, living, dying, and rising at all levels. For me, there is a mutuality between educational pedagogy/student development theory and the liturgies/rituals (in and out of church) which help us process and celebrate. One of the rituals in the Catholic Church, in its best sense, that is most identified with conversion is the Sacrament of Reconciliation. Because my understanding of conversion and reconciliation is so tied to healing, I thought that by using the ritual as an analogical template, I could parallel the movements of the rite with a curricular model of healthcare education that would broaden and deepen students understanding of their professional and moral responsibilities.

Organizational culture and structure.

In some of the narratives, participants referred to Catholic health care as being formative in their understanding of mission. Their hospitals, their units and their co-workers added dimension to their commitment to the mission. For others, their mission commitment was more personal in nature. They may have appreciated working in a place that mirrored or supported their values, but a few felt as though they could be mission-minded in a variety of settings. This insight begs a look at the organizational culture and structure of Catholic health care.

What is distinctive about Catholic health care? The public face of Catholic health care engages the religious tradition through the sponsorship of women religious,

suffering, healing, prayer, and efficacy. Many of the gifts of the Catholic health care have been written about in previous chapters. More challenging is the name of the Roman Catholic Church and public juridic person nature of Catholic health care—either through the sponsoring congregation(s) or through system status. Catholic health care must be accountable for what it does in the name of the Church. However, the current lack of effective dialogue between bishops and Catholic health care poses problems for the future of the industry and undermines the legitimacy of its good work.

An analysis of the culture reveals that the entity of Catholic health care ministers to the sick out of religious convictions—not only out of social justice, humanistic, or benign convictions. One of its goals is to transmit, through a healing environment, a vibrant and viable culture that witnesses to the life of the Church—for the sake of the kingdom.

Catholic health care is in flux. It faces financial, authority, and identity challenges. Although many people, including patients and employees of Catholic health care, embrace its mission, not every employee will personally internalize the mission of Catholic health care. Hospitality is a mark of Catholic health care. It has always invited others into the mix: doctors, nurses, patients, who were not Catholic. It is important to employ a critical mass of committed and informed employees—some of whom are Catholic—in order to have an effect on the institution and its core identity. A part of the organizational study would be to unpack what employees understand of the Catholic culture and how does it impacts what they do—similar to the research presented in this dissertation (Morey, personal communication, March 9, 2009).

Final Thoughts

Czikszentmihalyi and Beattie (1979) postulated a generation ago that professionals generalize their personal scripts into a life theme which often becomes their life work, and proceed to structure their vocational identity around this life theme. I began this study with the intent of studying the personal scripts and life themes of a select group of participants in order to discover which kinds of undergraduate experiences produced, promoted, or enhanced mission commitment.

What I discovered instead, in the course of the interviews, was that collegiate experiences in fact played a minimal role, if any, in this formation. Three other factors were far more significant indicators. First, family climate shaped the “commanding voice” of each personal narrative (Goodson & Adair, 2007, p. 2), followed closely by professional work environment. Third, a common theme was a predisposition toward primal learning. This was exhibited in participants own “interior identity work,” not imposed from the outside, but rather their own “internally generated pursuit of meaning” (2007, p. 3).

These discoveries have implications both for Higher Education and for the profession of nursing, implications that have been explored at length in this study. The insights and elements identified by the participants can and should be integrated into curriculum development and professional “best practices.” The findings are also prescriptive for human resource policy in Catholic health care as it seeks to maintain the continuity of its rich heritage of caregiving, a heritage endangered by waning numbers of women religious who provided such crucial service and leadership in its founding years.

Afterword

Notes of Gratitude

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Appendix A

Sample Intake Form

Name:
Date of Birth:
Sex: Male or Female
Faith Tradition (if any):
Contact phone:
Contact email:
Preferred Pseudonym:

Employed by:
Hire Date:
Current position:
Unit:
Shift:

Degree(s) earned:
Degree Conferred by (name of college/university):
Date Degreed Conferred (graduation date):
College Living Situation: On-Campus, Off-Campus, or Combination
Co-Curricular Activities (list):

Degree(s) earned:
Degree Conferred by (name of college/university):
Date Degreed Conferred (graduation date):
College Living Situation: On-Campus, Off-Campus, or Combination
Co-Curricular Activities (list):

Degree(s) earned:
Degree Conferred by (name of college/university):
Date Degreed Conferred (graduation date):
College Living Situation: On-Campus, Off-Campus, or Combination
Co-Curricular Activities (list):

Briefly describe the Excellence in Mission award you were given:

Would you be willing to participate in two or three face-to-face interviews to discuss mission-commitment further?

Appendix B

Sample Interview Questions and Probes

Current Professional Situation/Selection Criteria or Abstract

- Tell me about receiving your award, and about its meaning for you.
- Tell me about your mission commitment at work, and outside of work.
- Tell me your understanding of the mission of *X* hospital.
- Tell me about people you work with who you consider to be mission committed.

Background/History or Orientation

- Tell me about your choice to become a nurse.
- Tell me about what influence your faith and family background has had on your professional nursing career.

Happenings /Opportunities/Action

- Tell me about childhood and young adult experiences that have impacted how you perform your nursing responsibilities.
- Tell me the story of how you chose where to attend college, and the reasons you chose that college.
- Tell me what you remember about the mission of your college.
- Tell me about the curricular, co-curricular, and other life experiences/activities during your college years that changed the way you looked at things?
 - Was there a class or professor that really impacted how you saw the world?
How you wanted to be as a nurse?

Evaluation and Result (back to start)

- Tell me about any connections you see between being an engaged citizen and your work as a nurse.
- Tell me about receiving your award, and about its meaning for you.
- Tell me about your mission commitment at work, and outside of work.
- Tell me your understanding of the mission of *X* hospital.
- If I am trying to understand the development of mission-committedness, what do you think is most important to consider?
- Is there anything else you would add?

Appendix C

Labov's Structure of Narratives

(adapted from Labov & Weletzky, 1966 and Labov, 1972)

Abstract

- One or two clauses summarizing the whole story

Orientation

- Orients the listener in respect to person, place, time, and behavioral orientation
- The given circumstances
- When displaced, orientation section can serve evaluation function

Complication or Complicating Action

- The main body of narrative clauses
- Usually comprises a series of events
- What happened?

Evaluation

- Reveals the attitude of the narrator
- Emphasizes relative importance of narrative units

Resolution

- Defines the result of a narrative
- Either follows evaluation or coincides with evaluation

Coda

- Returns verbal perspective to the present

Appendix D

Participant Demographics

Table D1

Participant Demographics

Chosen Name for Study	Gender	Age	Faith Tradition	Highest Degree Earned	Type of Institution
Maria	F	31	Catholic	BSN	Historically Faith Based/Non-Catholic
Terri	F	46	Catholic	BSN	Historically Faith Based/Non-Catholic
Lyn	F	61	Catholic	BSN	Faith Based-Catholic
Kristi	F	41	Catholic	BSN	Faith Based-Catholic
Bob	M	61	Christian Missionary Alliance	BSN	Faith Based-Catholic
Sarah	F	25	Catholic	BSN	Faith Based-Catholic
Craig	M	37	Christian Non-Denominational	BSN	Public
James	M	45	Catholic	BSN	Public
Kim	F	50	Church of Christ	BSN	Historically Faith Based/Non-Catholic
Rose	F	49	Methodist	BSN	Public
Amanda	F	29	Christian Non-Denominational	MSN	Public
Ann	F	50	Catholic	BSN	Historically Faith Based/Non-Catholic
Jackie	F	34	Christian Non-Practicing	BSN	Historically Faith Based/Non-Catholic

Appendix E

Commitment to Mission Narratives

Table E1

Craig's Commitment to Mission Narrative (CSSV020711)

ORIENTATION

[20- 25] I now work in psych [where] we see a lot of people who are homeless, at the poverty level [with] poor family support. So when people come in generally they are at their lowest [point] to begin with and it is our job to take care of them. It does not matter who they are, where they came from, if they have insurance or not. Also just being here in the system, people do have a sense of insecurities and disbeliefs, but it is because they are feeling so low and down. They sometimes wonder, you know, "why me?"

