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Nursing Faculty Shortage: Nurses' Perceptions as a Key to Administrative Solutions

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**NURSING FACULTY SHORTAGE
NURSES' PERCEPTIONS AS A KEY TO ADMINISTRATIVE SOLUTIONS**

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ABSTRACT

Nursing Faculty Shortage Nurses' Perceptions as a Key to Administrative Solutions

The nursing faculty shortage is well documented. Higher education administrators turn away qualified student applicants because of the lack of qualified nursing faculty. Furthermore, they find recruitment and retention of qualified nursing faculty a challenge. The purpose of this study was to explore perceptions of the nursing faculty role, causes of the faculty shortage, and solutions to the shortage as perceived by: 1) nurses currently in a faculty role and 2) nurses with a master's degree who were not employed in a full-time faculty position.

A qualitative study using the phenomenological method was undertaken. Two groups of nurses were interviewed. The faculty group was eight nurses teaching full-time selected from faculty teaching in schools of nursing in West Virginia. The service group was eight nurses with masters' degrees in nursing but not in a faculty position selected from nurses licensed in West Virginia. In interviews, participants were asked to describe their current position, perceptions of the nursing faculty role, causes of the shortage, and solutions to the shortage.

Participants believed the causes of the shortage included low salaries, lack of nurses with advanced degrees, nurses without training in teaching, and other career options. Their solutions included presenting a positive image of the nursing faculty role, supporting doctoral education, utilizing nurses with masters' degrees, mentoring new faculty, and networking with nurses in service positions. Those in both groups described a passion for nursing and teaching and viewed themselves as educators. The positive aspects of the faculty role were relationships with the students, watching students develop into nurses, relationships with colleagues, and flexible schedules.

Nursing administrators will continue to be challenged with recruiting and retaining qualified nursing faculty. This study found that nurses in both faculty and service settings enjoyed teaching but they selected their positions based on cost-benefit analyses. In other words, for these participants, the costs of pursuing faculty positions are unduly high considering the perceived benefits.

DEDICATION

To my sons, Lee and Christopher, and my mother, Jessie Klocke.

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NURSING FACULTY SHORTAGE
NURSES' PERCEPTIONS AS A KEY TO ADMINISTRATIVE SOLUTIONS

CHAPTER ONE: INTRODUCTION

Over the years the supply and demand for nurses in the United States has fluctuated between oversupply and shortage (Brendtro & Hegge, 2000). Currently, many nursing leaders are saying nursing is again facing a major nursing shortage. During the 20th century, the nursing shortage did not result in a shortage in the ranks of the nursing faculty. The nursing faculty work force was able to keep up with the demand. With the current nursing shortage, however, the number of qualified nursing faculty has declined. This faculty shortage threatens to make the overall nursing shortage worse due to the lack of enough faculty members to educate the new nurses (Brendtro & Hegge, 2000).

Higher education administrators are facing the problem of not being able to admit all of the qualified students to the nursing programs because of the lack of qualified nursing faculty. This is validated by a survey in 2002 conducted by the American Association of Colleges of Nursing (AACN) in which they found that 5,283 qualified applicants were not admitted to nursing programs at all levels including baccalaureate, master's and doctoral programs. In 41.7 % of the schools responding, this was due to the insufficient number of nursing faculty members (AACN, 2003). Higher education administrators cannot afford to lose prospective students because of insufficient numbers of faculty.

In addition higher education administrators are facing the issue of recruiting and retaining qualified nursing faculty. Even though the standard is for faculty teaching at the collegiate level to have a doctorate, only half of the full-time nursing faculty across the country in 2001 held a doctorate degree. Of those nursing faculty members with doctorate degrees, only 58% held doctorates in nursing (Berlin & Sechrist, 2002). The results of the special survey conducted by the American Association of Colleges of Nursing (AACN) in 2003 indicated that the faculty vacancy rate has increased to 8.6% which is up from a 7.4% vacancy rate in 2000. Of the 614 faculty vacancies reported by 300 nursing schools, 59.8% of the vacancies required a doctoral degree (AACN, 2004).

The literature indicates several factors that are contributing to the decline in nursing faculty which include age, fewer nurses receiving master's and doctorate degrees, lack of competitive salaries, faculty workload, and alternative career choices (AACN, 2003; Berlin & Sechrist, 2002; Brendtro & Hegge, 2000; De Young & Bliss, 1995; Fong, 1993; Hinshaw, 2001; Princeton, 1992). Administrators in higher education need to understand how these factors contribute to difficulties in recruiting and retaining nursing faculty. The current perceptions of the nursing educator role and the faculty workload may contribute to nurses choosing or not choosing to pursue the role of a nursing educator. The purpose of this study was to explore the current perceptions of the nursing faculty shortage by nurses currently in education positions as compared to those who have at least a master's degree in nursing but are not in an education position. This study also explored the perceived attractions and barriers to nurses choosing the nursing educator role.

Theoretical Lens: Evidence-Based Practice Model

More and more professionals are expected to base their practice on research and data-based studies. This is very true in the medical and nursing professions (Jennings & Loan, 2001). Ingersoll (2000) has defined evidence-based practice in nursing as “the conscientious, explicit and judicious use of theory-derived, research-based information in making decisions about care delivery to individuals or groups of patients and in consideration of individual needs and preferences” (p.152). Goode and Piedalue (1999) expanded the evidence to include other forms of data beyond research. They have defined evidence-based practice as “the synthesis of knowledge from research, retrospective or concurrent chart review, quality improvement and risk data, international, national and local standards, infection control data, pathophysiology, cost effectiveness analysis, benchmarking data, patient preferences, and clinical expertise”(p. 15). Goode and Piedalue (1999) acknowledged that there are other sources of data that are used to make practice decisions. Ingersoll (2000) further revised the definition so that it could be used in the practice area of nursing education. Evidence-based practice in education was defined as “the conscientious, explicit and judicious use of theory-derived, research-based information in making decisions about education options and approaches with individuals or groups and in consideration of individual or group needs and preferences” (p. 152).

For education K-12, the United States Department of Education developed a guide for identifying and implementing educational practices based on rigorous evidence (U. S. Department of Education, 2003). The assumption is that if practitioners can identify evidence-based interventions, then they will be able to improve American

education by implementing these interventions. The first step is to evaluate whether there is strong evidence of the effectiveness of the intervention. Strong evidence means that the intervention has been tested using randomized controlled trials and tested in two or more typical school settings including settings similar to the setting in which the intervention is to be implemented. In education, randomized controlled trials are not always possible to conduct, therefore well designed comparison group studies are used as the evidence for making decisions. In the comparison group study, randomization is not possible so two groups are very closely matched in academic and demographic characteristics. In order to be helpful in making practice decisions, the research study should clearly describe the intervention, how it was administered, and who received the intervention. The measurements of outcomes should be valid and reliable and preferably measure the outcomes over time to determine if the intervention's effects are sustained. After evaluation of the evidence, a decision is made to implement the intervention in another setting or school. Whether an intervention will be effective in another setting may depend on how closely the same procedures are followed when implementing the intervention in the new setting.

The call for improving education is not just coming at the Kindergarten through 12 levels. Oliver and Conole (2003) stated that universities are being made more accountable to the public and the government. Evidence-based practice in higher education is a way to link research with practice and policies. In the United States Department of Education's guide for implementing evidence-based practice, the emphasis is on basing decisions on well designed randomized controlled trials. Although controlled trials are considered the gold standard, especially in medicine, some in

educational research argue that controlled trials are not always appropriate due to the unpredictability of human behavior (Cziko, 1989; Erickson, 1992; Oliver & Conole, 2003). Cziko (1989) argues that because of individual differences, a teaching approach that works for one student or school may not work for another student or school. Cziko indicates that in addition to the quantitative approach, there is a need for the qualitative approach in educational research to provide important information and understanding of a phenomenon. With the qualitative approach, educational phenomena can be described, interpreted and a further understanding of the individual behaviors and cognitive processes can be developed. Erickson (1992) argues that clinical trials and the replication of practices do not take into account the local events that are inherently unpredictable. Oliver and Conole (2003) state that both qualitative and quantitative research approaches have a role in improving education. They caution that research in education needs to help describe and study the best practice and not be used primarily to influence public policy. In addition, Doyle (2002) argues that while data and solid evidence are important to school administrators implementing interventions in a new setting, implementation is not a guarantee of success or improvement in education. The same data can be used to improve practice or to point the blame. All too often data have been used by policy makers to point the finger. In addition, what is being measured is given attention while areas not being measured or evaluated often go neglected (Oliver & Conole, 2003). Therefore, Doyle (2002) states that administrators need to be informed of the facts, to rigorously analyze the data, and constantly re-analyze, and re-interpret the evidence. Decisions then are made based on scientific evidence along with professional judgment that has been gained from insight and experience in the field.

Based on definitions of evidence-based practice, Goode and Piedalue (1999) developed a model of evidence-based practice. The first step is to identify and define the practice problem. The next step is to explore the research base that is available. This research base would include both quantitative and qualitative research. It is important to continually search for the latest research data and to evaluate the quality of the research data. Besides research, other sources of evidence are examined in order to strengthen the evidence base. Other sources include governmental and professional organizational reports, quality improvement data, practice standards, cost analysis data, benchmarking with other institutions regarding their practice, and experts in the field. In the education area, sources would be expanded to include admission and retention rates, passage rates on national exams, faculty and student satisfaction, and data about the faculty. Once the data have been synthesized and evaluated, a decision is made as to whether there is enough evidence to make a change in practice or that more study is needed. If there is enough evidence, then the new practice is developed and implemented. After implementation, the outcome of the new practice is evaluated to determine if it is effective or if further changes need to be made. If there is not enough evidence, then a research study may be conducted to gather more evidence.

Factors Contributing to the Shortage

Several factors have contributed to the development of the current nursing faculty shortage. One of the first factors identified in the literature is the age of nursing faculty (Anderson, 2000; Berlin & Sechrist, 2002; Brendtro & Hegge, 2000; Craine, 2000; Gray et al., 1997; Marshall, 2001). The current mean age of nursing faculty is nearly 50 years

and one third will retire by 2006 (Brendtro & Hegge, 2000; Craine, 2000; De Young & Bliss, 1995). In addition nurses tend to seek doctoral degrees at a later age and take longer to complete doctoral programs than doctoral recipients in all other disciplines (Berlin & Sechrist, 2002).

The graduate education experience and the decline in nursing doctoral graduates is another factor contributing to the nursing faculty shortage (Berlin & Sechrist, 2002, SREB, 2002). In the 2002 survey conducted by the Southern Regional Education Board (2002), there was a 28% drop in doctoral recipients from 2002 to 2001. Studies of doctoral students in various programs of study have described the struggles and concerns that doctoral students have (Anderson & Swazey, 1998; Gray et al., 1997; Lovitts, 2001). These students need support from both the institutions and their families in order to complete the programs. Nurses in doctoral programs are often going to school part-time and are balancing the demands of work, school, and home (Berlin & Sechrist, 2002; Gray et al., 1997).

Another contributing factor noted repeatedly in the literature is the lack of competitive salaries in nursing education as compared to positions in hospitals and in the community (AACN, 2003; De Young & Bliss, 1995; Hinshaw, 2001; Berlin & Sechrist, 2002) and the increase in career opportunities other than academic positions (Brendtro & Hegge, 2000; De Young & Bliss, 1995; Hinshaw, 2001). The salaries for nurses in service positions have been over \$20,000 more than salaries for nurses in faculty positions (AACN, 2004; De Young & Bliss, 1995). Nurses with graduate degrees are finding jobs as hospital administrators, clinical researchers, nurse practitioners, clinical nurse specialists, and entrepreneurs just to name a few (Brendtro & Hegge, 2000; De

Young & Bliss, 1995; Hinshaw, 2001). But in national and regional surveys of nursing programs (Rosenfeld et al., 2003; SREB, 2002), salary issues were not the number one reason that nurses left nursing faculty positions. Other reasons for leaving included retirement, changing careers, and family obligations. The reports of the Southern Regional Education Board suggested more investigation into why nursing faculty members resign (SREB, 2002).

Once a nurse decides to become a nurse educator, the transition from a clinician role to an educator role may be difficult since clinicians are socialized differently from educators (Esper, 1995; Neese, 2003; Siler & Kleiner, 2001). Several qualitative studies have described stages of transition experienced by both nurses and those from other disciplines (Esper, 1995; Neese, 2003; Rosch & Reich, 1996; Siler & Kleiner, 2001). They describe the beginning stages of learning the expectations, to struggling to meet the expectations, to finally establishing their role as educator or becoming disillusioned and leaving the institution. Other studies have indicated that nurses are unfamiliar with the educator role and have not received training in nursing education during their graduate studies (Esper, 1995; Siler & Kleiner, 2001). On the other hand, Herrmann (1997) found that educational preparation assisted in the transition into the faculty role. During the transition period, mentoring by senior faculty members and support from colleagues was found lacking in some studies and in others was found to be very helpful (Brown, 1999; Rosch & Reich, 1996; Siler & Kleiner, 2001).

Another factor contributing to the nursing faculty shortage is job stress related to the nursing faculty position. Several studies have examined the stresses, burnout, and exhaustion that nursing faculty experience (Dick, 1992; Fong, 1993; Langemo, 1990;

Lease, 1999; Lewallen, Crane, Letvak, Jones, & Hu, 2003; Lott, Anderson, & Kenner, 1993; Mobily, 1991; Oermann, 1998). The studies have found multiple sources of stress including job expectations, heavy workload, balancing work and personal responsibilities, and balancing research, teaching, and service responsibilities (Lott, Anderson, & Kenner, 1993; Mobily, 1991; Oermann, 1998). These stresses have been found to be buffered by individual hardiness, environmental support, peer support, and participant management (Dick, 1992; Fong, 1993; Lease, 1999; Langemo, 1990).

The final issue related to the nursing faculty shortage is job satisfaction and intent to leave a position or the role. Both in the education and nursing literature, job satisfaction has been directly linked to intent to leave (Johnsrud & Rosser, 2002; Rosser, 2004; Larrabee, et al., 2003). As job satisfaction increases the intent to leave decreases. A few studies have examined nursing faculty satisfaction (Gormley, 2003; Kuennen, 2002; Moody, 1996; Snarr & Krochalk, 1996). The overall job, supervision, coworkers, and workload contributed to job satisfaction. In some studies, factors contributing to job satisfaction varied with the type of institution, the experience level of the faculty member, and whether they were tenured (August & Waltman, 2004; Moody, 1996; Olsen, 1993; Rosser, 2004). If job satisfaction is negatively related to intent to leave, then administrators need to understand what contributes to job satisfaction in order to retain faculty members. Snarr and Krochalk (1996) recommend further research of indicators of job satisfaction that are unique to the academic environment such as professional environment, professional status, autonomy, and self-actualization.

From the review of the literature, the factors that have contributed to the nursing faculty shortage include the increased average age of nursing faculty members, the

decline in nurses pursuing doctoral degrees, and the potentially stressful experience of doctoral study. In addition, nurses are potentially selecting positions outside of higher education due to the lack of competitive salaries, the increase in career opportunities, job related stress, and job satisfaction. The next question concerns recommendations that have been suggested for the resolution of the nursing faculty shortage.

Recommendations to Reduce Shortage

Many potential solutions to the faculty shortage have been suggested to enhance the recruitment and retention of nurses into a nursing faculty role. Under the category of recruitment, younger nurses need to be attracted into a doctoral program, complete the program in a timely manner, and then be recruited into a nursing faculty position (Brendtro & Hegge, 2000). One proposal is to add education courses to all master's degree programs and to develop post-master's degree programs in education for nurses with master's degrees in other specialties (Brendtro & Hegge, 2000; De Young & Bliss, 1995; De Young, Bliss, & Tracy, 2002). These nurses then would have the additional skills needed to become a nurse educator. This would increase the number of nurses trained in the area of education and increase the potential for those nurses to become interested in teaching as a part of their career (Brendtro & Hegge, 2000; De Young & Bliss, 1995). What is lacking is the evidence as to what will attract young nurses into advanced education, especially doctoral programs.

Another recommendation for recruitment involves improving the image of the nurse educators by sharing the positive aspects of the nurse educator role (AACN, 2003; SREB, 2002). Faculty need to share with their students the joy and rewards of teaching

so that they will become interested in choosing teaching as a career (Craine, 2000). In 2004, a coalition of nursing organizations, Nurses for a Healthier Tomorrow, launched a national advertising campaign that promoted the image of nurse educators and shared four testimonials of nurse educators. It is too early to know the impact of this campaign.

Repeatedly, competitive salaries and rewards for teaching are seen as a solution to the nursing faculty shortage (Brendtro & Hegge, 2000; Craine, 2000; De Young & Bliss, 1995; Hinshaw, 2001; SREB, 2002). Some nurses may not want to give up their clinical practice and higher paying salaries but are willing to teach part-time. Some institutions are utilizing joint appointments in which part of the salary is paid for by a hospital or a clinic and the remainder of the salary is paid for by the teaching institution. These joint appointments potentially provide higher salaries for nurses than adjunct positions that are notoriously paid low salaries (Brendtro & Hegge, 2000; De Young & Bliss, 1995). In addition, the promotion and reward system in higher education needs to recognize nursing faculty members who are interested and excel in teaching in addition to excellence in research (Marshall, 2001).

During the transition to becoming an educator, new faculty members who may not have been trained in pedagogy may become overwhelmed with their first teaching experience (Esper, 1995; Siler & Kleiner, 2001). Recommendations to assist new faculty members during the transition period include mentoring by senior faculty members, gradual retirement of senior faculty members who can serve as mentors (Hinshaw, 2001), and support groups for new faculty members (Lewallen, Crane, Letvak, Jones, & Hu, 2003).

Finally, if there are fewer nursing faculty members, higher education administrators must more effectively distribute the faculty workload and consider new pedagogy to enhance the quality of student education. Undergraduate clinical rotations require a lot of faculty energy and time and may need to be restructured (De Young & Bliss, 1995). Other methods such as preceptors, computer simulations, and web courses need to be considered because they utilize less faculty time but still develop the students' clinical skills that are needed for practice (AACN, 2003; De Young & Bliss, 1995).

Even in light of the recommendations discussed, the literature is limited on nurses' perceptions of the nursing faculty role, what would attract them to the faculty role, and what would keep them in that role. By learning more about what nurses think about the faculty role, it is hoped that administrators in higher education will be better able to develop and put into practice ways to recruit and retain nursing faculty members.

Statement of Problem

After collecting and examining the evidence found in the literature, the next step in the evidence-based practice model is to decide if there is enough evidence to make a practice change. For the nursing faculty or administrator, the task is to determine if the solutions found in the literature can help to solve the nursing faculty shortage they are experiencing. Most of the ideas reported above from the literature seem like good ideas but have not been tested or are not based on research. Yes, we need nurses educated at the masters' and doctorate level at an earlier age but the ways to do it are not clear or based on research findings. Once nurses are in advanced degree programs, having them take education courses may or may not interest them in a career as nursing faculty. If the

nursing administrator in a school of nursing is able to obtain higher salaries for the nursing faculty members, the increased salaries may not be enough to attract nurses to nursing education. The mentoring programs may or may not really help make the teaching experience more attractive and thus help retain new faculty members.

The need for higher education administrators is to learn what would attract nurses with master's degrees to a career path in nursing education, and if any of the solutions offered in the literature such as mentoring programs, educational course in all master's degree programs, and higher salaries would attract nurses into faculty positions. A more in-depth understanding of nurses' perceptions of the faculty role and the advantages and disadvantages of a career path as nursing faculty would provide insight into solutions to the nursing faculty shortage. If the higher education administrator better understands the perceptions of those both currently in nursing faculty positions and those working in other areas, they may be able to come up with better solutions to recruit and retain nurses to nursing faculty positions. The data from various surveys show a decline in the number of nurses choosing a career as nursing faculty but they do not explain why. The data show a large difference in salaries between academia and clinical practice, but this difference may not be the only factor drawing nurses away from the nursing faculty role. In an economic time when many institutions of higher education are facing budget cuts, they may not be able to improve the salaries enough to attract nurses into faculty positions. We need to look deeper to find other ways to attract nurses into a career of nursing education.

Purpose of Study and Research Questions

The purpose of this study was to explore the current perceptions of the nursing faculty role and faculty workload as held by those currently in a faculty role and those nurses with at least a master's degree who are not in a faculty role. Also the purpose was to determine what they think of the solutions to the faculty shortage that have been offered in the literature such as mentoring programs, higher salaries, changes in workload, and nurses pursuing advanced education at an earlier age. By asking both groups of nurses, administrators in nursing education can better understand what solutions might work. Knowledge of these perceptions should help administrators identify what attracts nurses to teaching and what are perceived as barriers to choosing the faculty role.

Research questions

How do nurses currently in a faculty role perceive their role as educator and their workload?

How do nurses in a service position perceive the role of a nursing faculty and faculty workload?

What are the differences and similarities if any between the perceptions of the nursing faculty role held by the two groups of nurses?

What do the nurses in nursing faculty positions and those nurses with at least a master's degree but in service positions see as causes for and solutions to the growing nursing faculty shortage?

Methods

This research was a qualitative study that utilized phenomenological methods. According to Jasper (1994), phenomenological research seeks to access the description of an experience in the person's own words. The main method of data collection in this type of research is in-depth interviews. During the interview process researchers often have to use the bracketing technique, which is to deliberately examine their own feelings and temporarily suspend their own beliefs. During this study, I sought to better understand the nursing faculty role as experienced by those who are currently in a teaching role. At the same time I sought to understand how nurses who have masters' degrees in nursing and are in service positions perceive the faculty role. More specifically, I wanted to discover the positive aspects of the role that have the potential for attracting nurses to the faculty role and those aspects that were perceived as reasons for not choosing the role. This information was collected through in-depth interviews with nurses who are licensed in the State of West Virginia since they were easier to reach for interviews.

In qualitative research, the major instrument for data collection is the researcher (Bogdan & Biklen, 1998). In choosing the location for a qualitative study, Bogdan and Biklen (1998) suggest that it not be in an area too familiar to the researcher or where the researcher is too involved because it becomes more difficult for the researcher to remain neutral and be open to the opinions and concerns of others. Another issue is if the research involves the researcher's colleagues and peers in the study. These colleagues and peers may feel coerced to participate in the study. Thus Bogdan and Biklen (1998) suggest that researchers choose locations and participants that are less familiar to the researcher. In this study, I was familiar with the faculty role since I currently hold a

nursing faculty position. I had to be careful to suspend my concerns and opinions in order to learn more about how other nurses perceived the role. I purposefully selected participants with whom I was not acquainted in order to learn new and different perspectives.

Demographic data were collected from each participant in order to compare the nurses in faculty positions and those who are in other roles with regard to age, years in nursing, years in current position, current position, current salary, length of time between completing the basic degree in nursing and starting a masters' degree, age when received masters' degree in nursing, and highest degree held. Age was selected since the literature notes that the age of nurses in general and those in faculty positions is increasing (Brendtro & Hegge, 2000). Salary was selected since the literature noted that the salaries of faculty members tend to be lower than nurses in other positions (De Young & Bliss, 1995; Hinshaw, 2001). The time frame for starting a masters' degree was selected because the literature indicates that nurses wait longer to seek an advanced degree and take longer to complete the degree (Berlin & Sechrist, 2002).

The in-depth interviews followed a semi-structured interview guide. As Kvale (1996) indicates, the interview guide in qualitative research contains the broad topics to be discussed and suggested wording of some questions. The exact wording and sequence of the questions may change during the interview based on the judgment of the interviewer during the interview. The questions need to reflect the topic being studied but also be dynamic enough to promote the flow of the interview and encourage the participants to share their experiences and perspectives. In this study a set of questions was used that reflected the research questions and was similar for all of the interviews so

as to facilitate comparisons across the different interviews. Follow-up questions were used during the interviews to gain more description and in-depth information.

Significance

Implications for Nursing

By the late 1990s, fewer than half of the faculty in baccalaureate and higher programs had doctorate degrees (Brendtro & Hegge, 2000; Hinshaw, 2001; Anderson, 2000). The number of doctorate programs in nursing has increased over the years and is now well over 70 programs but many are small and only graduate one to ten students a year. This will not fill the growing need for qualified faculty. In addition, many faculty with doctorates are trained more in research than teaching and thus do not want to teach baccalaureate level students. They want to devote most of their time to research (AACN, 1999; Anderson, 2000). Research is important in generating new nursing knowledge. Therefore, fewer faculty members are available to do research and add to the nursing body of knowledge. On the other hand, fewer faculty members will be available to teach new nurses at the baccalaureate level if senior faculty members only want to do research. In addition, those without a doctorate degree have difficulty gaining academic rank and tenure because they are not seen as on equal footing with other academic disciplines (Marshall, 2001). If they cannot achieve rank and tenure then job security is in jeopardy.

Another implication of the “graying” faculty is a lack of mentors for the younger faculty and as faculty become older they are less willing to take on the physical demands of clinical teaching (De Young & Bliss, 1995). Will the new faculty have to learn by trial and error? The demands of clinical teaching then fall on a few numbers of faculty and

lead to burnout. The demand of clinical teaching has become greater because the patients are sicker, the hours are long, and clinical sites are limited (Anderson, 2000).

With increased difficulty in finding qualified faculty to fill positions, nursing programs are unable to enroll as many students as they would like. This contributes to the inability to educate new nurses and intensifies the current nursing shortage (AACN, 1999; De Young & Bliss, 1995). In 1999, AACN (1999) reported that 64 of its member schools had been unable to increase school enrollment because of problems recruiting qualified faculty. Nurses are going to the better salaried positions in clinical practice. In 2004, AACN (2005) reported that 32,797 qualified applicants had been turned away due to lack of qualified faculty. In addition, by February 2002 in the Southern Regional Board of Education alone there were 432 faculty vacancies and 350 newly budgeted positions that need to be filled.

Implications for Administrators

Gulick and Urwick (1937) identified seven functions of an administrator that still hold true today. They are planning, organizing, staffing, directing, coordinating, reporting, and budgeting. For the higher education administrator who is facing the nursing faculty shortage, the functions of planning, organizing, and staffing are particularly important. According to Gulick and Urwick, the function of planning involves studying the future and making plans that enhance the accomplishments of the organization. If administrators in higher education do not look to the future and plan for replacing retiring nursing faculty they will find themselves unable to fill the vacancies. They need to learn what will attract nurses to the nursing educator role by learning how the role is perceived by nurses both in the role currently and those in other nursing roles.

From the results of this study, the higher education administrator may gain insight into what will attract nurses to the education role and thus be able to plan recruitment strategies. The function of organizing is to organize both material and human resources in such a way to ensure the work of the organization (Gulick & Urwick, 1937). If and when the nursing administrator is able to attract nurses to the nursing faculty role, he/she will have to organize the workload so that students receive an education while preventing overload and burnout of faculty members. From this study a better understanding of nurses' perceptions of the workload of faculty may indicate needed changes in workload that would help retain and recruit faculty members. Finally staffing will be important in order to have the number of faculty necessary to accomplish the goal of educating new nurses and creating an environment conducive to learning.

According to Haller and Kleine (2001), educational research has too often focused on the administrator him or herself rather than the responsibilities of the administrator and how to improve the ways he or she carries out these responsibilities. Following their argument, the ultimate goal of this study was to generate empirical evidence that educational administrators can use to improve the education of nursing students. In this study what the higher education administrator learns about nurses' perceptions of the nursing faculty role might then be used to enhance recruitment and staffing practices. The end result would be to have qualified faculty members available to educate new nurses.

Limitations

Since this was a qualitative study with a relatively small sample size, generalizability is limited. According to Merriam (1995), generalization in qualitative

research is often viewed as a limitation because the sample is not randomly selected and thus is not representative of a larger population. On the other hand, Merriam argues that the insights gained from qualitative research studies can be applied to similar situations. Whether the results are helpful is often left up to the reader of the research to determine if the results are useful and can be applied to similar situations.

A second limitation was that the sample was drawn only from nurses licensed in West Virginia and thus may not apply to other areas of the country. The circumstances in higher education, the economic conditions, and the demand for nurses are not necessarily the same in all parts of the country. This area of the country was chosen because these nurses were more accessible for interviewing.

CHAPTER TWO: REVIEW OF THE LITERATURE

This chapter consists of a review the literature related to the nursing faculty shortage. I start with the history of the shortage and the current assessment of the problem. Then I review the literature that addresses the faculty role, factors that have contributed to the nursing faculty shortage, and the recommendations that have been proposed to solve the shortage.

History of the Nursing Faculty Shortage

Throughout history, the supply of nurses in the United States has fluctuated between oversupply and shortage but the supply of qualified nursing faculty has been able to keep up with the need. In recent years, the supply of nursing faculty has not kept up with the demand. The current nursing faculty shortage impacts the overall nursing shortage because not enough nursing faculty are available to educate new nurses (Brendtro & Hegge, 2000).

The first major force producing a decrease in faculty was the decline in nursing school enrollment in the 1980s (Brendtro & Hegge, 2000; De Young & Bliss, 1995; Hinshaw, 2001). Because of the declining enrollment, institutions cut faculty position and did not fill positions as faculty members retired or left. Students were deciding to enroll in other programs rather than nursing, therefore, fewer nursing faculty members were needed. Along with the cut in position, came decreases in other budgetary support for nursing programs.

Then in the 1990s, the enrollment to nursing programs increased (Brendtro & Hegge, 2000; Hinshaw, 2001). Unfortunately, by this time there were increased

opportunities for nurses with doctoral degrees in other areas besides teaching. As a result, institutions had difficulty filling all of the needed full-time positions and thus started using more part-time faculty positions. This was seen as a way to save the institution money since they would potentially not have to pay for benefits (Princeton, 1992). Over a twenty year period the ratio of full-time positions to part-time positions has gone from 5.81:1 in 1972 to 2.43:1 in 1992 (Brendtro & Hegge, 2000). Again in the late 1990s, the nursing student enrollment declined and institutions froze nursing faculty positions as a result of the lower tuition revenues. The institutions again increased the use of part-time faculty. Thus, twice in the last two decades, institutions have reduced or frozen nursing faculty positions as a result of declines in nursing student enrollment (Hinshaw, 2001). Hinshaw (2001) indicates that the cumulative effect has been a decline in full time positions and has reduced the availability of nursing leaders to resolve the nursing shortage and the nursing faculty shortage.

Ryan and Irvine (1994) surveyed 296 nursing programs accredited by the National League of Nursing. This represented a 58% response rate. Sixty percent of the respondents had difficulty finding and getting qualified applicants to accept nursing faculty positions. They had more difficulty when recruiting nursing faculty with expertise in specialty areas such as pediatrics, maternity, community, and psychiatric nursing. In this study, the schools of nursing with graduate programs indicated that students in masters programs were most often preparing to be specialists in the clinical area. Graduate students preparing to be administrators (1,350) ranked ahead of those students preparing to be educators (less than 800). This trend also held at the doctoral level with

clinical preparation being first with over 100 students and administration and educational roles lagging behind with fewer than 100 students.

