OPPRESSION IN NURSING: DOES EDUCATION LEVEL MAKE A DIFFERENCE IN A HOSPITAL ENVIRONMENT?

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ABSTRACT

The purpose of this research was to determine if the bachelor degree nurse self-reports a different level of oppression than the associate degree nurse in a hospital environment. Assimilation, marginalization, and horizontal violence are discussed within nursing literature and were used to create an instrument to measure oppression within a hospital environment. This project used these issues to evaluate the present state of nursing within one hospital setting and compare degree levels to determine if a difference existed.

An instrument was developed, and made available to registered nurses within a hospital setting to measure self-reported levels of oppression. The tool was available online for 30 days. Results were formulated to look for significant differences between the associate degree and bachelor degree nurse's self-reported oppression. A factor analysis was completed to explore the validity of the questions. The results revealed no significant difference between the two educational groups.

DEDICATION

"If a man does his best, what else is there?" General Patton

This dissertation is dedicated to Edward Ashton, Bob Weston, my parents (Joe and Emily Meadow), husband (Jim), and children (Brigid and Alex). Edwin Ashton passed it on in a way that changed my life forever. Bob Weston always believed in me, he taught me that my best . . . plus God . . . equals enough. My parents, husband, and children have lived this journey with me; it is as much theirs as it is mine.

LIST OF ABBREVIATIONS AND SYMBOLS

BSN	Baccalaureate Degree in Nursing
CVI	Content Validity Index
DSN-c	Doctor of Nursing Science
FAAN	Fellow of American Academy of Nursing
ICU	Intensive Care Unit
I-CVI	Item Content Validity Index
EFA	Exploratory Factor Analysis
IRB	International Review Board
MANNOVA	Multivariate Analysis of Variance
NOI	Nursing Oppression Index
PAF	Principal Axis Factor
PhD	Doctor of Philosophy
RN	Registered Nurse
S-CVI	Subject Content Validity Index
SPSS	Statistical Program for Social Sciences

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CHAPTER I

INTRODUCTION

Some researchers have suggested that the field of nursing is structured within an established hierarchy and is oppressed by those practicing medicine are placed at the top (Roberts, 2010; Roberts, Demarco, & Griffin, 2009). Within oppression, the dominant group has the ability to control a subservient group and silence them in favor of the more valued dominant group (Freire, 2000; Matheson & Bobay, 2007). It has been suggested that the oppressed internalize the values of the dominant group (Freire, 2000). The subservient group diminishes their own value, actually participating in the oppression by acting as if values internalized were true (Purpora, Blegen, & Stotts, 2012). The minimum requirement for licensure as a registered nurse is a 2-year associate degree. Advancing to a 4-year baccalaureate degree in nursing does not change the licensure or practice limitations of a registered nurse. There may be a difference in the way associate and baccalaureate nurses experience oppression. Pope (2008) stated within her dissertation, *Transforming Oppression in Nursing Education: Towards a Liberation Pedagogy*, "To say the staff resented my BS degree would be a gross understatement. I was under the impression that all nurses would share my commitment and philosophy of nursing, but I was wrong" (p. 5). The purpose of this research was to determine if the bachelor degree nurse self-reports a different level of oppression than the associate degree nurse in a hospital environment.

Significance of Problem

The nursing educational systems produce new graduate nurses that value critical thinking and questioning (Adams, 1999). The ability to think critically enables the nurse to question,

analyze, and develop answers to problems as they are presented in clinical nursing. By increasing problem-solving skills, nurses are able to increase their options for solutions to clinical situations. In an article entitled, "Nursing Education for Critical Thinking: An Intgrative Review," Adams (1999) stated that present nursing care requires critical thinking, especially with advances in technology and increased acuity of patients.

The values of the new graduate nurse's experienced co-workers reflect a desensitized view of nursing core values (Wolff, Pesut, & Regan, 2010). There may be a scheme in the clinical practice that determines the nature of nursing's identity in the realm of professional practice (Holyoake, 2011). The medicalized environment of hospitals may not support social justice, or a humanistic approach to patient care. Nursing core values determine a common core of beliefs for nursing. A desensitized view of these values in clinical nursing presents a conflict for new graduates. In "The Prevailing Winds of Oppressions: Understanding the New Graduate Experience in Acute Care", Duscher and Merick (2008) described the conflict between new graduates and establishing a clinical practice in hospitals is underpinned by hierarchical and economic values which are in opposition to a viewpoint that values the human existence above money and property.

The unspoken and often hidden characteristics of the relationships within professional practice (and the reflective hierarchy of power) may deviate from the written rules of practice and do not promote clinical thinking. Within professional practice, nurses are interchangeable and may not experience any identity related to nursing expertise when treating patients. The hospitals of today want to be able to float nurses and patients in a way that keeps the beds full, ensuring that a patient can be moved around to an empty bed (Gordon, 2005). It has been suggested that nurses need to become more aware of the power and oppression within their

personal working environments and the nursing profession (Van Herk, Smith, & Andrew, 2011). Gordon (2005) explained that the decisions within hospital environments are being made based on availability of resources rather than patient needs and this reflects that a nurse is no more than one of the resources available for the hospital to utilize. Researchers have suggested that the experience of oppression may result in nurses' lateral violence as a result of self- hatred. Matheson and Bombay (2007) suggested that oppressed groups, like nurses, display passive-aggressive behaviors when more powerful people are present. One example is the nurse who complains about physicians; however, almost never confronts them relating to the behaviors (Matheson & Bombay, 2007).

Another negative consequence within issues of oppression may be issues of retention. Between 33% and 61% of new registered nurses may leave the profession or change their employment within the first year (Duchscher & Myrick, 2008). The work environment for nurses may have some influence on a nurse's decisions to leave. In an article entitled "Is Anybody Listening? A Qualitative Study of Nurses' Reflections on Practice," Huntington et al. (2011) stated that substantial research documenting the increasing acuity within settings of acute and chronic care delivery further exacerbated by political and economic targets has created an environment for the high turnover of nurses and a hostile work environment. Within the study issues about managerial support and the physical/emotional cost to the nurse working within acute and chronic care delivery settings were identified (Hunting et al., 2011).

In clinical practice there is no differentiation of licensure between baccalaureate and associate degree nurses. "The nineteenth-century notion that a nurse is a nurse is a nurse" should be challenged within the oppression of nurses (Gordon, 2005, p. 279). An increase in educational level may change the way a registered nurse views the clinical environment.

Education should be a way of transforming the way one sees the world. In the foreword to *Pedagogy of the Oppressed*, Richard Shaull (1970) expressed that education either creates conformity or freedom and suggested that learning is never neutral. It is further suggested that teaching freedom is the equivalent of teaching men and women how to transform or liberate their world (Freire, 2000)

A need exists for transformative education in the way nurses are taught (Shultz, 2014). Awareness of oppression and liberative pedagogy should be part of this transformation. Educators and philosophers have, for many years, encouraged the advancement of education as a mode of liberation for the oppressed (Cordington, 2013). Freire (1970) believed that the most important task of the oppressed was to liberate them and that liberation should be supported through advancing education.

A better understanding of the impact of oppression on the nurse may be helpful. One approach to increasing our knowledge of oppression in nursing is the development of ways to measure the construct, oppression. The development of a tool to measure oppression within nursing environments and evaluate the level of oppression between educational groups will create a first step toward giving educators a measure of the present state of nursing oppression. The measurement of oppression within a hospital environment will evaluate the success of educators in moving towards a liberatory narrative in registered nursing practice.

Associate Degree and Baccalaureate Degree in Nursing

The associate degree in nursing consists of a 2-year commitment to education, and in 2008 represented about 50% of the nursing workforce (Orsolini-Hain, 2012a). Associate degree nurses do not perceive that a baccalaureate degree would be any greater benefit in the present professional practice settings (Orsolini-Hain, 2012b). Recent perspectives suggest that nurses'

experience is more imperative than their didactic learning (Aiken, Clarke, Cheung, Sloan, & Silber, 2003).

Associate degree nurses have a higher level of lifetime earnings than their BSN counterparts, when the cost of education is factored into those equations (Spetz, 2002). Nursing education does not equal a higher paying position. The clinical nurse does not receive a significant financial benefit from increasing his/her educational level from associate degree to baccalaureate degree. The financial return for a registered nurse varies very little depending on the degree obtained. Goals and private situations most often encourage the RN's pursuit of increased education (Spetz, 2002). Mahaffey (2002) stated that the biggest issue with associate degree nursing is the lack of consistent efforts to distribute information about associate degree nursing practice.

The second way to obtain permission to test for the registered nursing licensure is by obtaining a baccalaureate degree, which consists of a 4-year educational commitment. Some nurses with BSN degrees have reported greater job satisfaction, advancement, and mobility (Starr & Edwards, 2010). Higher levels of BSN nurses within a hospital setting have been correlated to lower mortality in surgical patients in a cross-sectional analysis of outcome data of 232,342 patients discharged from 168 Pennsylvania hospitals (Aiken et al., 2003). The study further found that "[h]ospitals with higher proportions of baccalaureate-and master's-prepared nurses also had slightly less experienced nurses on average and significantly lower mean workloads" (Aiken et al., 2003, p. 1619). The two entryways into professional nursing create two separate groups and lead to issues of acceptance in the work environment. Both degrees are entryways into the field and require a passing score on a national exam, meaning that both

entryways into nursing have graduates that are capable of providing safe care within the present system (Starr & Edwards, 2010).

Associate degree nurses are being encouraged to complete their baccalaureate degree within the next 10 years, but it is not a requirement for entry into the nursing profession (Starr & Edwards, 2010). A strong theoretical base and the ability to incorporate evidence-based nursing practices is one argument supporting the advancement of nurses' education to a baccalaureate degree (Starr & Edwards, 2010 In "A Reflection on Nursing Education and Practice" by Wu (2013), the gains of America's efforts to elevate nursing practice were recognized. The introduction of science into nursing research through the use of theories and the implementation of university nursing education an evidence-based practice have improved nursing as a science while improving quality of care delivered (Wu, 2013).

The workforce needed is not being provided by the baccalaureate degree nursing programs and the existence of associate nurses to meet the growing need for nurses is a reasonable explanation (Orsolini-Hain, 2012b). Continuing the process of providing safe care is yet another argument for sustaining associate degree programs (Orsolini-Hain, 2012b). Mahaffey (2002) further stated some nursing organizations continue to have differing opinions about present and future registered nursing practice.