COMPLICATION

[34-38] When we had Alice over there and she was doing services every Sunday for our people, they got so much out of it. It is hard for just the nursing [staff] to sit down and do a group like that. It was amazing...because you really got to see afterwards the effect that it had; you would see people brought to tears; it was just a new foundation in their life.

[62-67] One of my old charge nurses, over at St. Andrew's, she was just amazing. I mean her dedication to her patients. We even had talks about our religious beliefs. You know she just portrays that when she comes in every day. You can tell she is sincere, she is true to her words, she just stands out. The patients that she takes care of, they know that, they can sense that in her all of the time, and she is just great. She has this very calming demeanor about her and it just carries with her everywhere.

EVALUATION

[25-27] I think that sometimes being able to sit down with them and talking one on one. It does give them hope, and it really shows that we stand behind what we are doing.

[51-56] I do take a lot of that home, how I treat people on a daily basis, how I live my life, I look at treating others the way that I want to be treated. I care how people perceive me. Am I perceived the same at work that I am at home. I think that it should carry over. Of course you are in a different role and a different thing, but overall, you are the same person, you have the same values and the same beliefs, that never changes no matter where the cross line is. So it is like I want to make sure that people see me as I really am.

CODA

[194-205] Nursing or non-nursing, whatever, you know, it is still because of the people that we treat and how we take care of people every day. It is just a sense of knowing that they have a need. Some people when they come in it is a medical need and it is a medical necessity, but at the same time it is people that come in and have the smile on their faces when they come into the room because that helps patients feel more at ease and less anxious. No one wants to be sick and no one wants to be here. It does not

matter who you are walking into that room. That patient that is there— the last thing that they need is somebody that does not want to be here...because the patient wants to feel important, like they are the #1. But everybody has a difference sense of what #1 is and what they need. There are patients that just want to be left alone, but also you need to let them know that you are there for them if and when they need something. There is that sense of security like I am not being completely left alone.

Table E2

Kristi's Commitment to Mission Narrative (KKSA012711/Lines 28-82)

ABSTRACT

[28-32] Everyone asks this question [about mission] in different interviews. When we were going through the Magnet Program, I was part of the nursing excellence team and everyone asked about "The Mission". To tell you the truth I had read it 32 times at least, but it was just the way that I do things. It is not like OK, this is the "Grace Mission" and how do you incorporate that into what you do every day. It is what I do, so honestly I do not think twice about it at all.

ORIENTATION

[36-38] It is what I do and...I get frustrated if I see people doing things not the way that I do it. I actually attribute it to my parents. I do not feel that it has anything to do with my work environment. I think that it has to do with the way that I was brought up.

COMPLICATION

[38-44] My mom always said "would you want that to happen to you?" So it is the way that I was raised. If I am at work and I am walking past a room, I am observant of the fact that the patient might be trying to sit up and having trouble, granted it is not my patient but I am going to run in the room and help them out of the bed, adjust the bed. If someone's phone is ringing and they cannot reach it, and maybe it rings four more times than it should, I run in the room and I grab it.

EVALUATION

[44-57] I am observant, I am aware of my surroundings. I think that some people go through life with blinders on at times and that is one thing that I do not ever want to do. You know my parents always said treat people the way that you want to be treated and I think that has to do with awareness. [. . .] I do not have my work face and my home face. I do the same thing regardless of where I am at. Whether I am bringing a stray dog home or giving someone money on the corner. If someone is pulled over and their car is broken down, I am the one that is going to stop, and I will probably be someday in a ditch. I have an overwhelming sense of humanitarianism in my blood. Whether it relates to animals or people, I want to save the world, I think that is my problem.

RESULT or RESOLUTION

[65-72] I do not understand why people do not do it—people who just drive past somebody drives me crazy. You see somebody that needs help...I was heading south on Seymour Road and there was a lady heading west on Adams street carrying groceries. I pulled up to her and said "get in I will give you a ride" she looked at me like good god no. No, seriously you are safe. You need a ride. You are carrying a lot of stuff. Where are you going? "I am going to the bus stop" she says and I say "Oh, hell no you are not." I say "where do you really need to go?" and I gave her a ride home. I got home late that night and I had to explain why. So it is like when people's call lights go off, the phone rings at work, it drives me crazy.

CODA

[77-82] Caring. I can count on both hands the amount of people that I work with on a daily basis that do the same thing that I do. I would say outgoing as well. I think that in order for you to be aware and caring you have to be outgoing. Sometimes you are not

crossing the bridge to help the person if you are not willing to be outgoing and do that. I think there is a loyalty factor as well. If you are loyal to yourself it allows you then to recognize what other people need and respond to that or react to that I guess.

Table E3

Lyn's Commitment to Mission Narrative (MZSC011811/Lines 26-53)

ABSTRACT
[26] [. . .] passionate [. . .] is the word that I truly feel after all of these many years of nursing, which would be almost 43 years.
ORIENTATION
[29-41] Just as little as a smile from this little old fellow that you have been trying to get to smile all day long and he has just been pretty grouchy or in pain, and then all of a sudden you coax that little smile out. You know that is just so worth every effort that you have done. To know that you have made their day. Sure, thanks and all of those things are great, but some of those other ones are just that extra bonus. [. . .] I try to put everything that I can into every single day. Then, the teamwork that comes with knowing that a lot of these girls that I work with—maybe the whole 30 years that I have been here—we are still working on the floor together. It is just marvelous. We can anticipate each other, what our needs are.
COMPLICATION
[39-46] When I was a charge nurse I could say "Well, she does not do too [well] with alcoholic people", and this person who loves to deal with that would get that and you know she would shine in that area. So you would find a place where each one would shine. You just knew it. Along with some of that, the girls would say "You have got your mom smiling again". You could just go by a room and you see a nurse sitting on the bedside and patting the patient, talking to them and calming them down, reassuring, teaching or whatever, and doing it all in the warmth that you know it should be done.
EVALUATION
[34-35] I would really like to see nurses dedicated and not just there for the job. I have made it truly a career [. . .]
[46-48] I guess that is my feel for nursing that I hope will continue with all that huge, huge, technical aspect of what is going on. I feel we are losing quite a bit of that and it breaks my heart to see that.
RESULT or RESOLUTION
[50-53] Sometimes it is impossible [to balance the technical aspect with that human connection] because of the demands over here, maybe we should let go of some of those little demands and go back to this. That has been a really huge depressing point in my life in the last couple of years.
CODA
[27-29] I would do it all over again if I had the choice, either that or Carpentry, but I think that nursing would be the one. It is just so rewarding to be helping people in their time of need.