Over the years, the number of graduate programs preparing master's students to become educators has declined. This is important since to maintain accreditation, faculty members teaching in baccalaureate programs need to have at least a master's degree. In 1978, almost 23% of the graduate programs provided teaching preparation as compared to 6.2 % in 1996 (Brendtro & Hegge, 2000). In the 2002 SREB survey (SREB, 2002), 51 master's and 16 doctoral programs offered courses in nursing education. This represented 56% of the programs in the southern region. Unfortunately in 2001, only 237 graduates or 1.2 % of the graduates completed courses in nursing education. As Hinshaw (2001) stated, many of the graduate programs do not provide experiences in teaching unless the student is a graduate assistant. Thus, most of these students do not have an opportunity to become comfortable with the teaching role. By the late 1990s, the majority of master's degree students were preparing for roles in advanced practice such as nurse practitioners rather than faculty roles (Craine, 2000; De Young & Bliss, 1995; Hinshaw, 2001). These nurses were being asked to fill clinical faculty roles, but they had not received any education regarding the teaching role. Many doctoral programs focus on research and do not provide training in pedagogy. Unfortunately, these nurses may be excellent clinicians or researchers but that does not assure that they will be good teachers or even want to be in the teaching role (Kelly, 2002; Princeton, 1992). Kelly (2002) indicated the need for a practicum in teaching during graduate education and mentoring by senior faculty for new faculty members. In addition, this decline in enrollment at the master's degree level reduces the source of future doctorate students. Nurses' experiences and reasons for

pursuing the master's degree may be very different from those in the doctorate programs since the focus of the master's degree is advanced education in various practice roles while the doctorate degree is more research focused (Hinshaw, 2001). The environment for graduate education needs to support the value of both teaching and research (Kelly, 2002).

Anderson and Swazey (1998) examined why students pursue doctoral studies. They surveyed 2,000 randomly selected doctoral students from 99 departments at major research universities across the United States in the fall of 1989. These students were from chemistry, civil engineering, microbiology, and sociology departments. The number one reason for pursuing a doctoral degree was the desire for knowledge. Research was a very important reason for nearly two-thirds of the students. Forty percent did note that the desire to teach at a university was an important part of the decision. There is not a similar survey indicating the reasons nurses pursue a doctoral degree.

Current Nursing Faculty Shortage

The deficiency in nursing faculty is making it difficult for schools to admit all of the qualified students. In 2002, nationally 5,283 qualified applicants to nursing programs were turned away. For 41% of the schools, this was reported to be due to the insufficient number of faculty (AACN, 2003). In another national survey by the American Association of Colleges of Nursing (AACN) fall 2003 enrollment into baccalaureate nursing programs increased by 16.6 percent, but at the same time over 11,000 qualified students wishing to enter baccalaureate-degree programs were turned away because of lack of faculty, limited number of clinical sites, and lack of classroom space (AACN,

2003). The fall 2003, findings were based on surveys from 564 nursing schools with both baccalaureate and graduate degree programs. This represented an 82.7% return rate. From 2002 to 2008 there has been a steady increase in students enrolled in both baccalaureate and graduate nursing programs along with an increase in qualified candidates being turned away for schools of nursing (AACN, 2009). Still, in 2008, the number one reason for turning away qualified nursing students was the lack of nursing faculty (AACN, 2009).

The vacancy rate for nursing faculty positions is on the rise. The American Association of Colleges of Nursing (AACN) reported in 2000 that 379 (7.4%) of the faculty positions were vacant at the 220 institutions they surveyed. In 2004 the nurse faculty vacancy rate had increased to 8.1% which represented 717 faculty positions at 395 nursing schools (AACN, 2005). In 2007, the trend continues with faculty vacancy rate reported at 8.8% for 344 member schools which represented 767 faculty positions going unfilled (Fang, 2007). The National League for Nursing (NLN) conducted a national survey in 2002 and had similar results. The NLN survey was sent to 1,419 nursing programs nationally and the response rate was 77.4% or 1,098 completed surveys. The total number of unfilled positions was 1,106. The vacancy rate was 6% for baccalaureate and higher programs, 5.1% for associate degree programs, and 3.6% for diploma programs (Rosenfeld, Kovner & Valiga, 2003). In this NLN study, the largest number of unfilled nursing faculty positions (475) was found in the South, while the largest vacancy rate of 6.8% was found in the West. A 2006 NLN survey found an increase in the number of full-time and part-time faculty positions and student enrollment since the 2002 survey but the faculty vacancy rate continues to increase. The faculty

vacancy rate has increased to 7.9% in baccalaureate programs, to 5.6% in associate degree programs, and 3.5% in diploma programs. The region of the country with the highest vacancy rate has changed to the West with an 8.1% vacancy rate as compared to the region with the lowest vacancy which is the Midwest with a 4.9% vacancy rate. This was based on surveys being sent to 1,374 nursing programs with 801 returned for a 58% response rate (Kovner, Fairchild & Jacobson, 2006). On the regional level, the Southern Regional Education Board (SREB) conducts annual surveys of its member states to assess the faculty shortage. The member states include Alabama, Arkansas, Delaware, Florida, Georgia, Kentucky, Louisiana, Maryland, Mississippi, North Carolina, Oklahoma, South Carolina, Tennessee, Texas, Virginia, West Virginia, and the District of Columbia. At the beginning of academic year 2000, the vacancy rate was 4.9% or 314 unfilled nursing faculty position (SREB, 2002). The annual survey results for 2003 yielded similar results with a vacancy rate of 4.7% or 275 unfilled nursing faculty positions.

Another concern is the educational level of the nursing faculty. According to Hinshaw (2001), only recently have institutions required nursing faculty to have a doctoral degree in order to be tenured or placed on the tenure track. As recently as 1978, only 15% of the nursing faculty in baccalaureate and higher degree programs held a doctorate in nursing or a related field. Even though the standard is for faculty teaching at the collegiate level to have a doctorate, only half of the full-time faculty across the country in 2001 held a doctorate degree. Of those faculty members with doctorate degrees, only 58% were nursing doctorates (Berlin & Sechrist, 2002). In the 2002 NLN survey, about half of the full-time faculty members in baccalaureate programs held a

doctoral degree (Rosenfeld et al., 2003). In contrast the majority of faculty members in associate and diploma programs held master's degrees as the highest earned degree. In the 2000 SREB survey, only 25.7% of the nursing faculty had earned a doctoral degree (SREB, 2002). The SREB report indicated that nearly 500 nursing educators did not hold a master's degree in nursing which is considered the minimum academic credential. The percent of doctoral prepared faculty has increased to 33.5% according to the 2003 annual survey by the SREB.

Based on these national and regional surveys, budgeted nursing faculty positions are going unfilled. Nursing administrators in higher education must examine the factors that have caused the nursing faculty shortage and solutions to the shortage. As Hinshaw (2001) indicated, faculty shortage relates directly to the nursing shortage in the United States. As enrollments in nursing schools go up and down, faculty positions are affected. With a lack of nursing faculty, nursing enrollments have been limited.

Faculty Role

Very few studies focus on the responsibilities of the nursing faculty role. The three major nursing faculty roles include teaching in classroom and clinical settings, service including committee work and student advising, and research (Penn, Wilson & Rosseter, 2008; Zambroski & Freeman, 2004). Many nursing faculty add a fourth role by maintaining a clinical practice in order to keep their knowledge of practice up-to-date and meet certification requirements (Hawkins & Fontenot, 2009). Faculty responsibilities vary based on the type of institutions and its mission. Nursing programs are located in both community colleges and research universities. The mission found in community

colleges focuses on workforce development. In contrast, the mission for universities focuses on research and scholarship. Therefore, faculty members in university settings have the additional expectations to conduct research and be leaders in the community, state, region, and nation (Zambroski & Freeman, 2004).

Finding enough time to teach, conduct research, provide service, and maintain clinical practice is a real challenge for both novice and expert faculty members (Hawkins & Fontenot, 2009). One novice faculty member questioned how she was going to be able to handle all of the demands of teaching, research, practice, and service. As she transitioned into the faculty role, she wanted to maintain a clinical practice in order to remain current and in touch with practice. She wondered how easy it would be to find a location to practice one day a week and whether her academic employer would be supportive. Her greatest challenge was coordinating clinical placements for nurse practitioner students and maintaining connections with preceptors in the clinical settings. Once she navigated some of the teaching responsibilities, she was able to start participating in research efforts because of guidance and support from mentoring by a senior faculty member. One expert faculty member found it very gratifying to mentor new faculty and assist them to master the many faculty roles including teaching, scholarship, and service.

Teaching as one major component of the faculty role occurs both in classroom and clinical settings. The National League of Nursing (2008) surveyed 2,218 faculty members across the country and from a cross-section of educational programs. The purpose of the study was to examine clinical education in nursing. They found that clinical education was a key component of nursing education and was the foundation for

students being able to apply theoretical concepts to patient care. This takes place in a variety of settings, throughout nursing programs, and faculty are responsible for developing and arranging these experiences.

Gazza (2009) conducted one of the few studies on the role of nursing faculty in baccalaureate nursing education programs. In this qualitative study eight faculty members were interviewed regarding their experiences teaching full-time in a baccalaureate nursing program. They had taught for an average of 6.1 years and had been in nursing for an average of 13.4 years prior to beginning a career in teaching. Gazza identified five themes. First, the faculty informants felt they made a “difference in the student, profession, and the world” (p. 221). They not only made a difference with the students while they were in school and seeing the students learn but their influence continued to make a difference as their students became a part of the profession and interacted with others. This was like a ripple effect. The second theme was “being a gatekeeper to the profession” (p.222) which meant the faculty were responsible for assuring that the students maintained a high performance standard in order to become safe practitioners. The third theme involved the need to balance the many roles including working with the students, committee work, scholarship, clinical practice, and personal lives. The fourth theme addressed the fact that faculty could not do it alone and support from others was vital. Support came from other faculty members who were colleagues and mentors as well as from secretarial staff. Finally, the informants described workplace relationships. Those relationships could be very positive and like family. Others described conflicts at various levels including between faculty members, between new and senior faculty, and between faculty and administrators.

In addition to the different faculty responsibilities, a survey of 220 deans and directors of schools of nursing addressed the essential skills they thought new faculty members needed. First were teaching skills, especially the ability to assist students in learning the skills and knowledge to become a professional nurse. These skills go beyond simple transmission of content but involve engaging the students in actively learning and applying knowledge. Next was the need for new faculty to have clinical expertise and if possible have preparation in teaching. Other essential skills included knowledge of curriculum development, along with methods for evaluating and testing student performance. Finally deans and directors looked for new faculty to demonstrate personal and professional attributes that promoted collegial relationships with fellow faculty members and positive relationships with students (Penn, Wilson, & Rosseter, 2008).

Besides research about the nursing faculty role, one of the nursing journals regularly publishes testimonies by nursing faculty. One such testimony was by David Rabinowitsch, an assistant professor who teaches in a community college in an associate degree nursing program. He found gratification in seeing how well former student were doing when he visited local agencies. He described being a mentor and professional role model for his students ("Faculty Matters," 2009). Carolyn Nickerson teaches at a university and teaches students starting as freshmen in baccalaureate program as well as nurses returning for advanced degrees. She indicated that there is nothing better than working with students at all different levels and having a positive impact on health care ("Faculty Matters," 2008b). Patricia Kelly is a staff educator at a large university hospital who spoke of hoping that she inspires students and is able to role model commitment to lifelong professional growth ("Faculty Matters," 2008a). All three of these educators

found satisfaction from working with students and felt they were able to make a difference for students and the profession.

From both the testimonies and the study by Gazza, faculty found gratification from the relationships with students. This theme is also found in the educational literature. One such example is a qualitative study by Hargreaves (1998). Thirty-two teachers who taught seventh and eighth grades were interviewed. The informants in this study described an emotional connection with their students that went beyond the cognitive instruction. They found great satisfaction from seeing the students grow and change. The students were what kept these teachers going. The teachers made adjustments in their teaching based on the needs of the students and used a variety of teaching strategies to reach their students.

Factors Contributing to the Shortage

Age

Age is a major factor in the nursing faculty shortage. The current mean age of nursing faculty is nearly 50 years (Brendtro & Hegge, 2000; Craine, 2000; De Young & Bliss, 1995). In the 2002 and 2006 the National League of Nursing national surveys (Rosenfeld et al., 2003; Kovner et al., 2006), two-thirds of full-time nursing faculty members were between the age of 45 and 60 years. The age of faculty members was the same regardless of the region of the country. An AACN national survey (2005) found the mean age of doctoral faculty had increased from 49.7 years in 1993 to 54.3 years in 2004. This trend was also true for faculty with masters' degrees whose mean age was 46 in 1993 and had increased to 49.2 years in 2004. Contributing to this problem is the fact that

in 1996 the average age of graduates of doctorate programs was 45 years (Brendtro & Hegge, 2000). This trend has continued in 1999 with the average age being 46 and almost half of the graduates being between 45 and 54 years of age (Berlin & Sechrist, 2002). This is in contrast to doctoral recipients in all other disciplines having a median age of 33.7 years. If the nursing graduates decide to become faculty members, they have only 15-20 years to teach. As a nursing profession, we have fostered the idea that clinical competence is important to be successful in graduate school and becoming a faculty member. Therefore, nurses practice for awhile before pursuing further education, whereas other professionals are encouraged to immediately go on to graduate study (Anderson, 2000; Marshall, 2001). Frequently, students are now taking longer to finish doctorate programs because they are going part-time rather than giving up full-time jobs and lucrative salaries (De Young & Bliss, 1995). Many doctoral graduate programs are small and only graduate one to ten students a year (Anderson, 2000). All of these factors contribute to completion of the doctorate education at a later age with fewer potential years to teach.

Graduate Education

In addition to the advanced age of nursing faculty, there are the issues of the shortage of doctorally prepared nursing faculty and the experiences they have while they are in doctoral programs. In the SREB 2002 survey, there was a 28% drop in doctoral graduates from 2000 to 2001. The 89 graduates in 2001 were less than the number needed to fill those positions vacated by faculty with doctorates that retired or resigned in 2001 (SREB, 2002). More recently the number of doctoral programs has increased with 93 programs in 2004 as compared to 54 programs in 1992 but schools are not producing

more graduates (AANC, 2005). Once in a doctoral program, nurses are taking longer to complete the program. Berlin and Sechrist (2002) reported that nursing graduates take a mean of 8.3 years to complete a doctorate as compared to 6.8 years for students in other disciplines. Nurses are waiting longer to begin doctoral study. In 2002, nursing students in doctoral programs had a median age of 47.3 years as compared to 33.3 years for doctoral students in other disciplines (AANC, 2005).

Another factor to consider is the pool of nurses pursuing a master's degree and whether they will then continue on for doctoral education. A longitudinal study of nurses in North Carolina compared a cohort of nurses who were first licensed in 1984 with a second cohort of nurses who were licensed in 1994 and a third group licensed in 2004. The latter two groups were older when first licensed, included more men, and were more culturally diverse. Over time there has been a steady decline in the number of nurses graduating from diploma programs and an increase in the number graduating from baccalaureate programs. The number of nurses graduating from associate degree programs is about the same for the last two cohorts. Of concern is the fact that fewer than 20% of the first two cohorts completed an additional degree in the ten years since beginning practice and less than 6% completed masters' or doctorate degrees. Those most likely to pursue a master's degree started their careers with a baccalaureate degree. In addition only 11% of those completing masters' or doctorate degrees became nursing faculty. In this study, very few nurses pursued a degree beyond the initial degree for licensure and even fewer continued for a second additional degree (Bevill, Cleary, Lacey & Nooney, 2007). A study by AACN (2005) shows that the enrollment in master's degree programs has steadily increased since 2001 and since 2003 has resulted in more

graduates. This may increase the pool of nurses who continue on for doctoral education but may not increase the number of new faculty members because many of those in doctoral education are already in faculty positions (AACN, 2005). The issue still remains whether nurses will pursue further education beyond their original degree for licensure and whether the majority will only obtain only one additional degree.

What is not reported is the attrition rate for those starting in a graduate program as compared to those who finally complete the program. Berlin & Sechrist (2002) reported that from 1997 to 2001 there was an increase of 43 doctoral students per year but that the graduation pattern was erratic. Therefore, if institutions are managing to attract nurses into graduate education, there is still the question of whether or not the students are completing the program. There is limited information in the literature on the experience of students in doctoral programs, and their progression through doctoral programs.

The Gray et al. (1997) qualitative study of eleven women doctoral students identified three themes that include support, confidence, and self-discovery. Students received support from other students and faculty primarily but they also received support from family and work colleagues. Under the theme of confidence the students had feelings that went from self-confidence to self-doubt. Feelings of self-confidence were tenuous at times because of the difficult academic requirements and it helped to get validation from faculty members. Finally under self-discovery, Gray et al. (1997) included personal growth, exposure to new ideas, and discovery of personal strengths. In addition, they talked about the trade-offs and sacrifices made by the students. The participants' ages ranged from 30 to 44 years with a mean age of 40 years. Of the eleven participants, seven were enrolled in nursing doctoral programs and four were in

education. The majority of the participants were working and going to school part-time. The fact that these students were older and going to school part time is similar to what the literature indicates is true for nurses who pursue doctoral education (Berlin & Sechrist, 2002; De Young & Bliss, 1995).

Maher, Ford, and Thompson (2004) used a 46-item survey to study the factors that facilitate degree progress through a doctoral program. The items covered both items that would facilitate progression and those that would constrain progress in the doctoral program. These items included funding issues, advising issues, experiences during and before the doctoral program, preparation for dissertation study, motivation to complete the program, and personal obligations. The survey was completed by 160 alumni who represented a 54% response rate. They were grouped into early-, average- and late-finishers. The early-finishers completed the doctoral degree in less than 4.25 years while the late-finishers took 6.75 years or more to complete the degree. Interestingly, more women comprised the late-finishers with 61% as compare to the early-finisher with 44%. Six themes emerged that distinguished between the early- and late-finishers. First was the commitment to complete the degree in a timely manner. The early-finishers were more goal-directed and came into the program with an idea of a topic for the research dissertation. The late-finishers linked the desire to finish quickly to financial concerns but were less clear on the goals and did not feel the urgency to complete the degree quickly. A second theme was the relationship established with faculty. The early finishers were more likely to have established a strong working relationship with a faculty member, especially with their major advisor. Funding issues were a concern for both early- and late-finishers but the late-finishers had more funding issues. A fourth theme was family

issues. This affected both groups. The early-finishers more often had family support than the late-finishers. Late-finishers were often slowed down by family obligations such as child-care responsibilities. The fifth theme identified focused on research experience. The late-finishers had more difficulty identifying a research dissertation topic and encountered more obstacles during data collection or analysis. Finally, the early-finishers were able to better work the academic system to facilitate their progress. These early-finishers were more likely to seek and ask for help. Overall the early-finishers reported fewer constraints and more facilitating factors that assisted in completion of their doctoral degree.

Lovitts (2001) conducted a large mixed-methods study to examine the causes and consequences of students leaving doctoral programs before completion. The sample included a total of 816 students from two universities, one rural and the other urban. Of the sample, 511 had completed a program and 305 had not. The participants were in a variety of Ph. D. programs including mathematics, chemistry, biology, economics, sociology, psychology, history, English, and music. The reasons for attrition fell into three categories: academic, personal, and financial. Under the academic category were students who could not meet the academic standards and students who became dissatisfied with the program or their advisors. The students' concerns with the program or their advisors were often not recognized by the institution. Very often more blame for the attrition was placed on the student rather than recognizing the environment at the institution as a contributing factor. Personal reasons included burnout and family issues. Those students who completed the programs were able to find the information they needed and developed a sense of community and support from both students and faculty

members more than students who left the program. A major consequence of not completing the program was personal disappointment and the need to find another career path.

Anderson and Swazey (1998) sent surveys to 2,000 doctoral students across the United States. They had a 72% response rate including students from chemistry, civil engineering, microbiology, and sociology. Most of them were employed through at least part of the time in the graduate program including two-thirds who held research assistantships. Over two-thirds of the respondents indicated they were treated with respect and that faculty and students cared about each other. But the sense of community was tempered with considerable competition. Many of the students faced role conflicts and over 40 percent felt that their graduate work interfered with their personal lives. The demands made from faculty contributed to the conflict. Sixty-three percent of the respondents felt that the faculty expected that the student responsibilities should come before anything else.

Some common themes found in the studies of students in doctoral programs included the need for support from other students, faculty, and family members, the need to feel a part of a community, the need for clear information about the program, and financial support. These students are often dealing with varying levels of stress and anxiety but over time are able to increase their self-confidence. Graduate students have to balance their student responsibilities with other responsibilities. Based on the findings of all four studies (Lovitts, 2001; Gray et al., 1997; Maher et al., 2004; Anderson & Swazey, 1998), institutions need to identify ways to support doctoral students in order for them to successfully complete the doctoral program.

Competitive Salaries & Increased Opportunities

The lack of competitive salaries in nursing education is another major factor contributing to the growing shortage of nursing faculty (De Young & Bliss, 1995; Hinshaw, 2001). In 1992 for example, at the master's degree level, clinical nurse specialist salary was \$42,253; head nurse salary was \$45,501; while assistant professors without a doctorate made only \$40,486 (De Young & Bliss, 1995). In 2003 the American Association of Colleges of Nursing (AACN) reported the average salary for master's prepared nurse practitioners was \$80,697 as compared to master's prepared faculty with a salary of only \$60,357 (AACN, 2004). At the doctorate level, salaries at four year institutions averaged \$66,132 as compared to some in clinical positions making closer to \$90,000 (AACN, 1999). In the past, nurses chose faculty positions for altruistic reasons such as the desire to teach and to influence future nurses. Today nurses are looking more towards specialization because of the autonomy, job security, and the better salary (Craine, 2000). Thus, as Berlin and Sechrist (2002) stated, nurses with advanced degrees—including doctorally prepared nurses—are leaving academia and are going to more lucrative careers in the clinical sector. They reported that the percentage of nursing doctoral recipients planning careers in areas other than education has increased from 15.5% in the early 1980s, to 26.9% in the late 1990s. In the same time period, those nurses going into education declined from 70.8% to 59.5%. Berlin and Sechrist (2002) reported data from the National Sample Survey of Registered Nurses that showed a decline in nurses with doctorates teaching in schools of nursing, “from 67.7% in 1992 to 61.9% in 1996 and 49.5% in 2000, which represents an overall decrease of 18.2%” (p. 53).

Much of the literature (Brendtro & Hegge, 2000; DeYoung & Bliss, 1995; Hinshaw, 2001) indicates that nurses with graduate education have more choices including administration, entrepreneurial work, and clinical research, along with academic positions. Often these positions value the leadership and research skills that are developed during graduate education and provide better financial compensation than faculty salaries. In addition, many graduate programs do not provide opportunities to develop teaching experience and thus the graduates are not as comfortable with the teaching aspect of an academic career (Hinshaw, 2001).

In 1998, nursing programs in Georgia were surveyed (Craine, 2000). Of 30 programs, 27 programs responded. The survey of these graduate programs indicated that there was a decline in graduates at the master's degree level being prepared as nurse educators. In 1997-1998, eleven of 315 masters' graduates were nurse educators as compared to only four of 169 in 1998-1999. The majority of the graduates were prepared as nurse practitioners (87%). The fewest number were prepared in education and administration. The reasons for choosing a specialty were autonomy (30%), job security (13%), and salary (12%). Interestingly salary was not the number one reason for selecting the area of specialization. Of the 245 faculty responding to the survey the majority (53%) indicated that they had entered academe for personal satisfaction and altruistic reasons ranging from love of teaching to being able to influence future nurses.

In both the NLN national survey of nursing programs (Rosenfeld et al., 2003; Kovner et al., 2006) and the SREB regional survey of nursing programs (SREB, 2002), salary issues were not the number one reason that nurses left faculty positions. In the NLN in both 2002 and 2006 survey, the number one reason for departure was retirement

followed by wanting to change careers. In 2002, family obligations came in third and salary issues were fourth while in 2006 salary issues moved up to third most frequent reason for leaving academia. In the southern regional survey, the number one reason for departure was family obligations followed by career advancement and third was salary. The NLN survey results indicated that the programs with vacancies often had the higher median salaries than those without vacancies. Thus the reporters of the NLN survey suggest that salary is not the only issue in recruiting nursing faculty (Rosenfeld et al., 2003; Kovner et al., 2006). The reporters of the SREB survey suggest that more study is needed of why faculty members resign (SREB, 2002).

Transition to Academia

Once nurses have completed advanced education, either at the master's degree or doctoral degree level, and have accepted a nursing faculty position, they experience a transition than the clinician role to the educator role. Clinicians are socialized differently from educators and during their graduate programs may or may not have had courses to prepare for the faculty role (Esper, 1995; Neese, 2003; Siler & Kleiner, 2001). Qualitative studies describe the transition that new faculty experience and how they adjust to their new role. These studies are found in both the educational and nursing literature.

Transition process. From the educational literature is a qualitative study of three newly hired tenure-track faculty (Rosch & Reich, 1996). Two of the faculty members were from departments in the humanities and one was from a social science department. The participants completed a questionnaire about their perceptions of the institutional culture. Over nine months, observations and interviews were used to gain an

understanding of the enculturation process that the participants experienced as they became members of the faculty. The results of the study indicated that the participants progressed through four stages in their enculturation to becoming a faculty member. The first stage or pre-arrival stage was described as a time when the new faculty examined the values and role orientation they had experienced in graduate school and began to assimilate to the new setting. The three participants came with similar values that included “self-motivation and self-reliance; individual autonomy and academic freedom; a profound interest in scholarly activities; and an appreciation of the intellectual climate surrounding professional work” (Rosch & Reich, 1996, p. 124). But how they developed their role orientation was different and shifted slightly as they assimilated to the new setting. During the second stage or encounter stage, the participants developed impressions of the work setting, learned the institutional expectations of faculty, and set their own goals for the first year as a new faculty member. In the third stage or adaptation stage, the participants were socialized into the department. This socialization varied greatly by department along with the amount of orientation and support provided by the chair of the department. Some were given a lot of autonomy and limited direction. As a result, the participants had to draw on their graduate student experiences for teaching style and teaching methods. Those participants who experienced the least difficulty in adapting to the new teaching setting were in departments where the morale and work climate were rated the highest. In the final stage or commitment stage, the participants settled into a routine and were working on developing their own niche. They had learned about their departments from their observations and both formal and informal meetings. Ironically new faculty members were often reluctant to ask for help or express their needs

due to fear of negative impressions. Very often they relied on their graduate student training as they performed their new role as assistant professors.

From the nursing literature, Esper (1995) described similar stages as a nurse transition from the clinician role to the nurse educator role. In the first stage the new educator comes with the ideal that in the educator role is an opportunity to change the future of nursing by educating new nurses. They are impressed with the prestige of the academic position and the flexible schedule. In the second stage the new educator is faced with the various conflicts between old and new role expectations. They may not have had graduate training in the teaching role and theory and thus lack skills needed in the new educator role. The new educator is faced with trying to fit with the current curriculum and still try to present what he/she knows from practice. If providing clinical instruction, the new educator must act as the middle person between the college and the clinical agency in addition to demonstrating clinical proficiency for the students. Thus in the second stage, the new educator learns and develops in many facets of the educator role. The third and final stage is that of acceptance of the new role or inability to assimilate the new role and return to the clinical arena. Mentoring and faculty development assisted in the transition process and assimilation into the new role.

Transition experience. Further description of the transitional experience of novice faculty was found in the qualitative study by Siler and Kleiner (2001). Twelve participants from five different states were interviewed in order to learn of their experience of being new nursing faculty members. Six of the participants had previous teaching experience and were changing institutions. The other six were novice faculty with no previous teaching experience. The experienced faculty had more realistic

expectations of the educator role. They mainly had to compare the old and new settings in order to adjust to the new position. The novice faculty revealed much about what it was like to navigate the academic culture for the first time. The major common theme revolved around expectations of academia and the novice faculty members' lack of preparation or socialization to the educator role. The participants chose teaching for various reasons including encouragement from others, the desire to teach, opportunity for professional development, and the availability of faculty positions after completing an advanced degree. They found that they were unfamiliar with the faculty role and graduate education had not prepared them for the faculty role. Their expectations of the role did not match reality. For example, they spent more time in preparation for classes and in committee meetings than they had expected. Colleagues did provide assistance in learning the new role but often the novice struggled to find answers and mentoring relationships did not always work to meet all of their needs due to scheduling conflicts between novice and the mentor. In addition, the novice relied on the students to validate their performance due to the lack of peer or administrative observations of teaching and feedback on performance. At some point during the first year, many of the novice faculty questioned their ability to meet all of the work expectations. But all of the novice faculty members did plan on continuing to the second year of teaching despite initial feelings of being overwhelmed. At the end of the first year they had a much clearer understanding of the role expectations.

In the educational literature, Boice (1991) interviewed newly hired faculty at a comprehensive university and a doctoral campus to explore their experiences during the first two years as faculty members. During the first semester, support from colleagues

was not universal and new faculty felt under-stimulated intellectually. They found that their time was dominated by lecture preparations and thus had to put off any scholarly work. Universally the help they needed was in determining the appropriate level of difficulty to make the lecture material for the students. Over time there was a decline in collegial support, an increase in frustration with teaching, and they received poorer teaching ratings from the students than anticipated. New faculty members were not often counseled on the meaning of the student ratings nor did many of the new faculty seek assistance in learning ways to improve their teaching methods or learning alternative teaching styles. They often blamed external factors for their poor student ratings. These external factors included poor student abilities, heavy teaching load, and invalid evaluation tools. Regardless of their background most of the new faculty members utilized “fact-and-principles style” (Boice, 1991, p. 167) of teaching in the first couple of semesters of teaching. Those faculty members with teaching experience started to use more student participation by the third and fourth semesters. Three inexperienced faculty members who received high student ratings exhibited different characteristics. These faculty members had more positive attitudes toward the students, lectured in a more relaxed style, sought out support and advice on teaching methods, and participated in faculty development programs. Boice (1991) suggested that new faculty need more assistance in finding their comfort level and adjusting the content of lectures so as to increase student participation and learning. Institutions need to provide support and feedback to new faculty member rather than letting them “sink or swim”.

Mentoring by senior faculty members has been suggested as a way to assist novice faculty members in the assimilation of the new educator role (Anibas, Brenner, &

Zorn, 2009; Brown, 1999; Dunham-Taylor, Lynn, Moore, McDaniel & Walker, 2008; Esper, 1995; Siler & Kleiner, 2001). Brown (1999) studied the response to a new mentoring program implemented in a university in North Carolina. New faculty or protégés met as a group to be oriented to the mentoring process. The protégés were matched with experienced faculty members or mentors. At the end of the mentoring year, both the mentors and the protégés were asked about the experience. There were 33 mentors or 70% who returned the questionnaires. Of the protégés, 39 returned the questionnaires for a response rate of 83%. For the protégés, the activities that were beneficial included “the mentor’s being available, listening, and providing feedback about teaching” (Brown, 1999, p. 49). The mentors assisted the protégés in learning the system, handling problems, and preparing course materials. Some protégés wished they had more time to discuss teaching strategies with the mentors. From the mentors’ perspectives, they used many activities to assist their protégés including frequent meetings, helping them handle problems, anticipating first experiences and preparing them, and helping them implement their new teaching responsibilities. Mentors also benefited from the relationship. Mentors gained fresh insights from the protégés and the questions posed by the protégés helped the mentors to reflect on and clarify their own ideas. Both the mentors and the protégés found the relationship beneficial and agreed that mentoring of new faculty needed to continue.