This research did not seek to solve this educational dilemma, but only to identify its existence and role in the presence of oppression in nursing. As a result of this research, a quantitative tool was created to measure oppression in nursing as self-reported by the nurses participating. The data collected were used to look for a statistical difference of oppression between the entry-level educational groups existing within Registered Nursing. Bartholomew (2010) discussed the divergence of power through differing pathways to licensure. Her main

argument was that by failing to identify one entry point into the profession, oppression within nursing has been amplified from inside the profession (Bartholomew, 2010). The existence of two varying levels of education as an entranceway into the profession can be used as guidepost to identify whether the difference in educational level makes a difference in oppression within the field of nursing. This researcher could not find any literature that examined the registered nurses' view of oppression and a correlation to the level of education received. The purpose of this research was to determine if the bachelor degree nurse self-reported a different level of self-reported oppression than the associate degree nurse in a hospital environment.

Theoretical Framework

How does one address whether issues of differential treatment exist based upon educational level? Freire (2000) potentially provided a model. The theoretical framework used for this study was the model of oppression by Paulo Freire (Freire, 2000). Freire identified oppressed group behaviors that begin when a group is silenced by confrontation with authority, leading to anger and aggressive behaviors towards one's own peer group (Freire, 2000). This model has five prominent elements: assimilation, marginalization, self- hatred and low self-esteem, submissive aggressive syndrome, and horizontal violence (Freire, 2000). The framework will be discussed as it relates to nursing's state of oppression and its relevance to education.

A central theme throughout Freire's work is the idea that education must be pivotal in the evolution of social change (Gottesman, 2010). It has been recognized many times that people respond negatively when one person is awarded more readily for an equal effort (Moosa & Ud-Dean, 2011). Dominant groups in these discussions are physicians, who are seen as having the normal decision-making authority within the healthcare system (Matheson & Bobay, 2007).

By being provided with more credit for equal work, physicians impose their identity within the medical model upon the lesser group, nurses. "The medical model is viewed as exhibiting the 'right' values and norms for the health care system. This truth is borne out on all healthcare professions who are assumed under the physicians' control and direction" (Matheson & Bobay, 2007, p. 227). The oppression of one group by imposing their identity upon another through the work of the lesser group creates a system of myths that contribute to the identification of the lesser group (Freire, 2000). "Nursing's work is often exploited by others in the healthcare system" (Dubrosky, 2013, p. 205). This can be seen in the groups of nurses who, through long hours of labor, care for a patient who recovers, after which the doctor is credited with the attributes of said recovery. This example demonstrates the myth that the doctor ordered and created all the care provided for the patient. Education creates the identification of myths perpetuated by the oppressors (Freire, 2000; Matheson, 2008; Matheson & Bobay, 2007). Nursing education should teach toward liberation (Pope, 2008). This suggest that nursing education should teach toward empowering practices.

Empowering practices potentially create better nurses. Nurses who identify themselves as empowered may have better work practices (Donahue, Piazza, Griffin, Dykes, & Fitzpatrick, 2008). Empowering practices create better health outcomes for patients (Laschinger, Gilbert, Smith, & Leslie, 2008). Higher levels of performance have been associated with the empowerment of nurses (Leggat, Batram, Casimir, & Stanton, 2010). Empowerment has also been identified as a possible indicator of positive work behaviors that lead toward more positive working environments (Oyeleye, Hanson, O'Connor & Dunn, 2013).

Relevance of Freire's Work in the Nursing Profession

Freire's work has been used in the nursing literature to define oppression in nursing. Duchscher and Myrick (2008) used Freire's (2000) work within marginalized societies to discuss new graduates' experiences in acute care, claiming that the prominence of critical reflection and

ability to act independently defines the culture of our environments. Some have suggested that a change in behavior and empowerment are called for in oppressed groups and the culture of nursing environments. The theory of oppression suggests rejecting damaging images within work beliefs and replacing it with a sense of group pride and abilities (Roberts et al., 2009).

Roberts' assertion of Freire's model within nursing was addressed in 1996 by the American Nurses Association when its president was recorded as saying, "There is nothing from the outside that can endanger us. It will come from within" (Matheson & Bobay, 2007, p. 227). Freire believed that the origin of oppression came from within, and that freedom may only be gained by the efforts of the oppressed group. No outsider can free them or it would be further oppression in the guise of something that, once given, could be taken away (Freire, 2000). The oppressors cannot liberate the oppressed, and attempts may be viewed with some suspicion (Mithra, 2014).

The same issues seen in Freire's work can be seen in the present nursing profession. Purpora et al. (2012) defined lateral violence in nursing as the way oppressed individuals (nurses) deal with their state of oppression and further cited oppression theory as an underlying theme. Nursing as a profession has argued about many issues, and experience violence from the doctors they work with, each other and patients. Dubrosky (2013) stated that nursing has an extensive interprofessional violence. He further stated that nurses experience violence from patients, families, and others to the extent that nurses are fighting from many perspectives and as a result cannot form a singular voice.

Paulo Freire's theory of oppression (2000) has been used in nursing literature to define the oppressed state of the nursing profession (Dong & Temple, 2011; Duchscher & Myrick, 2008; Matheson, 2008; Matheson & Bobay, 2007; Pope, 2008; Purpora et al., 2012; Roberts,

2010; Roberts et al., 2009; Vickers, 2008). Freire's work transcends individual disciplines and applies to the present state of the nursing profession (Dong & Temple, 2011). Nurses, practicing in institutions that employ a hierarchy in their communities, shape their behaviors and views of themselves from the physician hierarchical models presented within the institutions (Purpora et al., 2012). Assimilation into the culture of domination prevents the nurse from defending an individual practice (Duchscher & Myrick, 2008). Marginalization, the next step, keeps nurses within a narrow area of responsibility, allowing the physicians to take credit for the recovery and treatment of patients (Duchscher & Myrick, 2008; Roberts et al., 2009). Belittled by the more powerful physicians, nurses allow their practice to be defined by the physicians they work for (Mantzoukas & Jasper, 2004). Finally, acts of violence against each other in the profession erupt. Nurses display horizontal violent behaviors (Sheridan-Leos, 2008).

Operational Key Terms

Assimilation. In this study, assimilation refers to the inclusion of new nurses entering into nursing environments, including orientation and acceptance of new graduates and/or experienced nurses into the culture of professional nursing practice.

New graduates experience a conflict between the professional values in nursing and the task-oriented job requirements in professional nursing (Feng & Tsai, 2012; Thrysoe, Hounsgaard, Wagner, & Dohn, 2012). Relations between new nurses and established staff can have a direct effect on the new nurse's assimilation (Thrysoe et al., 2012). While being orientated as a new graduate, there are differences between philosophies of the new nurse and their more experienced peers (Wolff et al., 2010). Current new nurse graduates are taught in a method that values questioning, critical thinking, obligation to nursing as a profession, and prejudice against the demands of subservient (and patriarchal) healthcare systems (Wolff et al.,

2010). Assimilation into professional practice is exacerbated in acute care situations where nurses are frequently required to make complex nursing decisions, work long shifts, and balance rapid patient admission and discharge (Hartigan, Murphy, Flynn, & Walshe, 2010; Hayes, Bonner, & Pryor, 2010). Entering into professional nursing practice is a difficult transition (Duchscher & Myrick, 2008; Hartigan et al., 2010; Stevens, 2002; Thrysoe et al., 2012; Wolff et al., 2010).

Marginalization. In this study, marginalization refers to the ability of nurses to make independent decisions of care based on their licensure. This refers to the nurse's ability to make decisions without the approval of a physician or another approving body.

Physicians are seen as having the 'right' or normal decision-making authority within the healthcare system (Matheson & Bobay, 2007). The illusion is that the oppressors are somehow more competent than members of the subservient group (Breault, 2003). All other groups within healthcare are lesser groups than the physicians, because permission to proceed must be obtained from this dominant group (Matheson & Bobay, 2007).

Inadequate communication between doctors and nurses is a common issue in relation to near errors and mistakes (Colombo, 2009; Tschannen & Kalisch, 2009). The power struggle creates an illusionary picture of reality, allowing the dominant group (physicians) to define nursing practice (Mantzoukas & Jasper, 2004). Nurses often use a hidden manner of communication to provide information and make suggestions without challenging the hierarchy (Churchman & Doherty, 2010).

Horizontal Violence. In this study, horizontal violence referred to any acts of aggression or perceived aggression from one nurse to another. This includes lateral violence as an interchangeable term.

Modern hospitals offer a very challenging environment for the new nurse in which to acclimate (Duchscher & Myrick, 2008). Lateral violence has been discussed as bullying, horizontal violence, workplace violence and most recently workplace aggression (Becher & Visovsky, 2012; Hayes, Bonner, & Pryor, 2010; Sheridan-Leos, 2008; Stevens, 2002; Townsend, 2012). Nurses display horizontal violent behaviors (Sheridan-Leos, 2008, p. 401). Horizontal violence can take the form of workplace aggression (Rodwell & Demir, 2012; Thobaben, 2011; Townsend, 2012). Nurses, both experienced and new graduates, working in hospitals are at risk for horizontal violence (Purpora et al., 2012). Horizontal violence can lead to poor patient outcomes and compromises in patient safety (Brann, 2010). This lack of unity and increased aggression toward one another in nursing is a direct result of oppression (Roberts et al., 2009).

Specific examples of horizontal violence include complaints not shared with the individual first and shared with co-workers not involved, sarcastic comments, and withholding assistance (Lachman, 2014). An article entitled "Horizontal Violence in Nursing" claimed that behaviors could include intimidation, fighting, public humiliation, and withholding (Becher & Visovsky, 2012). In a quantitative review of nursing literature that estimated exposure rates, 36.4% of nurses reported exposure to physical violence and 39.7% reported exposure to bullying (Spector, Zhou, & Che, 2014).

Oppression. In this study, oppression refers to a state of being in which one group is controlled or dominated.

Oppression is created when a person is restricted between opposing forces that when combined stop the free movement of that person (Frye, 1983). This phenomenon is further exacerbated when it refers to a group. When a group is diminished in importance by a structural

force that controls them, it is called oppression (Young, 1990). Oppression, in this study, refers to the domination of a group by forces that seek to diminish the group's decision-making ability.

Self-Report. In this study, self-report was defined as a person's own opinion or impression.

Summary

It has been suggested that nursing is an oppressed occupation (Roberts, 2010; Roberts et al., 2009; Pope, 2008). Differing educational levels—BSN and Associate degree—may impact the amount of oppression clinical nurses experience in a hospital setting. The hospital view of the nurses as interchangeable is devaluing, creating a stressed situation where physicians are dominant. According to Freire (2000), increased education should mediate the oppressed state. Nursing education should empower nurses within the profession and the greater educational investment should reflect a difference through the eyes of the graduates.

Nursing educators must be able to prepare graduates for present nursing environments. This study compared the associate and BSN graduates to evaluate the current levels of self-reported oppression experienced within a present nursing environment. The results evaluated the differences between the two groups as self-reported by the members of each group. The identification of differences between the two groups can create an evaluation of the success of education as expressed by Freire's model of oppression. This research sought to determine if the bachelor degree nurse self- reported a different level of oppression than the associate degree nurse in a hospital environment. Below are the hypotheses and null hypotheses associated with this study.