Table E4

Maria's Commitment to Mission Narrative (RESC011311/Lines 10-55; 298-307)

ABSTRACT

[10-11] I do not really see [mission commitment] as a category at work, you know, it is kind of my whole life I would say. Sometimes I do not even think about what I am doing, I just do it.

ORIENTATION

[11-17] Only because with my family and the way I grew up, we always were taught to respect the elderly and our grandparents [and] be respectful. You treat people how you would want to be treated or not want to be treated. So it has always been kind of like [when] you see someone walking across the street and they need help, you help them. You know, anything like that. Maybe you see someone and they need help with their groceries or maybe they dropped something, you go and pick it up for them. I can't say that [mission commitment] is at work specifically, it is just kind of what I have always known to do.

COMPLICATION

[30-34] I know I have kind of grown into it and as far as nursing the skills that I had to learn at first it is kind of hard to do all of that and remember to be courteous and kind. "Let me clean your tray off for you", and when you are so task focused like "I have to start your IV" and "I have to get everything done", "I need to call the doctor", "I need to get your medications."

EVALUATION

[21-23] Yes, so I guess as far as at work, like I said, I do not really think of it as work because that is what I would do anyways. It just so happens that I have a specialty in this.....and I get paid for it.

[27-30] Since I think that it is so close to my values already I just kind of embody it already. It is kind of a smooth transition as far as compassion and justice, and equality, just caring for people, I guess I am already there so it makes it easier to, I guess, live a mission through Grace because that is what I already do.

[34-44] In the beginning it was harder to try to take all of those things together plus all of the values in nursing and stick them all in one person. By now I have the nursing part down, of course, we are always learning something new. I think that with time I definitely learned how to tie both together and it is not always like "Oh I am Mary Poppins every day." I do not think that at all. I know I have bad days and sometimes I am grumpy and I come in and I sometimes have to say if I am having a bad day I have to tell myself "OK change your attitude, change your attitude, smile and be nice". It is not like every day I come and I am like "Oh yea I am so happy to be here". It is not like that, but when I get to work and if I am having a day like that, I do have to talk to myself and say "I am at work, change your attitude, the people that I am working with are my patients and they do not know anything about you."

RESULT or RESOLUTION

[44-53] I'm not taking anything personally and I try to drop some of the family stuff

before I get to work. or any issues that I might be having, because I know that it can affect my personality, but at the same time, when I get to know my patients over 12 hours or you know if I have them for 3 days in a row, and I am taking care of them, I can use that to help build a relationship with them. Maybe say "well you know I have had this happen in my life and be able to relate it to the patient or their situation, and a lot of times you know they are just so close that they can't believe that. I think that it helps me to build a relationship with them and they trust me to take care of them or their family can trust me to take care of their loved one while they are dying.

CODA

[53-55] I think at the same time I have to know when to stop and move on to the next patient. Kind of like " Okay, I love you guys, but I gotta go". Someone else needs me right now.

[298-307] Maybe just an etiquette, maybe a cultural class, maybe being culturally etiquette [might be helpful for nurses]—whether it be rich, poor, black, white, brown, and/or religion. I am really surprised that at a lot of individuals who do not know anything about other religions; that surprises me sometimes. Just be aware to be culturally sensitive, and understanding, that is really important. Especially now, I see healthcare being so broad, it is kind of like America, I see it kind of transforming, you know in the USA everyone is so free, and you have so many different types of people, and backgrounds, and religions. These are the people that you are treating. It is not like 50 years ago where you have a small community type hospital but you see the transitions and cultures that move in and out. We have to be prepared for that I think that is maybe where we lack.

Table E5

Sarah's Commitment to Mission Narrative (SSSV012811/Lines 5-64; 293-297)

ABSTRACT:

[5-7] I understand that our mission is mainly to serve regardless of any standards as far as race, culture, financial, to treat everyone as an individual. Live by the standards to do no harm and do what is best for the patient.

ORIENTATION

[11-22] [Living the mission] is an everyday thing. Being at St. A's we see a lot of the inner city, so it is one of those things, some days are harder than others, not to pass judgment. But everybody is sick, everybody has a reason why they come to the hospital. A lot of people do not choose to be at the hospital, they would rather be at home. I try to keep that in mind. Understanding as well, that Grace does serve the inner city. Knowing that because we serve the inner city, we can't expect to be paid. [. . .] A lot of times, once you get to know a patient, you break down the layers of the patient and you find out why they are there, color, gender, age, none of that really matters.

COMPLICATION

[27- 37] I think that one of the biggest frustrations is that people feel entitled to things for different reasons. Some people feel that they are entitled to specific treatment because their ancestors were treated differently or because they are from a different socio-economic class, they feel that they should be treated differently. That is one of the hardest things to overcome. They think that if you explain to the patient [that] this is how we treat everybody, we do not give preferential treatment based on financials, we do not even look at that. We explain to them that we are looking out for their best interest; we are here to treat them; we are not here to treat the issues around them. Sometimes you know the issues that you do have to treat are you know their family, and family circumstances can in fact lead to their illness. But as far as you know you do not treat their money; you do not treat their race; you do not treat their gender.

EVALUATION

[43-50] I think that nurses in general are mission committed. They have a heart. I find that a lot of those that do not have a heart do not tend to make it. They do not find that nursing is for them. I think that nursing actually nursing in general, regardless of the facility whether it be Grace or Prescriptia you have to kind of live that mission in order to be a nurse. I think that sometimes it seems that the younger ones, or people that are from outlying areas, [those who] do not deal with the inner city all the time, sometimes they tend to be a little more mission driven because they have not felt that hard attitude I guess you could say.

RESULT or RESOLUTION

[56-64] There are definitely times that I feel hardened. You know, prisoners, or someone that comes in complaining of pain that we see no evident reason why they are having pain, and it appears that they are just driven by.....just seeking medication. They also tend to be the ones that are more irritating of a personality, so they tend to make you harder. It is one of those things that I try to keep my feelings in check because I know I am the kind of person that my feelings show, so if I harden myself then it affects

the patient. There have been times that I really just want to open my mouth and let things fly and I always have to step back and be a professional. Sometimes I will walk out to the station and vent with my co-workers and I usually end up feeling better, but I am not taking it out on patients.

CODA

[293-297] I know when you are hired, they give you a mission and I think that sometimes we needand I know Grace offers ARISE and a Me Time, an opportunity to tune back into the mission. I also think that it is good that the mission is posted like by the elevators, kind of as a reminder, I think that sometimes we just need a little reminder, a little nudge. Whether it be from our co-workers, from administration, just that little nudge.

Table E6

Bob's Commitment to Mission Narrative (JSSA012411/Lines 2-42)

ABSTRACT

[For me, mission commitment is] to do the best job that I can for the unit I am on and treat my patients and fellow staff members, like my family (and I do like my family).

ORIENTATION

This my profession and I try to make sure that when somebody is here at St. Mary or one of the other Grace Health Centers that they remember us for good things. I want to make the system work as well as it can.