In another study, Anibas, Brenner and Zorn (2009) interviewed ten new faculty members who held short-term and part-time contracts. The participants were concerned about their performance and had feelings of frustration, confusion, and isolation. They faced challenges including learning how to teach and evaluate students, how to manage

demands of the position, and understanding the organization. They expressed the desire to establish a long-term mentor relationship with more senior faculty members they admired and wanted to emulate. New faculty members viewed senior faculty as a support system. So even faculty on short-term contracts need the support of senior faculty.

The transition from clinician to educator may begin during graduate preparation. Neese (2003) described her experience of transformation during graduate study in nursing education. Neese had wanted to be a teacher for a long time and finally had the opportunity to return to graduate school in nursing education. She came with the assumption that education meant lots of classes filled with content-laden lectures and lots of readings. Neese soon learned that she had started a transformational journey in which she had to articulate her old assumptions about education, critically reflect on them, become open to alternative viewpoints including different pedagogies and adult learning theories, revise assumptions about nursing education through critical reflection, and finally act on those revisions. This journey culminated in a teaching practicum in which she was able to participate in various teaching and learning experiences. Through this experience Neese (2003) realized that clinical expertise is not enough to be qualified as an educator. Mentored practice was essential in her transformation from a clinician to an educator.

Herrmann (1997) studied whether graduate preparation in educational theory and practice increased the self-perceived effectiveness of clinical nursing faculty. This involved a national survey of 434 National League of Nursing accredited baccalaureate nursing programs. They had 692 usable questionnaires for a response rate of 52%. The number of years in clinical teaching experience ranged from one year to 39 years with a

mean of 11 years. Over 60% of the respondents had courses in curriculum development, theories of learning, and teaching methods. Only 46%, however, had participated in an educational practicum. Fourteen percent reported no preparation to teach nursing. Those faculty members with more educational preparation reported significantly more often that they felt better prepared to teach in the clinical setting. Faculty members found courses in curriculum, teaching methods, and teaching practicum as the most beneficial in preparing them for teaching in the clinical setting. This study did not show a significant difference in the teaching methods and teaching activities used by those faculty members with and without educational preparation. In order to assist faculty in clinical settings, Herrmann (1997) concluded that more research is needed to determine what content will be most helpful in preparing faculty to teach in the clinical settings, and which methods are better for teaching students in the clinical settings.

Faculty Expectations and Work Stress

After transitioning from the clinical role to the educator role, those nurses who do select academic careers are faced with meeting the high expectations set by the higher education institutions in the areas of teaching, research, and service (AACN, 2003; Hinshaw, 2001, Mobily, 1991). Not only are faculty members expected to teach but they also have to conduct research, seek outside funding, provide community and university service, advice and mentor students, master new technology, and update and develop courses while at the same time keeping current and building clinical expertise. Several studies have examined the stresses that nursing faculty experience and the need to have realistic job expectations (Dick, 1992; Fong, 1993; Langemo, 1990; Lease, 1999; Lewallen, Crane, Letvak, Jones, & Hu, 2003; Lott, Anderson. Kenner, 1993; Mobily,

1991; Oermann, 1998). Job stress can contribute to increased absenteeism and decrease in productivity (Lease, 1999; Dick, 1992). In the higher education arena, increased stress can translate into withdrawal from student-professor interactions, decreased accessibility, and decreased involvement in the activities and goals of the department (Lease, 1999).

Buffers to stress. Lease (1999) studied occupational strain in tenure-track faculty at three universities in the southern region of the United States. The random sample was stratified by gender and academic rank to ensure variability at all levels. The final sample included 131 faculty members of which 64% were female and 46% were considered new professionals having completed their doctorates in the last five years. No difference was found in role stressors or personal strain across gender. The significant finding was that the individual hardiness and environmental support were negatively related to stress while avoidant types of coping styles related positively to stress. These three factors, hardiness, environmental support, and avoidant coping, accounted for 49% of role stress. Individual hardiness is based on three interrelated components including control over life experiences, commitment to daily activities, and perceiving stress as a challenge and a way to develop and improve. Hardiness was found to have a buffering effect against stress. In contrast, increased role overload and the use of avoidant coping were related to an increase in strain.

Langemo (1990) studied similar factors of individual hardiness and work stress in female nursing faculty. Three nursing programs were randomly selected from six different geographic regions of the United States for a total of 18 programs. The sample of 287 full-time and non-administrative female nursing faculty was drawn from these 18 programs. Similar to the above findings by Lease, this study found that those with higher

hardiness scores experienced less emotional exhaustion, depersonalization, and more feelings of personal accomplishment. Work stress was the greatest contributor to emotional exhaustion. Four organizational factors contributed to emotional exhaustion. A positive relationship was found between emotional exhaustion and more contact hours with students for part-time faculty members, poorer economic situation for the school of nursing, and higher number of full-time faculty. A negative relationship was found between emotional exhaustion and the faculty task complexity. The results indicated a lower level of stress in nursing schools with only undergraduate baccalaureate nursing programs and the highest level of stress in nursing schools with both graduate and undergraduate degree programs. The work stress varied from school to school as measured by the work stress subscales and the nurse educators' perceptions of the work environment. Langemo (1990) suggests that administrators need to be supportive, available, and realistic in their expectations of faculty in order to help allay work-related stress.

Sources of stress. Oermann (1998) studied work-related stress experienced by nursing clinical faculty. Oermann surveyed 226 faculty members from both baccalaureate and associate degree nursing programs. The majority of the participants (64.6%) held master's degrees. The major sources of stress were coping with job expectations, feeling physically and emotionally drained at the end of a clinical teaching day, job demands that interfered with personal activities, heavy workload, pressure to maintain clinical competence without time to do so, feeling unable to satisfy the demands of work-related constituencies, and teaching inadequately prepared students.

In another study, Fong (1993) studied the relationship between role overload,

social support, and burnout among nursing educators. Fong surveyed 140 full-time nursing educators and did a follow-up survey two years later with 84 of those nursing educators. She found that emotional exhaustion was positively and significantly correlated with overload variables, which included extreme time pressures, high job demands, and feelings of inadequacy. When examined over the two year period, high job demands were the best predictor of emotional exhaustion. Both chairperson and peer support helped to decrease all aspects of burnout. The support from chairperson and peer support negatively correlated with burnout.

Mobily (1991) conducted a national survey of 102 full-time nursing faculty members in nationally accredited nursing programs with a response rate of 69.4%. She found that 50% of those surveyed were experiencing a moderate to high level of role strain. The sources of strain included having adequate time to complete the job expectations, coping with the variety of job expectations, having to find outside funding, interference of job with personal activities, heavy workload, feeling both physically and emotionally drained at the end of the day, the volume of work interfering with being able to do it well, and having adequate resources. There was significantly higher role strain when the nursing faculty member had only a master's degree, was teaching on the undergraduate level, provided only the clinical instruction or a combination of clinical instruction and classroom lectures, had more than ten hours per week in clinical instruction, did not have the opportunity to participate in faculty development, experienced a lack of fit between faculty and dean role expectations, was enrolled in a doctoral program, was married, and had children.

Lott, Anderson, and Kenner (1993) interviewed 11 non-doctorally prepared

undergraduate faculty members from a nursing school that had recently initiated a doctorate program. These respondents indicated that they needed to work full-time to meet family obligations while being faced with the future decision to pursue further education or find another job. They found it difficult to fulfill the faculty role expectations while going to graduate school. With the changes in the school of nursing they experienced an increase in workload with more time spent in clinical instruction, not enough time to balance the demands of teaching, research, and service, and negative interactions between the undergraduate and graduate nursing faculty. Thus, undergraduate faculty members experienced additional stress when their school of nursing added the doctoral program and changed their work expectations. The respondents expressed a need for open communication between all faculty and administration, and for non-doctorally prepared faculty members to be recognized and valued for their contribution to the overall mission of the college.

In another study, Dick (1992) focused on doctorally prepared nursing faculty and the issue of burnout. Dick (1992) defined burnout as being “characterized by exhaustion, by feelings of being used up, and by fatigue that is not relieved by rest or vacation” (p. 341). When burnout occurs work productivity is affected. The sample was from doctorally prepared members of the American Nurses Association who were nursing faculty in a school of nursing. They mailed 400 surveys to nurses from 22 different states and had 261 returned for a response rate of 65 %. Of those responding, 59% were females with the average age of 47.3 years, and 57% were tenured. The academic ranks held included three percent instructors, 30 percent assistant professors, 44% associate professors, and 23% full professors. On the Matthews Burnout Scale, 39% of the faculty

scores were at the moderate to high burnout level. The perceived management style of the dean was the strongest predictor of burnout scores. As the faculty member perceived increased levels of participative management there was decrease in burnout, a decrease in emotional exhaustion, a decrease in depersonalization scores, and an increase in personal accomplishment scores. Collegial support was another factor that reduced the negative effects of burnout. Each workload component was compared with the burnout score. The only relationships that were statistically significant included clinical supervision hours, research hours, clinical practice hours, and professional service hours. As clinical supervision hours increased so did burnout. Burnout decreased when there was an increase in time spent in activities such as research, clinical practice, and professional service. But when multiple regression equation was used the only factors that were significant at the .05 level were management style, collegial support, and research time. Thus, the results of this study indicate that doctorally prepared nursing faculty members do experience burnout and administrative management style is the strongest predictor.

In a qualitative study, Wareham (1996) interviewed ten nursing faculty to examine the joys and constraints of working as a part-time or full-time nursing faculty. Four themes emerged from the interviews. The first theme involved communications and the fear by the part-time faculty that they were not kept fully informed regarding organizational and curriculum issues. Lack of communications was also identified as a constraining factor for the full-time faculty but to a lesser extent. The second theme related to feelings of being vulnerable if not included as part of the team and thus being isolated. Both part-time and full-time faculty members experienced feelings of vulnerability and thus needed to develop satisfying relationships, and be recognized as a

valuable part of the team. The third theme involved feeling pressured to work beyond the contracted hours and to bring work home. The last theme was experienced by part-time faculty. They felt very positive about their flexible hours that enabled them to balance professional and personal responsibilities.

Positive components. In contrast to the potentially negative aspects of faculty work stress and expectations, other researchers have found a number of satisfying characteristics of an academic career. Hinshaw (2001) outlines several positive aspects of an academic career including the opportunity to develop and educate new professional nurses, to participate in creative discussions with colleagues and students, to conduct research, to contribute to changing and improving health care, to provide leadership in nursing, and to help shape health care policies.

Brendtro and Hegge (2000) conducted a statewide survey of 288 nurses with graduate degrees in a midwestern state. Of the sample, 27.4% held faculty positions. The return rate for the survey was 61%. They found both negative and positive aspects of the nursing faculty role. Satisfaction with the current position was the same for both faculty and nurses in other positions. The nurses indicated they were satisfied with their current positions because of the many opportunities for service, the flexibility, variety, and the opportunities for collegiality. The nurses indicated that they would consider leaving their current positions if there were “non-supportive leadership, blocks in innovation, and unreasonable workload” (Brendtro & Hegge, 2000, p. 101). The nurses were deterred from the faculty role because of high expectations in higher education, work pressures, and inadequate compensation. Those in the survey indicated that “closer proximity to work, improved compensation, more realistic professional expectations, and increased

opportunities to continue clinical practice while teaching” (Brendtro & Hegge, 2000, p.101) would be incentives that would attract them to a faculty position. These positive aspects could help to attract and retain nurses in an academic career. The limitations of this study were that it was conducted in one rural midwestern state and those responding to the mailing may be very different from those who did not.

From these studies it is clear that nursing faculty do experience work related stress. This is true for part-time and full-time faculty, for non-doctorally and doctorally prepared nursing faculty, and for nursing faculty in both undergraduate and graduate programs. Multiple sources of stress were identified and included work expectations, workload, and time pressures (Fong, 1993; Lease, 1999; Lott, Anderson, & Kenner, 1993; Mobily, 1991; Oermann, 1998); the amount of time in clinical instruction (Dick, 1992; Oermann, 1998); lack of recognition and feelings of not being valued (Lott, Anderson, & Kenner, 1993; Wareham, 1996); lack of communication (Wareham, 1996); changes within the institution (Lott, Anderson, & Kenner, 1993); economic situation of the institution and the available resources (Lease, 1999; Mobily, 1991); and personal responsibilities (Mobily, 1991). Several factors were found to contribute to buffering the effects of stress. These factors included individual hardiness (Langemo, 1990; Lease, 1999), environmental support (Lease, 1999), participant management (Dick, 1992; Brendtro & Hegge, 2000; Hinshaw, 2001), and collegial support (Brendtro & Hegge, 2000; Dick, 1992; Hinshaw, 2001). Other positive aspects of the nursing faculty role identified were opportunity to do research and impact health care (Hinshaw, 2001; Dick, 1992) and the flexibility of the position (Brendtro & Hegge, 2000; Wareham, 1996). Administrators need to closely examine factors related to work stress in order to retain

nursing faculty.

Job Satisfaction and Intent to Leave

After finally being able to recruit qualified nursing faculty, another area of concern is retaining faculty and maximizing job satisfaction (Gormley, 2003). When faculty members leave there is the cost of recruiting, training, and socializing new faculty members (Rosser, 2004). Research has linked intent to leave with job satisfaction. Johnsrud and Rosser (2002) conducted a study of ten campuses of higher education in a western state. The sample included 1,511 members of the faculty, 42.5% female and 57.5% male, for a response rate of 52%. Work life was defined as professional priorities and rewards; administrative relations and support; and quality of benefits and services. Morale was defined as engagement in their work, regard for their institution, and sense of well-being. Perceived faculty work life had a significant direct effect on morale while morale had a significant negative effect on intent to leave. Thus more positive morale was related to a decrease in the intent to leave. They found the quality of faculty work life and morale varied between institutions. Johnsrud and Rosser (2002) concluded that administrators need to attend to the aspects of work life that are important to faculty because work life impacts overall morale and indirectly impacts faculty's intent to leave the institution.

Rosser (2004) went on to conduct a national study of faculty members from 3,396 post secondary institutions to study faculty members' work life, job satisfaction, and intent to leave their teaching position or career. Satisfaction included faculty members' satisfaction with advising and course workload, benefits and security, and overall level of satisfaction. Work life comprised support for professional development, involvement in

committee and service work, administrative support, and technology support. There were 18,043 respondents for a response rate of 83 %. The sample included 44.5 % females and 55.5% males; 36.9% were tenured and 63.1% were untenured; and academic ranks included 21.6% full professors, 17.7% associate professors, 18% assistant professors, and 23.7% instructors. Rosser (2004) found that satisfaction had a significant negative effect on intent to leave; as satisfaction went up the intent to leave decreased. Work life had a significant direct positive effect on job satisfaction and an indirect effect on intent to leave. Females in this study were less satisfied with advising and course workload, benefits, job security, and salary than the males. Tenured faculty members were less positive about their work life than untenured faculty members.

Olsen (1993) studied the relationship between job satisfaction and job stress during the first three years of academic appointment. The sample consisted of the entire cohort of newly hired faculty at a large, research university. The participants were from the physical sciences, humanities, social-sciences, and professional school. Olsen found a significant negative correlation between job satisfaction and work stress. Consistently over the three years of the study, a sense of accomplishment, opportunity to use skills, and a sense of autonomy were the factors found most satisfying. The least satisfying factors included “salary, recognition by the university, conflict among work commitments, and time pressures” (Olsen, 1993, p. 460). Satisfaction with the compensation and the governance of the institution showed the greatest decline over the three years. The first year of the appointment, faculty satisfaction was most closely associated with being able to manage the complex work demands and recognition. By the third year, the shift was to autonomy, intellectual challenges, and accomplishments. Thus

what contributes to faculty job satisfaction appeared to change overtime.

Since nursing faculty is predominately composed of women, the study of career satisfaction among female faculty by August and Waltman (2004) provides relevant data on what factors are predictors of career satisfaction. The survey was completed by 247 female faculty who were either tenured or on the tenure-track. The response rate was 56%. The most significant predictors of career satisfaction involved environmental conditions such as good relationship with the department chair, involvement and influence in the department, quality relationships with the students, and the negative impact of departmental climate of conflict. Having a salary that was comparable with peers was more important to tenured faculty than junior faculty in tenure-track positions. Having a senior faculty as a mentor was more important to non-tenured women while being involved in and influencing department matters was more important to tenured faculty women. August and Waltman (2004) suggest that the differences between non-tenured and tenured faculty have to do with the fact that new faculty are overwhelmed with the new responsibilities and it takes a few years to notice details such as comparable salaries and departmental influence.

There is limited literature on job satisfaction among nursing faculty. Gormley (2003) conducted a meta-analysis of only six studies that related to job satisfaction of nursing faculty and were published between 1976 and 1996. The meta-analysis identified eight predictors of job satisfaction including professional autonomy, leader expectations, role conflict, role ambiguity, consideration of the leader, initiating structure behavior of the leader, organizational climate, and organizational characteristics. The strongest predictors were intrinsic factors and the perceptions of the leader's role in curriculum and

instruction. The organizational characteristics and organizational climate had little predictive power in determining nursing faculty job satisfaction.

Moody (1996) conducted a national survey of nursing faculty job satisfaction. The sample consisted of 285 nursing faculty from nationally accredited nursing programs that granted doctoral degrees. The response rate was 56%. The job satisfaction survey asked about satisfaction with the work itself, pay, promotion opportunities, supervision, and coworkers. Overall the nursing faculty members were satisfied with the work itself, supervision, and coworkers. They were neutral in regards to pay and promotion. Those faculty members who had increased years at an institution, taught in higher degree programs, and had higher salary ranges all were significantly more satisfied with pay and the job in general. Those who had increased years at an institution and taught in higher degree programs were more satisfied with their coworkers and more satisfied with promotion opportunities. Satisfaction with salary was significantly higher at institutions with a larger student population and collective bargaining units. Faculty who were teaching at the graduate level and participating in research and scholarly activities were more satisfied with pay and promotion opportunities.

Snarr and Krochalk (1996) found similar results about nursing faculty satisfaction. The sample was a stratified random selection from 469 baccalaureate nursing programs across the United States. The final sample represented 25 programs in 20 states and included 327 surveys. This yielded a 57% response rate. The results indicated that 86 to 93% of the faculty members responding were satisfied with their present job, the supervision, the coworkers, and the job in general. For pay and promotion opportunities, 60 to 70% of the sample indicated neutral to satisfied feelings. The characteristics of the

organization were not related to job satisfaction. Snarr and Krochalk (1996) recommended further research in the areas that are unique to academic environment such as professional environment, professional status, autonomy, and self-actualization and how these factors influence faculty job satisfaction.

Kuennen (2002) conducted a survey of nursing faculty from ten private and public schools in one midwestern state. The sample consisted of 85 nursing faculty members for a response rate of 72%. The participants had been teaching from one to over 15 years with 69.4% holding a master's degree and 30.6% holding a doctoral degree. The results indicated that the work itself, collegiality, and workload were predictive of job satisfaction. Collegiality was the job facet that was most predictive of job satisfaction. The majority of the participants were satisfied with their job overall and specifically with collegiality and the work itself while only half were satisfied with workload and half were dissatisfied with workload.

Garbee and Killacky (2008) used combined quantitative and qualitative methodology to study predictors for nursing faculty to remain in nursing education. The sample included 316 full-time faculty members teaching in the southern region of the United States which was a 40.4% response rate. Faculty taught in associate, baccalaureate, masters', and doctorate programs. They found a positive and significant relationship between job satisfaction and intent to stay both for one and five years. From the qualitative data the most frequent areas of job satisfaction included being part of student success, flexibility, faculty colleagues, collegial environment, supportive chair, autonomy, love of nursing, altruism, mentorship, and image of excellence. The areas of dissatisfaction include time demands, extremes in leadership behavior, low pay, faculty

attitudes, work environment, student attitudes, bureaucracy, no mentors, long commute, and lack of faculty. The correlation between mentoring and intent to stay was non-significant but comments by participants indicated that informal mentoring did affect their intent to stay. Organizational commitment scores significantly predicted intent to stay.

A study of registered nurses employed in a university hospital in West Virginia examined the relationship between job satisfaction and intent to leave (Larrabee, et al., 2003). The sample was 90 registered nurses for a response rate of 60%. Of those nurses, 40.5% indicated intent to stay, 37.1% were uncertain, and 22.5% expressed intent to leave. Those who had been on the job less than five years or graduated less than five years prior were more likely to express intent to leave. The results indicated that job satisfaction was the major predictor of intent to leave. Thus the more job satisfaction the less likely the nurse was to express intent to leave the job. The major predictor of job satisfaction was psychological empowerment with indirect influence from transformational leadership and nurse/physician collaboration.

Both the studies in nursing and in education indicate a negative relationship between job satisfaction and intent to leave (Johnsrud & Rosser, 2002; Larrabee, et al., 2003; Rosser, 2004). Thus the more job satisfaction the less likely the intent to leave. Many factors influence job satisfaction including workload, administrative support, collegial support, technology support, individual hardiness, quality of benefits and services, sense of autonomy, sense of accomplishment, and sense of psychological empowerment (August & Waltman, 2004; Johnsrud & Rosser, 2002; Larrabee, et al., 2003; Olsen, 1993; Moody, 1996; Rosser, 2004; Snarr & Krochalk, 1996). Faculty

members with different number of years in teaching may find different aspects of the job more satisfying than others (August & Waltman, 2004; Moody, 1996; Olsen, 1993).

Administrators in higher education need to consider job satisfaction and its relationship with intent to leave in order to take steps to retain faculty members.

From the review of the literature, the major factors that have contributed to the nursing faculty shortage include the increased average age of nursing faculty members, the decline in nurses pursuing doctoral and master's degrees, the potentially stressful experience of doctoral study, the lack of competitive salaries, increased career opportunities, faculty work stress, high work expectations, and low job satisfaction. Administrators in higher education need to better understand both the positive and negative factors that are related to the nursing faculty shortage in order to find solutions. Thus, the next question concerns solutions to the nursing faculty shortage that are found in the literature.

Recommendations to Reduce the Shortage

Following the evidence-based practice model, the next step is to evaluate recommendations for resolving the nursing faculty shortage problem. Many potential solutions to the faculty shortage have been suggested in the literature. These solutions fall into four categories, including recruitment, retention, mentoring, and restructure of workload. Under the category of recruitment, younger nurses need to be attracted to teaching so that their teaching careers are longer. Attracting younger nurses to doctoral programs and developing fast track programs could enable them to complete programs in a more timely fashion and have longer teaching careers (Brendtro & Hegge, 2000; De

Young, Bliss, & Tracy, 2002). Currently many faculty members are in academia for only 15 -20 years before they retire. Hinshaw (2001) comments that it takes 15 years to master teaching skills, build a research program, generate professional practice, and become a nursing leader. If they leave soon after that, the institution and nursing have very little time to benefit from their expertise. Faculty need to share with their students the joy and rewards of teaching so that they will become interested in choosing teaching as a career (Craine, 2000). What is lacking is the evidence as to what will attract young nurses into advanced education, especially doctoral programs.

One national effort to attract nurses to the educator role is a 2004 national advertising campaign by Nurses for a Healthier Tomorrow (2004c), a coalition of 43 nursing and health care organizations. The focus of the campaign is to convey the personal rewards and satisfaction of being a nurse educator. The ads feature four different nurse educators and their experiences as nurse educators (Nurses for a Healthier Tomorrow, 2004a). The Nurses for a Healthier Tomorrow's website (2004b) provides information about the nurse educator role including a description of the role, the qualifications to be a nurse educator, the practice settings, the salary range, and how to obtain the educational requirements for the role. This national recruitment effort is an example of what the Southern Regional Education Board recommended in their 2002 report on the nursing faculty shortage (SREB, 2002). They went on to recommend that this type of recruitment effort start at the undergraduate level in order to increase students' awareness of the rewards of the nurse educator role.

Another suggestion for attracting nurses into an educator role is to add more education courses in all masters' and doctorate programs and to develop post-master

degree programs in education for nurses with masters' degrees in areas other than education. This would increase the number of nurses trained in the area of education and increase the potential for those nurses interested in teaching as part of their career (Brendtro & Hegge, 2000; De Young & Bliss, 1995). This preparation of nurse educators has started to occur. In 2000, 80 masters' degree programs in nursing had education as a major area of study and this number grew to 89 nursing programs in 2001. With the increase in the number of programs in nursing education came a 14.5% increase in enrollment (De Young, Bliss, & Tracy, 2002). De Young, Bliss, & Tracy (2002) reported the opening of many post-masters certificate programs for nursing education. For example, a post-graduate education program was developed by the faculty at the University of Pennsylvania (Krisman-Scott, Kershbaumer, & Thompson, 1998). The program was nine months long with three one-week sessions on campus and awarded a post-master's certificate in teaching. The participants in the program were experienced clinicians, certified nurse midwives, or nurse practitioners, and were either currently employed, or had accepted employment, as nursing faculty. The first session, held early in the fall semester, focused on classroom teaching and discussion of various learning theories. The students returned to their own campuses with assignments to apply the principles discussed in the first session. Early in the spring semester, the students returned for the second on-campus session with the focus on clinical teaching. Again they were given application assignments to complete at their home institutions. The final session late in the spring covered a variety of topics such as ethical and legal issues, trends in nursing education, and special student needs. During the final session, the participants shared their experiences as they moved from clinical expert to novice

teacher. Participants were very positive about their experience in the program. In addition, a number of deans and directors who had faculty participants in the program were pleased with the teaching skills and knowledge gained by the participants.

Davis, Baker, and Carlson (1994) suggest the addition of nurse educator courses throughout the master's degree program rather than completing all of the clinical specialty courses and as an afterthought providing nurse educator courses at the end of the program. The nurse educator courses would include the tripartite faculty role, curriculum theory and development, instructional technologies, and theory and methodologies for evaluation of students and courses. These courses would be spread throughout the master's degree program. The culminating course would be an internship or practicum in nursing education in order to provide the student with actual experiences in all aspects of the educator role.

Seldomridge (2004) incorporated a shadowing experience for senior nursing students during their leadership experience. In this experience the students shadowed nursing faculty and gained a better understanding of the faculty role including how diligently the faculty worked, and the patience and organization ability they demonstrated. After the experience, a third of the students were considering a career in education. The students identified potential deterrents to pursuing an academic career including complexity of the role, the liability of supervising students, work demands, lower salaries, and doctoral education. Through this experience students had a glimpse of a career in teaching.

The Southern Regional Education Board (2002), in their report on the nursing faculty shortage, made further recommendations for the establishment of a regional

consortium of nursing programs. The purpose of the consortium would be to establish the core curriculum guidelines and the competencies needed to prepare nurse educators. The consortium would share resources and use distance learning and continuing-education conferences to help prepare nurse educators and to assist nursing faculty who lack formal preparation in nursing education.

Another solution being utilized by many institutions is the hiring of part-time faculty to cover undergraduate clinical courses and utilizing the expertise of clinical experts (De Young, Bliss, & Tracy, 2002). Some nurses wish to maintain a clinical practice and are interested in a joint appointment in which part of their salary is paid for by a hospital or clinic and the remainder of the salary is paid for by the teaching institution. The joint appointments provide a higher salary for the nurse and at the same time attract the nurses to teaching (Brendtro & Hegge, 2000; De Young & Bliss, 1995). This could potentially be a better solution than using adjuncts since the salaries for adjuncts are notoriously low and few nurses stay in these positions for very long. Another benefit of joint positions is the ability of hospitals and other service organizations to benefit from the research expertise of nursing faculty. Levin, Vetter, Chaya, Feldman, and Marren (2007) described a partnership between a university and a visiting nursing organization. Through this joint position, the nursing faculty members were able to mentor nurses on the frontline regarding evidence-based practice and the impact that research can have on nursing practice. Therefore joint appointments can potentially increase faculty salaries while both institutions benefit from the clinical and research expertise of the nurses.

For both recruitment and retention, the compensation and reward systems need to be improved based on the large differences in salaries between academia and practice. More competitive salaries are needed to attract nurses to teaching rather than clinical practice. Once they are in teaching they need competitive salaries so that they will stay in teaching (Brendtro & Hegge, 2000; Craine, 2000; De Young & Bliss, 1995; Hinshaw, 2001; SREB, 2002). Gone are the days when nurses go into teaching just for the love of teaching. The reward systems need to be revised in order to retain nurses in teaching. The reward system would include earlier promotions and higher academic rank, lighter teaching loads, release time for research, and realistic expectations (De Young & Bliss, 1995). Excellence in teaching needs to receive the same degree of reward that research currently is granted (Marshall, 2001). Currently in most four-year institutions, research is what is rewarded and is needed for promotion and tenure.

New faculty members are often not trained in pedagogy and may become overwhelmed with their first teaching experience. They would benefit from being mentored by a senior faculty member. Hinshaw (2001) suggested that retirement be preplanned so that new faculty can be hired and mentored before faculty retires. Retirement could be a gradual process so as to allow mentoring time. New faculty members not only have to build their teaching skills but also learn to balance the expectations of teaching, research, and service to the institution. A mentor could help in this professional development and growth. Dunham-Taylor, Lynn, Moore, McDaniel, and Walker (2008) suggest mentoring as assisting in successful transition for new nursing faculty and contributing to the retention of faculty. They viewed mentoring as an ongoing process and outlined several components that are essential to the mentoring process. The

components include socialization, collaboration, operations orientation, expectations, documentation, feedback, inspiration, modeling, and sharing wisdom. No studies were found that tested the effectiveness of mentoring programs in the retention of new faculty.

In addition to mentoring, Lewallen, Crane, Letvak, Jones, and Hu (2003) tried self-governing support groups to enhance the success of new faculty. Their concern was that during this nursing shortage, once one is able to attract high quality faculty, institutions need to support new faculty members and assist them in becoming successful. The support group met to discuss their feelings of stress, strategies for being successful in the university setting, and how to incorporate the tripartite mission of the university. They all had a variety of teaching, clinical, and research experiences. They were able to explore ideas for joint projects and to ventilate feelings in a safe environment. Clearly they benefited from the camaraderie, the emotional support, and assistance in working toward tenure. The group focus was expected to evolve over time as the needs of its members changed. A major barrier for the group was finding the time to meet and maintain group participation in light of faculty members' very busy schedules. Another concern was becoming isolated from other members of the nursing faculty. The participants countered the potential for isolation by forging other working relationships within the department. In addition, the group considered adding members over time or assisting new faculty in forming additional support groups.

Finally, if there are fewer nursing faculty members, higher education administrators need to utilize faculty time more effectively and still provide nursing students with quality education. Student educational experiences may need to be restructured in order to reduce the time demands on nursing faculty. Administrators need

to consider ways to use new technology, such as computers and the Internet, to enhance education and decrease the demands on faculty. Undergraduate clinical experience may need to be restructured (De Young & Bliss, 1995). Clinical rotations require a lot of faculty energy and time. Other methods need to be considered that utilize less faculty time but still develop the students' clinical skills that are needed for practice (AACN, 2003; De Young & Bliss, 1995). These changes include use of preceptors, computer simulation, and web courses. With the preceptor, the student has more one-on-one experience with a clinician while the faculty member oversees the total learning process. Computer simulation provides practice with a variety of cases that the student may not have the opportunity to see during a clinical experience because of the decline in available clinical sites.