Hypotheses

1. Nurses with a bachelor's degree will self-report less oppression than associate degree nurses working in a hospital setting.

2. Nurses with a bachelor's degree will self-report less difficulty with assimilation than associate degree nurses working in a hospital setting.

3. Nurses with a bachelor's level of education will self-report less marginalization than their associate level coworkers working in a hospital setting.

4. Nurses with an associate degree education will self-report nursing environments to be more laterally violent than their baccalaureate-educated co-workers working in a hospital setting.

5. The validity of the hypothesized factors based upon the research literature—assimilation, marginalization and lateral violence—will be determined within a factor analysis.

Null Hypotheses

1. Nurses with a bachelor's degree will not self-report less oppression than associate degree nurses working in a hospital setting.

2. Nurses with a bachelor's degree will not self-report less difficulty with assimilation than associate degree nurses working in a hospital setting.

3. Nurses with a bachelor's level of education will not self-report less marginalization than their associate level coworkers working in a hospital setting.

4. Nurses with an associate degree education will not self-report nursing environments to be more laterally violent than their baccalaureate-educated co-workers working in a hospital setting.

5. The validity of the hypothesized factors based upon the research literature-assimilation, marginalization and lateral violence will not be determined within a factor analysis.

CHAPTER II

REVIEW OF THE LITERATURE

This chapter will involve discussion of the historical development of the hospital hierarchy, nursing oppression in the 20th century, and the modern day registered nurse within a hospital. The discussion will end with nursing assimilation, marginalization, and horizontal violence. Nursing has been hypothesized to be an oppressed group (Dong & Temple, 2011). Three of the elements in Freire's model, assimilation, marginalization, and lateral violence, appear to be associated with oppression within the present day nursing literature (Dong & Temple, 2011; Duchscher & Myrick, 2008; Holyoake, 2011; Roberts et al., 2009). Freire wrote about education and its connection to oppression. Freire (2000) defined the dilemma of the oppressed within his text, "The Pedagogy of the Oppressed." He stated that the oppressed experience a dichotomy within their beings. This dichotomy creates the discovery that they are unable to be themselves, and even more insightful is reality that the oppressed fear their freedom. Freire expressed that the oppressed have internalized the oppressor in some aspects and are conflicted about that internalization. The dilemma that Freire stated education needs to address is the oppressed group's inability to create the environments and decisions they desire.

In this chapter, there will be a discussion of the historical oppression of nurses and lead to the present state age where assimilation, marginalization, and lateral violence are identified within the nursing literature.

Historical Development of the Hospital Hierarchy

In the early 19th century, most hospitals were charitable institutions that were run by nurses and doctors were only visitors (Gordon, 2005). Most doctors had little formal education with the exception of the larger medically driven hospitals in North America and Europe. Nurses were offered no education, and women serving within hospitals were often viewed negatively (Joel & Kelly, 2002). The perception at the time was that proper women did not work outside the home, and those religiously influenced women that worked within hospitals did so for very little or no cost (Joel & Kelly, 2002). Nurses within hospitals were servants to the patients and in return were granted food and shelter (Joel & Kelly, 2002).

Most patients were visited by doctors within the home, in the office, or within the community. Only the poor and destitute patients were to be found within hospitals. Doctors often competed for patients to the extent that doctors often had difficulty maintaining a living wage and often discredited each other (Gordon, 2005). Churches and community-run hospitals yielded space to doctors to oversee patients as visitors. A lay board was made up of employed doctors and/or community leaders who made major decisions related to which indigent patients could get admitted, placing doctors in the position of making broad hospital decisions but giving them little voice in actual patient care (Gordon, 2005).

In the late 19th century, scientists and doctors began increasing knowledge and developing more accurate diagnostic equipment. Medical professionals sought to defend the idea that they possess understanding of special information and belonged in control of the hospitals (Gordon, 2005). During this time, nurses began to be discredited for the work they had done for years. At Guy's Hospital, Sir William Gull, who was a consulting physician, stated that "there is no proper duty the nurse has to perform, even to the placing of a pillow, which does not

or may not involve a principal, and a principal which can only properly be met by one who has the advantage of medical instruction" (Petterson, 1978, p.183). The physician oversight began to limit the nurse to following doctor's orders.

In London, nurses attempted to gain education that would result in clinical knowledge; this struggle resulted in Guy Hospital becoming a focal point for nursing educational reform. Nursing supervisors wanted to educate nurses in the treatment and diagnosis of patients, group patients according to diagnosis and create written records so patients could be better cared for within hospitals. One example of the conflict between nurses and doctors is the story of Margaret Burt as documented in "Nursing, Physician Control, and the Medical Monopoly: Historical Perspectives on Gendered Inequality in Roles, Rights, and Range of Practice." Margaret Elizabeth Burt was educated at St. John's House, worked at King's College Hospital, and was appointed matron of Guy's Hospital in 1879. Burt had learned a system of nursing that was successful at King's College Hospital. It is important to note that Burt did not transfer any of the staff from King's College Hospital or bring any of her sisterhood (her sisterhood is not specified, but it is noted that she had one in the document) because physicians used religion as a criticism of her administration. The only religious requirement of the Hospital was attendance at the morning and evening prayers. Libelous statements were written about her character and her hypothetical abuse of patients. Reports of Margaret Lonsdale, a supporter of Burt, identified the fight over nursing reforms as a characteristic fight by physicians to assure that untrained women were available to meet the needs and study the charms of medical men.

In another example of the conflict between doctors and nurses, Dr. Braxton Hicks represented the physicians with opinions against a central nursing system. The physicians did not want a matron or superintendent in charge of nursing as a whole. The physicians thought

that the women would band together against their authority. Dr. Hicks did not want the nurses, as a group, to oppose the physicians' authority as medical experts (Gordon, 2005).

At this time within the ward system in England, nurses were expected to serve physicians. Dr. John Neale stated that the medical residents (training within the hospitals) were additionally self-assured with a woman present to assist them. Neale further believed that a matron who was assured housing might become egotistical and make statement of a derogatory nature about medical staff. He also believed that women were easily influenced by bias. Another physician, Dr. Moore, agreed stating that women lacked sensible thoughts.

Burt's improvements were mostly structural in nature, offering clinical training in nursing types, grouping patients according to need and keeping a written record. At Guy's Hospital, Dr. Moore insisted that these changes were dangerous, even challenging a woman's use of a thermometer. Burt continued to struggle with the physicians at Guy's Hospital until Lonsdale publicized the arguments.

Further limitations in nursing activities followed in court cases where nurses' independent actions in the late 19th century were blamed for the deaths of patients. Guy Hospital presented a documented court case as the result of altercations between Burt and the physicians struggling for control, as discussed by Group and Roberts (2001). At Guy Hospital, a manslaughter change was levied against a nurse named Pleasant Louisa Ingle. She was charged with the death of a consumptive patient after giving the patient a bath.

The case was published in the *New York Times* (August 7, 1880). In the article entitled, "A Nurse Guilty of Manslaughter," it claimed that the patient had died because the nurse had acted without physician approval. Nurse Ingle had not been informed of the patient's diagnosis and was not one of the nurses hired under Burt's new nursing system. Burt was not allowed to

testify—it is noted that she was available. Dr. William Gull, from Guy Hospital, testified that the nurse had not caused the death because the underlying condition was sufficient to cause the patient's death. Ingle was convicted related to the testimony of Dr. F.W. Pavy (another physician at Guy's Hospital) stating the nurse had caused the patient's death due to negligence by making an independent decision. This patient's death and the ensuing court case was purposely used to negate the basic question related to nursing's independent decision-making ability. The conclusion made from the decision of the courts was that physicians needed complete control.

In the United States, a parallel of struggles for nursing independence was occurring. In an article, "On the Training of Nurses for the Sick," Dr. Packard argued his opinion that nurses did not need scientific knowledge and that doctors wanted nurses that had practical knowledge about completing tasks only. At this point in historical development, nurses were gaining. Packard (1876) further stated that nurses need no knowledge above how to do an assignment (defined by the physician), stating further knowledge would create someone who might have an opinion.

In a 1906 article within the *New York Times*, Dr. Thompson called nurses overly educated and suggested changes in their course of study. Thompson (1906) stated that physicians should require their presence on nursing boards and the curriculum within the schools should be submitted for approval before implementation. The early 20th century brought nursing educational issues to the forefront. Nurses began to receive education and physicians refused to grant independent educational opportunities. The beginning of nurses' training, subjected to the empowered physicians, created a duality wherein nurses were servants to the physicians as well as the patients.

The physicians cemented their control of the medical field through statutes of law (practicing 'medicine' is against the law if one is not a trained physician), and nurses were marginalized into a subservient position (Gordon, 2005). Nurses could be prosecuted for practicing medicine without a license. Primarily because of the court case at Guy Hospital, a nurse could not make independent decisions without fear of being prosecuted. Nurses had lost the ability to make independent decisions about their patients and required a physician order to administer care (Gordon, 2005).

Oppression in the 20th Century

> "Yet, although they desire authentic existence, they fear it. They are at one and the same time themselves and the oppressor whose consciousness they have internalized" (Freire, 2000, p. 48).

By the end of the 19th century, there was no change to growing evidence that the nurse was an important contributor to the care of the sick; however, many limitations existed. During this timeframe, the nurse would solidify the role of handmaid, binding them to the more powerful physicians. Nurses were then denied education and became participants in the marginalization of their practice, supporting the more powerful physicians. Thus, nursing silence became an important part of assimilating into nursing practice within hospitals (Gordon, 2005).

An article in the *Boston Medical and Surgical Journal* published October 24, 1889 explained the role of the nurse as no less important that the doctor. The article elaborated that the nurse has a responsibility to be supportive and impede any prejudice she has because he is there at the request of the family, not her. Finally, any attempt to sway the patient or family away from confidence in their doctor must be considered obtuse and malicious (The Reciprocal Relations of the Nurse and the Physician, editorial).

Nurses served in a supporting role for physicians. The nurse's responsibility now included supporting the physicians' clinical decisions. The nurse was placed in the position of subservience to the more powerful physicians.

> Creating the virtuous, knowledge less, self-sacrificing nurse involved in not only intellectual restrictions but also behavioral prohibitions. . . . although they were instructed to reach doctors for orders day or night, interrupt them in surgery, or wake them up at home when necessary, nurses were socialized to sound sufficiently apologetic. (Gordon, 2005, p 63)

The nurse was silenced by being forced to persuade the physician to give permission for needed treatments or a course of action without having any say in the final decision other than persuasive speech.

In 1907, a nursing supervisor's work included keeping the doctors happy and managing all aspects of care to continue the running of the hospital. The supervisor was sometimes assisted by a housekeeper and perhaps a new graduate. The management of the kitchen, laundry, and storeroom were included in the duties. Included in the management of a hospital were physicians, all of which, must be greeted with sensitivity and kept happy (Gladwin, 1907). Keeping the physician happy had now become a part of a nurse's duty.