COMPLICATION

I worked at the old Riverside and the question was how is this going to be like the old place, then after a while, we find out that it does not have to be like the old place. The mission states that this small community hospital provides excellent service both physical and spiritual, we do not have to be like the big hospitals.

EVALUATION

[I think we are] aggressive...I work in intensive care so aggressive, patient- committed... they will protect their patient be it the spiritual being or physical being. The people that I work with I would say that the older personnel like myself realize more of what the potential this facility had and the ...I don't know how to put it...Everybody gets along together and is very, very professional but they are starting to get more to know each others' family. I can tell people that were brought up in the Grace system or went to a "Catholic/Christian type facility" they have a different outlook on patient care.

RESULT or RESOLUTION

[At] St. Mary we are one big family. It did not start that way but it has grown into that way. The mission of being this outstanding hospital and working with...whether it be working with people with a million dollars to those who do not have penny. Like St. A's, [we] started out helping the poor.

Appendix F

Familial Influences Narratives

Table F1

Jackie's Familial Influences Narrative (JUMW033011/Lines 86-145)

ABSTRACT

[87-88] I don't know [who I wanted to be]. (Laughter) I can't answer that. It's just...just inside of you, I guess.

ORIENTATION

[92-95] [Y]our family always molds you into who you are and I guess, you know. I looked up to, you know, parents and grandparents who may not have had a college education, but were always encouraging and did the right thing in life...and go forth from there.

COMPLICATION

[98-116] I think part of [who I was called to be] was always was molded by the fact that I did work here in a Catholic health care facility prior to becoming a nurse. I mean I was within this culture...you know...for however many years...five years before I even went to nursing school. [. . .] I was a secretary in the physical therapy department. I left here for a while...the first time that I left was when I was in nursing school and at the time I was working...like...Saturdays still out at the Wellness Center and that even got to be a lot because I had three kids at home and so...so I left for that brief period of time until I came back and...when school was getting ready to be finished up but then most recently when I left, I went to Central Health and took a management job there in all that stress.

EVALUATION

[116-130] I will say the culture is very, very different and you wouldn't necessarily expect it to be quite as different as it is. [. . .] I would never say that they don't give good healthcare because I believe that 100% that they do. [. . .] The culture's just different. That's the only way I can explain it. [. . .] I think partially it's because they're a little larger...you know...obviously than what we are here, too. It makes a difference. We know everyone. But I think even at that, when you walk through the hallways here, everyone makes eye contact and says, "Hello! How are you doing? How's your day?" as opposed to looking at the floor and walking past.

RESULT or RESOLUTION

[141-145] [I took a management position in] labor and delivery...assistant manager. [. . .] I came back in October. [. . .] Beginning of October.

Appendix G

Becoming a Nurse Narratives

Table G1

Amanda's Becoming a Nurse Narrative (ARMF032811/Lines 115-133)

ABSTRACT
[117] I don't know that I ever had a choice [whether or not to be a nurse,] to be honest.
ORIENTATION
[119-123] When I was little, I had a little...I had this book that my dad gave me and it was...you know...you could fill out your hopes and dreams and things like that...very little girlish...and...you know...of course it asks what you want to be when you grow up...and I said a nurse and a teacher and I am both of those things now...and I always knew that that's what I wanted to do.
COMPLICATION
[123-124] My grandparents...my grandmother, as I said, was the pharmacist technician. My grandfather is a pharmacist. My grandparents raised me.
EVALUATION
[124-127] So...I don't know. I've always wanted to be close to people when they were at their most vulnerable. I don't...and I can't say why, but that's always been sort of ingrained in me.
RESULT or RESOLUTION
[131-133] [. . .] something about being able to touch somebody's life in a real way with your own hands, with your own voice, with your own spirit was very appealing— and still is.

Table G2

Kim's Becoming a Nurse Narrative (KCLH032111)

ABSTRACT

[92-95] My mother, she thought that I needed a good job to provide me with resources and that I would not have to be dependent on a spouse or another person to support me. She saw at that moment, 30 years ago, that nursing was going to be a good job for me to get into.

ORIENTATION

[95-99] Ironically, I had already worked as a candy striper. This hospital that I was in was under construction when I was in high school and I worked as a candy striper for two summers before I got out of high school, so when I went to college, it just kind of followed the flow. I had been in the hospital and I liked the environment. I really thought that I was going to come in and do a great thing and change the world.

CODA

[103-106] I think that I have had opportunities over the years to make an impact on my little part and do the best that I could most times. But if there is an ocean out there and you only have a bucket... You have to be satisfied that you did the best that you could with the resources that you were given.

COMPLICATION

[112-122] We were fortunate to have a good community college in our town. It was just luck that I got into the program. Because back then, it was really hard to get into the Grace program. You really had to have [a] high ACT and school was just not high on my priority list at that time. It was just because I was a teenager, you know, it just did not seem that burning important until I got older and realized that my mom steered me into something that I really love. The people that worked with our youth group at our church, two of the couples that worked with us, one was a vascular surgeon and one was a general surgeon. As I started in nursing school and did rotations in clinical areas and kind of saw what they really did and got to talk to them and watch things, I thought "wow this is really cool." They were very supportive and then when I got out of school I worked with both of them on the surgical floor.

EVALUATION

[126-127] Literally straight out of school heading for my 20th birthday I was a team leader, it was scary... I think "people should have died" because I had no clue.

RESOLUTION or RESULT

[132-135] On the floor that I hired in on, I had worked as a tech in nursing school and so I was familiar with the floor. And when we graduated, 3 of the teams (there were 4 teams)... 3 of us took team leader positions over LPN's and Aides that had been here twice as long as we were old. It was really a tremendous eye-opening experience.

EVALUATION

[136-143] It was really a tremendous eye-opening experience because my aide would tell me every day "This is what you got to do" and I am like "OK, who has the hat?" And I decided I better do it now and I better do it her way. She knew, she was brilliant. She was absolutely a brilliant resource for me. I worked with her for another 15 years before she died. She was an awesome lady.

Table G3

Jackie's Becoming a Nurse Narrative (JUMW033011/Lines 33-86; 149-170)

ABSTRACT
[34-36] I became a mother very young and actually from that experience [in] which my child was born here, I thought that I wanted to be a nurse because of that.
ORIENTATION
[36-38] I was doing some medical assistant courses so I knew I kind of wanted to move in that direction but I wasn't sure I wanted to go fully into it. I decided I wanted to be a nurse and so that's what I did!
COMPLICATION
[40-51] [It] Took me several years to go that route because I had kids in between and you know kind of focusing on family life but... initially, I wanted to be a mid-wife
EVALUATION
[51-54] and I thought...OK...I'll do this in two steps, but there's no way I'll go back to school three times. And so I thought I'm just going to go and I'm going to get the Bachelor's and then I can get my Master's when I'm...you know... ready to do that.
RESULT or RESOLUTION
[65-68] [I chose to go to Northern Health because] they were the closest actually in the area that offered a Bachelor's program. Another reason that went into me deciding to get the Bachelor's as opposed the Associate's Degree was because, within Middleton, there's another facility that had a nursing program and that would be Central.
COMPLICATION
[70-71] [Central's] Associate's program is actually very difficult to get into. It takes years of a waiting list
EVALUATION
[71-72] and I thought, OK, so I'm going to be waiting and taking classes for four years to get an Associate's or waiting and taking classes and get my Bachelor's...
RESULT or RESOLUTION
[72-73] so, I thought I would go straight through.
CODA
[75-85] And so that's how I worked that out and thought it would be good for me. It was actually a little...it was competitive to get in there as well but there wasn't that waiting list because they were looking at wanting to draw more...more people in the program.
[. . .] I didn't necessarily look up to what others were doing but just kind of focused on who I wanted to be not somebody else.
EVALUATION
[149-154] Because I try to work the mission every day even...and it's...it's not conscious. It's just what I do. I don't even know how to explain it...but...like I said, I try to take care of the patient as a whole and not just...you know...whatever's going on with them. I think partially...you know... you talk about...you know...advanced degree nurses and such. And I think part of that...it is...part of what helps you work towards the mission.