From the synthesis of evidence in the literature, several suggestions have been made to improve the recruitment and retention of nurses into the educator role but there is little information on what has been tested and has worked. According to the NLN national survey in 2002 (Rosenfeld et al., 2003), a variety of strategies are being used to deal with the faculty shortage. The vast majority of programs reported hiring more part-time faculty to compensate for unfilled nursing faculty positions. In addition, one-half to two-thirds of the programs have increased the teaching load. Other strategies included limiting admissions, adding more students to theory and clinical sections, and cancelling sections. To recruit new faculty, the majority of programs increased salaries. In addition, programs reduced beginning workloads, paid moving expenses, provided tuition reimbursements, and offered bonuses.

Allan and Aldebron (2008) assessed the strategies implemented to counter the nursing faculty shortage and have been implemented since 2000. They conducted a systematic review of the literature from 2000-2008 and found an abundance of strategies but very little empirical data regarding outcomes. They grouped the strategies into four themes including advocacy, educational partnerships, academic innovations, and external funding. Advocacy meant raising the awareness of both the nursing and nursing faculty shortages through mass media campaigns and workforce data collection. Mass media campaigns included Nurses for a Healthier Tomorrow, Center for Nursing Advocacy, and the Johnson and Johnson Campaign for Nursing's Future. Various centers have been established around the country to collect workforce data and pilot solutions to the nursing faculty shortage. Educational partnerships have sought to open communications and expand educational capacities by adding scholarships, faculty, and clinical sites. These partnerships have occurred between schools and between schools and other agencies and government. Academic innovations has involved the use of non-traditional faculty including retired faculty, clinical practitioners and non-nurses, the use of new technology such as distance learning, and developing new curricula including accelerated programs. Finally, strategies have sought funding from public sectors, philanthropy, and the health care industry in order to increase funding for nursing faculty. Allan and Aldebron were concerned that strategies need to be sustainable and not just a short-term fix, need to be reproducible in other areas of the country, and need to have adequate funding. Even from the many exemplar strategies found in this review of the literature, little data was found on their effectiveness in solving the nursing faculty shortage.

It is true that the sooner a nurse takes on an educator role the more potential in education he/she has. But what is going to attract nurses to the educational role and the desire to pursue further education such as a doctorate degree? As Brendtro and Hegge (2000) suggest, providing courses in pedagogy to those with masters' degrees in the practice arena might increase their understanding of teaching but there are no data to support that these nurses will then be interested in an educator role. Providing more competitive salaries to those in education might help recruit and retain nurses in education, but administrators may have difficulty finding the funds when budgets are tight. Hinshaw (2001) suggests mentoring of new faculty members by faculty members who are close to retirement, but does not provide the data to show that mentoring has helped recruit and retain new faculty members. The literature is limited on the perceptions of nurses and what would attract them to the educator role and keep them in that role. By learning about more what nurses think about the educator role, it is hoped that administrators in higher education will be better able to develop and put into practice ways to recruit and retain nursing faculty members.

Conclusion

Two national nursing organizations, AACN and NLN, and one regional educational board, SREB, regularly survey nursing programs and provide descriptive data on the current status of nursing faculty. They all indicate that the average age of nursing faculty members is increasing; the salaries of nursing faculty are not competitive with those in other arenas; only half of the nursing faculty are educated at the doctoral level; budgeted faculty positions are going unfilled; nursing faculty members are retiring faster

than nurses are being educated at the doctoral level; and the number one reason for retirement is not low salary (AACN, 1999; AACN, 2003; AACN, 2004, Rosenfeld, et al., 2003; SREB, 2002). All of these factors contribute to the current nursing faculty shortage. In addition, the NLN survey provides data regarding the approaches nursing programs are using to deal with nursing faculty shortages.

These national and regional surveys provide a description of the current status of nursing faculty but do not give insight into what will attract and retain nurses in the faculty role. Brendtro and Hegge (2000) recognized the need to know what would attract nurses to, and retain nurses in, faculty positions and how to increase the number of qualified nurse educators. They used a survey method and relied on a self-selected sample for their results. The study was conducted in one rural midwestern state and thus has limited generalizability. Studies by Oermann (1998) and Fong (1993) focus on sources of stress and what mediates work-related stress for nursing faculty. They do not relate work stress with nursing faculty leaving their teaching positions.

Another issue not addressed in the national surveys, is what will increase the number of nurses educated at doctoral level who will be available to replace those nursing faculty with doctorates who will be retiring in the next ten to fifteen years. Lovitts (2001) and Gray et al. (1997) examined the experiences of doctoral students and the difficulties they face as they complete their programs of study. This addresses the need for support and resources during doctoral study so that students are more likely to complete the program but does not address what will attract students to advanced education. Anderson and Swazey (1998) studied doctoral students and the reasons they pursued doctoral education but the sample did not include nurses and nurses may not

pursue doctoral education for the same reasons.

This study used a qualitative approach in order to go beyond the information learned from the national and regional surveys and gain more insight into what nurses with graduate education think will assist in attracting and retaining nurses in education roles. Also, the goal was to learn more about what nurses in faculty positions and those in other positions see as causes for and solutions to the growing nursing faculty shortage. The goal was to gain in-depth information from the interviews with nurses that can not be obtained from a survey, even one with open-ended questions.

CHAPTER THREE: METHODS

The purpose of Chapter Three is to describe the research methods used in conducting the study. The discussion includes the research design, participant selection, data collection procedures, analysis of the data, and issues of validity and reliability.

Research Design

Basic research is conducted to add to the body of knowledge and for the development of theoretical foundations, while applied research focuses on addressing a practical problem or situation (Johnson & Christensen, 2000). This study is considered basic research in that it is an attempt to add to the body of knowledge regarding the nursing faculty shortage but not seek to determine a specific or immediate solution to a shortage in a particular site/location.

This research was a qualitative study that utilized phenomenological methods. According to Jasper (1994), phenomenological research seeks to describe an experience in the person's own words. This study sought to further understand nurses' perceptions of the nursing faculty shortage as they have experienced it and their perceptions of the nursing educator role. The nurses who are currently in higher education teaching positions have experienced the nursing educator role and some have experienced the impact of the nursing faculty shortage. The nurses who are not in teaching positions provided some understanding about how these nurses perceive the nursing educator role and why they would or would not consider such a role.

Participant Selection

Purposeful sampling as described by Patton (2002) is the type of sampling that is

most often used in qualitative research. In purposeful sampling the goal is to select “information-rich cases” (Patton, 2002, p. 46) or those participants that will be able to provide the most detailed and in-depth information regarding the phenomena being studied. Johnson and Christensen (2000) describe maximum variation sampling as a type of purposeful sampling used in qualitative research. The goal in this type of sampling is to obtain a wide range of cases to be observed or interviewed to gain insight into the phenomena being studied. This allows the researcher to explore common themes across multiple diverse cases.

In this study two types of nurses were interviewed. One category included nurses who were currently teaching in nursing programs in West Virginia. A letter was sent to the directors or deans of all nursing programs in West Virginia. Each was asked to recommend two or three faculty members who had insight into the nursing faculty shortage and would be willing to be interviewed regarding the shortage and the role of a nursing educator. West Virginia has 19 schools of nursing with a variety of programs including 10 associate degree programs, 10 baccalaureate degree programs, four masters’ degree programs and one school with a Ph. D. in Nursing and a Doctorate of Nursing Practice. From the letter of introduction, nine directors/deans out of 19 responded. Only one educator from each school was contacted and interviewed. Following Johnson and Christensen (2000), the goal was to select cases for this study that were representative of the different types of nursing programs since the experiences and perceptions may be different across the different types of programs.

The second category included nurses who had a master’s degree in nursing but did not currently hold a nursing faculty position. The population was all nurses who had

at least a master's degree in nursing, were licensed in West Virginia, and did not currently teach full-time in a nursing program. A list of all nurses who have a master's degree in nursing was obtained from the West Virginia Board of Examiners for Registered Professional Nurses. This list contained 688 nurses of whom 151 lived outside West Virginia and another 116 were nursing faculty. The remaining 447 received a mailing with an introductory letter, a copy of the consent form and a demographic sheet. Of those receiving the mailing, 109 responded for a 24% return rate. Of those responding, six were eliminated because they were nursing faculty. In addition one was now in anesthesia school, one had moved out of state, and one had just lost her job. Those individuals were eliminated from the sample. The remaining 100 nurses served as the target population from which the sample was selected. Proportional sampling was done so as to obtain a sample of eight non-educators which had similar demographics as the population. The demographics used to determine the selection included age, years as a nurse and years in current position, type of current position, and salary range. The small sample size is recommended when conducting a phenomenological study and using in-depth interviews (Johnson & Christensen, 2000).

Age distribution of the population was made up of two (2%) participants who were less than 30 years of age, 26 (26%) were in their 30s, 27 (27%) were in their 40s, 38 (38%) were in their 50s, and 7 (7%) were older than 60 years. Since the group of nurses less than 30 years of age was such a small number, this age group was dropped. Nurses over 60 were not used in the sample since they were reaching retirement age. Proportional sampling was used so the interview sample would have a similar age distribution as the population. The sample of 8 nurses included two (25%) in their 30s,

two (25%) in their 40s, and four (50%) are in their 50s.

The majority of the population had been in their current position for fewer than ten years and did not reflect the amount of experience in nursing, therefore was not used as selection criteria. For the population, the years of experience as a nurse ranged from fewer than 10 years to over 40 years. In the population, 12 (12%) had fewer than 10 years of experience, 27 (27%) had between 10 and 19 years of experience, 41 (41%) had between 20 and 29 years of experience, 17 (17%) had between 30 and 39 years of experience, and only 2 (2%) had over 40 years of experience. In order to have an interview sample that had the same proportion of nursing experience found in the population, the total years of nursing experience was used as the selection criterion. The interview sample had the following years of experience as a nurse: three (37.5%) had 10 to 19 years of experience, three (37.5%) had 20 to 29 years of experience, and two (25%) had more than 30 years of nursing experience.

The type of nursing position was another criterion for selection of the interview group. Of the population, 78 (78%) currently held a position as a nurse practitioner, nine (9%) held administrative positions and the remaining 13 (13%) were holding a mixture of positions. Of the total population, 18 (18%) had past experience with teaching but their current full-time position was not in teaching. Since the administrators and other types of positions made up a small proportion of these groups, they were combined into one group for determining what proportion to select for the interview group. The sample had six (75%) with current positions as nurse practitioners and two (25%) were in administrative positions. On the original demographic data sheets only two (25%) had indicated prior experience in nursing faculty positions but through the interviews I learned that an

additional four (50%) had limited experience in part-time nursing faculty roles.

The final criterion used to select the interview group participants involved salary. In the population 13 (13%) made less than \$50,000 and were often working part-time; 19 (19%) made \$51,000 to \$60,000; 29 (29%) made \$61,000 to \$70,000; and 36 (36%) made over \$70,000. In addition, three had retired. To make up the sample, they were selected so that one had a salary in the \$51,000 to \$60,000 range, three were in the \$61,000 to \$70,000 salary range and four had a salary over \$70,000.

Data Collection Procedures

The major form of data collection in phenomenological research is in-depth interviews (Johnson & Christensen, 2000). The in-depth interviews allow the participants to express in their own words how they experience or perceive the phenomena under study. The in-depth interviews in this study followed a semi-structured interview guide. As Kvale (1996) indicates, the interview guide in qualitative research contains the broad topics to be discussed and suggested wording of some questions. The exact wording and sequence of the questions may change during the interview based on the judgment of the interviewer. The questions need to reflect the topic being studied but also be dynamic enough to promote the flow of the interview and encourage the participants to share their experiences and perspectives. In this study I followed a set of questions that reflected the research questions and were similar for all of the interviews so as to facilitate comparisons across the participants. I used follow-up questions developed during the interviews to gain more description and in-depth information.

The interviews were conducted from July 2006 through February 2009 with all

but four being conducted in March 2008 and February 2009. Each of the interviews lasted from 30 to 60 minutes with most of them around 45 minutes. The interviews were conducted both in person and via telephone. Of the 16 interviews, ten were conducted via telephone because the participants lived all across West Virginia. Time and distance did not allow for all of the interviews to be conducted in person.

The interviews were audiotape recorded and then transcribed verbatim. In qualitative research, especially with interviews, the researcher will know who is being interviewed, but must maintain the confidentiality of the participants (Kvale, 1996). In this study, I explained to the participants how confidentiality of the data would be maintained and that identity would not be linked to the tapes or the transcriptions of the interviews or by any writing of the findings. Only first names were used in the transcriptions and the names were changed for any writings of the findings. In the transcriptions, any references to organizational names were omitted. The full transcriptions were only read by me and my dissertation chair.

Demographic data were collected from each participant in order to describe the sample and to compare the nurses in faculty positions and those who were in other roles with regard to age, years in nursing, years in current position, current position, current salary, length of time between completing the basic degree in nursing and starting a masters' degree, age when they received a masters' degree in nursing, and highest degree held. Age was selected because the literature notes that the age of nurses in general and those in faculty positions are increasing (Brendtro & Hegge, 2000). Salary was selected because the literature has noted that the salaries of faculty members tend to be lower than nurses in other positions (De Young & Bliss, 1995; Hinshaw, 2001). The time frame for

starting a masters' degree was selected because the literature indicates that nurses wait longer to seek an advanced degree and take longer to complete the degree (Berlin & Sechrist, 2002).

Analysis of the Data

According to Bogdan and Biklen (1998), the analysis of data in qualitative research is a process of examining and arranging the data so as to gain understanding of the phenomena being studied. This process typically takes place throughout data collection and is completed after the data collection ends. During data collection, I further refined the interview questions based on the analysis of data in the initial interviews. After the first few interviews, I refined the questions to not only ask about the participant's perceptions of the nursing faculty role but also to ask the nursing faculty why they had gone into the role and what educational preparation they had to assist them in the nursing faculty role. For those participants not in a faculty role, I asked why they had selected the role they were in and if they had ever considered the faculty role. This line of questioning assisted in learning more about the participants' feelings about the nursing faculty role and why it was a role they had taken, had considered, or had not considered. Another line of questioning that developed related to the educational background of the participants including any special training they received with the masters' degree in nursing that benefited them in their current role or would benefit them in a nursing faculty role. For example, some had taken courses specific for the faculty role while others had no special training in teaching.

The formal content analyses of data involved inductive reasoning that allowed the

patterns to emerge from the data and took place after all of the interviews are completed. From the two groups of interviews, I developed a list of code words and coding categories. Following Bogdan and Biklen's (1998) guidelines, I began this process by reading all of the transcripts and developing a preliminary list of code words. The list of code words was refined and from it a few major themes or categories that describe the nurses' perceptions and experiences were constructed/identified. The themes from each of the two groups of nurses were compared to determine the similarities and differences between the two groups. The themes were analyzed in relation to the literature in order to explore how the study added to what was known about the nursing faculty shortage.

Validity and Reliability

Internal validity has to do with truthfulness and the extent to which the findings are congruent with reality (Merriam, 1995; Kvale, 1996). In qualitative research, the researcher is especially interested in the reality as interpreted by the participant. This reality is multidimensional and often ever-changing (Merriam, 1995). Qualitative research's strength is internal validity since the goal is to learn from the participants about how they understand the essence of the phenomena under study. In order to enhance the internal validity of a qualitative study, Merriam (1995) recommends numerous strategies including the use of member checks, peer examination, and statement of the researcher's experiences and biases. In this study, Merriam's three recommendations were followed. The goal was to spend enough time in the in-depth interviews to gain an understanding of the reality of the nursing faculty role as perceived by those nurses currently in nursing faculty roles and those in service positions. By using

an interview guide, I made every attempt not to use leading questions that would influence the participants' answers and thus not truly reflect the nurses' perceptions and experiences. Peer examination was done through the dissertation committee chair who reviewed a sampling of the interview transcripts and provided feedback on the interview content and the analysis of data. The peer review was used to determine if rapport had been developed between the participant and the interviewer and if the interview captured the essence of participants' experiences and perceptions. As a member of a nursing faculty and being a part of the nursing faculty shortage, I had to bracket my opinions and perceptions in order to better understand the perceptions of the nurses being interviewed.

External validity is defined as the generalizability of the findings to another setting (Merriam, 1995). The goal of qualitative research is to gain an in-depth understanding of phenomena in a particular context rather than to generalize. In this study, the goal was to learn more in-depth what nurses in West Virginia think about the nursing faculty role and about the causes of and solutions to the nursing faculty shortage. The generalizability then is left to the readers, such as higher education administrators who may decide about the extent to which the findings apply to their situation. Merriam (1995) indicates that thick description of the methods and findings, and multi-site designs, enhance external validity. In this study several nurses were interviewed and the goal was to provide a great deal of thick description of the participants and their work context so as to provide information to assist higher education administrators in solving the nursing faculty shortage.

Research reliability has to do with whether the findings are consistent and can be found over time and by different observers (Bogdan & Biklen, 1998; Kvale, 1996;

Merriam, 1995). In qualitative research, the assumption is that phenomena change over time and thus are not static. According to Merriam (1995), reliability in qualitative research has to do with whether the findings are consistent with the data collected. For the analysis process, both Merriam (1995) and Kvale (1996) use peer examination as a strategy to increase the reliability of the analysis. Peer examination means that a peer is asked to examine the data and the analysis and determine if the analysis is consistent with the data. In this study, the dissertation committee chair reviewed the analysis process and the findings to check for plausibility of the findings and whether the analysis written was consistent with the interviews reviewed by the dissertation committee chair. According to Kvale (1996), the accuracy of interview transcriptions is another reliability issue. Consistency is needed between the typist and the researcher. In this study, two of the interviews were transcribed by a typist and then I reviewed the transcriptions for accuracy and made corrections as needed. I transcribed the remainder of interviews and reviewed the transcriptions for accuracy and made corrections as needed.

CHAPTER FOUR: PARTICIPANTS

This chapter describes the characteristics of each group of nurses who participated in the study. The first group, called the faculty group, was made up of nurses with at least a master's degree in nursing, living in the state of West Virginia, and currently teaching in a nursing program in West Virginia. The second group, the service group, was made up of nurses with at least a master's degree in nursing, living in the state of West Virginia, currently practicing in an advanced practice role but not in a full-time nursing faculty position. Participants in both groups enjoyed practicing in an advanced practice role and had considered contextual factors such as family demands and desire to help others when selecting the educator, nurse practitioner, or administrator roles. Nurse practitioners, those in the service group, chose to work directly with patients to enhance their health while nursing faculty worked with students to guide them in becoming a nurse. Nurse faculty participants were more likely to have gone beyond a master's degree to doctoral education. Both nurse practitioners and nurse administrators held higher paying positions than nurse faculty.

Faculty Group

The group of faculty was made up of eight nurse educators who taught full-time. Of the eight nurse faculty interviewed, three taught in associate degree programs, one had taught in both associate and baccalaureate degree programs, three taught in baccalaureate degree programs, and one had taught in both baccalaureate and masters' degree programs. All of the faculty participants had masters' degrees in nursing. In addition, one had a doctorate of philosophy (Ph. D.) in nursing and three held doctorate of education

degrees (Ed. D.). The four nurse faculty with doctorate degrees all taught in baccalaureate or masters' degree nursing programs. When compared to the population, the sample had a greater percentage with doctorate degrees as noted in Table 1.

The nurse faculty participants in the study sample were all female with a mean age of 53.8 years (range 44-62 years). The sample mean age is considerably higher than the population of nurse faculty in West Virginia who had a mean age of 41.65 years (range 30-60 years). The nurse faculty in the study sample had been nurses for an average of 32.4 years (range 23-41 years) indicating they were a very experienced and well enculturated in nursing having been in the profession for over 30 years. In comparison, nurse faculty in West Virginia as a whole have been in nursing for a mean of 22.3 years (range 2-44 years) thus on average having fewer years of nursing experience (see Table 1). Both the difference in age and experience as nurses between the sample and the population may be due to the sampling method. The deans/directors of the programs selected faculty who would have knowledge of the faculty shortage and thus appeared to have selected faculty with more experience and higher age.

During their years in nursing, the nurse faculty in the study sample held various types of positions including staff nurse, charge nurse, nurse manager, nursing supervisor, case manager, director of nursing, and office nurse. They completed the masters' degree education an average of 11.6 years (range 7-17 years) after they completed the initial degree in nursing. When they completed the masters' degree they were on average 32.9 years old (range 25-38 years old). There was no comparison data for the population in regards to when a master's degree in nursing was completed.

Table 1*Demographics of Faculty Group*

	Population N=262	Sample n=8
Mean Age (range)	41.65 (30-60)	53.8 (44-62)
Mean Years as Nurses	22.3 (2-44)	32.4 (23-41)
Mean Years as Educator	10.4 (0.5-37)	21.5 (6-38)
Highest Degree		
Doctorate	43 (16.4%)	4 (50%)
MSN	192 (73.3%)	4 (50%)
BSN	27 (10.3%)	0
Rank		
Professor	48 (18.3%)	4 (50%)
Associate Professor	44 (16.8%)	2 (25%)
Assistant Professor	91 (34.7%)	2 (25%)
Instructor	62 (23.7%)	0
Lecturer	17 (6.5%)	0

Nurse faculty participants have been in nursing education for an average of 21.5 years (range 6-38 years), an average of ten years more than those in the population who had a mean of 10.4 years in nursing education (see Table 1). Currently two hold the rank of assistant professor, two are associate professors, and four are full professors. As noted

in Table 1, the sample has higher percentages who are full professor as compared to the population. They have been in their current positions for an average of 12 years (range 5-21 years).

All salaries for the faculty group are at or below \$70,000. Five of them have a salary in the range of \$41,000 to \$50,000; two have a salary in the \$51,000 to \$60,000 range while only one has a salary in the \$61,000 to \$70,000 range. These salaries are in line with the salaries in the population where the average salary even for full professor is below \$70,000. More specifically, the data from the population indicate that the salaries of nurse faculty in West Virginia depend on academic rank. In the population of nursing faculty in West Virginia, the average salary for instructor rank is \$40,717; for assistant professor rank is \$46,362; for associate professor rank is \$53,296; and for full professor rank is \$64,669.

All but two of the faculty participants have worked outside the state of West Virginia, both as educators and as non-educators. They have worked in South Carolina, Virginia, Texas, Florida, Colorado, California, Pennsylvania, New York, Maryland, and Hawaii. Three of these had no teaching experience in other states and did not discuss differences in other types of nursing positions as compared to working in West Virginia. One faculty had taught for a couple of years in a neighboring state in a diploma or three-year nursing program and is now teaching in a baccalaureate program. She found differences because of the type of program rather than because of the difference in location. Another faculty participant described a big difference in pay when she plans to move out of state and change from a full-time faculty position to a part-time nurse practitioner position.

I mean here I sit with all of these degrees and I have been working now two jobs. Well, I have not always worked two job, in two different states, but when I go to South Carolina in May and cut back I will be working between 32 to 35 hours a week I'll make 1 ½ times my salary that I make here.

Finally, one faculty had traveled extensively as a travel nurse and had worked in five different states in different sized hospitals. While travelling, she learned to value that as a nurse she could go anywhere and opportunities were endless.

I graduated in May. By February, I was already leaving the state and going to another state with a job where at the time it was \$19,000 a year and I thought I was the richest woman. It gave me financial means; it allowed me in a profession that was so short everywhere that I could pick any location...I wanted, any type of floor. Every opportunity was open to me. It was incredible. There is nothing more empowering. I was able to, because of the flexibility with position and not feeling pressured, I was able to take time off and travel the world if I wanted to.... I have been able to travel to all the different states, meet just so many different cultures of people. You just can't learn without going and experiencing it and there is no limit also to nursing as to what you can do.

As she travelled, over time she became concerned that the new nurses graduating were not being as well prepared and this led her eventually into a nursing faculty position. She stated, "I saw that the new grads coming out just in general, there was no...[location] in particular, that they were coming out greener." In addition, she learned the need to continue her education because her basic education did not provide her all of the knowledge that she needed to know as a nurse. These travel experiences laid a foundation

for why she wanted to give back to the profession and become a faculty member.

Where I was before this was Denver and there was a strong limitation that without a bachelors I couldn't do home health and I couldn't work in the hospital [where] I was currently working. I got in as traveler [nurse]. I shouldn't have been employed there and I could see the limitations... I was working with master's prepared nurses who knew a lot more and I had never been exposed to that. I didn't understand how they knew what they knew. How did I miss out on this boat? And that's why I want to promote [further education].

The discussion of experiences in other states was very limited and thus we cannot make any conclusions on how this may have influenced the participants' perceptions of nursing in general, the nursing faculty role, or the nursing faculty shortage.

The interview data provide additional descriptive information about the faculty group. For six out of eight of the participants, family situations and resources provided by higher education institutions played a considerable role in decisions to become a nurse faculty member or to stay in nursing education. In the following description, one faculty shared how both family and financial support from the college led her to become a faculty member:

I got into education after my husband and I ended up in a little town and the job opportunities were really sparse but there was a little private college there and if I would come to work for them they would support me while I went back to school for my master's degree. That was the defining thing, action, moment, whatever that pushed me into education. I had always enjoyed patient teaching and that kind of thing....They would support me time wise and that meant money to go on

to school. Again that was the defining moment thing was the college supported me with giving me the day off. I had to travel quite a ways to get to school.

Another faculty shared the following about family circumstances that prompted her to stay in an educator role:

What made me stay is...many different reasons. As I got older more time with my family meant more and being able at the time that I took this job, my mother was just diagnosed with cancer and having the freedom to have a more flexible schedule versus you know, in a hospital working a number of shifts and that was your shift that somebody dictated to you telling you that's what you had to do. So having that freedom and having a flexible schedule you know, also kept me here.

Likewise, a third faculty described how flexible hours and a family situation prompted her to initially become an educator but the love of teaching has kept her in the role:

The first thing that attracted me into education was, I was a brand new single parent, of a one-year old and I wanted flexibility that [was not possible] working in the hospital, [where] you worked holidays, you worked evenings, you worked midnights. And so there happened to be a faculty member that quit two weeks before class, and this institution was desperate and I had the degree they needed and so I felt that I was the most incompetent person to be a teacher, but the flexibility and the hours [were good] and the pay was about equal to the hospital pay. The pay was not that important to me; it was more the flexibility being a single parent. Then, when I got into teaching and realized how much I enjoyed it, then...[I knew I had] to go on and get more education and it was definitely worth...[getting] more education to teach and the flexibility of the hours was still

important, but it got to be [that] my joy of teaching [was] more important, because even now I'm thinking, you know, sometimes I think I would just like to go back to the hospital where you show up at 7:00 and you leave at 3:30 and it's over with. You're not spending your weekends grading papers, you're not doing this other stuff, but it's just I really enjoy teaching and working with the students.

Yet another faculty matched her education path with that of her children and then stayed because of being able to help others:

To begin with, I think that to be honest it was very good for my family. My children were young and my goal when I went back for my first master's was that I could be teaching by the time my daughter started school so she and I could be on the same schedule. Now having that been said, my kids are grown now. Why have I stayed? You have to love this and there is such a reward when you see that light bulb go on in a kid's head or you've brought that mom off of welfare and now she has a career and she can actually take care of her family.

One faculty described the faculty community and culture that supported her and younger faculty members. It enabled her to balance family demands with work demands.

The community that you create as a nursing faculty makes a huge difference. I have an aging mother. If I need to go, people will trade days with me, trade lectures so my students don't lose anything but I can go be with my mother if I need to. We have younger faculty who have young children and we work really hard if they have a sick child, you know... creating that kind of atmosphere is wonderful. Not having to work shifts is wonderful.

In addition, she described how the institution supported other family needs such as tuition

support:

I have two adult sons and one of them chose to go to school here so went tuition free because I worked here. The other one had tuition for one year because he was on an exchange program with another private college. So that certainly is a perk you are not going to get in a lot of places especially with the cost of an education. Finally, the last faculty participant described how she lucked into the opportunity to teach and found it a chance to give back to the profession:

I needed to give back. The profession has been phenomenal to me. There is nothing in my life that would be the same other than my family members had it not been for nursing and the only way I can figure to give back, I thought, ...[was in] the role of a practitioner to give back to the population of West Virginia. But my last year of school this fell into my lap; this was on my 10 year plan but it wasn't on my immediate plan. I thought, you know, I can't pass up an opportunity and I took it and it is just more than I expected.

Looking at the faculty in this study as a group, the nursing faculty schedule and higher education resources helped them meet family needs and over time they found they really enjoyed teaching. The family circumstances varied from being a single parent, to caring for ill parents, to having time to attend family activities.

Half of the participants combined the faculty role with maintaining a practice position, thus holding a second job. They all expressed the belief that remaining in practice contributed to being a more effective educator and helped them maintain national certification in their specialty. The second job also contributed to a higher total salary. One faculty explained that working two jobs was not only something she did but several

of her fellow faculty members also worked two jobs due to salary needs and national certification requirements:

Then when I got my master's degree, we still worked two jobs, because there are six or seven of us here that have nurse practitioner, so to keep our certification, we have to work x number of hours, so you know, the pay is still an issue.

Another faculty described how continuing to practice helped her to be a more effective educator:

The other thing I've got to do is clinical practice and not only to keep up my certification as a nurse practitioner, but I feel like I can't teach unless I practice. I feel like I am a horrible teacher unless I'm out there practicing what I preach and even at the undergraduate level, I felt that I personally could not be an effective teacher unless I was in the hospital practicing as a staff nurse, or supervisor, or whatever area I was in and have the students in that same area. When I was out there, seeing patients on the same floor that I would have students, either everybody would say, 'Oh my gosh, you're going to confuse the patient' or 'you're going to confuse the staff nurses and everybody,' but it was great. The patients knew me that day as nurse and the next day I was teacher and even the nurses, they all would call me teacher, when I was the teacher, and then when I was working as a nurse they would call me nurse. And it was great, and I knew the patients and the patients knew me and they trusted me enough to trust the students and I could just give the students so much guidance and direction. It just complimented, like I said, it made me the best teacher.

Along the same lines, another faculty described how she continued working as a nurse

practitioner in order to be a better role model for her students:

Because I am a nurse practitioner, I see patients every week just to try to keep my certification. So I guess I see my role in a lot of ways. I feel it's important to stay clinically competent to be a good role model for your students which has been a challenge. I feel like I have to be up on medications and up on...what's going on and that's been hard to do that.

Thus four out of eight of the faculty in this study maintained a clinical practice in addition to the faculty role in order to complement what they were doing as faculty, to stay current with health care practices, and to supplement their faculty salaries.

All of the faculty participants described a passion for both nursing and teaching.

For example, one faculty shared:

I just enjoy the students. I enjoy watching people learn; I enjoy helping them learn. I have asked myself if this is an ego trip. Are you having a good time showing off or something? And that's not it.... But I honestly don't think so. I think I've some really unique experiences and I want to share those. It's not showing off as much as it is I think I've got some stuff to share. And I just enjoy that.

Another faculty demonstrated this passion for teaching and nursing since she was a little girl and described it this way:

I remember being a little girl and loving I had gotten a blackboard and loving to go up into the attic and pretend I was a teacher. But I always, always wanted to be a nurse, ever since I was born I think. I've always wanted to be a nurse, but I had never even thought of combining the two until this situation happened and then

I'm thinking, oh my gosh I really do like teaching. I like going to the blackboard, I like doing all of these things, and I remember doing that as a little girl.

Likewise, another faculty shared her long-standing passion for both teaching and nursing and how she makes a difference in the students' lives:

We do the Myers-Briggs with all of my students. My personality type is pedagogue so I'm absolutely a teacher at heart personality wise as well have my profession. I identify myself first as a nurse and then as a teacher but there has always been something in me that wanted to guide the next generation. And I find it very fulfilling. Especially because I think you can make a difference. I am an idealist and I think you can make a difference in the world by influencing people at the education level and that's important to me for people's health, mental health, wellness, and all of those.