Throughout much of the early 20th century, nurses yielded into subservience to the more powerful physicians. A well-publicized example of this subservience can be seen within the establishment of a community clinic in Manhattan, New York, to treat the poor and sick in the early 1900s. The clinic was challenged because nurses gave out ointments and pills to the sick without physician approval. After this altercation with the more powerful physicians, the nurses involved asserted that the nurses would, in future encounters, make every effort to support the doctors prescribed treatment instead of prescribing a treatment independently (Buhler-Wilkerson, 2001).

Nursing education, in the early 1900s, became dominated by physician control.

> The scope of nursing education was strictly limited and largely delivered to nurses by physicians. Indeed to call early hospital schools 'schools' would be an exaggeration. . . . Courses were squeezed in when pupils had a moment off the ward, but were generally too tired to absorb anything they were taught. . . . Nurse reformers engineered an enormous accomplishment, the first mass profession for respectable women working outside the house, however, the stage was set for nurses to be viewed as an endless source of cheap, disposable labor for hospitals, as servants to doctors, and as angels, saints, and martyrs to the public and the media. (Gordon, 2005, p. 68)

Modern Day Registered Nurse in the Hospital

> The conflict lies in the choice between being wholly themselves or being divided; between ejecting the oppressor or alienation; between acting or having the illusion of acting through the actions of the oppressor; between being speaking or being silent, castrated in their power to create or re-create, in their power to transform the world. (Freire, 2000, p. 48)

Doug and Temple (2011) stated, "Given the many instances where oppression exists, and the implications and impact oppression has on nursing and nurses, studies could be developed to further examine how nurses view and understand oppression" (2011, p. 174). The present nursing environment within the hospital is oppressive, creating a nurse who must yield within the present healthcare system (Gordon, 2005). Decision making at the bedside must be supported, and the nurses' control over the bedside practice is essential to nursing care quality (Castner, Cervavolo, Foltz-Ramos, & Yow-Wu, 2013). This research used assimilation, marginalization, and horizontal violence as markers to examine the present day indicators of oppression, because these are readily seen within the nursing literature (Dong & Temple, 2011; Holyoake, 2011; Roberts et al., 2009). As nurses are encouraged to raise the educational level for entry, we (as researchers) have a responsibility to determine whether this reduces the level of oppression in a professional setting.

Aiken et al. (2003) suggested that elevating the nursing level of education to at least a BSN will also affect the numbers of patients that survive surgery. Within the article, the

assumption that nursing experience is more important than educational achievement is challenged. The study examined patients from 168 hospitals and included data outcomes for over 232,342 surgeries. Aiken et al. (2003) asserted that failure to raise the nursing educational level to higher percentages of baccalaureate and master's level nurses within a hospital environment may be harming patients. The article also recognizes the differences between hospital environments. Hospitals reporting higher numbers of BSN and master prepared nurses, usually academic teaching hospitals, were noted to include lower numbers of experienced nurses and lower average workloads (Aiken et al., 2004). The statement recognizes the need to examine more closely the environments of hospitals within which nurses are employed. The article also establishes the connection of patient survival, education, and the care provided by the nurses within a hospital. The nurse's career begins when they assimilate as a healthcare provider.

Assimilation

Freire (2000) suggested that assimilation into an oppressive atmosphere creates a learning of behaviors presented by the dominant group. Practicing in institutions that employ a medical hierarchy within the environment, nurses shape their behaviors and views of themselves related to the power structure created where physicians have the final decision-making authority (Purpora et al., 2012). The theory of oppression suggests the need to reject damaging pictures presented in nursing workplace environments (Roberts et al., 2009). Nursing environments present a workplace where one person is credited with the work of another, giving the more dominant group decision-making authority (Moose & Un-Dean, 2011).

New graduates continually struggle to assimilate into the work setting (Peterson, O'Brien-Pallas, McGillis Hall, & Cockerill, 2011). Assimilation into professional practice is exacerbated in acute care situations where nurses are frequently required to make complex nursing decisions,

work long shifts, and balance rapid patient admission and discharge (Hartigan et al., 2010; Hayes et al., 2010). In a study examining the lived experience of oppression in nursing, "participants used words such as, 'destroy,' 'rejected,' 'hate,' 'angry,' and 'they kept me where they were comfortable" when receiving feedback from registered nurses working within a hospital environment (Tinsley & France, 2004, p. 9).

In "An Exploratory Study of the Orientation Needs of Experienced Nurses," the need to tailor orientation to meet the educational needs of the experienced nurse identified that previous work experience shaped their outlooks.

> With a rich work history similar to that of previously employed nurses, these nurses went through a process more like transitioning than orientating . . . They did however struggle with having to assume a novice role, although they all felt it validated their abilities. (Dellasega, Gabbay, Durdock, & Martinez-King, 2009, pp. 315-316)

In a study identifying nurse competencies administrators thought were necessary for the new graduate, Utley-Smith (2004) determined there was little data to identify which exact competencies that were needed for nursing professional practice. Utley-Smith (2004) concluded that over time the competencies change.

New nurses within the hospital environments experience high turnover and increasing job stressors (Clark & Springer, 2012; Duchscher & Myrick, 2008; Higgins & MacIntosh, 2010). Upon graduation from nursing educational programs, graduates are expected to meet the basic requirements for professional practice (Hartigan et al., 2010). The issue of educational preparation of nurses and their practice readiness has been debated since 1965 (Hartigan et al., 2010; Starr & Edwards, 2010; Wolff et al., 2010). There is a gap between what nursing educators believe is a practice ready nurse, and the professional view of what is a "good nurse" (Van Herk et al., 2011). This gap can cause assimilation issues for new nurses and students. Relations between new nurses and established staff can have a direct effect on the new nurse's

assimilation (Thrysoe et al., 2012). Gordon (2005) stated that given the makeup of present nursing work, it is understandable that veteran nurses do not encourage nursing students. Experienced nurses are often overburdened, and feel betrayed by the hospital system, management, and the nursing profession. Many nurses believe the crisis is so troubling that there is nothing to be done (Gordon, 2005).

New graduates experience a conflict between the professional values in nursing and the task-oriented job requirements in professional nursing (Feng & Tsai, 2012; Thrysoe et al., 2012). While being oriented, new graduate nurses express differences in their core values when compared to their experienced counterparts (Wolff et al., 2010, p. 190). Some seasoned nurses have adopted the cultural attitudes of the acute care environment and have become unaware of the nursing core values that have been systematically abandoned in favor of assimilation (Wolff et al., 2010). The task-oriented conflict can be seen through a study done related to nurses leaving the profession. A "hatch mark system" was developed by the older nurses to single out the mistakes of new nurses: "They [nursing staff] put hatch marks up there [to record mistakes made by new nurses]. I did not know what they were until someone came up, and showed me how many hatch marks that I had" (Tinsley & France, 2004, p. 9).

Experienced nurses encounter difficulties transitioning into new nursing environments as well (Dellasega et al., 2009). Many articles have been presented discussing new graduate transitions; less has been written describing the orientation of experienced nurses during job transitions. It has been noted that when designing orientation of experienced perioperative nurses, a multifaceted strategy should replace present orientation techniques. The multifaceted strategy should include socialization and clear communication of what is expected (Mellinger, 2013). Nursing expectations can vary between specialties and environments. Partnerships in the

future must reflect the clinical and educational sides of nursing, and create a global conception of nursing competencies (Hartigan et al., 2010). Patricia Benner was quoted in the book, *Nursing Against the Odds* thusly:

> This is a logical extension of the market model. There is well they work together, where they can learn from one another, it's all like these interchangeable parts and you create an institution that's inhospitable , or alien to the complexity of the work. no vision of a community of practice where people are assigned because of how (Gordon, 2005, pp. 282-283)

Marginalization

Freire (2000) stated that the use of unequal power in oppression seeks to marginalize and silence a group so they cannot control their own environments. The marginalization of nursing keeps the profession from receiving due credit and allows physicians to take exclusive credit for the recovery of patients (Churchman & Doherty, 2010; Duchscher & Myrick, 2008; Roberts et al., 2009). By creating an unjust social order, inequalities of power occur preventing the sharing of different opportunities (Farmer, 2003). Despite the progress of nurses, the medical hierarchy views the nurse as an accessory to the physician (Brooten, Youngblut, Hannan, & Guido-Sanz, 2012; "Power struggle between docs, nurses goes public," 2010; Salhani & Coulter, 2009). Organizational issues relating to the hierarchy within medical practice and the role of nursing continue to be unsupported by management (Clark & Springer, 2012; Huntington et al., 2011). Learning within the profession of nursing is often not supported by the physicians (Higgins & MacIntosh, 2010). The relationship between doctors and nurses has been described as a "covert power game" (Holyoake, 2011; Mantzoukas & Jasper, 2004, p.925). This marginalization begins at the entrance to nursing practice, and continues throughout a nurse's career.

New nurse graduates are stressed and marginalized from the beginning of entering into nursing practice (Duchscher & Cowin, 2004). In more sporadic, high-speed medical

environments, opportunities for conversations and rapport are limited (Brooten et al., 2012). Sometimes hidden and unspoken, the worthiness of a nurse has been defined by the helpfulness they offer physicians (Holyoake, 2011). Nurses often use a hidden manner of communication to provide information and make suggestions without challenging the hierarchy (Churchman & Doherty, 2010). Interestingly, nurses describe a lower amount of collaboration than do physicians (Brooten et al., 2012). Physicians continue to fight against the independent reimbursement of nursing services and view this as the wearing away of physician gross monetary potential (Brooten et al., 2012).

The oppressive behavior of some physicians is somewhat anecdotal; documented personal accounts of nurses includes throwing objects and demeaning nurses by accusing them of incompetence or negligence in front of patients (Higgins & MacIntosh, 2010; Holyoake, 2011; Johnson, 2009). In the operating room, nurses have reported being yelled at and, at times, kicked by the physicians they worked with (Higgins & MacIntosh, 2010). There are examples of sexual harassment of nurses which are linked to performance when the nurse does not comply. One story reported a physician stating a nurse was a poor performer after she refused to see him outside the hospital environment (Johnson, 2009). Inadequate communication between doctors and nurses is a common issue in relation to near errors and mistakes (Colombo, 2009; Tschannen & Kalisch, 2009).

The role of women supporting men in everyday life is common in the role of nursing within the practice of medicine (Brann, 2010). The power struggle creates an illusionary picture of reality, allowing the dominant group (physicians) to define nursing practice (Mantzoukas & Jasper, 2004). The illusion is that the oppressors are somehow more competent than those of the subservient group (Breault, 2003).