RESULT or RESOLUTION

[154-170] When we were being prepared as Bachelor's nurses, you are taught to look at the whole picture as opposed to those who go through...a diploma program or an Associate's program. They're more focused on skills and disease process. [As far as liberal arts classes are concerned, I took] the theology portion and things like that. You know...looking at nursing theorists and...you know...why we do what we do...all of those in different approaches to nursing. It makes a difference, I think. [. . . it] gives you a chance to grow as a person.

Table G4

Kristi's Becoming a Nurse Narrative (KKSA012711/Lines 82-108)

ABSTRACT

[86-93] I like to argue and initially I was headed towards law school. I think that is what my dad wanted. I was a young mom at the time and my mom was a nurse, and all of my aunts were teachers. I think growing up in that, you know even though my dad I think wanted me to go towards the law aspect of it, he was the same guy that I watched shovel everybody's driveway or take the neighbor to the store. So even though he kind of wanted to point me in one direction because he thought that I would be really good at it, he exemplified a different direction (whether he knew it or not) and I remember being in school.

ORIENTATION

[93-96] I have a minor in political science and history and I remember thinking to myself, in the political science aspect of it, I was more interested in the human part of it. I was at RU at the time and I was like, "well I am going to finish what I am doing here, you know as far as studies, I have to finish what I start."

COMPLICATION

[96-101] So I finished and I decided if I switched it and went towards a more independent study, they would allow me to finish with a curriculum that I wanted. But at the same time, I knew that I had to be around people more. I had to do something with people. I was going to be the prosecuting attorney. I was going to help the people. I was going to make \$32,000 working for the city. You know that is what I would have done.

EVALUATION / RESULT OR RESOLUTION / CODA

[101-104] But I needed to be able to save more people and that would not have provided me that opportunity. I see my mom doing the nursing thing and I liked what she did and I shadowed a few people. That gave me the opportunity to work a certain amount of hours a certain amount of days but yet still do other things on the outside as well.

Table G5

Terri's Becoming a Nurse Narrative (RJSV012011/Lines 86-160)

ABSTRACT

[121-125] [A]t that time there were three major players as far as a diploma, it was St. A's, Charity, and Middleton. I knew that my guidance counselor suggested a diploma because you go to school and you get clinical experience. So when you get done, you will have experience. You will have been on the floor. You have been working. That is what he really pursued and pushed.

ORIENTATION

[86-91] I can remember back in elementary school, I think that it was about the fifth grade, my fifth grade teacher's name was Ms. Baker, and I was always very good in math and apparently a lot of the class was struggling with math. I do not remember if we were doing fractions or what, but her point was math is very important no matter what you are going to be or do in your life, you are going to need math. So she went around the room and asked "What are you going to be when you grow up?"

[134-142] [. . .] this is like my third Grace Hospital really. I worked at Fordson when I first graduated back in 1985, jobs were hard for nurses to find, the DRG's were coming out and they were changing from team nursing to primary nursing and all RN. I actually got training at Middleton to do team leading where we ran the floor with one LPN and 10-12 patients, and you did not have IV pumps for everybody. We also did our primary nursing where we had our three to four patients as an RN. They taught us both ways because they did not know where we would go to work. So when I got out I wanted a full time job. I could only get a part time job, and I did get a part time job for about one month. And then I finally had my application in everywhere and I got hired by Fordson Grace which was full time.

COMPLICATION

[99-117] I pursued [the idea of being a nurse] all through high school and junior high. I would even come to St. A's, to their open houses, at the school of nursing. I was going to St. A's, I did not care what anybody said, and I came up here when I was a Junior to the open houses. I was accepted, everything, my guidance counselor was the one who suggested (he had a great report with the director of nursing at Middleton) and many of the girls that graduated before me in high school had went there [and] did very well. So when she came to our school, he would call me down and have me talk to the director. I went to their open house as well, and ironically, I was accepted at both schools. At that time you would get accepted and then you had to accept them back. So I was accepted and it was funny because I learned later in life that my parents had a little plot, which I did not know. I guessed that the reason I did not go to St. A's is that I had a boyfriend in high school and St. A's started in July and Middleton started in September with Ohio State schedule, and I had 2 more months after graduating high school to have fun. Also my other choice was that the guidance counselor was very supportive of me going there as there were a couple of girls that would be seniors when I was a freshman. He said that I could go to them and they could help me if you needed, [that] they have been through it. So that was kind of a support thing. So I went to Middleton. Now my

parents' plot was...I had aunt and uncles that lived here in Riverside...so their plan was, "hey, we can stop by and we can check on her, take her to dinner now and then." My parents never influenced my decision on which school to go to.

EVALUATION

[91-98] I remember sitting there [in class] thinking, "oh, now, what am I going to be?" Everybody was saying stuff, and I remember when she came to me; I said "a nurse." Her point was no matter what all of us choose to do we are going to need math. You need to know how to add, subtract, and do this stuff. That was her whole point of it. From that point on I always remember "I am going to be a nurse," and I even remember my parents reminding me, as they have gotten older, saying "You said you were going to take care of us when we get older," and my mom now says "I believe that you are doing that." They were thrilled for me to be a nurse.

RESULT or RESOLUTION

[146-148] [. . .] So I worked there for like four years. I met my husband and we started dating. When I got married, I transferred to Grace Memorial and worked there for eight years until they closed. Then I came to St. A's.

CODA

[125-127] I remember working on my bachelor's and I had to write a paper about myself. It is ironic, because I ended up at St. A's anyway, like I came full circle, you know what I am saying?

Table G6

James's Becoming a Nurse Narrative (ROSA030411/Lines 59-79)

ABSTRACT / ORIENTATION
[60-61] [My choice to become a nurse] started right out of high school and I did like 1 1/2 years and decided that I was going to switch over to respiratory. Then I decided to go back.
COMPLICATION
[73-77] Probably you know I was brought up Catholic and went 8 years to a Catholic school then I went to a public school for high school. I always had caring feelings from a large family. We had a lot of commitment there. My dad was kind of sick as I was a child. I had some dealings with the hospital and they were pretty much good experiences for what it was, so I think that kind of helped.
EVALUATION
[61-62] I felt in respiratory I was not doing as much...I kind of wanted to do everything. I wanted more of a commitment.
RESULT or RESOLUTION/CODA
[63] There are a lot of different aspects of nursing that you can do.