Thus all of the faculty participants expressed a love for nursing and enjoyed teaching. Some remember how this desire even began when they were a child.

The faculty group participants were located in both rural and urban areas of the state. In the sample five (62%) lived in rural areas and three (38%) lived in urban areas. This is similar to the 19 nursing schools in West Virginia with eight (42%) located in rural areas and 11 (42%) located in urban settings. In addition, five participants (62%) worked at publicly supported institutions and three (38%) worked for privately supported institutions. In the 19 institutions across West Virginia with schools of nursing, 12 (63%) are public supported institutions and seven (37%) are privately supported institutions. Those in the more rural communities described interactions with former students and being able to see how they had developed into practicing nurses. One faculty shared this

experience with former students who stayed in the area after graduation:

Anyway, where we worked together, we are able to see how the students have grown, not just how they were when they graduated but in their years of experience to see how far they've come and how they've seasoned....Some have seasoned for the good and some have not seasoned for the good but, you know you can...be like a peacock and let your feathers out and say that was one of mine, you know and I think it's good and I think it's good for our students to know that we are now equals.

Another faculty described how she is perceived in her rural community and how she contributes in the community beyond the hospital and higher education institution:

Being an educator, we just did a local health spot on the television down here that they wanted nursing faculty for, so it's good because you can educate the community and they do look at you as an expert. Another positive, when my daughter was playing high school soccer I was the team trainer.

For most of the faculty, family was important and for one faculty, living in a rural community was a great place to raise a family:

I think it's a wonderful place to raise children. I'm very glad we raised our children here. My husband and I are both from out of state and we moved here to go to college and decided to stay here in West Virginia. So we are here because we want to be.

Those in the more urban areas described involvement in state-wide professional organizations, opportunities for research, and exposure to a highly educated community.

One faculty described the following involvement in professional organizations: "At one

time I held an office for NLN [National League of Nursing] and our District One, WVNA [West Virginia Nurses' Association] I was vice-president of that and I have held offices over the years for that." Another faculty participant previously taught at a larger university and now at a smaller college found fewer opportunities for scholarly activities.

What I miss here is some time for scholarly productivity. There is less time for that because we are such a small faculty. We all have a very heavy teaching load so the scholarly piece really happens on the weekend and at night and on your own time because our work loads are such that there are not a lot of hours to do that. It's really hard to put together abstracts for presentations and get any writing done.

In one case, the urban setting was described as providing more clinical sites and learning opportunities for students.

We don't have to drive 50 and 100 miles to get to a clinical site which a lot of schools do. We do have to fight for the sites which every school has to. It's not special to us. We have really good clinical rotations; it really doesn't get much better. And it's also [a] highly educated population in Charleston as far as the students are able to find role models who have masters and definitely nurses who have bachelors and masters' degrees and Ph. D.s and they are able to see that. We are not in a secluded area.

Thus the rural and urban settings provide different but valued opportunities for nursing faculty. Those in the rural setting especially valued community and family opportunities while those in the urban setting and larger university setting valued professional opportunities such as professional and scholarly activities.

Service Group

The eight service group participants were selected from a list of all the nurses who have a valid West Virginia registered profession nursing license and hold at least a masters' degree in nursing. All but one of participants in the non-educator group was female. Proportional sampling was used so that the sample had similar demographics as the population. The sample was very similar to the population with regard to age and years as a nurse (see Table 2). The sample had a mean age of 44.6 years as compared to the population mean age of 48.3 years. The sample participants had been nurses for a mean of 22.6 years as compared to the population with a mean of 21.4 years as a nurse.

In addition, the sample of participants all had masters' degrees in nursing (MSN) as their highest degree which was similar to the population in which only one nurse reported a doctorate degree (see Table 2). The participants in the sample completed the MSN at a mean age of 33 years (range 27 to 40 years). The age when completing the MSN was found to be very similar in the population where the nurses had a mean age of 38 years when they completed the MSN. Both the participants in the study and the nurses in the population waited an average of 12 years between completion of the basic nursing education and the completion of the MSN.

When comparing salaries found in the population with the sample, the sample had salaries more in the upper range of the population salaries. For the sample, none were selected from the salary range below \$50,000 where individuals are more likely to be employed part-time than full-time. In the population, those earning less than \$50,000 made up 13% and were often working part-time; those earning \$51,000 to \$60,000 made up 19%; those earning \$61,000 to \$70,000 made up 29%; and 36% had a salary of over

\$70,000. In the sample one (12.5%) had a salary in the \$51,000 to \$60,000 range; three (37.5%) were in the \$61,000 to \$70,000 salary range; and four (50%) had a salary over \$70,000.

Table 2

Demographics of Service Group

	Population N=100	Sample n=8
Mean Age (range)	48.3 (28-65)	44.6 (33-54)
Years as Nurse	21.4 (5-44)	22.6 (11-32)
Highest Degree		
Doctorate	1 (1%)	0
MSN	99 (99%)	8 (100%)
Type Position Held		
Nurse Practitioner	78 (78%)	6 (75%)
Administrative & Other	22 (22%)	2 (25%)

Similar to the faculty group, five out of the eight in the service group had worked in other states including Illinois, Tennessee, Ohio, New York, Maryland, California, and North Carolina. In only one of the interviews, we discussed the participant's experience in other states besides West Virginia. There was not enough data to determine how and if experiences in other states impacted their perceptions of nursing, the nursing faculty role, or the nursing faculty shortage. In the one interview, the participant had worked part-time

as a clinical faculty member and part-time as a nurse in an intensive care unit. If she had wanted to become a full-time faculty member in another state, she would have had to pursue a doctoral degree which she did not want go back for and stated, “I remember once going for where I took my master’s exam. I thought, ‘Oh my... this is hard, it was really hard’ ...I thought I would never go back to school.”

The interview data provided additional descriptive information about the service group. As was true of the faculty group, all of the service participants had children or were responsible for elderly parents. Family responsibilities had to be balanced with work demands and schedules. For example, one service participant described her current position as being more compatible with her children’s activities than the faculty position that was available in her area. This position would have required teaching on weekends.

I understand that a lot of these programs are going more for adult students who may have other jobs and so lot of times their clinicals are weekends. And with a family, all my jobs basically, I mean I have had to be interested in jobs [where] the schedule has been more important to me than the salary so that I had the flexibility. Like I said, with four kids, to be able to do things, to go see their programs at school, you know that’s always been more important to me.

Two of the participants indicated that due to having small children they would not consider further education beyond the master’s degree at this time because it would take away from time with the family. Likewise, one of the participants in the service group had been encouraged to pursue a Ph. D. but saw that as taking time away from her family.

Part of my deterrent, because I have professors... asking [me] to go back and encouraged me to get my Ph. D., [but] I really just didn’t want to go back to

school. I didn't want to go through more of that... and all the time it takes. My kids are still fairly young and right now that is not where I want to spend my time. Interestingly, participants in both groups made career choices that were compatible with family demands though the nature of the choices differed. Both looked for flexible schedules that would fit with the demands in their private lives. Those in the faculty group found the higher education schedule more compatible with family demands whereas those in the nurse practitioner role found the schedules in clinics more compatible.

All but one of the service participants had at one time worked as a nurse practitioner but at the time of the study, six were in a nurse practitioner role and the other two were in administrative roles. The practice settings varied and included small private practices with one physician, large practices with several physicians, the state prison system, and large medical centers. These practices were located across the state of West Virginia with two in rural communities and six in urban areas. Three of the participants indicated that they had made the decision to go on for a master's degree and become a nurse practitioner so as to move out of the hospital and away from shift work and the physical demands of hospital nursing. Two of the participants had pursued the master's degree because they had a desire for additional education.

Service Roles

As background the following are descriptions of the roles held by service participants. The service participants held positions as nurse practitioners, clinical researchers, and administrators. One of the nurse practitioners held a combination role as

family nurse practitioner and clinical researcher. “I work for an endocrinology clinic part-time. I see outpatients on an outpatient basis obviously. I don’t do inpatient treatment at all. The other half of my job I do clinical research for research trials. I’m a sub investigator and also clinical research coordinator.”

Those who were nurse practitioners worked in a variety of settings with different levels of responsibilities and workload. All of the nurse practitioners gained great satisfaction from the direct patient care they provided. In contrast, the two participants in administrative positions found satisfaction in the development of programs that improved patient care. All of the service participants, whether nurse practitioners or administrators, were able to integrate teaching into their roles. The practitioners taught patients while the administrator taught other staff including other nurses.

Nurse Practitioners. The service participants in the nurse practitioner positions all saw patients in a clinic, physician’s office, or a hospital setting. One participant currently worked for a hospital where she performed physical examinations prior to patients being admitted for surgery.

This job is probably the lowest stress that I ever had before as a nurse practitioner. We just do history and physicals all day. That’s all we do. We just don’t really make a lot of decisions. We sometimes find abnormalities that have to be followed up on, and we may call the surgeon or we may call the family doctors about those things but most of the time we just do history and physicals.

She contrasted this position with the prior job she held working for a vascular center where she managed patients who were in the hospital. The prior position required a higher level of responsibility and was more stressful.

Well before I came down here I worked at the vascular center...and we had a lot of responsibility....[We] took care of in-house patients, in other words made a lot of decisions about their management, and wrote all of their orders, and wrote all of their progress notes and followed them on a daily basis in house, took call....We saw patients here and did histories and physicals and explained to them what was going to be done as far as informed consent, really explaining the surgery, what benefits and risks. We saw them in clinic in which we saw them pre-op and we saw them post-op most of the time after they had an intervention. The first time back to clinic they may, usually see their doctor but after that they did not see them again for quite some time, they saw the [practitioner].

So this service participant practiced in two very different types of positions. One was very low-stress seeing patients just before they had surgery and the other one was very fast-paced with major responsibilities.

Another service participant had worked in a busy physician's office and moved to her own private office. In the private office, this participant described being "proud of having my own little practice, and my patients come to see me. I'm not seeing somebody else's patients for them." This was in contrast to working in a busy physician's office.

My practice before was in a very busy internal medicine office and I was extremely busy and I was overwhelmed because the schedule was so heavy and a lot of the patients were mine that had followed me at a couple of different locations. But a lot of the patients were really the physician's that I was seeing them for educational reasons or just for an acute-care visit because they were sick that day.

For both of these nurse practitioners, they started in a very busy practice and moved to a setting that was slower paced and less stressful. Both expressed that they were very satisfied in their current positions

Another service participant described working collaboratively with a physician in a family practice physician's office. She especially liked the patient contact and the diversity of her role.

My current role is as a family nurse practitioner. I work in conjunction with... a family practice physician and he is a gerontologist specialist.... We alternate patients so that means that if I have seen somebody for a yearly this year he sees them next year. If I have seen somebody for a four month hypertension follow-up, he sees them next time....In addition to that...I do a lot of health promotion, a lot of chronic and acute treatments of different diagnoses, a lot of education, treatments, prescribing follow-ups for units of labs, testing and referrals and different things like that in addition to assessments and such. And I thoroughly enjoy it especially the patient contact and I think I would miss that if I would left the role.

Similarly another service participant worked in a private practice providing patient care along with administrative duties. Patient care included patient education and treatments needed post-operatively.

I do all of the intake work with the patient, all of their histories and physicals, order blood work if I need to. Do prescriptions if I need to. Get them ready for surgery. I do not go into surgery. I do all of the education per-surgery and post-surgery. I do wound care after surgery. And so consequently, that's pretty much

the nursing stuff that I do. Then there is another whole component that I do and that is like the administrative stuff. The administrative stuff that I do is all of the coding for billing procedure, I do any insurance forms that need to be taken care of, any letters that come in I pretty much take care of that. Oh I oversee the staff that is here. We have all part-time staff here in this office and so I oversee that.

Another service participant worked in the prison system as a nurse practitioner with a physician and physician's assistants. Autonomy was important in his position. He described his role as follows:

[In] my current position I'm a nurse practitioner. I see primary care, chronic care patients pretty much on a daily basis when I am there....I don't have any supervisory role at this time and I pretty much make my own schedule and work within the confines of a formulary that I can prescribe from and protocols.

Key for service participants in nurse practitioner positions was the continued patient contact. One participant stated, "I think primary care is more of a fit for me because I like talking with the patients and getting to know them and forming a relationship." Similarly, another participant saw the real positive aspect of the nurse practitioner position as "the satisfaction that I am helping someone" and being "nurse faculty I would imagine that being a full-time position they would not have any patient care or interaction for the most part." Another participant shared that as a nurse practitioner she may use different skills but always be able to maintain patient contact. "I just knew that with the family nurse practitioner I could see patients yet still may be able to take a role where I may be needed to be an administrator at times or may be needed to be an educator at times. Yet still be able to practice and still be able to have patient

contact.” Thus the direct patient contact was important in the participant’s choice of the nurse practitioner role.

The service participants in nurse practitioner positions worked in a variety of settings with varying levels of stress, autonomy, and diversity. Common to the nurse practitioners was close contact with patients, providing patient education, and providing primary patient care.

Administrators. For the two administrators in the service group, one had started in a nurse practitioner role and moved into an administrative position. In the practitioner position she had worked with four physicians and saw residents in a nursing home. She described that experience in the following way: “I would go up once or twice a week for just a few hours in the morning and see the residents that needed to be seen and I would fit in my routine visits with them.’ When she moved into an administrative position, the nursing home wanted to expand their services so as to better serve the needs of the residents in the assisted living portion of the institution. Over the years she has increased the staff and expanded resident services. As part of her administrative position, she describes her accomplishment as follows:

I think my favorite part has been the part that we are a small enough facility, we have 52 beds, we are small enough I could still stay involved with some degree with the nursing. You know if there were resident care issues, health issues, or whatever we would talk things over. I would talk things over with the nurses and give them some ideas, “Did we check this? Let’s look at this, or why don’t you call the doctor to see about this?” That’s probably been my favorite part, through the years has been getting to deal with the families and the residents and

providing good level of high quality care which we've had five years in a row had no deficiencies on our annual survey. The previous two years we had minimum, like I think one year the laundry door was not locked and because there were toxins that was a deficiency and I told them that door was always locked but we put an automatic lock and that took care of that... So I have also liked building the staff, trying to set the tone...how we want to do things.

Finally, the second administrator works in a hospital and was responsible for planning and implementing clinical programs within the hospital. Similar to the other administrator, her role focused on planning and implementing ways to improve patient care. She works with physician groups, nursing staff, and hospital administration to design and implement new programs and monitor quality of programs already established. The following example illustrates her passion for creating new programs which impacted patient outcomes:

I work with that physician group to establish that center based on what we find out externally as the best practice and that entails anything from development of protocols, algorithms, standardized practice guidelines, establishing nursing standards of practice for the care of the patient, establishing the quality system to monitor the outcomes of the matrix, develop reporting mechanisms so that service or system is integrated into hospital operations and reports quality standards through our quality structure, and globally get into whatever is out there in the industry in terms of what is the best practice....Just the fact that I am comfortable with what I am doing now, I have been here so long....It would have to be really something that I would be passionate about in order to jump at this point in my

career.

For both administrators, it was important to make a difference for patients but in order to accomplish that they worked by planning and making changes in the systems of patient care. They both found satisfaction in making a difference.

Patient/Staff Education. Common to both the practitioner and the administrator positions was the ability to integrate the nursing role with a teaching component. Five out of the eight participants saw providing patient or staff education as a very positive component of their current roles. So even though they were not in formal educator roles, such as a faculty position at a higher education institution or staff development position in a hospital, the participants in the service group were still educating others in their everyday roles. For example, one participant's primary role was seeing patients prior to surgery and performing initial assessment. In addition she provides education to patients on smoking cessation, the medications they are on, and the effects of drinking on their health. Another participant had worked both as a practitioner and as an administrator. Speaking of her role as a practitioner she stated, "People need to be educated. We can't just get these things ordered." In her view, patients need to understand what has been ordered whether it be laboratory tests or medications. As an administrator, she taught staff and families and stated, "I do enjoy teaching and maybe I have gotten my teaching fix by doing inservices and continuing ed programs through the years and caregiver education." Similarly, another participant commented, "I do enjoy teaching and think I can do that on some realm in what I do. It may not be the extent of our educators but it's just enough to whet my appetite and satisfy me for what I do." Finally, one administrator whose primary role was program development explained that she still provided staff with

education and mentored them. “I do a lot with staff nurses in mentoring, like right now I did a huge project this past summer in writing for publication and I had brought in a national speaker and have mentored a whole bunch of staff...[in how to make] poster presentations.”

Additional Professional Activities

In addition to their roles as nurse practitioners and administrators, two of the service participants were active in professional organizations both locally and state-wide. One participant was passionate about the need for nurses to become more politically active in order to advance nursing practice and not let others dictate future changes that would impact nursing practice.

I think it is important that nurses who do have this higher level of education that they be more active in their professional organizations and have more of a voice. We each take a responsibility in the future of our profession because I’m very concerned about it. But if we do not pull together that you know that it’s going to become a different bird or animal than even what it is now and I think we have an opportunity for change and if we let that go past us then somebody else is going to dictate what that change is going to be.

She considered lobbying an important way to educate state legislators on the issues related to the nursing shortage and the nursing faculty shortage. They often do not understand the issues that are facing nursing faculty such as funding for faculty salaries and having to turn qualified students away because of lack of clinical sites and faculty.

We must educate our legislators. I mean I am up there as frequently as I can be to

educate legislators about the issues with the nursing shortage and the acuties, the patients that we are dealing with, and our faculty shortage. And it is a multi-layered issue and problem. And one of the things they don't get is...if we get this funding can we get more faculty and why are we limited to the number of students? Why are we turning so many students away? Why can't we have more students going through clinical? So it is educating. It's explaining it over and over and over and over again to 135 different legislators until they understand those issues and those problems.

Comparison of Groups

When comparing the faculty group with the service group, the participants in the faculty group were older, with more years of nursing experience and had gone on for doctorate education. This difference may be due to the fact that the educator group was self-selected by the directors or deans of the nursing programs across West Virginia who had been asked to provide names of faculty members who would be willing to share their perceptions of the nursing faculty shortage. In contrast, the service participants were proportionately selected based on the demographics of the population.

In both the study groups, the participants waited to pursue a master's degree in nursing. The faculty group waited an average of 11.6 years as compared to 12 years for the service group. The same was true for the age when they completed the master's degree. The faculty group completed the master's at an average age or 32.9 years and the service group completed the degree at 33 years of age.

There is a distinct difference in salaries across the two groups. None of the

participants in the faculty group were making a salary over \$70,000 as compared 50% of the participants in the service group with a salary over \$70,000. Even in the population of faculty in West Virginia the average salaries were below \$70,000 as compared to 36% of the population in service roles being over \$70,000. So the faculty group had to do considerable more schooling and ended up earning less money.

From the interview data, participants in both groups considered contextual factors such as family demands, requirements for higher degrees, and personal satisfaction when making decisions about selecting and remaining in their current role. Participants in both groups determined that either educator role or nurse practitioner role enabled them to meet the needs of having children or caring for aging parents. They all chose to go on for a master's degree in nursing but each chose a different pathway in order to gain personal satisfaction and autonomy from the selected role. Both groups were passionate about nursing and many in both groups were passionate about teaching as well, whether teaching students or patients. The service group drew satisfaction from working directly with patients in order to make a difference while the faculty all drew great satisfaction from seeing the students learn and become excited about becoming a nurse. Those selecting the faculty role were more likely to seek further education such as a doctoral degree than those in the nurse practitioner or administrator role. This was often due to institutional requirements for further education.

CHAPTER FIVE: PERCEPTIONS OF FACULTY ROLE

This chapter addresses the answers to the first three study research questions regarding the role of a nurse in a higher education faculty position and how this role is perceived by nurses currently in such a position and nurses who are in service positions. How do nurses currently in a faculty position perceive their role as educator and their workload? How do nurses in a service position perceive the role of a nursing faculty and faculty workload? What are the differences and similarities if any between the perceptions of the nursing faculty role held by the two groups of nurses?

Faculty Role as Perceived by Faculty

The first research question focuses on the faculty role as perceived by nursing faculty themselves. Normally faculty responsibilities are divided into teaching, service, and scholarly activities. In the interviews, the faculty participants elaborated on their teaching responsibilities and how they were able to integrate nursing and teaching in order to guide the students in becoming nurses. They expressed a real passion for both nursing and teaching. From the description of the teaching role four themes emerged: variety in schedule, connection between clinical and classroom teaching, developing the professional nursing role, and individualizing teaching approaches. In addition to teaching, they provided service to the higher education institutions as well as the community in ways that only a nurse could. Not all of the faculty participants were expected to conduct or publish research and some had difficulty finding time for research due to teaching responsibilities. In addition, they described the positive and negative aspects of the faculty role. Positive aspects of the faculty role emerged into three themes:

relationships with the students, relationships with colleagues, and flexible schedules.

Negatives aspect emerged into two themes: low salaries and the requirement of a doctoral degree in order to teach full-time.

Teaching Component

As faculty, a major component of their role was teaching. For nursing faculty this meant helping the students establish a knowledge base needed by nurses. But more importantly, they wanted to help the students learn what it means to be a nurse and to role model for the students the skills and values needed to be a nurse. Nursing faculty teach both in the classroom and in the clinical setting. Their schedule varied from day to day and with the level of student.

Variety in Schedule. All of the faculty participants taught both in the classroom and in various clinical sites including the acute hospital setting and other community sites. The faculty schedule changed every day as they moved from teaching in the classroom to taking students to the clinical setting. As one faculty participant stated, “In a given week my role includes delivery of didactic materials, mentoring, advising, and clinical instructor. It includes everything.” The following is an example of how faculty schedule changed through the week.

On Mondays, I have office hours and am here for consultation with students having problems, having questions about classes, [or] clinicals. I make assignments for clinical days on Mondays. On Tuesdays and Wednesdays I’m in the clinical setting. I’m actually doing hands-on procedures, advising, teaching note-taking assessment skills, all the things you do in a day being a nurse.

Thursdays I teach class. Fall semester I teach psych, spring semester I teach

critical care. And also I am available during the class, before and after for students... with questions and that kind of thing. Also I have a practice day every week to keep my own skills current and to keep me abreast of the current happenings in nursing.

Another faculty participant taught senior nursing students who were assigned to work one-on-one with nurses in the community setting thus her schedule meant more travel so see students in a number of clinical sites. She described her week as follows:

Well right now I have seniors in the clinical settings and they are with preceptors, so much of the week is traveling to the different sites and touching base with preceptors and making sure that everything is going well...If there are any problems it's important for the preceptor to let me know as soon as possible so things can be corrected. In the classroom, I have only one class because I have two sections of the seniors. So my load is a little bit more so that means I only have the one class and it's a Monday class. It's a research class and it's a three-hour class on Mondays. Today the seniors are on campus...and part of the time in the afternoon is we have what we call seminar time and that's when they are all in a group and where I have an opportunity to talk with them about NCLEX, state board [exam], pull issues like that because that is the only time that you can get them in a group. The rest of the time they're [students] scheduled with their preceptors [on] different days, different shifts, weekends and all of that.

Connection Between Clinical and Classroom Teaching. As the faculty moved from the classroom to the clinical settings they all described how they worked to assist the students to use what they learned in the classroom, to apply the classroom knowledge

to what they were doing in the clinical setting. For one faculty, by taking the students to the clinical setting, she was not only able to help the students apply the knowledge, but also learned what content areas needed to be covered more clearly in the classroom.

Talking to the students and being able to go on the floor with them and say, “Ok, now remember last week when I talked about such and such. Let’s go in here, we have a renal patient and let’s see if we can remember, let’s look at the lab work.”...That was what made it better for me and I could see what I wasn’t stressing enough versus what I was.

Another faculty participant described taking advantage of each experience to turn the situation into a learning experience.

It’s taking each situation in the clinical setting and taking advantage of clinical settings we go to and when a problem arises, developing that into a learning situation for all of the students. So when they do see a conflict with the family or conflict with a physician we are able to discuss it, break it down, and talk [about]... how would you handle this [situation].

Only one of the faculty participants taught in a master’s degree program and she also related the benefit of bringing the theory into practice. She used real-life stories and brought actual case studies into the classroom.

When we have some class time or during my lecture, we talk about patients I see, knowing that there is confidentiality and I’ll pretend that I’m the patient and let them pretend that they’re the practitioner and [discuss]what questions are you going to ask, what exams are you going to do, what tests are you going to order....And every evaluation I get, that is the number one thing the students say,

it is talking about my real life stories and then I even have the students talk about the patients they may have seen when they were in with their preceptors you know. That means more to them [to the students] than anything.

All faculty participants shared experiences of taking the students to the hospital or other types of clinical experiences. They work with a group of students to learn skills needed for nursing practice. The following is an example of a typical day with students in a hospital setting:

The clinical sites vary hours wise, as far as who does clinical at what time. We are usually there six to eight hours a day, usually six hours and....we have eight to ten students in the clinical group and that involves taking care of actual patients on a floor with at least a minimum of two patients apiece to the maximum of four patients apiece. It varies from semester to semester how many [patients] that they take care [of]. And we do beds, baths, dressing changes, injections, IV sticks, IV medicines, PO medicines...The student has to be checked off in the nursing lab first in their first year here and then they are checked-off in the hospital by another instructor on different types of clinical procedures.

Developing the Professional Nursing Role. For all faculty participants, a big part of their role encompassed teaching the student to be a nurse in both in the classroom and in various clinical settings. In describing their role, the faculty participants indicated that they had to be role models, mentors, and facilitators in order to foster the students' development into professional nurses. One faculty participant described the role in this way:

The nursing education role to me, when I talk to other people that may be

interested in coming to work as an educator, I talk to them and tell them that you have to think of yourself as a mentor, someone that a student may want to grow up to be like. And you teach them in the manner that you remember someone from your education that taught you or you teach them in the way that you want them to be able to take care of you and yours when they graduate. I also explain to them that it has to be something that you dearly love or like to do, because the pay is definitely not worth what we do. And that's usually the deciding factor for people, in that they have to like teaching.

Similarly, another faculty participant defined the faculty role in the following way:

I view the nurse educator as the role is the nurse in a leadership role. It's bringing in new nurses and educating them not only to a profession of knowledge but also a profession of skills. It's providing more than education it's also providing [a] role model. Demonstrating to them how to handle and apply the knowledge they have achieved. It's more than just a nursing degree. It's not a degree as in any other field. This is a degree going into a profession.

Another faculty participant said she changed her approach based on whether she was teaching undergraduate students who were just learning what it was to be a nurse or teaching graduate students who had been in nursing practice and are now exploring various advanced roles in nursing practice. For both levels of students, she was a role model in order to assist the students to reach their greatest potential.

In the undergraduate [program], I really saw my role as role modeling what a nurse is to a degree along with giving them the knowledge...I also see that at the graduate level. But at the graduate level, I see more of helping the students to

discover themselves and their role and kind of just give them a little bit of direction. Because a lot of times in the graduate level, the majority of them are such motivators and they are sacrificing [to go to school]...They know what it is like to study and take exams and do papers and stuff, but it has kind of opening up another world to them and I see that mostly as my role as an educator in that area.

Individualizing. In the ever-changing student population, two faculty participants identified that faculty members have to adjust teaching approaches as they encounter different types of student. Some students are coming to college right after high school while others are returning to college for a second career or after raising a family. The following is a description of the challenges faculty face as they facilitate student learning.

You have to remember that if you are teaching an adult student they are already coming to you with a pre-set knowledge and they learn by drawing on previous experience whereas a new high school grad coming to college does not have that previous experience to draw on. They are still in the educational mode of where they are being taught and they regurgitate what they are taught...For instance in critical care I have four students in clinical at a time. I may have a high school student, an older college student that is still single. I may have a working mother at home with two children at home and she may have been up all night with her sick child but then got her mother to come in and watch that child so she that she could come on to clinical. I have to keep in mind all of the things that are going on with the students in a given day to make sure that they're safe, that I'm safe, that they are getting the best experience that they can get and you know to facilitate their learning.

Another faculty participant described the attitude of the newer generation of students who feel they are entitled to an education and do not have to work for it.

The students, especially the younger ones now seem to have...a sense they are entitled and should not have to work for something..... For many there is a sense that well, I'm entitled to this. I shouldn't have to work for it and you should teach me. You should tell me what I need to know. That might turn a faculty off because they are trying to get people to think which is hard work. And that might be something that would discourage a faculty person if they were sensitive to that.

Service Component

Besides working directly with students, faculty participants described spending time on committee work, in meetings, in advising students, providing university service, and participating in professional activities. These experiences were often directly related to the faculty participants' status as nurses. For example one faculty participant was also a nurse practitioner and along with other nursing faculty ran the university's student health center and provided sports physicals for the student athletes. Another participant assisted in university open house and recruitment activities on campus. Professional activities included membership in professional organizations and one faculty held the office of vice-president in the local district of the West Virginia Nurses' Association. All participants indicated that they had to advise students and participate on departmental and university committees. The following is a typical description of advising and committee responsibilities.

We are advisor for our students. I spend a lot of time talking to them about career and five year plan...and trying on what hospitals they might like to work at. Or

what future jobs they are thinking about. We spend an awful lot of one-on-one time....In general we have the 18 to 22 year old demographic, so I do spend a lot of sort of counseling time about problems, but about growth, and what does the future look like. And my door is just kind of open all of the time...I am on multiple committees across the campus. I'm on the curriculum council here at the college level. We are such small faculty that we are really a faculty as a whole for all of our departmental committees are comprised of all of us. We only have four full-time faculty members and we have a couple part-time people. So every single committee, we are all members of them for our department.

The participation in committee work was seen as both positive and negative. One participant shared, "I was very involved in university committees, faculty senate, and things like that and it was just really, really neat to be part of the university." While another faculty participant also saw positive aspects of the work accomplished in the meetings but on the negative side, noted the time involved and time taken from direct teaching.

We have way too many meetings, that I feel takes away from being able to educate. You have a meeting for curriculum development. That's not a bad thing. I think that's a good thing because that's where we use our assessment material to be able to make changes in our program. Then you have a division meeting and then you have a college-wide committee that you are on. And then you have all of what we call in nursing adhoc committees to where you are supposed to only be on that for a year, but that committee turns out to be a committee that goes on and on and on...lot of meetings that take away from the education aspect of it.

Scholarly Component

Another part of the faculty role involved conducting research or participation in other scholarly activities. The time commitment and the pressure to do research varied across institutions. Only three participants discussed conducting research or writing for professional journals and they were the ones with doctorate degrees and taught in either baccalaureate or master's degree programs. In addition, some faculty participants enjoyed conducting research while others felt they did not have the time to conduct research. One participant who taught at the master's degree level described the difficulty in finding time to fulfill all components of the faculty role.

There's always the push for research and that's not negative. It's just I personally cannot do everything. So I can't teach, advise, practice, be on committees, and then do research. I can do low-grade types of research. I could do surveys and things like that and barely get by but I can't do it all. Some faculty members can and I am very impressed with them but I personally can't...I personally feel like there are some good teachers and there's some good researchers. And I would not mind doing extra teaching if someone else that has a lighter teaching load and does good-quality research. I think research is very important. I think research is what guides us in practice, but I personally believe that well; I know that I can't do it all.