> "If a doctor says something against a nurse, who do you think [administration] is going to believe?" Nurses talked among themselves about incidents stating they felt that their reports failed to go beyond the administrator's attention. . . . Consequently, some nurses used strategies to gain control over their environment such as trying to keep ahead, pleasing physicians and making sure everything was perfect. (Higgins & Macintosh, 2010, p. 323)

Nurses within hospitals struggle with the control of their own work environments, including patient to nurse ratios. Nurses, as hourly workers, are not professionals who can determine their own work flow; nor can they make independent decisions about care needs of patients. Gordon (2005) described that the nurse does not control her workplace and is not a professional who determines how the day will progress. The nurse must complete a list of tasks determined by someone else. Gordon (2005) further elaborated by explaining that the nurse is not free to make independent decisions about care or care delivery.

Horizontal Violence

Freire (2000) suggested that horizontal violence is created in oppressed groups by the internalization of the views of the dominant group. Freire (2000) further stated that the internalization creates anger and feelings of dejection or repulsion in the oppressed group members. This anger cannot be spread against the more powerful group so it is formulated against members of the same group (Freire, 2000). Purpora et al. in 2012 published literary work on horizontal violence in nursing and identified the theory of oppression as the underlying theme creating the internalization of values of the oppressors. Horizontal violence is the final part of oppression, where the oppressed group expresses their feelings of self-repulsion against members of the same group (Freire, 2000).

Horizontal or lateral violence has been linked in many ways to workforce retention, perceptions, work environments, and lack of civility (Becher & Visovsky, 2012; Hayes et al., 2010; Sheridan-Leos, 2008). Lateral violence has been discussed as bullying, horizontal

violence, workplace violence, and, most recently, workplace aggression (Becher & Visovsky, 2012; Hayes et al., 2010; Sheridan-Leos, 2008; Stevens, 2002; Townsend, 2012). Lateral violence remains a significant issue and is directly linked to issues of oppression (Roberts, 2010; Roberts et al., 2009).

Horizontal violence can take the form of workplace aggression (Rodwell & Demir, 2012; Thobaben, 2011; Townsend, 2012). A change in the oppressive social structure of hospitals may be needed to address the issues of horizontal violence (Purpora et al., 2012). In one article, the statement that nurses are "educated to be subservient and dependent," resolutely places the problem within educational doorways (Thobaben, 2011, p. 477). Horizontal violence in nursing is the direct result of oppression subjugated through the more powerful physicians (Rodwell & Demir, 2012; Sheridan-Leos, 2008).

Summary

Historical developments and recent practices provide evidence that oppression in nursing exists (Duchscher & Myrick, 2008; Kutlenios & Bowman, 1998; Merlani et al., 2011; Moosa & Ud-Dean, 2011; Roberts, 2010; Roberts et al., 2009; Rodwell & Demir, 2012; Temple, 2011; Townsend, 2012). Dividing the individual parts of this phenomenon into assimilation, marginalization, and horizontal violence allowed it to be studied in a specific and directed way. These variables together may be seen as representing an overall level of nursing oppression.

Nursing has examined this phenomenon of oppression (Roberts et al., 2009). There is a gap in the literature relating to quantitative tools that measure the distinctly different parts of oppression. Developing a tool that will measure the documented areas of oppression within nursing is necessary. With a quantitative tool, nursing educators can measure oppression. This measurement maybe used to prepare graduates for the transition into professional nursing and

identify areas in need of improvement in present hospital environments. Measuring the success of nursing oppressive experiences in relation to the advancement of education may identify if advancing education is helping mediate experiences in hospital clinical environments.

CHAPTER III

METHODOLOGY

Purpose

The study evaluated the current levels of self-reported oppression experienced by nurses within a hospital environment. Oppression in nursing was examined using an instrument developed as part of this research. The instrument included three subscales of oppression: assimilation, marginalization, and lateral violence. Bachelor and associate degree nursing graduates were compared to determine whether there was a significant difference in self-expressed levels of oppression between the two groups. Understanding varying levels of oppression by educational level provided information related to the self-report of BSN and associate degree nursing graduates. There was no delineation in the degree awarded to an associate degree to baccalaureate nursing student and a degree obtained by a traditional baccalaureate student; therefore, this research did not delineate between the two degree pathways.

Hypotheses

1. Nurses with a bachelor's degree will self-report less oppression than associate degree nurses working in a hospital setting.
2. Nurses with a bachelor's degree will self-report less difficulty with assimilation than associate degree nurses working in a hospital setting.
3. Nurses with a bachelor's level of education will self-report less marginalization than their associate level coworkers working in a hospital setting.

4. Nurses with an associate degree education will self-report nursing environments to be more laterally violent than their baccalaureate-educated co-workers working in a hospital setting.

5. The validity of the hypothesized factors based upon the research literature- assimilation, marginalization and lateral violence- will be determined within a factor analysis.

Instrument Development

The instrument was developed utilizing the literature as a guide, and the Content Validity Index (CVI) to determine content validity. The instrument was designed to measure the documented areas of oppression, divided into three subscales: assimilation, marginalization and horizontal violence. The original questions were taken from the literature related to the documented areas of oppression (Becher & Visovsky, 2012; Breault, 2003; Churchman & Doherty, 2010; Duchscher & Myrick, 2008; Feng & Tsai, 2012; Hartigan et al., 2010; Hayes et al., 2010; Mantzoukas & Jasper, 2004; Matheson & Bobay, 2007; Purpora et al., 2012; Rodwell & Demir, 2012; Sheridan- Leos, 2008; Stevens, 2002; Thobaben, 2011; Thysoe et al., 2012; Townsend, 2012; Tschannen & Kalisch, 2009; Wolfe et al., 2010). The process for determining the original questions included several steps. First, the three subscales of oppression were determined: assimilation, marginalization, and lateral violence. The subscales were determined using the Freire (2000) theory of oppression as a guide. Second, definitions were established for the subscales. The definitions were obtained using Friere's (2000) theory of oppression as a guide, and reviewing the literature in nursing. Third, a target audience was established to assure readability of questions: nurses working in a hospital setting with, at a minimum, an associate degree. Fourth, a thorough reading of the literature, using the subscale definitions as a guide, yielded an original set of questions (Appendix A).

The fifth step in creating the original questions was to align the questions with the literature in a chart and re-examine the content. The formation of a chart (Appendix A) allowed the researcher to confirm the questions aligned with statements from the literature and the definitions of the subscales.

The original questions were a starting point for the development of the final tool. The next step involved determining validity of the questions. The CVI was utilized to determine if the constructs and definitions used within the tool had subject validity. Subject validity is important in determining the content relevance of the questions. The next section will discuss the development of the final questions using the CVI.

Determining Content Validity of the Instrument

The CVI was the process used to determine content validity of questions and create the final questions to be used in the instrument for this study. Assimilation, marginalization, and horizontal violence were used as three subscales or constructs of the instrument. The instrument was validated for content using CVI procedures (Polit, Beck, & Owen, 2007). Content validity of an instrument is extremely important to ensure the items actually represent the domain of content (Polit et al., 2007). The CVI is one of the most commonly utilized methods within nursing research to validate a tool (Polit et al., 2007).

The CVI is an index of the agreement of experts on the context of an instrument, thus determining content validity (Polit et al., 2007). The process of CVI involves contacting identified experts (usually two or more) in the area of study, and having them rate each item using a scale—a 4-point Likert-type scale is the most common (Polit et al., 2007). The nursing experts were selected primarily by having obtained a doctoral degree and secondarily on their expertise in nursing oppression as demonstrated through their literary contributions. An email

was sent to eight experts in the field of nursing oppression requesting that they review and determine validity of the individual items that composed the three subscales: assimilation, marginalization, and horizontal violence. Five experts completed the instrument (see Table 1 below). Qualtrics (2015) was utilized as an online forum to collect responses, and IP addresses were collected to assure the experts identified were the only ones participating. Questions were emailed to each expert with a 1-4 Likert-type scale (1-not relevant, 2-somewhat relevant, 3-quite relevant, 4-very relevant) used to determine content validity.

Table 1

Experts Completing CVI

Expert	Degree Obtained/Nursing Licensure	Demonstrated Expertise
1	Doctor of Philosophy (PhD)/ Registered Nurse	Research Associate for Hospital in the United States Associate Professor of Nursing at University Specializes in quality improvement Noted literary contributions on the subject of nursing oppression
2	PhD/Registered Nurse	Associate Professor of Nursing at University Specializes in research that broadly focuses on the value of Registered Nurses in providing safe, high quality care and the effects on patient outcomes Noted literary contributions on the subject of nursing oppression

Table 1 (con't)

Expert	Degree Obtained/Nursing Licensure	Demonstrated Expertise
3	Doctor of Nursing Science (DSNc)/Adult Nurse Practitioner and previous licensure as Registered Nurse	Fellow of American Academy of Nurses (FAAN) Professor of Nursing at University Specializes in the research development of knowledge related to the oppression of women Noted literary contributions on the subject of nursing oppression
4	PhD/Registered Nurse	Associate Professor of Nursing at University Dissertation was qualitative study on nursing oppression Noted literary contributions on the subject of nursing oppression
5	PhD/Registered Nurse	Assistant Professor of Nursing at University Specializes in the study of nursing issues with the workplace Noted literary contributions on the subject of nursing oppression

The CVI is an index of interrater agreement (Polit et al., 2007). The number of questions originally sent to the experts for rating was 20 for marginalization, 25 for assimilation, and 18 for horizontal violence. Evaluating the scale's subject content validity index (S-CVI) can be determined by agreement of experts rating items a 3 or 4 on a 4-point scale (Polit et al., 2007).

Item rating using the S-CVI varies greatly, with some item content validity (I-CVI) conceivably less than 0.6 (Polit et al., 2007). The standard recommended item agreement is 0.8 for scale developers (Polit et al., 2007). The I-CVI was used to determine individual item interrater agreement. The I-CVI was determined by the number of experts in agreement divided by the total number of experts participating. An I-CVI of at least 80% or four out of five expert agreements was required for item inclusion in the final instrument. The numbers of questions found to be valid with an item content validity index (I-CVI) 0.8 or greater were 11 for marginalization, 13 for assimilation, and 11 for horizontal violence. The S-CVI was determined using the average of all individual items included. The S-CVI for the original questions was 0.68. After the I-CVI and removal of questions receiving an I-CVI of <0.8, the S-CVI for the final instrument was 0.845 (see Table 2).