Table G7

Sarah's Becoming a Nurse Narrative (SSSV012811/Lines 68-92)

ABSTRACT

[68-73] I have known that I wanted to be in the medical field since I was young. I wanted to be a doctor and my Junior and Senior year in high school I had the opportunity to shadow a physician in the Riverside area. I had a chance to go to a conference in Chicago and the conference was very unique as I got a chance to explore different things in the medical field. I went from thinking that I wanted to be an M.D., to thinking that I wanted to be a D.O., and somebody suggested that I go to a workshop [about nursing].

ORIENTATION

[74- 76] I put up this front and I was like "I am not a nurse, I want to be a doctor" and somehow I ended up in the workshop. Not sure how, but it really opened up my eyes to nursing.

COMPLICATION

[76-77] Then, when I got the opportunity to shadow the position, I kept getting brushed off onto the nurse.

EVALUATION

[77- 80] It gave me the opportunity to see the way that my grandfather was, a physician that was, I guess you could say, old school. Physicians are not like that anymore. They do not have the time. Insurance dictates how many patients they have to see, this, that, and the other thing.

RESULT or RESOLUTION

[80-86] So I came to the realization that nurses are the ones that sit down with the patients. They are the ones that put their hand on yours and say "It is going to be okay, I am going to get you through this." That is what I wanted—that kind of impact. That was probably the best thing about my new patient this morning...getting to wrap my arms around the daughter and letting her cry on my shoulder and say "it is going to be okay." That is one of the motivations for me switching from nights to days, because you do not have the impact with the family at night as during the day.

CODA

[90-92] You get the interaction with the new patient, and sometimes it is not the patient that needs your help, it is the family. On night shift a lot of the patients are sleeping so I do not feel that I have as big of an impact.

Appendix H

Collegiate Experience Narratives

Table H1

Kim's Collegiate Experience Narrative (KCLH032111/Lines 145-222)

ABSTRACT

[149-151] [Jackson Community College] was five minutes from my parents' house. The location was everything. I had already put in an application and had been accepted into a nursing program in Nashville.

COMPLICATION

[151-152] [I] had a boyfriend and I was going to be crushed if I did not get to stay here and go to school.....I did not go [to Nashville], I got into Jackson.

EVALUATION

[152-155] My mother was very disappointed, and that would have been huge for me because I probably would have come out with a Bachelor's immediately. But whether I would have appreciated it as much, I don't know.

COMPLICATION

[159-164] Me going back when my kids were hitting high school, all of us studying...I mean every youth event I was camp nurse, I was the band nurse, I was the youth group nurse...and me and my backpack went everywhere. I did homework everywhere. Road trips...it did not matter. I had a back pack and I did homework. So my kids saw me working all the time and there was no question that they were going to college and they were going to get a degree. [A] bachelor's was my minimum.

RESULT or RESOLUTION

[166-168] I have two kids that are done and one has a master's and one has a bachelor's. That was just part of life. Pick a degree, pick a goal and I don't care if it will make you rich, but you need to do it. They saw me working for it and the expectation was that they would too.

ORIENTATION

[174-179] They had three brand new instructors when I hit the program, and I am still working with those three instructors and with their students when they do their clinicals. We have their students and we take them all in for clinicals. So after all of these years, and they will tell you that it was their first year and they were totally overwhelmed, and to look back now and see where we have got to, it is pretty amazing. Of course [now], they all have their doctorates.

COMPLICATION

[194-198] I had trouble it seems, like the end in Peds. Of course you know I had never babysat, and I had never had kids, and I did not know much about them. So one of them sat me down and they said "Your grade is this and you are struggling. You are never going to make it through OB, and you might think about a career change. If you cannot get through this semester because the next semester be incredibly hard."

EVALUATION

[198-201] I kind of thought, "wait a minute...you can't tell me that I am not going to do

this,” and so I got through it and I got twice as high grades. I do not know if she was trying to motivate me or what, but it made me think “I made it this far and I am not going to give up now.”

RESULT or RESOLUTION

[201-204] It really did help. They were very supportive but I think that their teaching style has changed a lot over the years; it is not as intimidating for students. I think that there is more of a peer working relationship now.

CODA

[220-222] I do not think that it is quite the way it is anymore. It is much more conducive to learning, and making them feel comfortable around people and being a better professional.

Table H2

Jackie's Collegiate Experience Narrative (JUMW033011/Lines 33-86; 149-170)

ABSTRACT
[34-36] I became a mother very young and actually from that experience [in] which my child was born here, I thought that I wanted to be a nurse because of that.
ORIENTATION
[36-38] I was doing some medical assistant courses so I knew I kind of wanted to move in that direction but I wasn't sure I wanted to go fully into it. I decided I wanted to be a nurse and so that's what I did!
COMPLICATION
[40-51] [It] Took me several years to go that route because I had kids in between and you know kind of focusing on family life but... initially, I wanted to be a mid-wife
EVALUATION
[51-54] and I thought...OK...I'll do this in two steps, but there's no way I'll go back to school three times. And so I thought I'm just going to go and I'm going to get the Bachelor's and then I can get my Master's when I'm...you know... ready to do that.
RESULT or RESOLUTION
[65-68] [I chose to go to Northern Health because] they were the closest actually in the area that offered a Bachelor's program. Another reason that went into me deciding to get the Bachelor's as opposed the Associate's Degree was because, within Middleton, there's another facility that had a nursing program and that would be Central.
COMPLICATION
[70-71] [Central's] Associate's program is actually very difficult to get into. It takes years of a waiting list
EVALUATION
[71-72] and I thought, OK, so I'm going to be waiting and taking classes for four years to get an Associate's or waiting and taking classes and get my Bachelor's...
RESULT or RESOLUTION
[72-73] so, I thought I would go straight through.
CODA
[75-85] And so that's how I worked that out and thought it would be good for me. It was actually a little...it was competitive to get in there as well but there wasn't that waiting list because they were looking at wanting to draw more...more people in the program.
[. . .] I didn't necessarily look up to what others were doing but just kind of focused on who I wanted to be not somebody else.
EVALUATION
[149-154] Because I try to work the mission every day even...and it's...it's not conscious. It's just what I do. I don't even know how to explain it...but...like I said, I try to take care of the patient as a whole and not just...you know...whatever's going on with them. I think partially...you know... you talk about...you know...advanced degree nurses and such. And I think part of that...it is...part of what helps you work towards the mission.

RESULT or RESOLUTION

[154-170] When we were being prepared as Bachelor's nurses, you are taught to look at the whole picture as opposed to those who go through...a diploma program or an Associate's program. They're more focused on skills and disease process. [As far as liberal arts classes are concerned, I took] the theology portion and things like that. You know...looking at nursing theorists and...you know...why we do what we do...all of those in different approaches to nursing. It makes a difference, I think. [. . . it] gives you a chance to grow as a person.

Table H3

Maria's Collegiate Experience Narrative (RESC011311)

ABSTRACT

[225-227]

[. . .] I think that Valley Hill University definitely made me think about reflectively looking at nursing. One instructor was a "Faith in Community" instructor. That is what my focus was, faith in community and nursing.

ORIENTATION

[189-193]

[. . .] when I went to Mason [Community College]. I was 18 years old and I always thought that I wanted to go off to school. You know, I thought I could try to go to State or I could try to get a scholarship somewhere else, but you know at the same time I did not want to be away from my family. I always thought that my family needed me and I can't leave. I have to help my mom and my dad or I have to help my sister. There is always someone in need.