She went on to describe how when she had first graduated with a doctorate she had planned on conducting research but had been asked to help start the nurse practitioner program and thus took a different focus.

Because when I first got my terminal degree...I loved research. I could not wait to

get out and do research and I had all these plans to do research and then I was approached by people here to say, “We’ve been approached by the legislators to start a practitioner program. We need someone with a terminal degree to do this. Will you go become a practitioner?” And I said, “No...What I want to do is research and besides, I’ve got so many student loans out there, that’s the last thing I’m going to do is go back for more.” So they said, “You’re not going to pay a thing, we’ll do whatever, please.” And I said, “I’ll give it a try.” Well, I loved it....but I still think I’d just like research but again, one person I don’t think can do it [all].

In her situation, in order to achieve tenure she did have to be involved in research but she shared how the department assisted her in meeting the research requirements for tenure while devoting more time to the teaching components of the faculty role.

[My faculty colleagues said], “We know that to get tenure here at this university that you have to do research. We will make sure that your name is on some articles, and that you will assist some of our faculty who do nothing but research. We will get you through that whole process. We will mentor you and make sure you get through that process because for us, your practitioner skills are more important. And you’re going to help collect data and participate in the research area.” I mean that was perfect to me.

The other two faculty participants had written articles for juried journals. One viewed writing as a way to grow and “I’m thinking about doing something with my dissertation, an article or a book, I’m not sure. So you can grow in that direction.” The second participant was a journal editor and had both written and edited journal

manuscripts which she does outside of her assigned workload. She expressed a love for scholarly activities but noted that in her current position “the scholarly productivity and the service is a part of your review but time is not given to you in your workload to include [research]. She had a positive experience with a project supported by National Institute of Health (NIH) funding.

I have enjoyed the scholarly part of it. I love to write; I love to look things up. I have loved that part of my life. I have done a lot of wonderful things. I did a post doc[toral study]...[and] I've had NIH funding. I've done things that in my wildest dreams I would have never thought I would have done. I have two patents. I have done great things and at so many levels. It's been terrific.

In summary, the expectation for faculty to conduct research and participate in other scholarly activities such as writing for publication was found in those institutions with baccalaureate and master's degree programs. Often the workload made it difficult for the faculty to have the time needed for scholarly activities. None of the faculty teaching in associate degree programs indicated that research and scholarly activities was an expectation of the faculty position.

Positives of Faculty Role

Faculty participants identified positive aspects of the faculty role which contributed to their satisfaction with the role and explained why they stayed in the faculty position. First, they valued relationships with students including both what the faculty member was able to give to the student but also what the faculty member gained in return. Second, faculty valued the relationships they had with their colleagues. Finally, faculty appreciated the flexibility of schedule so that they could meet personal

obligations.

Relationship with Students. Strikingly, the number one positive aspect of teaching shared by all of the faculty participants was the relationships with the students, the experience of seeing the students mature as they become nurses, and the excitement when students finally understand a concept. This relationship with the students and giving birth to a new nurse was clearly the main reason these faculty members loved teaching and why they stayed in teaching. One faculty described the joy of seeing the students achieve their goals to become nurses.

Seeing them achieve their goals is something that has always made me happy.

Seeing them after they graduate and they come up to you and say, “Thank you so much. If it wasn’t for you I wouldn’t have stuck nursing out.” or “You were a really good mentor and you were a really good educator and I really appreciate that. You might have been hard on me, but you knew I needed to have that.”

Another participant found excitement in seeing students grow over the years that they are in the nursing program. She was able to experience this with students both on the undergraduate level and with those students returning for graduate degrees.

I know that at the undergraduate level, it was kind of neat to see them grow from a high school graduate and then all of a sudden two or four years later, become a registered nurse where they had a responsibility, they were taking the responsibilities, they were stepping up to the plate....It was fun in doing that growing up thing with them. And at the graduate level, I just really like sharing my stories and helping them open up new worlds for them to go into and take off and just see what they can do.

One faculty participant experienced a different kind of enthusiasm when working with students who were already registered nurses (RNs) and were returning to school for a baccalaureate degree. These students were able to build on what they already knew and loved about being a nurse.

I do enjoy the RNs because they are very eager to learn. They're coming back for their degree and they are just a very enjoyable group. I like hearing their various experiences and encouraging them to share their experiences with the rest of the people in the class and they enjoy that.

The work with students gave another faculty participant a feeling that she contributed to the future of the students and helped them to grow. She maintained contact with the students after graduation and continued to be a part of their lives.

It's fun to see people grow. It's fun to make your profession come alive in someone else's eyes. It's great to get emails and they update you and tell you what they are doing and how happy they are. And when people come back and visit and send you pictures of their baby or their marriage pictures. And I think feeling part of a legacy is really an incredible feeling and there's probably nothing better in the world. It's almost [like] you feel like you have had a part in their life and for me that has been phenomenal.

Often students struggle to grasp a concept. When a faculty member assists a student in understanding that concept, this becomes a great accomplishment. In some instances the faculty members guide students to collaborate with each other in order to learn a concept. One of the faculty participants remembered one such experience when teaching in the clinical setting.

I had a student last semester, who was brand new out of high school, and she has some home-life problems. First person ever to go to college in her family and I really reamed her over her notes. Her documentation in the clinical setting last semester was horrible. I had her in tears. I rallied the entire clinical group around her and said, "Somebody is going to have to help me out of this. Group, teach this child how to write these notes because I'm not connecting with her." Well the group took hold of her and said, "Ok we are going to do this." I said, "Pick people that are good at writing notes. This student is good and this student is good. And see what they know, copy their style, not copy their notes but copy their style." And she came to me this semester and said, "Thank you. I am doing wonderful." And every instructor here will tell you that this child has risen to the occasion and she is one of the better nurses coming from this program this year.

Finally, two faculty participants felt great reward when they saw the students have what they called a "light-bulb experience." The first participant shared this experience as follows:

You have to love...[teaching] and there is such reward when you see that light bulb go on in a kid's head or you've brought that mom off of welfare and now she has a career and she can actually take care of her family. That has to be why you stay. It's not monetarily the reason. Lord knows teaching in West Virginia you don't get monetary pay.

The other participant described similar experiences and also the gratifying feeling of seeing the students graduate.

The rewards in nursing are far and few between. You have to find your rewards.

It's the same in education. But the students...watching them have their light-bulb moments as I call it....There's no amount of money that would replace that and watching them fall in love or deeper love with the profession than they had [been] when they came in with their ideological, perfect little nursing world that they have seen on TV and watching them grow into real nurses. That's what it's all about. It's incredible...It's [like] giving birth to nurses....But it's just you watch them and when they walk that stage at pinning and that's why pinning is still so important. It's just watching them come up as a student and they leave as a nurse and you have watched and you can envision them as nurses.

For all of the faculty participants, the major factor of why they loved teaching and why they stayed in nursing despite lower salaries was the relationship they had with the students and the joy they experience in seeing the students grow and join the nursing profession.

Relationships with Colleagues. Four out of eight of the faculty participants considered the relationships they had with their colleagues as a positive aspect of the faculty position. One of the participants shared that colleagues had become long time friends. "I have also enjoyed my interaction with my colleagues. I have really enjoyed that. I feel I have made some very good friends along the way, people who have sort of been my friends forever." Another participant compared the peer relationships she had experienced in the hospital setting with the relationship with faculty peers.

On the floor [at the hospital] there are 40 or 50 nurses and you work with two or three of the same [people] but you are going to have a rotation with everybody. But here [in teaching] you have the same [group of faculty] day in and day out,

nine months a year. You are with [the] same five people and anything you want to do, all five of you have to work together as a clump... Nobody can run off and be a renegade. You have to take everybody with you if you are going to be a renegade and you have to convince them and you do work together. Its problem solving and it's nursing at its best really.

Supportive peer relationships can develop within nursing faculty but also can develop with professionals in other areas of the institution. One faculty spoke about the relationship she had with a campus counselor:

I like the people I work with and I like my job. One of the things that I value about this place [is that] I have a real good relationship with the campus counselor who is also a nurse and a counselor and I do a lot of crisis counseling [for the students]. It's just because I'm a psych nurse. When they go into psych...it ends up opening up pain in their own lives and we end up having to facilitate and help them through crisis. I never do more than crisis work with them....I often end up patching them up and sending them on to the mental health center or the campus counselor. That is real fulfilling.

In addition, having diversity within the faculty can help in bringing new ideas needed to make changes needed to improve programs. During the process of change disagreements may arise but one faculty participant described how a supportive and diverse faculty group can agree to disagree in order to support change.

The diversity of the faculty is a plus. And we can disagree and we can scream at one another and the disagreements are over little stuff...that we don't think that this should be a policy or this should be a policy. And then after it's all over with,

we [say]... “So where are we going for lunch?”...And if you don’t have a faculty that can do that, and get through the change then you are going to suffocate; you are going to become stagnant because the medical field changes every day....So I think diversity as well as being able to agree to disagree really helps you get through change.

The faculty participants viewed the relationships they built with peers as a positive. They were able to build long-term friendships, close working relationships, and make changes because of diversity within the faculty group.

Flexibility. For all of the faculty participants, the second positive aspect of the faculty position was the flexibility of the schedule and how it fit with the demands they had in their personal lives. Four of them specifically referred to having the summers off. One faculty participant was able to adjust her schedule so that she could have time with her family.

Time with my family is very important and knowing that I have a flexible schedule and that’s something that people don’t realize and they think that when you come to work at an institution that you’re going to be there from morning to night...thinking that you have to teach classes from daylight to dark. They don’t realize that you can have a set schedule and each semester is different, you know, so I think if we would just educate the public a lot more, I think that would help.

The schedule in teaching was viewed by one faculty as better than working in the hospital. “The schedule [in teaching looks] good, especially if you are coming from a hospital where you’ve work every holiday, you’ve work every weekend, you’ve worked night shift.” Another faculty saw the flexibility she had with teaching as a draw for

others to come into teaching. “Flexibility of hours, I think that is a big draw and you know it is conducive with families [and] that ought to be our focus so we could be getting younger, energetic faculty in here.”

Negatives of Faculty Role

Low Salaries. All of the faculty participants indicated that relatively low salaries for nursing faculty were a concern. They all loved teaching and stayed despite the low salaries. One participant coped with the low salary by holding a second job in addition to the faculty position.

You take a humongous pay cut when you become a nursing educator and most of us, especially those that have worked here, when we first started, going back 17 years ago, you would leave what was then considered a 30 plus thousand-dollar job to a 16 to 18 thousand-dollar job. And everybody kept telling you, “But do the math.” ...Most of us had to work two jobs, just to be able to make the bills.

Another participant observed faculty receiving support while they completed a master’s degree and then leaving within a year. She attributed this constant turnover to the low pay and what the newer generations of faculty saw as important. In her view, the newer generation was looking for the pay; in contrast she was willing to take the lower pay in order to have more time with family including summers off.

It’s always those people who come and stay and they’ll get their Masters or they’ll finish up their Masters that they have already started. And then they’ll stay here for maybe six months to a year and then they leave...I feel like, well, we’re just educating them and biting our nose off to spite our face, because we’re paying for their education and then they leave us and then we have to start all over

again...It comes right back to that nice money thing. They don't, and I guess it's because [of] the difference in generations maybe. They don't see that...in the basic operation we're here eight or nine months a year and then we have the rest of the time off and they don't see that....The older I get, the more I want to be with my family. That is more precious to me than anything. Money is nice, it pays the bills, and that's all I'm worried about but I think if they had a better pay, that you would see a lot more people stay.

Being a profession made up of primarily females, some of the participants were able to tolerate the lower pay because they had support of a husband. One participant expressed it this way, "If you have a male that is trying to support a family. Well, you know it is really hard to do on my salary."

Doctorate Degree. Another major negative issue had to do with whether everyone needed to have a doctorate in order to teach. Of the faculty group, four had a master's degree as their highest degree and two of these questioned whether there needs to be a push for all faculty to complete a doctoral degree.

I think that having a doctorate would be wonderful. You know I only have my master's. I also think it's not always the answer. I have seen people with doctorates who were off the wall, wrong with their information, to me the wrong attitude towards students. And I liked to think that my masters and lots of experience is very valuable too....A lot of folks with master's and a lot of experience do very well in bachelor education [and] maybe in some situation graduate education. I don't know. Meaning, do you have to have a Ph.D. or Ed. D. to be able to teach at the graduate level? I don't know. I have taught some

master's. Well let's put it this way; I have guest lecturer in the masters' courses in nursing and in counseling and students seem to have received me well. Maybe always having to have a doctorate isn't necessary.

Another participant questioned whether faculty with a doctorate would be the best individuals to be teaching the basic nursing skills for the beginning students. "Those that have [a] doctorate have other focuses than clinical settings. Are these the nurses who should be teaching how to insert a Foley [catheter] and give a bed bath?"

For one participant, another problem was having the time to go for a doctoral degree while meeting family commitments.

It would have been helpful had there been support with time to be able to go on for my doctorate....I got started late in life having children. I just wasn't willing to make the sacrifices that I would have had to make to go on for my doctorate.

Had the school been able to release me a little bit for time so that I could still have family things happening and so forth then I probably would have done it.

In summary, when the faculty participants were asked to describe the faculty positions they first expounded upon the teaching role and made connections between classroom teaching and clinical experiences, both of which they view as means of assisting students in their journey to becoming nurses. They expressed a passion for nursing and a strong desire to promote the nursing profession by teaching students. These faculty developed positive relationships with students and their colleagues. When they provided service to the university and in the community, they often provided services that related to their status as a nurse such as health education in the community and student health services. Those with doctorate degrees and employed in larger universities

conducted research but some found it hard to balance the demands of research with teaching responsibilities. The faculty participants identified low faculty salaries and the pressure to have a doctorate degree in order to teach as negative aspects of being in a faculty position.

Faculty Role as Perceived by Nurses in Service

The second research question asked how nurses with a master's degree in nursing perceive the position of a nursing faculty. Five out of eight of the participants in the service group had interacted with nursing students in the clinical setting as a preceptor or as part-time faculty for a group of students. As preceptors, they mentored one student at a time in clinical settings. Three of the service participants had taught in the classroom either as a guest lecturer or as the instructor for one course. None of the participants in the service group had worked full-time as faculty. The service group participants described the faculty role mainly in relation to the teaching component of that position. Their perceptions were based on what they had experienced when they were students themselves and what they experienced while teaching on a part-time basis. Similar to the faculty groups, the first and major component of the faculty role was that of teaching both in the classroom and in the clinical settings. Those who had taught students in the hospital or clinic setting enjoyed working with the students, seeing them learn, and experiencing the students' energy. As with the faculty group, a theme that emerged from the description of teaching was helping the student develop the professional nursing role. The service participants provided very little description of the service and research aspects of the faculty position.

Teaching Component

Role Model. All participants in the service group had exposure to the faculty role when they were students. Two participants described the impact former faculty had on them. Faculty participants may have had similar experiences but did not describe any during the interviews. The first service participant spoke about her experience during her graduate program, describing how individual faculty members were role models for the students and set high expectations.

The faculty there was a very young faculty and very driven. They were in a pilot program that they were trying to make sure...was a success so they were very much workaholics. But they were also great examples and they had a great knowledge base and they were able to communicate that I guess and be good role models to us. And you could see that when we went into clinical settings there was no doubt they knew exactly what they were doing; they were sharp on their skills. You respected them because you could see that. And so you listened and you wanted to please them more too because the expectations were high and they knew what they were doing and so you knew that they knew what they were doing and you listened and paid attention and tried to do that.

Another service participant remembered how much she admired the faculty member she had as a student and thus saw this faculty as a role model.

I have faculty members that I still admire and would put up there as some of the best nurses that I have ever met. I remember one of my faculty members...I ran into her about five years ago and it was like we had just talked to each other the week before. And I just remember her just encouraging me, encouraging me that

you can do this...and that type of [student-faculty] relationships I think are very strong.

Thus these two service participants saw role modeling of nursing *and* teaching as a part of the teaching component of the faculty role. Similarly, being a role model for students was described by participants in the faculty group.

Clinical teaching. All of the service participants recognized teaching students in a clinical setting as a component of the faculty teaching role. One service participant previously taught part-time in another state and described the perfect balance of teaching role and clinical role when she taught students in the hospital. She did not continue teaching when she relocated to West Virginia.

When I was there it was a great situation for me because I taught with a group. The course we taught was medical surgical nursing...[I] taught with three other people and we all really clicked. You know what that's like...I did my clinicals in the hospital where I also worked...in the ICU there. And the people in the hospital there would let me go anywhere with my students, anywhere I wanted to go. If we were on a unit and there wasn't a whole lot going on, we could go to the ICU and do dressing changes, and suction people and do trach care, and maybe learn about aortic balloon pump and draw blood and everything else. It was so great. And the kids got such great experience from it...I liked being a part-time person in that I didn't have all those responsibilities the other instructors had and I basically just had my clinical group and I did my clinicals with them and I graded their papers and I think I had some lab things to do for school. I had to monitor some tests at school. I don't even remember what all now...but I didn't have all

the responsibility of a full-time faculty had. That was kind of a free feeling. Then my other job was that I worked for the hospital.

Another service participant was an adjunct and taught students in the clinical setting and thus was able to combine teaching and practice but would not want to teach full-time because of her love for interaction with patients.

I know I would love to teach but I don't want to give up the patient contact either so I want to be able to do it in a combo. So working as adjunct works well for me right now. Because I love teaching the students; I really get enjoyment out of it; I love being a preceptor when they come to the office with me. I really like that too but I just can't do it full-time right now.

Classroom Teaching. Similar to the faculty group, participants in the service group described classroom teaching as another component of the faculty role. Four service participants had experience in the classroom, one during graduate school, one as a guest lecturer, and two who had taught a class for one semester. Two of them discovered that they did not like public speaking and thus did not want to teach. The other two enjoyed being a guest lecturer and teaching for one semester.

One service participant had a positive experience developing and teaching one class but then she moved too far away to continue teaching. She especially appreciated the professional autonomy that is sometimes part of the educator role.

I did a quarter of teaching at the community college and I taught a gerontology pharmacology class that I got to develop and it was so much fun. It was a great class....But the class itself, teaching them, like I said, because these weren't going to be nurses but they were going to be like I think the concept of maybe people

like that would work in a senior center. So I taught them enough to know what questions to ask and the things to look for and how to work with their clients and you know part of it was just to get to develop it from the get go.

Another participant had teaching experience as part of her graduate study and learned she liked working with the students in the clinic but did not like planning and delivering classroom lectures. When working with students on a one-on-basis, she not only was able to help the students but she was challenged to continue learning herself.

I honestly went into the nurse practitioner program intending to teach....I changed my mind because I found out I really didn't like getting lesson plans together. I wasn't really crazy about getting up in front of a group of people and talking. I really liked the student interaction and the clinical part of it....We learned a lot about curriculum development and we did a little bit of teaching in the undergraduate and we did a little bit of teaching in the classroom, and we did some of the clinical preceptor which I really liked. I really liked being clinical preceptor and I like doing that now....Actually I learn a lot from the students. And it makes me think more about why I do what I do and it makes me base more of my practice on research instead of on gut feeling or habits. It makes me think about my practice a little more.

In contrast to the positive experiences in teaching in the clinical setting, two of the service participants had lectured but did not like the public speaking and thus had a negative view of teaching. The only male participant was especially reluctant to teach again. He described a couple of teaching experiences in which he felt a teaching role was not for him. The first experience was teaching a pathophysiology course and he had no

professional autonomy because he had to follow content outline that was already developed.

It was three hour block once a week. The material I had absolutely nothing to do with, the material or the content. I was given a box the first day with all of the lectures and tests and I was more of a facilitator and grader than anything. I won't necessarily consider myself an educator other than presenting the lectures that were given to me.... I thought that I maybe should have more input in the lectures and developing the tests and that sort of thing. But I just went with what was given to me and sometimes the lectures were rather dry. And the students could tell that it wasn't my material because it was rather monotone so when I would draw on points of experience from my past I would kind of get away from the plan and I would have to go back and get caught up with the actual power point slides.

The other experience was teaching at the hospital.

I think some people have an inclination to be either hands-on or direct with patients or they have more of an administrative type or teaching role that's kind of hands-off from patients and that's where it comes from, whatever their preference is prior to choosing a role.... I just spent several years in ICU and everything I did was hands-on and I would teach like an ACLS class or a CPR or something and I always kind of felt like a fish out of water...I mean I really never did like it.

Thus the service participants had both positive and negative experiences in teaching in the classroom and developing lectures. One had enjoyed developing the lectures and teaching the students what was important in practice. The others had not

liked the public speaking, the time it took to develop the lesson plans, and the lack of professional autonomy.

Developing the Professional Role. When the service participants were asked to describe the faculty role they focused on their experiences with students in a clinical setting or in the classroom. Similar to the participants in the faculty group, participants in the service group found reward in assisting others to learn and seeing the students' excitement when interacting with students one-on-one as a preceptor or a full-time faculty member. One of the service participants, who had been a part-time clinical faculty in the past, described this excitement in the following way:

They [students] change so much from the first. This is really their first hospital clinical and getting into the nursing role....They are scared to death coming in. And toward the end they get so much more familiar with their surroundings and they just gain that confidence. What's great to think about is the energy that psyched me up and gave me a lot of energy...It was a lot of fun and cool watching them learn stuff.

Another service participant had experience as a preceptor for graduate students in a clinical setting. The students were studying to become nurse practitioners. She recalled one student who came to the experience thinking she wanted to become an educator but became excited about the nurse practitioner role.

I had a positive experience last year when a graduate student that was in the education tract—and she was a psych nurse and was positive that she just wanted to be an educator and nothing else...came to me for health assessment....She was older, probably in her 40's but she had a great patient rapport....So she was able

to go in within a day and start interviewing these patients, talking to them about their problems, and she wasn't even in the nurse practitioner program. She was asking how to treat them and diagnosis them and this and that and the other and she fell in love with...[the practitioner role]. So you know I really had a lot of enjoyment precepting that student.

Similarly, another service participant worked with students one-on-one in her office as the students were studying to become nurse practitioners. She experienced the reward of making a difference with the students.

It's always fun to see that light bulb go on [with]someone else and to know that you helped give them information that made their practice a little bit better or [enhanced their] understanding of something....I guess it's a connection you make to know that you are communicating something of benefit that really makes a difference in changing or helping that learner.

In addition to helping the students learn, two service participants described how they learned from the students and were energized by the students. One stated:

Actually I learn a lot from the students. And it makes me think more about why I do what I do and it makes me base more of my practice on research instead of on gut feeling or habits. It makes me think about my practice a little more.

Similarly, the other service participant found that working with students helped her to continue her own learning and keep her knowledge up to date.

I think the other thing for me personally that's positive [about being a preceptor] is whenever I have to give instruction to someone and teach them something it just reinforces to me, my weak areas of where I need to get better on, or things

that I need to bone-up on. Or it really makes me have a better understanding of what the components of whatever it is that I'm teaching....It's helping me to stay current but it is also when you teach somebody something [that is] your weaknesses...it makes you bone-up on something and makes you sure that you are the most current on it and you are the expert on that little piece of information so that you are passing along things correctly.

So participants from both the faculty and the service groups experienced satisfaction from interaction with students and assisting others to learn and grow as they became nurses or continued their education at the graduate level. Those in both groups found it rewarding to experience the birth of a nurse and to see the light bulb go on when the student grasped a concept. In addition, the participants in the service group found they were challenged and grew themselves as a result of interactions with the students.

Service and Scholarly Components

The service participants did not emphasize other roles and responsibilities of nursing faculty such as research and service. One service participant saw research as "opportunities to [increase] your own self knowledge, to continue to grow yourself in terms of...time to get involved in research or publication....I enjoy writing and so doing a research study and using that experience--I would enjoy that." Another faculty role component mentioned was committee work. "They [faculty] have to serve on committees and they have to review the curriculum and I know there is a lot of politics that are involved that I don't know a whole lot about."

Comparison in Perceptions of Faculty Role

The third research question addresses the differences and similarities between the perceptions of the nursing faculty role held by the two groups of nurses. Both groups of participants discussed teaching as the major component of the faculty role. Within the teaching component they both described experiences in the classroom as well as in various clinical settings. They viewed faculty as role models for the students and emphasized their goal of helping the students develop into a professional nurses. One difference was that some of the service participants also described how as students themselves they were influenced by the faculty who had taught them. Both groups described positive experiences with students and enjoying seeing the students grow and develop into nurses.

The service participants had very little to say in regards to the service and scholarly components of the faculty position. Only one participant talked about the committees that faculty serve on and another talked about the research in which faculty are involved in. This may be because they had very little exposure to these aspects of the faculty role.

Another difference between the groups' perceptions was the faculty participants' positive view of working with their faculty colleagues and their belief that the faculty position provided a more flexible and varied schedule than would have been possible in other nursing positions. Faculty participants viewed support of their colleagues and their relationships with them as a very positive aspect of their faculty position. Both groups had sought a more flexible schedule than that found in the hospital so as to better match with family and personal demands but they differed in which positions they selected to

obtain a flexible schedule.

CHAPTER SIX: FACULTY SHORTAGE

This chapter addresses the final research question which directly addresses the issue of the nursing faculty shortage. What do the nurses in nursing faculty positions and those nurses with at least a master's degree but in service positions see as causes for and solutions to the growing nursing faculty shortage? Causes identified emerged into four themes: financial issues including salary and educational costs, lack of nurses with higher education, lack of nurses with training in teaching, and other career opportunities. Solutions recommended emerged into six themes: included higher salaries and financial support for education, promoting a positive image of nursing faculty, support for doctoral education, utilization of nurses with masters' degrees, mentoring new faculty, and networking with nurses in service positions.

Perceived Cause of Faculty Shortage

In order to address the first part of the question, participants of both groups were asked what they saw as causes for the growing nursing faculty shortage. Both groups identified financial issues, lack of nurses with higher education, lack of nurses with training in teaching, and other career options.

Financial Issues

Salary. Participants from both groups identified low faculty pay as contributing to the nursing faculty shortage. All faculty participants shared that nurses make more working in service than they would if they decided to go into nursing education. One faculty participant was very descriptive in discussing the difference in salaries between faculty and service positions.

Why would an expert nurse want to go into nursing education with a \$20,000 to \$40,000 even \$60,000 pay cut when they could go into nurse practitioner, nurse anesthesia, [or] sales. There are so many more advanced roles today than just education. It's not very appealing. I'm sorry it's financial and the generations we have coming up I'm afraid are not going to like it either. And we empowered these nurses to think for themselves. This is what we are. And then to think for yourself, to look out for yourself, do the best, it's your profession, it's your career. "By the way, come back [into nursing education], take a \$15,000 pay cut from working just three days a week on the floor that you are working and come work with us [teaching] six days a week."

Similarly all of the service participants identified the difference in pay between faculty and service positions. But in contrast to those in the faculty group, they would not be willing to take the pay cut in order to become a faculty member full-time. One service participant stated, "I think about...[if I] started out as an educator role and learned to deal with the salary it would be different but... it is hard to come down. It's hard to be a certain level [of pay] and come down especially when you have children." These comments suggest that if someone becomes accustomed to a certain level of pay, it is hard to accept a large drop in pay as a part of changing roles or positions such as moving to a faculty position. One faculty participant had moved from a service position to a faculty position when the pay for faculty was very similar to salaries in the hospital and thus she did not experience a drop in salary. But today, with the large difference in pay between faculty and service positions, the decision to take a faculty position is much harder especially for those who start their careers in service positions.

In addition, one faculty participant who had been in her current position for ten years had seen new faculty going to other institutions and making more than she was making as an experienced faculty.

It makes me think of leaving one institution and going to another...when one of my students who graduates, leaves and goes to another institution in another town and makes the same salary as I'm making and in fact, making a few thousand dollars more than what I'm making as a brand new teachers...I've been at this for 20 some years, and you could only take this as you're not worth it...and then you sometimes get above it and say, "I don't care whether you think I'm worth it or not, I feel I'm worth it and just go on and do it."...So, I think that's one negative and I think that you go into a career because you love it but you know love is important and love is what gets you through it. But as human beings we need to have some sense of other people thinking we are worth it and unfortunately, I think in this day and age, money is an important way [to show worth].

Another faculty participant mentioned that faculty salaries were higher in other states. "You can go to Pennsylvania and make \$30-40,000 more than what I'm making right now for the same rank." The difference in salaries in other states was also noted by one of the service participants. "[In] West Virginia that's been the issue too why we have so many staff nurses leaving the state. We're surrounded by several different states which are paying higher levels of money and we are losing. We're losing and until we compete with those states that surround us, we're going to continue to lose." According to the May 2008 Occupational Employment and Wage Estimates by United States Office of Occupational Employment Statistics (OES), the national mean annual wage for nursing

instructors and teachers in postsecondary institutions is \$62,660 as compared to West Virginia which is \$51,370. Based on the data from OES, the mean annual wages for the surrounding states of Maryland, Pennsylvania, Virginia, Kentucky, and Ohio is \$66,568. Thus in West Virginia not only is there a big difference between salaries for nursing faculty and nurses in service positions but there is a big difference between salaries for nursing faculty in surrounding states. With these differences, why would nurses move into nursing faculty positions in West Virginia?

Educational Costs. Added to the difference in pay was the cost of having to go back to school. Many would expect a higher salary after obtaining further education and a higher degree. One service participant gave this example. “When I think about the pay, you need to go back to school to do something different. You know, became a CRNA [Certified Registered Nurse Anesthetist] and make \$200,000 a year or get a doctorate and make I don’t know [what as faculty].” Another service participant stated, “Probably most nurses don’t want to go on for further schooling that it takes [to teach] and I can make so much more money clinically for the same hours.” With the further education come more student loans as clearly stated by this service participant: “But when you are looking at I have \$48,000 in student loans right now to pay from my previous education. Adding to that [for more education] and then looking at getting a lower salary. It is really hard to justify.” The issue of student loans was also identified by a faculty participant.

I just think there are so many options for people now and so much is market driven we’re not really competitive for people to be really interested [in teaching]. And you have to work hard to get the advanced degrees you need so that’s certainly both a financial and a time commitment on people’s part. And at the end

of that you have to really want to do this to make \$40,000 for the rest of your life. You have to be really committed to do that and I think this generation...has a little different approach....I mean, people want to get paid what they are worth....It's really important to them how much they make. And a lot of our students have significant student loan debt....I'm pretty sure making \$40,000 for the rest of their lives and never getting a raise is not really appealing to the current crop of young people.

Financial issues including initial faculty salaries, student loans, and salaries found in surrounding states were identified by both faculty and service participants. In addition, for those with family financial obligations discussed in chapter four, the participants in both groups had to determine if the faculty salary would meet these obligations. Faculty participants recognized the difference between faculty salaries and those they could get in service positions but still chose to stay in a faculty position. In contrast, those in service positions saw the difference in pay as a deterrent and would not consider moving to a full-time faculty position at this time.

Lack of Higher Education

In order to teach full-time in a university setting often a doctorate degree or having plans to obtain a doctorate degree are required. One of the participants in the service group explained that if she did not pursue a doctorate degree she would not be able to teach full-time.

I had to begin work on my doctorate and I had to have it within seven years or I would lose my job. I would not only have not obtained tenure but would lose my job. And I really wasn't interested in pursuing my doctorate and I am still not.