Table 2

Computation S-CVI for Final Instrument

Questions	Expert	Expert	Expert	Expert	Expert	#Agree	ICVI
Professional nursing values are important.	4	2	3	4	4	4	0.8
Nursing professional values are easily incorporated into nursing tasks.	3	2	3	4	4	4	0.8
Nurses value the orientation process.	4	3	2	4	4	4	0.8
From the first day here, I felt included in my working environment.	4	3	3	4	4	5	1
New staff is welcomed as an important part of the team from the first day.	4	3	3	4	4	4	0.8

Table 2 (con't)

Questions	Expert	Expert	Expert	Expert	Expert	#Agree	ICVI
Experienced staff value new graduates as a valuable resource.	3	2	4	4	4	4	0.8
Nurses like to orientate new staff nurses.	3	2	4	4	3	4	0.8
Nurses like to orient new graduate nurses.	3	2	4	4	3	4	0.8
Nurses value the orientation process.	4	3	2	4	4	4	0.8
The values I learned in nursing school helped me perform as a nurse.	4	2	3	4	3	4	0.8
As a nurse, I am not subservient to the healthcare system.	4	3	2	4	4	4	0.8
I value critical thinking as a professional nursing skill.	4	3	2	4	4	4	0.8
My supervisors value nursing judgment	4	3	3	4	1	4	0.8
I have decision making authority.	4	3	4	4	4	5	1
Nurses have decision making autonomy.	4	3	4	4	4	5	1
I am encouraged to participate in rounding as an equal partner.	4	3	4	4	4	5	1
My professional opinion matters.	4	2	4	4	4	4	0.8
I am valued for my professional nursing skills.	4	3	2	4	3	4	0.8

Table 2 (con't)

Questions	Expert	Expert	Expert	Expert	Expert	#Agree	ICVI
Patients value my independent judgment.	4	3	2	4	3	4	0.8
Nurses can perform care independently without physician approval.	4	2	3	4	4	4	0.8
Doctors listen to me.	4	3	3	4	1	4	0.8
Communication here is excellence.	4	2	4	4	4	4	0.8
Nurses can challenge physician orders.	4	3	4	4	1	4	0.8
Nurses here are mean to one another.	4	3	4	4	4	5	1
I have witnessed violence between staff members while working as a nurse in this hospital.	4	3	2	4	4	4	0.8
I have been afraid of violence at work.	4	2	3	4	4	4	0.8
As a nurse, you have to defend yourself.	4	1	3	4	4	4	0.8
Sometimes, I am afraid of other nurses at work.	4	3	3	4	4	5	1
I have seen nurses call each other nasty names.	4	2	3	4	4	4	0.8
I have been a victim of horizontal violence.	4	3	3	4	4	5	1
As a new nurse, I felt welcomed immediately.	4	2	3	4	4	4	0.8

Table 2 (con't)

Questions	Expert	Expert	Expert	Expert	Expert	#Agree	ICVI
As a nurse, I have kept my professional opinion to myself for fear of retribution from other nurses.	4	2	4	4	4	4	0.8
Workplace violence is just part of being a nurse.	4	3	4	4	4	5	1
I have refused to work with someone at this hospital.	4	3	2	4	4	4	0.8
S-CVI Value							0.845

Field Test of Instrument

Once the scale had been validated for validity, a field test was completed to determine if the research process and the instrument were viable. The field test utilized email and included participants that were not part of the intended sample. The instrument was made available for online completion through email, using a Likert-type scale (never-1, seldom-2, about half the time-3, usually-4, always-5). Utilizing an online format, Qualtrics (2015), internet invitations to participate were emailed to 13 nurses. The instrument was available for 1 week online. Two invalid email addresses returned invitations unopened, and two nurses (of the 13 invited) never accessed the instrument in Qualtrics (2015). Nine responses were started and eight completed. Five BSN nurses and three associate nurses participated in the field test. All nurses worked within an intensive care unit. Sixty-two percent of invited participants were able to complete the instrument in Qualtrics (2015), meaning the process was working correctly.

Instrument Questions

The final instrument questions included in the study were validated for content using CVI. The three subscales included were assimilation, marginalization, and lateral violence. The

original questions were assimilation (25), marginalization (20), and lateral violence (18). After completion of the CVI, the questions were reduced to assimilation (13), marginalization (11), and lateral violence (11). The final instrument used is included as Appendix B.

Institutional Review Board for the Protection of Human Subjects (IRB)

An IRB application was submitted to The University of Alabama Institutional Review Board. IRB approval was granted and later renewed. As an ethical consideration, IP addresses of participants were not collected within the data set.

A second IRB expedited application was submitted to the hospital internal review board and approved. A copy of this has been shared with the dissertation chair but does not accompany the final submission of this dissertation to protect the confidentiality of the site (Appendix C).

Study Procedures

Based on data from the CVI, an instrument was developed. IRB approval was obtained. The study design was causal comparative, using the two existing registered nursing degree types (baccalaureate and associate degree) as the independent variable, and three subscales (assimilation, marginalization, and lateral violence) as dependent variables. Both educational groups completed the same instrument using the same process. Causal comparative research does not include experimental manipulation (Schenker & Rumrill, 2004). An invitation to complete the developed instrument was emailed by the central nursing officer to all RNs who were employed within the selected hospital environment. The nurses accessed the instrument on Qualtrics (2015), and were required to complete an informed consent before access to the final instrument was granted (see Appendix B). Nurses with advanced degrees were excluded from completing the instrument. Nurses who advanced to baccalaureate degrees after obtaining associate degrees were included because the quality of the education should be equivalent to

those nurses initially choosing a baccalaureate degree. Qualtrics (2015) automatically forwarded the RNs to the instrument once informed consent form was complete and degree level established. The nurses answered questions within the instrument using a Likert-type scale (never-1, seldom-2, about half the time-3, usually-4, always-5). Data from completed instruments were stored online using Qualtrics (2015). The IP address collection option within Qualtrics (2015) was set to not collect IP addresses, as per the requirement of the IRB. The instrument did not collect any identifiers that could reasonably identify participants, including race or gender. The hospital used has some smaller areas where gender or race could easily identify a participant, and the area of employment within the hospital was requested as part of the demographic information. Participation requests were emailed four times (once a week on Tuesdays) throughout a 30-day study period.

Participants

Potential participants in the research were solicited from a hospital within the southeastern part of the United States. The hospital is a 266 bed, non- magnet, Joint Commission accredited facility. This hospital has several ICUs, a women's center, and employs registered nurses within differing specialties including critical care, perioperative, cardiac, medical surgical and emergency. The hospital offers a range of services including cardiology, obstetrics/gynecology, emergency services, neurology, orthopedics, urology, and gastroenterology coupled with medical and surgical services. The emergency room services more than 45,000 visits per year. The primary investigator obtained permission from the central nursing officer, UA's IRB, and the facility's IRB to complete the study with RNs employed there.

Registered nurses within the hospital setting (both BSN and Associate Degree) comprised the sample for this study. Employment within the hospital inferred that RN status as licensure is a requirement for working within the system as a RN. Enrollment in the study was determined by the level of education noted in the demographics section of the instrument. All entries with advanced nursing degrees noted on the tool were excluded. There were 527 registered nurses employed within the hospital system. Group A was comprised of associate level nurses, and group B was comprised of baccalaureate level nurses. More associate nursing graduates completed the survey than BSNs. The submissions were equalized using random selection to assure the same number of nurses were included from each nursing educational group.

Recruitment

Nurses were recruited through emails forwarded by the Chief Nursing Officer. Nurses were emailed a request to participate explaining the study and providing a link within the email to the online instrument. Validation of registered nursing status and employment was verified through the individual institution. The email was forwarded once a week on Tuesday for 4 weeks. The researcher was available to present at staff meetings if requested. One meeting was attended with hospital leadership to explain the study participation. No other request for more information or researcher presence at staff meetings was made.

Rationale for Research Method

For the research method, three dependent variables and one independent variable were examined. The independent variable was the level of education (baccalaureate degree versus associate degree) a nurse had obtained. The dependent variables were the self-reported levels of assimilation, marginalization, and horizontal violence noted by the members of both groups.

Baccalaureate level nurses were hypothesized to self-report themselves as less oppressed when compared to associate degree nurses.

This study used a causal comparative design to determine if there were any differences in indicators of oppression between the two groups of nurses included within the independent variable. Causal comparative research usually involves groups that are already in existence and explores differences between those groups; these groups include demographic or status characteristics like education (Schenker & Rumrill, 2004). Causal comparative research is not manipulated experimentally; therefore, causality is usually not determined (Schenker & Rumrill, 2004). This process consisted of the construction of an instrument that permitted the comparison. The same tool was used for both groups.

CHAPTER IV

RESULTS

The purpose of this research was to determine if the bachelor degree nurse reported a different level of oppression than the associate degree nurse. An online survey platform, Qualtrics (2015), and Statistical Program for the Social Sciences (SPSS) (2013) were used to compile and analyze data. A secondary goal of this research was to develop an instrument (Appendix B) to measure three factors present in the nursing literature: assimilation, marginalization, and horizontal violence. Cumulatively, these three factors yield a measure of oppression. The instrument was completed by nurses within a hospital environment. The hypotheses for this study were

1. Nurses with a bachelor's degree will self-report less oppression than associate degree nurses working in a hospital setting.
2. Nurses with a bachelor's degree will self-report less difficulty with assimilation than associate degree nurses working in a hospital setting.
3. Nurses with a bachelor's level of education will self-report less marginalization than their associate level coworkers working in a hospital setting.
4. Nurses with an associate degree education will self-report nursing environments to be more laterally violent than their baccalaureate-educated co-workers working in a hospital setting.
5. The validity of the hypothesized factors based upon the research literature- assimilation, marginalization, and lateral violence- will be determined within a factor analysis.

The null hypotheses for this study were

1. Nurses with a bachelor's degree will not self-report less oppression than associate degree nurses working in a hospital setting.

2. Nurses with a bachelor's degree will not self-report less difficulty with assimilation than associate degree nurses working in a hospital setting.

3. Nurses with a bachelor's level of education will not self-report less marginalization than their associate level coworkers working in a hospital setting.

4. Nurses with an associate degree education will not self-report nursing environments to be more laterally violent than their baccalaureate-educated co-workers working in a hospital setting.

5. The validity of the hypothesized factors based upon the research literature-assimilation, marginalization, and lateral violence will not be determined within a factor analysis.

Study Analysis

The study analysis included several steps. First, the data were downloaded from Qualtrics (2015) and entered into SPSS (2013). Second, the completed instruments were separated from the 127 instruments that were started. Sixteen were culled from the sample because the items were not completed. Nine were redirected to the end of the instrument and did not complete it because they had completed a graduate degree or higher; these were removed from the sample. The total number left in the sample was 102. The 102 completed instruments were referred to as the full sample. Third, demographic data were obtained from the instrument using the sample of nurses who started the instrument in Qualtrics (2015) and filled in the information requested. Fourth, the sample of completed instruments consisted of more associate degree nurses than BSN nurses; the associate degree group was randomized to create two equal

groups. The two groups with a randomized sample were called the reduced sample. Each group contained 33 completed instruments. Fifth, a Cronbach's Alpha was performed on the reduced sample and the full sample to assure internal consistency. Sixth, a multivariate analysis of variance (MANOVA) was performed that compared the BSN and Associate degree groups in the reduced sample to answer the hypotheses. Finally, a factor analysis was included to support the development of the instrument. The following chapter outlines and explains the above processes in detail.