COMPLICATION

[193-215]

At that point there was some struggle between my mom and dad, and so I really did not want to leave. And then I had just started dating my husband at that time too, so I thought, "well, I am just going to go to Mason." That was always kind of the plan. I had some thoughts about going to other colleges but I thought that Mason would be simple, it is nearby, it is convenient, I can get into the nursing program and finish up in 2 years and then start working. I think that mainly what kept me here is my family nearby and it worked out that way because when I was in nursing school my sister was diagnosed with non-Hodgkin's lymphoma. [. . .] so we lived together already and she had a 3 year old daughter that she adopted and she was a single parent. I was in nursing school, and I was working, and she got sick. So I stayed and helped her. She would get sick often and she would throw up and I would just be there to help her. I would take her daughter for her, and you know, take her to go play or take her to see Santa or different things. I took care of her three year-old a lot and stayed there with her. I would hold her throw up pan/bucket.

[. . .] that was the first round. It was hard, but we still did it. Again, we were not rich, we were poor. I went to school off of scholarships and grants and it was definitely enough to pay for Mason. So, I just used the money, whatever I had, to help pay for bills like, gas, phone, electric, taxes, things like that.

EVALUATION

[227-232]

[. . .] You get busy on the floor so much, you know you work your 12 hours and you get home (actually it is more like 13-14 hours that you are working). You just do not have time to think about what you did all day, you just want to go to bed or you have to go home and take care of your kids, take care of home, and then go to bed, maybe. Finally, you know by midnight and hopefully get a full night's rest.

RESULT or RESOLUTION

[232-233] I guess she kind of helped everyone see, reflectively, throughout the day...like what you are doing at that time.

CODA

[233-236] So instead of looking back, just like, know what you are doing at the time—when you are doing it, as far as being a nurse, being a person. [. . .] She was not really focusing on the nursing, the tasks, she was focusing around the nurse as a person.

Appendix I

Civic Engagement and Public Face of Nursing

Table I1

Amanda's Civic Engagement Narrative (ARMF032811/Lines 101-115)

ABSTRACT
[103-104] It's really a blessing to me to be able to feel like I'm serving the way God intended me to...inside my job.

ORIENTATION
[104-108] Some people feel like they need to volunteer...they need to do outreach projects through their work...through their church and through other means and sometimes that's great, too. I'm not diminishing that, but I feel like I get to do that every day and I get to be close to God every day in what He's called me to do. That, to me, is amazing and it's one of the driving factors that keeps me here.

COMPLICATION
[111-112] I would say that I'm active in church and that I go to church. I work so much it makes it difficult for me to do outside activities.

RESULT or RESOLUTION
[112-114] but I try to be involved in any of the outreach stuff that we're doing here. And then I do a lot of things through Grace. I am a ARISE mentor and I will be joining the faculty this year.

Table I2

Kim's Civic Engagement Narrative (KCLH032111/Lines 224-241; 271-322)

ABSTRACT

[228] I think that if you are a nurse, you are a nurse, no matter where you are.

ORIENTATION

[228-241] I think that it is just inbred no matter where you are; if you see something that needs to be done, you step in. Sometimes you think you are crazy saying “shut up and sit down,” but you do it anyway, because it is just what you do. I think that once you start in that mode of service, you do things no matter where you are. You jump up and start doing them. . . . we have a St. Lucy Clinic which is a free clinic where I have worked for several years. This clinic runs by donations and funded by different things and health care professionals donate their time. But it got to where, with kids and school, I could not possibly manage it, so I quit doing that. But we do stuff at church regularly...whatever volunteer stuff that we have to do.

COMPLICATION

[271-279] . . . when I did hire in as an associate, and I was not really involved in any extracurricular anything to do with the hospital the first couple of years. I just kind of did my job and coasted and it was nice. I got invited into several committees and finally was I was told I needed to participate in and on a committee. They were trying to figure how to increase involvement or engagement and how to get nurses to do more things. What . . . would it take to get them to participate more? What kinds of things that they could give credit for doing, you know, community things, because they did not want just hospital [activities], they wanted us to be in the community doing things.

EVALUATION

[279-286] So for volunteering, and at that time with no kids, no activities, that I really wanted to pursue outside that were involved with the hospital. I really did not see it, but then started saying “how can we bring the nurses into the community to share or lure staff with the community?” Kind of make it a working relationship. You know, go into the ball park and the first person with the first aid kit that would be available on certain days, even if you did not have a kid in the ball park. All of these different public things that people already participate in, and do, you participate in your own church doing these things.

RESULT or RESOLUTION

[286-300] We worked on getting a first aid kit together and a team. We had meetings, we tried to make things to where we were more involved in the community. Did we volunteer at the schools? Did we do blood pressure clinic? Going to the mall...did we offer free things. So we all kind of got plugged into different opportunities and you would get points for opportunities. You got cash payoffs at the end of the year for the career ladder . . . So we sat for a board certification where we got more points, then it kind of evolved to going back to school, and the more we talked about it the better it sounded and this would provide us with better job security, and we talked ourselves right into it. It took a while. I went back to school and ended up with two board certifications. Now we don't even have a career ladder but we get more people involved.

CODA

[304-319] This is our community and this is our facility and so [we ask,] “what is best for what we do?” . . . At church we have like 500 people feel comfortable that I am a health provider. They do not care what part that you work in they just know that you work there.

My grandmother lived 65 miles away and she would call and say "hey so and so is down there are Loretto, do you know what is wrong? Have you seen them? So, they associate the whole building—it does not matter what you do in the building—you are part of the organization and that means therefore you should be helpful. Even if you cannot answer their questions you can maybe steer them someplace that can.

Table I3

Jackie's Civic Engagement Narrative (JUMW033011/Lines 20-32)

ABSTRACT

[23-24]. . . what we do outside of here is a reflection on what people think of us here as well.

ORIENTATION

[24-25] So you always have to be somewhat aware of how you are perceived in the community so that you can keep good standings with your patients.

COMPLICATON

[28] I don't live directly here, but I live like 12 miles from here.

RESULT or RESOLUTION

[28-29] [But] people in my community access this facility also . . .

Table I4

Kristi's Civic Engagement Narrative (KKSA012711/Lines 246-344)

ABSTRACT

[246-249] You can't be one person in one place and one person in another. You are who you are, and if you are trying to be two different people in two different places, it is not going to work. Maybe that is a problem with a lot of people, they do not know who they are anywhere, so they are putting different faces on.

ORIENTATION

[277-282] I also teach at an LPN school and I only do the clinical part. I won't do the lecture part, and then in the ER I am a preceptor to the new hires. Nursing has to do a clinical practicum of like 90 hours depending on which school you are in, whether it is Riverside U, Grace or Loretto, and I do that as well. It has always been interesting to me. I can pick out of 20 people (I do not want to say good nurses, but) the ones that I know that their minds are in it and they are sharp, but their heart is in it as well.