When teaching in an associate degree program, faculty members may be able have a master's degree in nursing as their highest degree. Three of the faculty participants noted they have found it hard to find applicants with the needed degree when they have tried to fill faculty positions. One stated, "We even had some difficulty finding people with masters' when we were doing our job search."

Lack of Encouragement. One faculty participant noted that in West Virginia hospitals, more nurses had associate degrees than baccalaureate degrees and there was little incentive to get more education.

When I moved back to Charleston ten years ago there was no one, I didn't see anybody higher than a bachelors' degree and then only a few...four had bachelors' degrees. There was absolutely no motivation [to get a higher degree]. Now nobody discouraged me, I didn't get any of the cutting me down for going for my masters' degree but there was no motivation.

One of the service participants also observed that in her area of West Virginia most nurses did not even have a baccalaureate degree and more education was not valued by her peers.

A lot of nurses around here are either diploma prepared or [have an] associate degree....Administration in different places do not push education....And sometimes I feel like a lot more women would go back if even a peer just a peer [encouraged them]....When I went back and got my master's degree not one person supported me....They were all like, "What do you want to do that for? You will never make more money; nobody is going to hire you."

Lack of Access. Participants from both groups found lack of access to doctoral

programs to be an obstacle to further education. Until recently, there were no doctorate programs in nursing in West Virginia. Therefore, one had to travel out of state for a doctorate in nursing. One faculty participant shared the following observation:

I think also at the university level they want a terminal degree, so that means you won't stop at a master's, you've got to go on and get a doctoral degree. And here in this state, that's very hard to come by...I had to leave the state to get my doctorate degree...but it was not easy to get a doctoral or terminal degree in nursing, here in this state. And I know that's why a lot of the faculty left this university. They went to other teaching institutions that did not require a doctoral degree because they did not want to go back to school. And some were saying that doesn't make me a better teacher to get a doctoral degree. So I think the main thing is having to go back to school to get a terminal degree and then also salary, that's probably the two biggest things.

Difficulty of Doctoral Study. Five out of the eight service participants specifically stated they would not be willing to go on for a doctoral degree. One reason was the perceived difficulty of the doctoral study as described by one participant: "Part of my deterrent... I really just didn't want to go back to school. I didn't want to go through more of that...I have sat out for a long time, it would be awfully hard to go back." Another service participant described the fear of returning to school.

I am scared to death of getting that DNP. I am scared to death of having to do statistics again. I'm scared to death of the papers because it's been so long since I have had to do anything and gee can I do it again and I know that is what deters a lot of them. It's do I want to go through all of that work again and can I do and oh

I feel too dumb to do that.

Another participant expressed concerns about being able to complete a doctorate if she started.

I know for myself, I loved taking classes and even going through my masters, I could have continued taking classes but when it came down to that final push or that final project and getting all of those I's dotted and T's crossed that was [what] seemed like a royal pain in the butt. And I mean, I probably would not mind taking classes toward a doctorate but would I actually ever get it [finished]? I don't know.

Another difficulty in entering a doctoral program identified was the time involved to go back to school and continue to work. For example, one service participant stated, "I would have had to teach full-time and I would have had to have worked at least 16 hours a week as a nurse practitioner plus me getting my Ph.D. all at the same time. And I just thought that there were just not enough hours."

Lack of Timely Career Knowledge. Finally, one service participant did not know early in her career that a doctorate degree would be required in order to teach full-time and now at this point in her career would not consider going back to school.

The idea of getting a doctorate really never came into my head at all until after I had already finished my masters' degree and it was only really then that I realized that I really couldn't teach full time at an institution of higher learning without getting my doctorate.

Thus service participants saw obtaining a doctoral degree as a deterrent to teaching full-time. These nurses who had gone on for advanced education at the master's

degree level were not interested in continuing for a doctoral degree and thus limited their opportunities to teach full-time. One participant summarized that the nursing faculty shortage is because “it mandates a higher degree. And I don’t want to go back to school if it is required before you even get there...or [they] can’t afford the degree, or they don’t have the time to go back [to school].” In contrast, those participants in the faculty group had either found positions that did not require the doctorate degree or had found the support/resources needed to complete the additional education.

Lack of Training in Teaching

Even if someone had the needed advanced degree, they may not have had training in teaching methods or experience teaching. They became overwhelmed when they started teaching and lacked self-confidence. Three of the faculty participants found great value in having training in nursing education as part of their masters’ degrees. One faculty participant clearly described the difference in the preparation she received during her master’s program in nursing education as compared to many nurses who graduate from other types of masters’ programs.

I came into this thing knowing learning styles, and looking at adult education versus kids coming right out of high school. I didn’t learn on the job how to write objectives and distracters and all of those things. I was taught that. I think that people who have masters’ degrees as nurse practitioner or a clinical specialist...are trying to play catch-up for the first couple of years [teaching]. I don’t think it takes you forever to learn it but I think they were playing catch-up.

Another faculty participant had similar experiences with new faculty. She took courses in nursing education as part of her master’s degree to become a clinical specialist

but found that new faculty—especially nurse practitioners—do not have the same training.

Ads are for nurse practitioners but then you may have a practitioner that has no education background in test development and areas like that... They had no formal mentoring to assist them... But what happens is sometimes you take someone under your wings and guide them along a little bit, but it's not formal. Similarly, a third faculty participant had taken educational classes and found what she learned from these classes to be very valuable in her faculty position. She thought that even nurses studying to become nurse practitioners might benefit from taking some education courses since practitioners often are preceptors for nursing students or are asked to teach part-time.

I just know my teaching classes were so valuable to me and you learn so much from those and anyone who is going to be a practitioner if they are thinking of education, I really encourage them... [to] go through the education track and get that experience... Or after you get your practitioner's come back and get your post-masters certificate in education.

In addition, three of the service participants identified that lack of training in teaching and lack of confidence in their ability to teach. One stated, "Maybe some people have never thought they could fulfill that role... I mean maybe self esteem issues, they don't think they are smart enough or they would be able to educate." Another one who had not worked in the hospital setting for a while shared, "I feel like I probably do have a lot to offer but maybe... for me part of it's been a little bit of self confidence... partly because I haven't done a lot of clinical... in the hospital." The third participant would not

want to change to teaching because “I could teach a class but I wouldn’t have background, the educational background to do it.”

In summary, contributing to the nursing faculty shortage is the lack of qualified candidates. Finding nurses with advanced degrees including masters’ degrees and doctoral degrees is a challenge. Time, money, and concern about the effort need to complete a doctorate degree are all deterrents to nurses entering doctoral study. In addition, not all nurses with advanced degrees receive training in teaching and they lack confidence to teach or potentially have a more difficult transition to a faculty position.

Other Career Options

Both groups of participants identified increased career options as contributing to the nursing faculty shortage. Most often-identified careers were nurse anesthetist and nurse practitioner but others roles included nurse administrator, nurse midwife, and sales. One service participant considered several career paths before deciding to become a nurse practitioner.

Anesthesia school, I considered med school. I honestly went into the nurse practitioner program intending to teach. I changed my mind because I found out I really didn’t like getting lesson plans together. I wasn’t really crazy about getting up in front of a group of people and talking.

In summary, both participant groups identified financial issues as the number one cause of the nursing faculty shortage. The other causes for the shortage identified related to the lack of nurses with higher education degrees, lack of specific training in education, and competition with other career opportunities.

Potential Solutions to the Faculty Shortage

The second part of the final question asked participants in both groups for solutions to the growing nursing faculty shortage. In addition to improving higher education salaries and financial support for doctoral studies discussed previously, both groups suggested sharing positive images of the faculty role, assisting nurses through doctoral education, utilizing nurses with masters' degrees in teaching positions, mentoring new faculty, and networking between nurse faculty and nurses in service roles.

Positive Images

The most frequent suggestion for a solution to the nursing faculty shortage after improving faculty salaries was presenting a positive image of the nursing faculty role and sharing with students the positive aspects of being a faculty member. In the participants' views, more explicit, concerted effort needs to be made to communicate information about the nursing faculty role and a positive image of the role needs to be featured.

Mass Media. One faculty participant suggested in addition to commercials that institutions use to attract students, other commercials and word of mouth could be used to share a better image of nursing faculty so as to counter negative images. Key to participants' understanding of the nursing faculty position is the integration of nursing and teaching. As a nursing faculty, one remains very much a nurse first.

You hear a lot of people say those that can't work in the mainstream anymore will teach....Those that can't do nursing anymore just come and teach. To me a nurse has always been an educator and it matters not if you're in a hospital or if you're here. We've always been an educator and they don't realize that we actually take care of true patients.

When they find out that we [faculty] actually are in the hospital taking a true, live patient, they're amazed and then their attitude changes a little bit and I think it is left up to us. And I think that as we talk to people, and people ask us questions that we need to do that and that we need to let them know what it's like. I don't know a commercial, you know because a lot of colleges will have commercials trying to get students to come to their institution. If it's commercials or if it's just word of mouth...just by talking to people who are interested in applying [to teach].

Another example of using commercials was shared by a faculty participant who saw a commercial produced by Johnson and Johnson. When she heard it while at the dentist office, she found the image very positive and appreciated its depiction of the integration of nursing and teaching in the faculty role.

I was actually at the dentist yesterday and there was one of those Johnson and Johnson commercials and...I thought it talked about nurses but it was one about nurse educators on it....It said something about being thankful for all of the nurses we have but then it said, "but you need to know that for every nurse there was a nurse educator." It was really nice.

Another faculty participant saw a similar commercial by Johnson and Johnson and commented about the importance of being "proud of what we do....And you see on TV nurses being proud that they are nurses. Johnson and Johnson has that commercial....that I'm proud that I'm a nurse. We should be proud that we are educators and in nursing." In addition, a third faculty participant saw the Johnson and Johnson ads as very positive and said, "They have done a wonderful thing in promoting health care

and nurses and that type of stuff. I think media is going to speak volumes.” Besides the Johnson and Johnson commercials, one faculty participant had been on local television presenting health information and thus as a faculty member presented a positive image of nursing. “We have just done a health spot on the local TV and one of us talking about heart disease. I went on and talked about diabetes and modifying your carbs and you know being out there and being very visual.”

Daily Encounters. In addition to mass media depictions, the image of a nurse educator is shared everyday as instructors interact with students and early on provide students with information about the faculty role. One service participant thought that more information about the faculty role and the positive aspects of the role need to be shared with students during their basic nursing education program. One faculty participant remembered a former teacher and being inspired by what that teacher accomplished.

I do remember when I was an undergraduate loving one of my teachers, and thinking, “Gosh she’s the best,” you know, “I wish I could be like her.” I do remember that. Then later when I was first working, she was doing a fellowship at the hospital where I was working and [I] really admired her for doing that because she was married and had children and I was thinking how cool...that she was doing a fellowship even though she was married and has children....I think she was a wonderful role model because that was back in the 70’s. That was sort of the time when people weren’t doing that kind of thing. So I think she was a really good role model.

Similarly, one service participant remembered the encouragement she had received from

one of her instructors and that experience continued to be important to her.

I remember one of my faculty members...I was an ADN [associate degree] graduate first...I graduated in 83, I ran into her about five years ago and it was like we had just talked to each other the week before. And I just remember her just encouraging me, encouraging me that you can do this, you can do this and that type of relationships I think are very strong,

Further, the positive image needs to be presented every day as faculty members interact with students and others in the hospital. One faculty participant described how this image can be presented.

Every job, has it's pros and has it's cons...and I personally could go back to doing hands on, but I love doing what I'm doing right now [teaching] and I just think that we need to build that up a whole lot more than what we do...I always tell the students, 'learn by what you see and if you see somebody who you think is not helping you the way you think they should, remember that, and when you graduate and a student comes up and asks you a question or an instructor comes up and asks you a question, be more willing to assist them.' And I think if we would do that with the staff on the floor or whatever, it might be more enticing for them to come work [teaching].

Another example of how faculty can present either a positive or negative image of their role was discussed by another faculty participant. This description again shows the integration of teaching and nursing in a positive image.

I think when they see you enjoying teaching, and see you know, if you go in and say, "Well here I go again and oh I'm so busy; I'm so swamped" and have such a

negative attitude, who's going to want to do that? I think role modeling is the most important...[way] we teach anybody. And so, when you come in happy and say, "Oh yes, this was a problem, but we've solved this or that. I love teaching" and have enthusiasm and show that you love it,...that's going to...[rub] off on the students. You know when they see you as being a competent nurse in sticking that IV or helping that family whose patient or family member had just died or whatever, then they can feel that this is what nursing is all about and I want to be like this...So if you're enthusiastic and positive, I think that plays a big role. If you're just constantly negative, who wants to get into teaching when there's nothing but a negative.

Another way to present a positive image is by inviting nurses to shadow a faculty member and learn more about the nursing faculty role and consider the faculty role as a career option. One faculty participant thought if a potential faculty could observe positive experiences with students then they might consider teaching full-time.

Get them [potential faculty] here through role modeling I think. Letting them see us not so stressed about our pay....Possibly opening up some shadowing. Even if you are slightly interested in education come over for a couple of days. See the positives....We have all worked with nursing students if we work in a hospital. And we may have been lucky as floor nurses to have seen a light-bulb moment once and here it is as an educator you can see it almost weekly at different points. So let them experience that benefit [of working with students].

Public Encounters. Another identified arena in which to present a positive image were national professional nursing conferences because nurses from a variety of work

settings attend. One faculty participant described this potential in the following way:

I think we need to be maybe more visible. I don't know how you go about that. I don't have a lot of ideas other than attending national conferences and things like that. And I think that when we [faculty]...do workshops and we do poster presentations or we mingle, we need to make it attractive and we need to let people know about the benefits of teaching.

Working directly with high school students and discussing career choices is another avenue to present a positive image of nursing and teaching nursing. One service participant has worked a lot with young people and often has asked them what career they are interested in.

I deal with high school students a lot too, and dealing with them it's really interesting to me when I hear "Oh, I'm going to go to school to be a nurse." Then I say, "Why?" And some of them I can guess because I know them real well and a lot of them say "because I can get a job. There's a shortage out there and I can get a job in that area." And that is the first response, "because I can get a job." I guess that is an okay thing, I don't know. I just want to know that they are in it because they want to help someone and also because they need a job. But they also want to take care of someone so that they, so that when someone is in need of help they get that help because it is the right thing to do and not just because it's a job....Maybe I'll start asking this, people who say, "I want to be a teacher" and then I could say, "Have you ever thought about being a nursing teacher?"

Both service and faculty participants saw improving the image of the nursing educator as a solution to the nursing faculty shortage. In their view, an important part of

this image is the integration of the nursing and teaching roles. As faculty, one does not give up being a nurse but continues to be a nurse and role modeling what it means to be a nurse *and* a teacher. This could be accomplished with commercials, during interactions with students, and with other nurses.

Doctoral Education

Since one of the major barriers identified by the service participants was obtaining a doctoral degree, another solution to the nursing faculty shortage related to assistance with doctoral education or being able to use nurses with masters' degrees in faculty positions. Both faculty participants and service participants suggested supporting individuals returning to school for a master's degree or a doctoral degree even after they started teaching. At one institution if the faculty was hired with a bachelor's degree they had one year to start back to school for a master's degree but they had arrangements so that they could obtain tuition waivers for further education. Another way to support further education would be through assistance with student loans, forgiveness for student loans, or scholarships.

In addition to the financial issues, the availability of doctoral programs was an issue. One suggestion was online doctoral programs but a concern was attrition rate and the percentage of students actually completing a doctorate. One faculty participant identified the growing availability of online doctoral programs but noted that people who start the programs often do not complete the degrees.

I was talking to someone who was an online faculty...and he was saying that...research was showing that about 50% of people that started online programs did not finish them. And this was just last year he shared that. So

assuming that's accurate, having online doctorates completed in nursing might be helpful, but how many will actually do it I don't know.

She had also seen fellow faculty who had started a doctoral program and not completed the program. "I know three people who did just that, did all of the course work, got to the dissertation part and dropped it. So there must be some kind of barrier right there that stops people that I'm not familiar with."

Another suggestion was to encourage students at the undergraduate level and share with them the possibility of eventually teaching nursing. If they are interested in teaching, students need to know early in their careers about the need for further education and eventually a doctorate degree. As one of the service participants shared, when she started she knew she would need more education to eventually teach but did not know that it might mean a doctorate degree.

When I was in our original program [an associate degree] they talked about getting your bachelor's degree and how important that would be, so that was in our minds. I mean we were nineteen so that was in our minds to get the bachelor's degree you know. And then I knew I wanted to teach and I knew some day I want to get my master's degree.

Utilization of Nurses with Masters' Degrees

Besides supporting further education, another avenue would be considering ways individuals with masters' degrees can be hired in faculty positions. One faculty participant suggested having two different faculty-type positions or tracks.

I think maybe having tracks where they do not have to have a doctorate degree,

because... a big part of it is very clinical and technical... I am all for a terminal degree. I think experience that you get from that makes you a better, well-rounded person [but] it's just, you know, you don't realize it until it's over with. So I just encourage everybody to get that degree. But I also believe that we need good clinical faculty and once you go on and get a terminal degree a lot of times, your other worlds open to you, which is fine. But I just think maybe having a track where you just focus on the clinical areas. You can still participate in research or do whatever and go on and get your degree if you want. But maybe not requiring a terminal degree from [all] faculty might be one [idea].

Another suggestion was to utilize nurse practitioners and others with masters' degrees as preceptors for mentoring students one-on-one in clinical settings or for those with masters' degrees to fill part-time or joint positions. For example, one service participant had worked part-time teaching and part-time for the hospital. In this case, the hospital was willing to be flexible with her schedule in order to work with the teaching schedule.

I liked being a part-time person in that I didn't have all those responsibilities the other instructors had and I basically just had my clinical group and I did my clinicals with them and I graded their papers and I think I had some lab things to do for school. I had to monitor some tests at school... But I didn't have all the responsibility of a full time faculty had. That was kind of a free feeling. Then my other job was that I worked for the hospital... And the hospital there was very flexible; we wrote our own schedule... Over Christmas break if I wanted to work every day, fine. If I wanted to take a week off, fine. They were really cool. If at the end of the semester I had tests to do and a bunch of papers to grade and I

didn't want to work that week they were okay with that.

Another service participant described an agreement between a hospital and university to provide joint funding for a faculty position. This allowed salary to potentially be higher and the university and the hospital together could establish expectations.

We have been very successful with our nurse researcher position...[as] a dual-funded position in which she is part-time in each place. But the salary is one; you know that is the hospital funds. She has a defined role between what she provides the school and what she provides to us [the hospital]. And I think some dual roles that are funded perhaps at a higher level would work.

Another issue is that not all nurses with advanced degrees have received training on components of being an educator. Nurses such as nurse practitioners are being recruited to become faculty but do not have the extra training in the educator role. Some universities offer an educator track of study as part of a master's degree or as a post-master's certificate. One suggestion was to include a course on teaching in all master's degree programs since nurses are educators at many levels and in many settings not just in a faculty position.

Mentoring New Faculty

When transitioning to a faculty role, if new faculty members do not have experience or training in the educator role, they can become frustrated and overwhelmed. As a result, they may leave teaching and increase turnover of faculty. As a solution, five of the faculty participants stressed the importance of mentoring new faculty members—especially those with no teaching experience or training. One example of a mentoring program was described by a faculty participant.

When I started the lady that was over the whole Allied Health, decided that she was going to pair us up with another seasoned faculty member...to be able to ask simple questions, like, "Well when do we take lunch? Or what about the phone? How do we answer the phone?" Or you know, "What time do we go home?"...Those kind of things and they mentored us....And they have done that every year since then. And it has helped.

Another example of effective mentoring not only gave the new faculty member direction but provided support. For this faculty participant, she did not have training in nursing education but did receive good mentoring when she started teaching.

Of course you have got to get them in first, but you've got to have someone work with them. You don't just throw a brand new faculty out by themselves in this big university....Help them with what's it like to teach a class, advise students, and grade papers, and do tests...We need more mentoring. I was very fortunate I had that and that's what really got me through. I had people that helped me in the clinical area. "I'm right on the next floor over, if you need me and why don't we spend a few days before it starts?"...I know when I did my first lecture, you know I had a faculty member right there helping me and helping me do test questions and I just learned so much.

Without good mentoring, new faculty members any flounder and have a horrible experience as one faculty participant described. She had a master's degree in nursing education and knew that without that foundation, new faculty members could have a rough start.

There are not good mentoring programs with new faculty. If you don't have a

buddy or somebody that's nice to you and that will say, "Here you know let's work on these objectives or here are objectives I have used in the past or here's an old test let's tweak this one a little bit." They are out there floundering. I have been doing this forever. But any time you change a book even you are re-doing everything and it's old hat to us but [for] a new faculty that's a horrible first semester....So we're losing them....They're thinking, "Let's go back to what's familiar."

Another faculty participant did not have educator training in her master's degree program. She described how when she first started she did not understand things being said in faculty meetings.

I had no knowledge. I am sorry, [but] I had never heard of Bloom. I had no idea what they were talking about. But it was the willingness. I would write down in meetings words everybody was throwing around, I had no idea. I didn't know the word didactic...pedagogy. I'm writing down something that looks like pedagogy and so...I did my homework every night. And I didn't have an orientation program per se or a mentoring program but I did have enough faculty that no one got sick of answering my questions and just listened.

So this same faculty participant saw a need for a good mentoring program and described one that she would have liked.

Getting them a very good mentoring program and that is one thing I am working on here. Is to have someone to go to because there are so many different situations that come up as we are nursing faculty to the nursing students we need to show them. You got the didactic world and the real world...Then every single question

that they have [they need] one person that they can come to and help them feel comfortable. And also have enough faculty to where they don't get thrown in over their heads... Have enough faculty as back up so that they can do almost at least a semester of what I would consider internship.

As expressed by these four faculty participants, once someone decides to become a faculty member it is important to assist her in the transition into the new role. They recommended mentoring as a means of making the transition smoother.

Networking

Networking with nurses in service settings and inviting them to quest lecturer is another means of potentially recruiting nurses into the faculty role. In addition, a suggestion was to nurture part-time or adjunct faculty so as to encourage them to move to full-time status. One faculty participant described how they supported the adjunct faculty who took a group of students into the hospital for their clinical experiences.

When we utilize our adjunct faculty it is not just saying ok, "Here's your clinical rotation, here's your books..." We actually talk to them and ask them.... "Do you think that what you do now is worth the pay that you are getting? Do you think that you might want to do this on a full-time basis? And here's some pros to that [teaching full-time]."

Another faculty participant described how she maintained a connection and a dialogue with staff at the hospital and thus formed a link to a potential pool of nurses who might want to teach.

Any time that we in education can connect with people in the field, again that's one of the values of having faculty who practice. But I think anytime, we create

that dialogue, like how are our graduates doing? Or this is what I wish you would be teaching students. Anytime you create that kind of dialogue you are going to increase the communication, the potential for recruitment has got to increase I would think....We just hired a new faculty in pediatrics who worked at the hospital. And again if ...we as nursing faculty are out there working, that keeps us linked to a potential pool of nurses...who might be willing to be faculty some day.

Similarly, one service participant suggested developing a connection with those in the hospital who provide education to the hospital nursing staff. "You may have nurses who work in hospital settings who are the education coordinators. Find out who all those people are and try to get them to be in the university system instead of hospital instructors."

One institution was successful in encouraging and recruiting faculty from the ranks of their former students.

Many times for recruitment it has been our former students and that...[is] good news and bad news. Now they have advanced degrees from other places and that at least stirs us up a little bit so we do not get too inbred. But otherwise I think it is difficult. I think maybe sharing faculty between institutions may be another idea.

From the service participant's perspective, guest lecturing and being a preceptor for students may be an entrance into teaching. One service participant had been a guest lecturer and when asked if that could have been the first step for her to consider teaching, she stated, "I certainly know I would have. I guess if somebody had said, 'Gee you know

we really enjoyed them, we have an opening.’ But like nobody ever did.” Being an adjunct faculty also might be an entry to full-time positions. One service participant stated, “Opening up adjunct positions for people like me may snag a few for full time.” Another service participant described how exposure to teaching as an adjunct or preceptor could result in a full-time position.

My adjunct position made such a difference.... You know really encouraging people to be preceptors because that was my first taste of education and you get a good experience...If you don’t put your feelers out there and kind of befriend some of the people out in the public. I don’t know...that I would have ever ended [up] teaching if I didn’t stay close [to] all of the friends at...[the university]. Like I always kind of stayed in contact with my professors and then I had friends that ended up teaching there and I kind of stayed in contact with them so I always kind of stayed kind of in touch with the university itself.

So for both service and faculty participants, solutions to the nursing faculty shortage included presenting a positive image of nursing faculty, assisting those pursuing doctoral degrees, funding dual positions including both service and academia, clinical teaching positions for those with masters’ degrees, and networking with nurses in service positions. According to the study participants, the positive image needs to be presented on multiple levels including mass media and through everyday encounters with students and the public. Overall they stress the importance of remembering that behind every good nurse is a nursing faculty member. In other words, in order to have nurses for the future, we need nursing faculty to prepare the nurses for practice.

CHAPTER SEVEN: CONCLUSION AND IMPLICATIONS

With the growing nursing faculty shortage, higher education administrators are searching for a better understanding of the causes and solutions. In order to explore nurses' perceptions of the nursing faculty shortage, a qualitative approach was used. Nurses currently in nursing faculty positions and nurses in service positions with at least a master's degree in nursing were interviewed and their perceptions were compared. The purpose of the study was to explore perceptions of the nursing faculty role and faculty workload as held by these two groups of nurses. In addition, the nursing faculty participants were asked what attracted them to the nursing faculty position and what had kept them in that position. The nurses in service positions were asked what would attract them to a nursing faculty position and what they viewed as deterrents to teaching full-time. The second purpose of the study was to identify what both groups thought were causes of the nursing faculty shortage and what they would recommend as solutions to the faculty shortage.

Research Questions

How do nurses currently in a faculty role perceive their role as educator and their workload?

How do nurses in a service position perceive the role of a nursing faculty and faculty workload?

What are the differences and similarities if any between the perceptions of the nursing faculty role held by the two groups of nurses?

What do the nurses in nursing faculty positions and those nurses with at least a

master's degree but in service positions see as causes for and solutions to the growing nursing faculty shortage?

Major Findings

Major findings address the study participants' perceptions of the nursing faculty role, causes of the nursing faculty shortage, and solutions for the shortage. In addition, participants in both the faculty group and the service group described their current positions. When describing their current positions, both faculty and service participants described a real passion for nursing and for teaching. Faculty participants taught students and shared with students what it meant to be a nurse. At the same time, these participants often continued to practice as nurses. Service participants were practicing nurses and incorporated teaching into their practice as they taught patients, their families, other nurses, and were preceptors for students.

Nursing Faculty Role

Teaching. It is well known that teaching is a major component of many higher education faculty positions. This was confirmed by both faculty and service participants. Both groups described teaching that occurred both in the classroom and in clinical settings and involved role modeling what it was to be a nurse. In order to fulfill their teaching responsibilities, faculty participants described variety in schedules including teaching in the classroom one day and being in a clinical setting the next day. Added to the busy schedule was the fact that many of the faculty participants continued to work in clinical settings in order to remain current in their nursing practice. A major focus of teaching was helping students make the connection between what they learned in the

classroom and what was practiced in the clinical setting. In making this connection for students, the faculty members assisted the students in learning what was needed to become a nurse. Even when teaching graduate students, faculty participants assisted the students to further develop as nurses and to explore more advanced roles in nursing.

The service participants may not have held positions in higher education or taught full-time in classroom or clinical settings but they still viewed themselves as teachers in their roles as nurse practitioners or nurse administrators. Those in nurse practitioner positions taught patients on a regular basis and believed they made a difference in the lives of their patients. Those in administrative positions taught staff and in this way attempted to impact patient care. These service participants integrated teaching into their nursing practice and showed a passion for both nursing and teaching. In addition, all service participants at some point had considered a teaching career but four had not wanted to pursue doctoral studies in order to teach full-time. Another two had tried classroom teaching and decided they did not like public speaking or lesson planning.

Service and Scholarship Components. In addition to teaching, study participants described service and scholarship activities that were a part of the faculty role. Most of this discussion came from the faculty group participants. Service activities included advising students, committee work, community service, and participation in professional organizations. Much of the service to the university and community was because of the faculty participants' status as nurses. For example they ran the university's student health services and conducted health education in the community. The faculty participants who conducted or participated in research were those with doctorate degrees and taught in either baccalaureate or master's degree programs.

Positives of Faculty Role. Strikingly, in fulfilling the teaching responsibilities, the most positive aspects of teaching related to experiences with students including the faculty relationships with students, the experience of seeing students mature as they become nurses, and the excitement when students finally understand a concept. Relationships with students and giving birth to new nurses were clearly the main reasons the faculty members loved teaching and why they stayed in teaching. Similarly, service participants found it rewarding to assist others to learn and to see students' excitement when interacting with them one-on-one as a preceptor.

In addition to their relationships with students, faculty participants gained satisfaction and support from their relationships with colleagues. These relationships were different from relationships they had experienced when working in the hospital with other nurses. In the hospital they may have worked with many different nurses while in a faculty position they developed close working relationships with a particular group of faculty. Through these relationships they were able to build on each other's ideas and strengths in order to provide students with the best possible experiences.

Flexibility and compatibility of schedule with personal life were important to both groups of participants. Both looked for flexible schedules that would fit with the demands in their private lives but each chose different career paths. Those in the faculty group found the higher education schedule more compatible with family demands whereas those in the nurse practitioner role found the schedules in clinics more compatible.

Cause of the Nursing Faculty Shortage

Financial Issues. Financial issues were identified by both groups as a leading

cause for the nursing faculty shortage. Faculty participants in this study had lower salaries than those in the service group. None of the participants in the faculty group were making a salary over \$70,000 as compared to 50% of the participants in the service group with a salary over \$70,000. In addition, faculty salaries in West Virginia are lower than those nationally and in the five surrounding states. Added to the low faculty salaries was the additional money and time required for doctoral education in order to qualify for a full-time faculty position in many institutions.

Lack of Higher Education. Especially for the service participants, they did not want to pursue a doctoral degree in order to teach full-time. Service and faculty participants both identified obstacles including no nursing doctoral programs in West Virginia until a few years ago, not understanding early in their career the need to have a doctorate in order to teach full-time, the perceived difficulty of doctoral programs, the time required to complete a program, and the lack of encouragement from peers to pursue advanced degrees.

Lack of Training in Teaching. Even with advanced degrees, nurses are not necessarily receiving training in teaching. Faculty participants who had training in teaching valued this training and found the transition from nursing practice to teaching easier. They have observed faculty without this training who had a harder time transitioning to the faculty role. Likewise, service participants identified that they lacked confidence in their ability to teach because they did not have training in teaching.

Other Career Opportunities. In the past, if nurses wanted to find a job outside of the hospital they went into teaching. Today they have many more options most of which pay higher salaries. Both groups of participants identified increased career options as

contributing to the nursing faculty shortage. Most often-identified careers were nurse anesthetist and nurse practitioner but others roles included nurse administrator, nurse midwife, and sales.

Solutions to the Nursing Faculty Shortage

Positive Image. Both groups of participants identified the need to get the word out and share a positive image of the nursing faculty role and present it as a rewarding career choice. This image needs to include the benefit of combining nursing and teaching and making an impact on the future generation of nurses. One favorable image presented in commercials is that behind every nurse is a nurse educator. Participants believed the positive image needs to be presented on many levels including mass media commercials, everyday encounters with students and other nurses, and through professional conventions.