Demographic Data

The population for this study included registered nurses with both BSN and associate degree education. The instrument was emailed to 527 nurses in one hospital. Qualtrics (2015) reported that 127 nurses started the instrument; 114 finished the instrument. Upon review, it was found that 102 responses were completed and usable for the study. The mean time for completion of the instrument was 12 minutes. The tables below (Tables 3-5) illustrate the raw data contained in Qualtrics (2015).

Table 3

Years of Experience in Nursing

Experience	Frequency of Answers	Percentage
Less than one year	8	7%
1-3 years	20	16%
3-5 years	8	7%
5-10 years	27	22%
More than 10 years	60	49%
Total	123	100%

Table 4

Areas of Employment Within the Hospital

Areas of employment	Frequency of answers	Percentage
Intensive care unit	24	33%
Intermediate care unit	8	8%
Floor nursing	34	33%
Pre-Operative area	4	4%
Operative area	1	1%
Emergency room	10	10%
Other	22	21%
Total	103	100%

Table 5

Highest Degree Achieved (Graduate Degree was Exclusion Criteria)

Degree	Frequency of answers	Percentage
Associate Degree	74	62%
Baccalaureate Degree	37	31%
Graduate Degree or Above	9	8%
Total	120	100%

Histograms

The histograms of the oppression measures prior to randomization and equalizing of the sample were compiled. To assess the normality of the data, histograms (see Appendix D) are presented to demonstrate the acceptability of the sample distributions for the measures used in the study. A researcher can get a sense of variability within a statistical data set by viewing the histograms prior to analysis (Argyrous, 2011). The histograms for this study represent a low variability in oppression, marginalization, and assimilation. Variability refers to the measurement of the spread of a data set (Argyrous, 2011). All three histograms have raised areas in the middle with tails sloping down equally on each side, indicating low variability. The histogram for horizontal violence data does not have a raised area, and the tails slope at a greater angle. The variability for the horizontal violence of the instrument was noted to be higher than the rest of the instrument as noted on the histogram (Appendix D).

Cronbach's Alpha

Cronbach's alphas were compiled on the full sample and the reduced sample. Cronbach's alpha is a test that assures the numerical coefficient of reliability in summated scales (Cronbach, 1951). This test was necessary to assure the reliability is acceptable for summated subscales in both samples, meaning the use of the randomized sample will still yield a high reliability. The acceptable reliability coefficient is 0.7, but lower Cronbach alphas are sometimes accepted within the literature (Nunally, 1978). The Cronbach's alpha was >0.7, indicating acceptable reliability within the data for the full and reduced sample (see Tables 6 and 7, below). The range of results for the reduced sample Cronbach's alpha was from 0.719-0.84.

Table 6

Cronbach's Alpha for Full Sample

Measure	Cronbach's Alpha	Number of Items	N
Overall Oppression	0.896	35	102
Assimilation	0.875	13	102
Marginalization	0.775	11	102
Horizontal Violence	0.726	11	102

Table 7

Cronbach's Alpha for Reduced Sample

Measure	Cronbach's Alpha	Number of Items	N
Overall Oppression	0.84	35	66
Assimilation	0.837	13	66
Marginalization	0.735	11	66
Horizontal Violence	0.719	11	66

Descriptive Statistics

Some measures that are commonly used to describe data sets are measures of central tendencies, including the mean and standard deviation. The descriptive statistics are used to

describe a data set. Descriptive statistics were calculated on the reduced sample of 66 respondents, including the mean and standard deviation for each group.

Table 8

Descriptive Statistics

Measure	Highest Degree to Date	Mean	Std. Deviation	N
Mean Assimilation Score	Associate	3.9464	0.44084	33
	BSN	3.8671	0.47895	33
	Total	3.9068	0.45848	66
Mean Marginalization Score	Associate	3.6970	0.46055	33
	BSN	3.7052	0.40211	33
	Total	3.7011	0.43431	66
Mean Horizontal Violence Score	Associate	4.4105	0.40727	33
	BSN	4.3857	0.35211	33
	Total	4.3981	0.37796	66
Mean Overall Oppression Score	Associate	4.0179	0.31636	33
	BSN	3.9860	0.31329	33
	Total	4.0020	0.31281	66

Inferential Statistics Results

A MANOVA was performed to answer four research questions (see Table 9 below). The use of a MANOVA was appropriate for this sample because the groups were drawn from a similar population and more participants existed than dependent variables (Carey, 1998). A MANOVA combines multiple dependent variables in a linear way to create an arrangement that divides the independent variables within the group (French, Macedo, Poulsen, Waterson, & Yu, n.d.). In addition to the linear relationship, the MANOVA corrects for the multiplicity of a type I error created by the replication of the same test multiple times within a single study. The Levene's test (see Table 10 below) shows that the data did not violate assumption of homogeneity of variance $F(3,62)=.215$ $P=0.886$.

Table 9

MANOVA Results by Subscale

Source	Dependent Variable	Type III Sum of Squares	df	Mean Square	F	Significance	Partial Eta Squared
Highest Degree	Mean Overall Oppression Score	0.017	1	0.017	0.170	0.682	0.003
	Mean Assimilation Score	0.104	1	0.104	0.489	0.487	0.008
	Mean Marginalization Score	0.001	1	0.001	0.006	0.939	0.000
	Mean Horizontal Violence Score	0.010	1	0.010	0.070	0.792	0.001
Error	Mean Overall Oppression Score	6.343	64	0.99			
	Mean Assimilation Score	13.559	64	0.212			
	Mean Marginalization Score	12.259	64	0.192			
	Mean Horizontal Violence Score	9.275	64	0.145			
Total	Mean Overall Oppression Score	1063.405	66				
	Mean Assimilation Score	1021.006	66				
	Mean Marginalization Score	916.339	66				
	Mean Horizontal Violence Score	1285.926	66				

Table 10

Levene's Tests of Equality of Error Variances

Measure	F	Df1	Df2	Significance
Mean Assimilation Score	0.592	1	64	0.481
Mean Marginalization Score	0.362	1	64	0.550
Mean Horizontal Violence Score	0.667	1	64	0.417
Mean Overall Oppression Score	0.035	1	64	0.852

Principal Factor Analysis (Common Factor Analysis)

As a procedure for the development and evaluation of the instrument developed within this study, a principal factor analysis (PFA) is included in this chapter. The instrument was developed using a Likert-type scale and measures of oppression. There was no identified previous scale that measures the three indicators of nursing oppression; therefore, an evaluation of the instrument was indicated. A factor analysis is a statistical procedure for the development and evaluation of an instrument (Floyd & Widaman, 1995). Clinical assessment instruments often contain Likert-type scaled items, and these scales are considered interval or quasi-interval meaning that a factor analysis performed on such data are usually successful in measuring constructs (Floyd & Widaman, 1995). The sample size should be at least 5 participants per variable (Gorsuch, 1983). A sample size of 102 is noted in this study indicating it is large enough for a PFA. Determining that the instrument could be successfully analyzed, and that the sample size was adequate, the items within the instrument were loaded using the data of completed instruments into SPSS (2013).

In addition to the PAF, an Exploratory Factor Analysis (EFA), was used to identify factors within the scale. The factors identified in Table 11 (below) were not set in SPSS (2013) in order to exclude weak associations so it includes all identified factors. The instrument was a 35-item questionnaire with a Likert-type scale rating of 1-never, 2-seldom, 3-about half the time, 4- usually and 5- always. The process yielded 11 factors. An exploratory factor analysis method ascertained the main dimensions of a concept through a preliminary investigation into the correlations among all identified variables (Kline, 1994). The EFA is the method used most often for self-reporting questionnaires (Williams, Brown, & Onsman, 2010). Items were loaded on a factor matrix, and were rotated to produce a condensing of the correlational matrix and produced a clear pattern of loading. Items with a low factor loading are usually weakly correlated with other items, and high factor loading are correlated with other items (Shea et al., 2007).

A higher factor was determined by using Eigenvalues. Eigenvalues are a measurement of the amount of total sample that can be accounted for by every factor. The items with a factor loading greater than 0.4 were considered to have a high factor loading; this was determined using the Eigenvalue plot. A Scree test was used to confirm the number of factors to be included (Appendix E). The Scree test involves drawing a straight line through the eigenvalues, and marking the point above the break (Williams et al., 2010). There were 11 factors identified; the break occurred at 4. Eleven minus 4 leaves 7 factors to be evaluated. Factors 8, 9, 10, and 11 indicated weak factors with a low factor loading throughout and therefore will not be discussed as constructs.

Table 11

Rotated Factor Matrix

Questions	Component										
	1	2	3	4	5	6	7	8	9	10	11
My supervisors value my judgment.	.029	**.760**	.076	-.065	.292	-.190	.189	.054	.029	-.134	-.026
I have decision-making autonomy.	.127	.195	.089	.061	**.691**	.066	.050	-.103	-.001	-.105	.103
I am valued for my professional nursing skills.	.256	**.686**	.203	-.083	.058	.239	.057	-.014	.003	-.102	.041
Patients value my independent judgment.	.139	.034	-.040	.040	.013	**.713**	.205	.015	.006	.072	.092
Nurses can challenge physician orders.	-.096	.174	.243	.200	.151	**.499**	.026	.214	-.036	-.026	.061
Doctors listen to me.	.068	.172	.013	.035	.273	**.536**	.249	.292	.085	-.146	.085
Communication here is excellent.	.311	**.575**	.037	-.052	-.031	.204	.096	.132	.139	.185	-.305
Professional nursing values are important.	.137	.276	.168	-.011	.274	.102	**.469**	.083	.020	.160	.101

Table 11 (con't)

Questions	Component										
	1	2	3	4	5	6	7	8	9	10	11
Nursing professional values are easily incorporated into nursing tasks.	.205	**.508**	**.426**	.013	.217	.023	.299	.163	-.035	.123	.160
Nurses value the orientation process.	.114	.299	.115	-.152	.015	.076	.234	.124	-.089	.285	.136
From the first day here, I felt included in my working environment.	.331	.207	**.684**	-.073	.051	.124	.152	.085	.197	-.041	.069
New staff is welcomed as an important part of the team from the first day.	**.518**	.157	**.677**	-.126	.039	.084	.116	.155	.107	.190	-.130
Experienced staff value new graduates as a valuable resource.	**.745**	.105	**.227**	-.178	.041	.095	.042	.027	.090	.049	-.138
The relationships between experienced staff and new graduates is very supportive.	**.739**	.026	.389	-.094	.076	.071	.208	.109	.079	.035	-.080
Nurses like to orient new staff nurses.	**.871**	.186	.129	-.109	.122	-.046	.081	.087	.077	-.093	.075