COMPLICATION

[282-301] I am pretty up front with people and if I feel that they are just there for like "okay, I'll get out and make some money," I tell them you get the heck out now. I have had a few people who have got really upset about that and I am like, "I can see it maybe because I am more observant, or I am more aware of what is going on, or I know what the future hold for you, but it is really interesting because out of a class of maybe 20, there will be two and I am like, no, no. I will pull them aside and I will say "what is your motivation and why are you doing this? For real, why?" I will confront people about it and there has been times where this one lady, it was so funny, she was laid off from an auto job and they provide a certain amount of money for re-education, I do not know how much and I did not get into the details, but she was flip-flopping it over and going into nursing, so I asked her "why are you doing this?" She had no desire to do it, she really did not. When I confronted her on it, she admitted saying "well they are paying for it and I can get a job fast." I said "OK, but it is not going to last." She said "well, my shoulder hurts, and my back, from the auto industry." I said "well that is number two, you are going to be lifting that person that you do not care about and that is going to be double hard for you, because I am lifting them and I care about them, and it still hurts my shoulder, but I care." So she just kind of looked at me, she actually quit the program. She rolled it over, the college that she was going to, there were other opportunities. It was more business related, but she rolled it over into something else and she still got the education. It was just something more for her.

EVALUATION

[301-305] So it is really hard to see people in that process. And for me, it is hard, because if I can identify that it is not for them or it is apparent that it is for the wrong reason, I do everything that I can to get them out of it. Not because of them, but because they are going to take care of me in 20 years and I do not want that nurse who is only doing it for the money. I want the nurse that has a heart.

RESULT or RESOLUTION

[305-330] I think that a lot of colleges, they do identify [what you have heart for], or they try to. I know that Loretto did, What are you doing it for? Why are you doing it? This is what we are about. I think that if you put that out there to begin with and then

there is that whole practicum experience, once they are in and they are doing it sometimes they are like "Oh my this is not what I thought it was going to be. You know they see things on T.V. and then it is totally different. I think in that process as far as with nursing in general. I feel that as someone who does education if I can identify them and get them out of there as fast as I can and then take the ones who you know are going to be good and just basically feed that and nourish them, and encourage them and utilize them. [. . .]

I have had people say "please come and teach or please come and lecture." Because I think the worst part of it is if you have a nurse who, oh god forbid, has worked 20 years and no one addressed it 20 years ago with her or him and said "Are you sure that you want to do this?" And now, 20 years later, that is the nurse that is educating. That is a huge problem and I do see it happen. I have students come to me and say that it happens. Why don't you teach or why don't you teach more? Then they identify certain individuals at certain facilities, oh they did this to me, or they just let me do this. I am thinking, "Oh my gosh! At least if you are educating these other nurses, think of the fact that a) they are going to be taking care of patients; b) they are going to be taking care of your relatives; and c) possibly taking care of you in the future. Why would you do that. I think that those who are recreating the environment of "eating your young" are the ones who 10-20 years ago should have been identified and maybe directed elsewhere.

CODA

[249-260] I think that you are what you do regardless where you do it. [. . .] if you are going to a really, really nice restaurant or a really nice meeting, you might have to wear different clothes, but the body that is in them better damn well be the same. You can't be different, if you are different than who are you true to.

[336-344] But see, I think that if I do not do that, what harm am I doing? If do not identify that, than how much more harm over the next 20 years have I just done? I do not want to do any harm. I want to identify the person who needs to go work at the zoo or who needs to go work for the city or who needs to go work somewhere else. Because they are going to be happier, you know whatever they are doing. Mean people suck.

Table I5

Maria's Civic Engagement Narrative (RESC011311/Lines 238-290)

ABSTRACT

[246-254] You always want to do the right thing regardless, but when you get to know them they are like "Oh, that was your grandpa," or maybe "Your grandmother is dying right now." It just makes it more positive that you are able to be in their lives and to share some kind of connection that makes you feel like you are always supposed to be there, like taking care of them as a patient.

ORIENTATION

[243-246] Since I grew up in Washington, and it is a smaller community, you know a lot of the families that come in, or they know you or they know your last name. "I know this family." "I went to school with this person." A lot of the patients that I take care of I know their grandchildren, or their daughters or sons, and it makes a closer connection.

[259-266] I have a five year-old and a five month-old. My five year-old is at Smith school, so he is in Washington City Schools. My daughter of course is five months-old. I do not have a lot of extracurricular type activities or hobbies. That is one thing that I want to get into, maybe finding an organization or maybe a little mini-organization that I could get into and help the community more. My husband is the same way too. We would really like to find an organization that we would participate in, but not right now. Just mainly little church projects here and there we will help out with. We belong to St. Peter's. We do not go every week.

COMPLICATION

[267-280] We do not go every week. I know we're Catholic and we are supposed to, like I said I was a catechism drop out. I was baptized at St. Peter's then we moved out to the country and then I went to Mt. Carmel and I made my communion and reconciliation, then after that I was kind of a drop out. I went back to the church and I wanted to get married, I was 21 and my husband was 22. He said "You have to make your confirmation" and I was like "Oh no," my husband had already made all of his sacraments up until that point. I made my confirmation the night before I got married. It was a one-on-one with Father since I was already going to get married and everything. We had gone back to St. Peter's church, so I had like a one-on-one every week with him for like an hour. My husband would go with me. This was on top of the marriage classes. I was taking classes at work and working on our house that we were going to move into, and I just started nursing and was taking telemetry classes there.

EVALUATION / RESULT or RESOLUTION

[280-290] It has always been like this [. . .] I worked for Grace, but I also travel, so you know working two jobs and my husband works full time and he works a lot of mandatory overtime. We also own a six unit rental property. [I am busy], but I am not liking it so much. But I do not really know any other way. I have always been that way.

CODA

[251-254] You wonder "Was this always supposed to happen like this?" Almost like a telepathic..... you know "Is this supposed to happen?", or "I do know you and I went to school with you and this is why I am a nurse". Did God put me here for this? Is this what he was doing with me? What was he thinking?

Table I6

James's Civic Engagement Narrative (ROSA030411/Lines 107-115)

ABSTRACT / ORIENTATION

[108] My volunteering is more with school stuff. One is volleyball club, the other one is soccer. So we do a lot of like fund-raising things like that.

COMPLICATION

[109-110] We did some extra stuff this year and they actually used one of the church's gym, the boys got involved.

EVALUATION / RESULT or RESOLUTION / CODA

[110-113] My son is just doing his confirmation, so he has been doing service hours. He goes down to the Mission just for a couple of hours to observe. I thought it was a really good experience and it opened his eyes to see what else is out there.

Table I7

Sarah's Civic Engagement Narrative (SSSV012811/Lines 270-289)

ABSTRACT/OREINTATION

[270- 273] Jen: Do you see a connection between being an engaged citizen outside of your work environment and being a mission committed nurse within the walls of the hospital?

Sarah: Some days yes and some no.

COMPLICATION

[280-281] [I don't do]as much [community service] as I would like, but I do things for the church. I have not taken the next step as far as signing up for them.

EVALUATION

[285-288] One of the things that I keep reminding myself, because part of what is holding me back is "Oh, I do not know anybody." I keep telling myself that "you do not know anybody as you have not taken that step to meet anybody." I have not met anybody because I have not stepped outside my comfort zone.

RESULT or RESOLUTION/CODA

[288-289] I keep reminding myself of that. As the year progresses, I would like to become more involved in the community.