Doctoral Education. Both groups of participants viewed pursuing a doctoral degree as difficult. Individuals need support and encouragement to seek a doctoral degree and they need to know about the requirement for a doctoral degree early in career planning. Financial supports suggested by participants include student loans, scholarships, and loan forgiveness. In addition to financial support, time is needed in order to balance the demands of work and studying since many are working while they continue graduate degrees. The service participants especially, did not want to pursue a doctoral degree because of their lack of confidence that they had the ability to complete the program and how hard it is to complete both the courses and the dissertation requirements.

Utilization of Nurses with Masters' Degrees. Another group of solutions included ways to utilize nurses with masters' degrees in faculty positions. Faculty participants suggested two different faculty-type tracks, one of which would utilize nurses with masters' degrees. They also suggested providing the opportunity for post-master's certificates with specific training in teaching. Service participants suggested using nurses with masters' degrees as preceptors, in joint positions, and in part-time positions.

Mentoring New Faculty. Five of the eight faculty participants identified mentoring as a solution to the faculty shortage since this would assist nurses transitioning into the faculty role. Some participants had been mentored when they started teaching and through mentoring learned teaching methods since they had no prior training in teaching. Others observed that without mentoring, beginning faculty would flounder and have difficult transitions which would result in frustration and quick turnover in faculty positions.

Networking. Another solution was building connections and relationships between faculty members and nurses in service positions. As a result of this relationship, nurses in service positions might become guest lecturers, preceptors for students, or adjuncts for a semester. In order to introduce nurses to the faculty role, nurses could shadow a faculty member for a day. Another suggestion was maintaining connections with former students and encouraging them to return as faculty.

Comparison with Prior Research

The discussion of my findings in relation to prior research will first address

research related to the nursing faculty role. Then the focus will be on research regarding the nursing faculty shortage found in both nursing and educational studies.

Faculty Role

Very few studies describe the responsibilities of the nursing faculty role. The three major roles of nursing faculty include teaching in both classroom and clinical settings, service including committee work, and research (Penn, Wilson & Rosseter, 2008; Zambroski & Freeman, 2004). Zambroski & Freeman (2004) described a difference in these roles depending on whether the institution was a community college or a research university. Common to both institutions was the emphasis on serving the students and providing high quality instruction. Where they differed was in the area of service and research. Community colleges' missions were to service businesses and provide work-force development while the universities served through research. In this study, all participants talked about teaching and the work they did with students but only those teaching in universities discussed research activities. Gazza (2009) found that nursing faculty strived to balance multiple roles including working with students, committee participation, research, and clinical practice. In this study faculty participants also found it challenging to balance the multiple roles of teaching, service, and research. Especially those participants teaching at universities found it difficult to find time for research and other scholarly activities.

Teaching. In this study, both faculty and service participants described in-depth the teaching component of the faculty role. The faculty participants further described how they guided the students in making the connection between what they learned in the classroom and the knowledge needed to practice in clinical settings. The focus of their

teaching was to assist students to learn the skills and critical thinking needed to become nurses. They individualized their teaching methods to meet the needs of students, whether they were teaching beginning, senior, or graduate students. Similarly, nursing studies found faculty needed to help student make the connection between classroom theory and clinical practice in order to become a professional nurse (NLN, 2008; Penn, Wilson & Rosseter, 2008). The National League of Nursing (2008) conducted a survey on clinical education in nursing and found that clinical education was essential in order for students to apply theory learned in the classroom to patient care. In addition, faculty members were responsible for developing and arranging these clinical experiences. In a survey of 220 deans and directors of schools of nursing, they identified that new faculty members needed teaching skills that went beyond simple transmission of content but involved engaging the students in actively learning and applying knowledge (Penn et al., 2008). In a qualitative study, Gazza (2009) found faculty used a range of approaches to ensure that qualified students met high performance standards.

One finding in this study that was not found in the literature, was that both faculty and service participants saw themselves as educators and as having the ability to integrate nursing with teaching. Faculty participants taught students in higher education settings while service participants taught patients, families, other nurses, and students in clinical settings.

Positives of Nursing Faculty Role. In this study the positive aspects of the nursing faculty role identified by participants included relationships with the students, relationships with colleagues, and flexible schedules. The relationships with students meant making a difference, helping the students develop into nurses, seeing the light-bulb

experiences. The relationships with colleagues were described as supportive, collaborative, and as enhancing their nursing programs. Faculty participants found the flexible schedules in higher education were compatible with personal demands. Similarly, service participants looked for flexible schedules that were compatible with personal demands.

Several studies have addressed the positive aspects of the nursing faculty role and job satisfactions. These studies also found nurses valued making a difference for students, having positive relationships with colleagues, and having job flexibility. Specifically, Garbee and Killacky (2008) surveyed full-time faculty in SREB states regarding factors that influence intent to stay in academia. They did find a moderate correlation between job satisfaction and intent to stay in academia. When they asked more specifically about job satisfaction, the top three themes identified included being part of student success, faculty colleagues, and flexibility. In another study, Gazza (2009) interviewed nursing faculty in order to better understand the experience of being a full-time nursing faculty. Two of the findings included making a difference for students and relationships with colleagues. Brendtro and Hegge (2000) found nurses with graduate degrees both in faculty positions and those in non-faculty position were satisfied with their current positions because they found flexibility, variety, and collegiality.

In addition to studies of nursing faculty, one of the nursing journals regularly published testimonies by nursing faculty. In these testimonies, faculty members expressed rewards of working with students, being a mentor to students, having an impact on health care, inspiring students, role modeling lifelong learning, and seeing students after graduation (“Faculty Matters,” 2009; “Faculty Matters,” 2008a; “Faculty

Matters,” 2008b).

Garbee and Killacky (2008) also found a significant correlation between the faculty’s perception of the dean’s leadership behaviors and faculty’s intent to stay. Along the same lines, August and Waltman (2004) found that the most significant predictors of career satisfaction involved environmental conditions including relationship with the department chair. In my study, the relationship between faculty and leadership of the nursing dean or chair was not identified by most faculty participants as a reason for staying in an academic role. However, one participant indicated she had taught for one institution for over twenty years because she respected the dean’s leadership but recently left due to the university’s administrative changes that did not support faculty.

Cause for the Nursing Faculty Shortage

Age. In prior research, a major factor identified as a contributor to the current nursing faculty shortage was the age of faculty. The current mean age is nearly 50 years (Brendtro & Hegge, 2000; Craine, 2000; De Young & Bliss, 1995). In the 2004 AACN survey, the age of nursing faculty continues to increase. Faculty with doctoral degrees have a mean age of 54.3 years which is up from 49.7 years in 1993 and faculty with masters’ degrees have a mean age of 49.2 years as compared to 46 years in 1993. In the interviews for the current study, age as a contributing factor was identified by only one of the faculty participants. This may be due to the fact that the mean age for the faculty group was 53.8 years and they did not think about their own age as an issue. The service participants had a mean age of 44.6 years and did not identify age as a cause for the nursing faculty shortage.

Doctoral Education. Participants in this study identified graduate education, and especially doctoral level education, as a barrier/obstacle to teaching full-time. In this study participants in both the service and faculty groups who had not gone on for a doctorate degree noted deterrents including time commitment, cost, lack of encouragement, perceived difficulty of doctorate programs, lack of doctoral programs within West Virginia, and not knowing early in their careers that a doctorate would be needed to teach full-time. Similarly, Maher, Ford, and Thompson (2004) found that those who took longer to complete doctoral programs indicated they were slowed down by family commitments, financial issues, and difficulty with identifying the research dissertation topic. Anderson and Swazey (1998), in their study of 2,000 doctoral students, found doctoral study very demanding and that it often interfered with personal life. Gary et al. (1997), in a qualitative study of 11 women in doctoral studies, found that the participants' feelings of self-confidence were tenuous at times because of the difficulty of academic requirements. Lovitts (2001) conducted a study examining attrition from doctoral programs and found some students left because of burnout and family demands. Those who stayed in the program were those who were more often able to find support from other students and faculty. In survey studies of nurses, nursing graduate students are older and take longer than students in other disciplines to complete a doctorate degree. (Berlin & Sechrist, 2002; AACN, 2005).

Salaries and Other Opportunities. In this study, both faculty and service participants identified lack of competitive salaries for faculty as a reason for the nursing faculty shortage. One faculty participant indicated that years ago when she made the move from a hospital position to a faculty position there was not a salary difference but

that is not true today. In this sample none of the faculty participants made over \$70,000 as compared 50% of the participants in the service group with a salary over \$70,000.

In this study both groups of participants identified increased career options including nurse anesthetist, nurse practitioner, nurse administrator, nurse midwife, and sales as a reason for the nursing faculty shortage. According to an AACN report (2005), nurses both at the doctorate and masters' prepared level are selecting other career paths besides faculty positions. For example, 22.4% of those graduating from doctoral programs in 2004 were committed to positions in settings other than academia. This trend away from careers in academia has increased steadily since the 1980s. In addition, nurses graduating from doctoral programs who do take positions in academia are reported to be more interested in conducting research than teaching and even fewer want to teach undergraduate students. In contrast, in the current study, four nurses with doctoral degrees continued to emphasize the teaching role and taught both graduate and undergraduate students. Over the years fewer nurses have graduated from master's degree programs with a major in nursing education. In 1997, nurses in nursing education comprised 24.7% of graduates at the master's degree level and that number has declined to 11.3% in 1994, and to 3.5% in 2002. Instead, at the master's degree level, 64.4% of the graduates become nurse practitioners or a combination of nurse practitioner/clinical nurse specialist in 2004 (AACN, 2005).

Solutions to Reduce the Shortage

The solutions to reduce the nursing faculty shortage found in the literature can be divided into recruitment, retention, and restructuring faculty workload. The solutions suggested by the participants of this study would impact recruitment and retention of

nursing faculty.

Recruitment. As a result of national surveys of schools of nursing, the American Association of Colleges of Nursing (2005) identified the need to present a positive message that expresses the value of higher education and nursing careers in academia. One national advertising campaign has been sponsored by Johnson & Johnson and positively portrays nursing as a career as well as the career of nurse educator. Other recruitment campaigns have included more local efforts with schools of nursing going into local elementary and high schools to present programs about nursing careers. Caine (2000), as a result of a study of nursing faculty in Georgia, suggested the need for faculty to share the positive aspects of teaching with their students. Seldomridge (2004) found providing senior nursing students with a shadowing experience during a leadership course to be an effective method to introduce students to the faculty role. In this study, both service and faculty participants identified the need to present a positive image of the nursing faculty role. They also cited the national advertising campaign by Johnson and Johnson and thought these ads presented a very positive image of nurse educators. In addition to the national campaign, they suggested ways to present a positive image of the nursing faculty roles as they work with students, nurses in service positions, and as they attend professional conferences. Another recruitment source suggested in this study was networking with nurses in service positions and inviting them to guest lecture or consider part-time teaching positions.

Another component of recruitment involves encouraging and supporting nurses in the pursuit of advanced education including doctoral study. National survey data indicate that nurses tend to wait longer to pursue doctorate education than other disciplines

(AACN, 2005) and thus nurses need to be encouraged to enter doctoral studies earlier in their careers. The white paper from AACN (2005) suggested other approaches to doctoral studies including online programs and accelerated programs. In this study, participants identified the need to discuss with students, early in their careers, the potential of teaching and the importance of pursuing further education including doctoral education. Along with earlier pursuit of further education is the need for financial support and assistance in meeting academic challenges students face during graduate programs.

The latest NLN national survey (Kovner et al., 2006) reports that more than half of the full-time faculty in baccalaureate and higher degree programs hold less than a doctoral degree as their highest degree. For associate degree programs, the majority of full-time faculty members hold masters' degrees as their highest degree. Based on this, many schools of nursing are already relying on nurses with masters' degrees as full-time faculty. In this study, the participants thought that better utilization of nurses with masters' degrees would be a solution to the shortage. This would include different faculty tracks that would require only a master's degree, part-time positions, and use of preceptors for clinical experiences. Since many nurses with masters' degrees are in service positions with higher pay, joint positions were suggested as a way to continue the higher salaries and at the same time to attract these nurses into faculty roles at least as a portion of their responsibilities.

Another solution found both in the literature and this study was providing nurses with specific training in teaching. DeYoung, Bliss and Tracy (2002) reported an increase in post-masters certificate programs in nursing education. An example of such a post-graduate education program has been developed by the University of Pennsylvania

(Krisman-Scott, Kershbaumer, & Thompson, 1998). Davis, Baker, and Carlson (1994) suggested the addition of a teaching course as part of masters' degree programs. In this study, participants also suggested both post-graduate education programs and adding to all master's degree programs some training in teaching.

Retention. Five of the faculty participants noted that the first year as new faculty can be overwhelming especially if they did not have training in teaching as part of their graduate programs. They recommended mentoring programs as a way to assist new faculty in the transition into academia. This recommendation is supported by prior research. For example, we know that clinicians are socialized differently from educators and during their graduate program may or may not have had courses for the educator role (Esper, 1995; Neese, 2003; Siler & Kleiner, 2001). In a qualitative study, Siler and Kleiner (2001) found those who were novices were unfamiliar with the faculty role and graduate education had not prepared them for the faculty role. Mentoring by senior faculty members has been suggested as a way to assist novice faculty members in the assimilation of the new educator role (Brown, 1999; Dunham-Taylor, Lynn, Moore, McDaniel & Walker, 2008; Esper, 1995; Siler & Kleiner, 2001). In another qualitative study, Anibas, Brenner and Zorn (2009) found as a result of the nursing faculty shortage more nurses with masters' degrees are being pulled into short-term contracts and these nurses found the first year overwhelming and often struggled. Even though they had a support person during this transition more support and information was needed.

Strengths and Limitations

The strengths of this study include the qualitative approach, participant selection,

and the comparison between faculty and service participants. Most studies of the nursing faculty shortage have been surveys. By using a qualitative approach, this study was able to explore nurses' perceptions through rich descriptions of the issues and thus provide a more in-depth understanding of the phenomenon. For example, Garbee and Killacky (2008) measured faculty satisfaction with a survey instrument and asked participants to list the top three factors that contribute to job satisfaction. The most frequently expressed area of faculty satisfaction was faculty being a part of student success. The best description of what it meant to be a part of student success was limited to short sentences such as "to harvest the gifts within students and help them see their own personal worth" (Garbee & Killacky, 2008, p.9). In this study, faculty relationships with students were explained more fully by more than one participant. An example of such a description follows:

I know that at the undergraduate level, it was kind of neat to see them grow from a high school graduate and then all of a sudden two or four years later, become a registered nurse where they had a responsibility, they were taking the responsibilities, they were stepping up to the plate....It was fun in doing that growing up thing with them. And at the graduate level, I just really like sharing my stories and helping them open up new worlds for them to go into and take off and just see what they can do.

Another example are surveys that have found that nurses wait longer to pursue doctoral education and take longer to complete doctoral degrees but these studies have not identified how or why this occurs (Berlin & Sechrist, 2002; AACN, 2005). In contrast, the participants in this study addressed why they viewed doctoral education as an

obstacle. One example of such descriptions is as follows:

I got started late in life having children. I just wasn't willing to make the sacrifices that I would have had to make to go on for my doctorate. Had the school been able to release me a little bit for time so that I could still have family things happening and so forth then I probably would have done it.

Sample selection was another strength of this study. The participants were purposefully selected from a variety of backgrounds. Participants in both faculty and service groups were selected from across the state of West Virginia from both rural and urban communities. Faculty participants included individuals who had taught in both private and public institutions as well as in different types of nursing programs including associate degree, baccalaureate degree, and master's degree programs. The service participants worked in a variety of settings and some had experience teaching part-time. By interviewing nurses from a variety of locations and job experiences regarding their perceptions of the nursing faculty shortage and nursing faculty roles, the findings could be triangulated. For example, participants from both faculty and service groups described giving birth to new nurses and making a difference in the lives of students. Another example is that participants in both groups identified low faculty salaries as contributing to the nursing faculty shortage. Interviewing nurses both in faculty and service positions allowed comparison of their perceptions which has not been done in survey studies.

The major limitation of qualitative studies is not being able to generalize the findings due to the small sample size and the sample being purposefully rather than randomly selected. In addition, for this study the sample was drawn only from nurses living and working in West Virginia and thus may not reflect perceptions found in other

areas of the country.

Conclusion and Implications for Practice

Based on national surveys by both the National League of Nursing (2005) and American Association of Colleges of Nursing (2006), the vacancy rates for nursing faculty continue to increase and as a result schools of nursing are unable to admit all of the qualified student applicants. Many nationwide efforts have been implemented to counter the nursing faculty shortage but there is little data regarding the effectiveness of these initiatives. These efforts have included mass media campaigns to present a positive image of nursing, establishment of centers to collect nursing workforce data and pilot solutions, development of partnerships between academic institutions and service institutions, initiation of academic approaches to optimize faculty resources, and expansion of funding for schools of nursing (Allan & Aldebron, 2008). Despite the national efforts to address the nursing faculty shortage, the supply of nursing faculty has not kept up with the demand.

The causes for the nursing faculty shortage identified by the study participants had been identified by prior nursing research. One was low faculty salaries which for West Virginia was even lower than surrounding states and nationally. The lack of doctorally prepared nurses had been found by national surveys. This study further added information as to why nurses in West Virginia were not pursuing doctoral study including lack of access to doctoral programs in the state, time commitments, and the perceived difficulty of doctoral study. Because of the decline in nurses receiving training in teaching during masters' degree programs, some of the study participants observed new

faculty being overwhelmed and frustrated when they first began teaching.

The solutions suggested by the study participants were often found in the nursing literature. The first solution suggested by most of the participants related to presenting a more positive image of nursing faculty. They went beyond the use of mass media and suggested the need to present a positive image every day when working one-on-one with students and interacting with nurses in service positions. Clearly the service participants and faculty participants without a doctorate degree were reluctant to pursue doctoral education due to time demands, cost, and difficulty of doctoral study. If higher education institutions want nursing faculty to possess a doctoral degree, then nursing administrators need to provide earlier career guidance regarding the degrees needed to teach, to encourage nurses throughout doctoral study, to provide financial support to cover the cost, and to compensate them upon their completion of graduate study. Mentoring is a suggestion from nursing research. The study participants valued mentoring because they had been mentored and experienced a smooth transition into academia or they had observed new faculty floundering because did not have a mentor.

In addition to learning more about the causes and potential solutions to the nursing faculty shortage, the results of this study indicate that nurses both in faculty and service positions have a passion for both nursing and teaching. Nurses in service positions already process many skills in teaching as they teach patients and nursing staff every day. Many of the service participants had previously considered a career in nursing education but they have selected service positions because of issues such as salary, doctoral education, flexible schedules, patient contact, and other career options. They stayed in their current positions because they loved what they were doing and the ability

to make a difference in the lives of patients or in the health care system. In order to recruit nurses with advanced education into academic positions, nursing administrators need to network with nurses in service positions, share the benefits of faculty positions, assist in transitioning into academia, and consider joint appointments. All of this involves getting nurses in service positions more involved in teaching experiences.

Nursing administrators in higher education need to better understand what keeps nurses in faculty roles. Very clearly this study found the faculty relationship with students and the experience of seeing the students develop into a professional nurse was a primary reason why nurses went into teaching and why they continued to teach despite low salaries. Participants in both the faculty and the service groups described being energized by students, being excited to see the students grow and develop, and seeing the light bulb go on when the students finally understood a concept. Nurses in all settings and positions need to be reminded that if we are going to continue as a profession, we must all support and encourage the enthusiasm for nursing seen in students.

Relationships with colleagues were another positive factor identified by the study participants. Especially faculty participants described the support they received from colleagues which was different than they had experienced working in a hospital as a staff nurse. They covered for each other when needed. They were able to enhance the nursing program because they combined everyone's ideas. Nursing administrators need to support these relationships so as to foster development of new ideas and innovations.

Participants in this study indicated that they left hospital nursing in order to have a more flexible schedule that was more compatible with personal and outside demands. By obtaining at least a master's degree, they had more career options and could select one

with a more flexible schedule. For some that meant a faculty position and for others it meant a service position as a nurse practitioner or nursing administrator.

In this study, participants believed a major factor contributing to the nursing faculty shortage was the low faculty salaries. Both groups of participants already enjoy flexible schedules, teaching others—students, patients, other nurses—and working with colleagues. They all decided to complete advanced education in order to have more career choices and be able to advance from hospital staff nursing positions. In selecting their current positions, they analyzed the benefits including autonomy, working relationships, and making a difference in the profession. In making their career choice, they compared the benefits of each option with the costs including those related to time, to education qualifications needed, and to salary differences. Service participants would not teach full-time because they found the costs of further education, in some cases time away from family, and cut in salaries as too much when they already enjoyed their current service positions. In order to counter the salary differences, higher education administrators may want to consider market-based salary structures that will support more parallel salaries for nurses in faculty and service positions. Faculty members are instrumental to students' success and a very valuable human resource. Administrators may need to explore funding sources in order to invest in qualified faculty who are needed to maintain and expand nursing student enrollment. Despite many initiatives that have been put into place since 2000, the nursing faculty vacancy rate continues to increase. More research is needed to determine the effectiveness of initiatives that have already been implemented.

In conclusion, nursing administrators in higher education institutions will

continue to be faced with the challenge of recruiting and retaining qualified nursing faculty. The findings of this study suggest that for those already in faculty positions, nursing administrators need to further recognize and strengthen those areas that faculty view as rewards. For example, administrators could find ways to support and recognize the impact faculty members have on student success, foster collegial relationships among faculty members, assist faculty to balance multiple roles, and support their efforts for further education. For nurses in service positions, nursing administrators may need to find the additional funding in order to attract these nurses to faculty positions and take advantage of the teaching abilities these nurses already possess.

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APPENDICES

Appendix A: Informed Consent

Appendix B: Letters to Participants

Appendix C: Interview

Appendix D: Demographic Forms

APPENDIX A: INFORMED CONSENT

Informed Consent

Nursing Faculty Shortage: Nurses' Perceptions as a Key to Administrative Solutions

Linda Spatig, Ed. D, Principal Investigator

Evelyn Klocke, Doctoral Candidate

Introduction

You are invited to be in a research study. Research studies are designed to gain scientific knowledge that may help other people in the future. You may or may not receive any benefit from being part of the study. There may also be risks associated with being part of research studies. Your participation is voluntary. Please take your time to make your decision, and ask your research investigator or research staff to explain any words or information that you do not understand.

Why Is This Study Being Done?

The purpose of this study is to explore perceptions of the nursing faculty shortage by nurses currently in education positions as compared to those who have at least a masters' degree in nursing but are not in a higher education position.

How Many People Will Take Part In The Study?

Between 15 and 20 people will take part in this study. A maximum of 20 subjects will participate in the study.

What Is Involved In This Research Study?

You will be interviewed either in person or via telephone and asked questions regarding your perceptions of the current nursing faculty shortage and the role of the nursing educator. You will also be asked some demographic information to help describe those participating in the study.

How Long Will I Be In The Study?

You will be in the study for an initial interview that will last approximately one hour and a follow-up interview to clarify any information from the first interview. Both interviews will be conducted within a six month period. You can decide to stop participating at any time. If you decide to stop participating in the study we encourage you to talk to the study investigator or study staff as soon as possible. The study investigator may stop you

from taking part in this study at any time if he/she believes it is in your best interest; if you do not follow the study rules; or if the study is stopped.

What Are The Risks Of The Study?

There are no known risks to those who take part in this study.

Are There Benefits To Taking Part In The Study?

If you agree to take part in this study, there may or may not be direct benefit to you. We hope the information learned from this study will benefit other people in the future. The benefits of participating in this study may be a clearer understanding of the nursing faculty shortage and the perceptions of the nursing educator role.

What About Confidentiality?

We will do our best to make sure that your personal information is kept confidential. However, we cannot guarantee absolute confidentiality. Federal law says we must keep your study records private. Nevertheless, under unforeseen and rare circumstances, we may be required by law to allow certain agencies to view your records. Those agencies would include the Marshall University IRB, Office of Research Integrity (ORI) and the federal Office of Human Research Protection (OHRP). This is to make sure that we are protecting your rights and your safety. If we publish the information we learn from this study, you will not be identified by name or in any other way.

What Are The Costs Of Taking Part In This Study?

There are no costs to you for taking part in this study. All the study costs, including any study tests, supplies and procedures related directly to the study, will be paid for by the study.

Will I Be Paid For Participating?

You will receive no payment or other compensation for taking part in this study.

What Are My Rights As A Research Study Participant?

Taking part in this study is voluntary. You may choose not to take part or you may leave the study at any time. Refusing to participate or leaving the study will not result in any penalty or loss of benefits to which you are entitled. If you decide to stop participating in the study we encourage you to talk to the investigators or study staff first.

Whom Do I Call If I Have Questions Or Problems?

For questions about the study or in the event of a research-related injury, contact the study investigator, Linda Spatig at 304-696-2875 or Evelyn Klocke at 304-776-3684. For questions about your rights as a research participant, contact the Marshall University IRB#2 Chairman Dr. Stephen Cooper or ORI at (304) 696-7320. You will be given a copy of this consent form.

SIGNATURES

I agree to take part in this study and I confirm that I am 18 years of age or older. I have had a chance to ask questions about being in this study and have those questions answered. By signing this consent form I have not given up any legal rights to which I am entitled.

Subject Name (Printed)

Subject Signature

Date

Person Obtaining Consent (Printed)

Person Obtaining Consent Signature

Date

APPENDIX B: LETTERS TO PARTICIPANTS

NURSING FACULTY

SERVICE PARTICIPANTS

Letter of Introduction to Nursing Faculty

Dear Nursing Colleague:

I am a Marshall University Doctoral Candidate and am interested in the nursing faculty shortage that is occurring along with the general nursing shortage. In order to better understand this shortage and potential solutions, I plan to interview nurses in West Virginia who have at least a master's degree in nursing and are in a nursing faculty role. Your dean has given me your name as a potential participant in the study. I am especially interested in your views about the nursing faculty shortage and the nursing faculty role. If you would be willing to participate in this study, respond to this email in the affirmative by _____ and I will contact you to set up a confidential interview to be conducted in person or if necessary via the telephone. The interview will be scheduled at a time and place that is convenient to you. The interview will last approximately one hour and then a follow-up interview will be conducted to clarify any information.

Thanks so much for help with this. I look forward to hearing from you soon.

Sincerely,

Evelyn Klocke, RN, MSN, Ed. S.

Marshall University Doctoral Candidate

Letter of Introduction
Service Participants

Dear Nursing Colleague:

I am a Marshall University Doctoral Candidate and am interested in the nursing faculty shortage that is occurring along with the general nursing shortage. In order to better understand this shortage and potential solutions, I plan to interview nurses in West Virginia who have at least a master's degree in nursing but are not in a nursing faculty role. I am especially interested in your views about the nursing faculty shortage and the nursing faculty role. If you would be willing to participate in this study, return the enclosed information by _____ and I will contact you to set up a confidential interview to be conducted in person or if necessary via the telephone. The interview will be scheduled at a time and place that is convenient to you. The interview will last approximately one hour and then a follow-up interview will be conducted to clarify any information.

Thanks so much for help with this. I look forward to hearing from you soon.

Sincerely,

Evelyn Klocke, RN, MSN, Ed. S.
Marshall University Doctoral Candidate

Enclosed is a copy of the consent form with the official approval stamp from the Marshall University Institutional Review Board. If you participate in the study you will sign the consent prior to the interview.

APPENDIX C: INTERVIEW GUIDES

NURSING FACULTY

SERVICE PARTICIPANTS

Semi-structured Interview Guide

Nursing Faculty

The purpose of the Nursing Educator interview is to understand the nurse educators' perceptions of the role of the nursing educator and perceptions of the growing nursing faculty shortage. Each interviewee will be asked about the following topics.

1. Role of the nursing educator
2. Negatives of the role
3. Positives about the role
4. Perceptions of the nursing faculty shortage
5. Causes for the shortage
6. Possible solutions

Semi-structured Interview Guide

Service Participant

The purpose of the Non-Nursing Educator interview is to understand from nurses with master's degrees, their perceptions of the role of the nursing educator and their perceptions of the growing faculty shortage. Each interviewee will be asked about the following topics.

1. Positives and negatives of current position
2. Perceptions of the role of nursing educator
3. Attractions to nursing educator role
4. Barriers to becoming nursing educator
5. Perceptions of the nursing faculty shortage
6. Causes for the shortage
7. Possible solutions

APPENDIX D: DEMOGRAPHIC FORMS

NURSING FACULTY

SERVICE PARTICIPANTS

Demographic Information

Nursing Faculty

1. Age _____
2. Years as a Nurse _____
3. Current position title _____
4. Number of years in this position _____
5. Number of years in nursing education _____
6. Other types of nursing positions held _____

7. Highest degree held _____
8. Is the highest degree in nursing? _____ If no, then what field?

9. Number of years between completion of basic nursing training and completion of masters' degree _____
10. Age when completing masters' degree _____
11. Current annual salary range:
Less than \$30,000 _____
\$30,000 to \$40,000 _____
\$41,000 to \$50,000 _____
\$51,000 to \$60,000 _____
\$61,000 to \$70,000 _____
over \$70,000 _____
12. Have you ever worked in any other state besides West Virginia? _____ If yes, in what state(s)? _____

Demographic Information

Service Participant

1. Age _____
2. Years as a Nurse _____
3. Current position title _____
4. Number of years in this position _____
5. Other types of nursing positions held _____

6. Highest degree held _____
7. Is the highest degree in nursing? _____ If no, then what field?

8. Number of years between completion of basic nursing training and completion of masters' degree _____
9. Age when completing masters' degree _____
10. Current annual salary range:
Less than \$30,000 _____
\$30,000 to \$40,000 _____
\$41,000 to \$50,000 _____
\$51,000 to \$60,000 _____
\$61,000 to \$70,000 _____
over \$70,000 _____
11. Have you ever worked in any other state besides West Virginia? _____ If yes, in what state(s)? _____

**CURRICULUM VITAE
EVELYN MARIE KLOCKE**

EDUCATION

Marshall University
Doctor of Education in Educational Leadership, 2009
Marshall University
Education Specialist, 2001
University of Wisconsin
Master of Science in Nursing, 1985
University of Illinois
Bachelor of Science in Nursing, 1976

CERTIFICATION

American Nurses Credentialing Center, Certification in Pediatric Nursing

PROFESSIONAL EXPERIENCE

1976-1978 Staff Nurse, Evanston Hospital, Evanston, Illinois
1978-1979 Staff Nurse, Children's Memorial Hospital, Chicago, Illinois
1979-1981 Staff Nurse, Swedish American Hospital, Rockford, Illinois
1981-1985 Staff Nurse, University of Wisconsin Hospital and Clinics, Madison,
 Wisconsin
1985-1987 Clinical Nurse Specialist, Swedish American Hospital, Rockford, Illinois
1987-1995 Clinical Nurse Specialist, Charleston Area Medical Center, Charleston,
 West Virginia
1995-1999 Clinical Instructor, West Virginia University Institute of Technology,
 Montgomery, West Virginia
1999-2007 Assistant Professor, West Virginia University Institute of Technology,
 Montgomery, West Virginia
2007-Present Department of Nursing Chair, West Virginia University Institute of
 Technology, Montgomery, West Virginia