Table 11 (con't)

Questions	Component										
	1	2	3	4	5	6	7	8	9	10	11
Nurses like to orient new graduate nurses.	**.897**	.220	.034	-.061	.025	-.089	-.047	.096	.023	.001	.057
Nursing values are universally important.	**.509**	.092	**.437**	.015	.210	-.084	.169	.085	.187	.130	-.030
The values I learned in school helped me perform well here as a nurse.	**.348**	.092	.039	-.139	.048	.145	.304	.296	.003	.020	.360
As a nurse, I am not subservient to the healthcare system.	.274	.158	.123	.077	.039	.163	-.039	.058	-.018	-.260	-.007
I value critical thinking as a professional nursing skill.	.051	.114	.039	.038	.016	.097	**.643**	-.011	.283	-.028	-.033
Nurses here are mean to one another.	-.230	-.057	-.075	.035	.137	-.152	.044	**-.807**	-046	-.021	.007
I have witnessed violence between staff members while working as a nurse in this hospital.	-.115	-.064	-.085	-.023	-.023	-.002	-.233	-.066	**-.576**	-.014	.007
I have been afraid of violence at work.	-.177	-.112	.019	**.696**	.028	.013	-.142	-.008	-.162	-.146	-.045

Questions	Component										
	1	2	3	4	5	6	7	8	9	10	11
As a nurse you have to defend yourself.	-.220	-.038	-.169	**.582**	.003	-.086	.138	-.147	.078	.137	.350
Sometimes I am afraid of other nurses at work.	-.030	-.037	-.390	.375	-.191	.056	.073	.063	-.350	.209	-.055
I have seen nurses call each other nasty names.	-.334	.001	-.324	.244	.113	-.103	-.224	-.325	-.193	.270	.155
I have been a victim of horizontal violence.	-.049	-.112	-.254	**.583**	-.297	.123	-.081	.044	.187	.257	-.087
As a new nurse, I felt welcome immediately.	.202	.060	**.550**	-.162	.119	-.021	.156	-.005	-.061	-.104	-.022
As a new nurse, I have kept my professional opinion to myself for fear of retribution from other nurses.	-.333	-.048	-.345	.241	.052	-.208	-.028	.040	.024	-.282	.036
Workplace violence is just part of being a nurse.	.016	-.058	-.122	**.753**	.184	.164	-.019	-.033	-.205	-.172	-.080
I have refused to work with someone at this hospital.	.018	.021	-.197	.089	.104	.132	**-.411**	.041	.023	.000	.017

Table 11 (con't)

Questions	Component										
	1	2	3	4	5	6	7	8	9	10	11
Nurses have decision-making autonomy,	.057	.247	.080	.053	**.758**	.064	-.037	-.057	.091	.120	.033
I am encouraged to participate in rounding as an equal partner.	**.434**	.098	.111	.008	.208	.215	-.183	.022	.252	-.067	.124
My professional opinion matters.	.273	**.683**	-.040	-.211	**.218**	.343	-.170	-.101	.164	.074	.222
Nurses can perform independently without physician approval.	.102	-.107	.034	.044	**.493**	.083	-.012	.033	-.027	-.048	-.347

Note: Factor Loadings > .40 are in boldface

Evaluation of an EFA using PAF includes the researcher examining identified factors, indicating which variables are attributed to each factor, and giving each factor a name or theme (Williams et al., 2010). Seven factors were identified, each with at least three variables loading on the factor and rating above 0.4. Two or three variables need to load on each factor used in EFA for meaningful interpretation (Williams et al., 2010). The factors were listed and examined by the researcher. The researcher then operationalized and descriptively labeled each factor using a review of literature to inform labels. Labeling of selected factors is a subjective, inductive and theoretical progression, and the significance of latent factors is dependent on researcher designation (Williams et al., 2010).

Table 12

Factors Using Factor Loadings from Principal Axis Factor Analysis

	Component						
	1	2	3	4	5	6	7
Orientation							
Q4#6 Experienced staff value new graduates as a valuable resource.	**.745**	.105	.227	-.178	.041	.095	.042
Q4#7 The relationships between experienced staff and new graduates are very supportive.	**.739**	.026	.389	-.094	.076	.071	.208
Q4#8 Nurses like to orient new staff nurses.	**.871**	.186	.129	-.109	.122	-.046	.081
Q4#9 Nurses like to orient new graduate nurses.	**.897**	.220	.034	-.061	.025	-.089	-.047
Q4#10 Nursing values are universally important.	**.509**	.092	**.437**	.015	.210	-.084	.169
Q2#4 I am encouraged to participate in rounding as an equal partner.	**.434**	.098	.111	.008	.208	.215	-.183
Worth							
Q2#1 My supervisors value my judgment.	.029	**.760**	.076	-.065	.292	-.190	.189
Q2#6 I am valued for my professional nursing skills.	.256	**.686**	.203	-.083	.058	.239	.057
Q2#9 Communication here is excellent.	.311	**.575**	.037	-.052	-.031	.204	.096
Q4#2 Nursing professional values are easily incorporated into nursing tasks.	.205	**.508**	**.426**	.013	.217	.023	.299
Q2#5 My professional opinion matters.	.273	**.683**	-.040	-.211	.218	.343	-.170

Table 12 (con't)

Assimilation							
Q4#4 From the first day here, I felt included in my working environment.	.331	.207	**.684**	-0.73	.051	.124	.152
Q4#5 New staff is welcomed as an important part of the team from the first day.	**.518**	.157	**.677**	-.126	.039	.084	.116
Q6#8 As a new nurse, I felt welcome immediately.	.202	.060	**.550**	-.162	.119	-.021	.156
Horizontal Violence							
Q6#7 I have been a victim of horizontal violence.	-.049	-.112	-.254	**.583**	-.297	.123	-.081
Q6#3 I have been afraid of violence at work.	-.177	-.112	.019	**.696**	.028	.013	-.142
Q6#4 As a nurse, you have to defend yourself.	-.220	-.038	-.169	**.582**	.003	-.086	.138
Autonomy							
Q2#3 Nurses have decision making autonomy.	.127	.195	.089	.061	**.691**	.066	.050
Q2#8 Nurses can perform independently without physician approval.	.102	-.107	.034	.044	**.493**	.083	-.012
Q2#2 I have decision making autonomy.	.127	.195	.089	.061	**.691**	.066	.050
Professional Judgment							
Q2#7 Patients value my independent judgment.	.139	.034	-.040	.040	.013	**.713**	.205
Q2#11 Nurses can challenge physician orders.	-.096	.174	.243	.200	.151	**.499**	.026
Q2#9 Doctors listen to me.	.068	.172	.013	.035	.273	**.536**	.249
Competence							
Q4#1 Professional nursing values are important.	.137	.276	.168	-.011	.274	.102	**.469**
Q4#13 I value critical thinking as a professional nursing skill.	.051	.114	.039	.038	.016	.097	**.643**
Q6#11 I have refused to work with someone at this hospital.	.018	.021	-.197	.089	.104	.132	**-.411**

Note. Factor Loadings >.40 are in boldface.

Findings

Research Question 1: Are there differences in the self-reported levels of oppression between the baccalaureate nurse and the associate degree nurse working in a hospital setting? To address this research question, a MANOVA was done using nurses' self-reported responses to an

instrument (Appendix B). The hypothesis was that nurses with a bachelor's degree would self-report less oppression than associate degree nurses. The null hypothesis was supported.

There was no significant difference between the two independent variables (baccalaureate or associate degree) within the overall oppression measurement (see Table 8). No statistical significance was noted between the mean (BSN=3.99, Associate= 4.00) or standard deviation (BSN=0.31, Associate=0.32) in the reduced sample of 66 respondents and the MANOVA found no difference, F (1,64)=0.170 p= 0.487 (see Table 10).

Research Question 2: Does education level affect a nurse's self-reported assimilation into professional practice while working in a hospital setting? To address this research question, a MANOVA was done using nurses' self-reported responses to an instrument (Appendix B). The hypothesis was that nurses with a bachelor's degree would self-report less difficulty with assimilation than associate degree nurses. The null hypothesis was supported.

There was no significant difference between the two independent variables (baccalaureate or associate degree) within the overall oppression measurement (see Table 8). No significance was noted between the mean (BSN=3.95, Associates= 3.87) or the standard deviation (BSN=0.48, Associate=0.44) in the reduced sample of 66 respondents and the MANOVA showed no difference, F (1,64)=0.489 p=0.487 (see Table 10).

Research Question 3: Are there differing levels of self-reported marginalization between the baccalaureate and associate educated registered nurse working in a hospital setting? To address this research question, a MANOVA was done using nurses' responses to an instrument (Appendix B). The hypothesis was that nurses with a bachelor's level of education would self-report less marginalization than their associate level coworkers. The null hypothesis was supported.

There was no significant difference between the levels of independent variable (baccalaureate or associate degree) within the overall oppression measurement (see Table 8). No significance was noted between the mean (BSN=3.71, Associates= 3.70) or standard deviation (BSN=0.40, Associate=0.46) in the reduced sample of 66 respondents and the MANOVA showed no difference, F (1,64)=0.010 p=0.939 (see Table 10).

Research Question 4: Does the level of self-reported horizontal violence differ between the baccalaureate and associate educated registered nurse working in a hospital setting? To address this research question, a MANOVA was done using nurses' responses to an instrument (Appendix B). The hypothesis was that nurses with an associate degree level education would self-report nursing environments to be more laterally violent than their bachelor-level educated co-workers while working in a hospital setting. The null hypothesis was supported.

There was no significant difference between the two levels of the variable (baccalaureate or associate degree) within the overall oppression measurement (see Table 8). No significance was noted between the mean (BSN=4.39, Associates= 4.41) or standard deviation (BSN=0.35; Associates=0.41) in the reduced sample of 66 respondents. The MANOVA showed no difference, F (1,64)=0.070 p=0.792 (see Table 10).

Research Question 5: What is the validity of the hypothesized factors based upon the research literature—assimilation, marginalization, and lateral violence? Based upon the PFA, a new set of items for subscales was identified. The questions and numbering are available on the final instrument (Appendix B). These new constructs or variables are listed above (Table 12). The seven variables were loaded as factors with a cumulative variance of 64.3%. Two of the variables, assimilation (factor 3) and violence (factor 4), were consistent with the instrument developed and validated the placement of questions: Q4#4, Q4#5, Q6#3,Q6#4, and Q6#7. The

PFA identified five subscales: orientation, worth, autonomy, professional judgment, and competence. The null hypothesis was rejected.

Summary

Using an instrument developed to measure nursing oppression, a group of nurses within a hospital environment was surveyed. The respondents included both BSN and associate degree nurses working within a hospital environment. The BSN group included 33 completed instruments. The associate degree group was randomized using SPSS (2013) to a sample size of 33 completed instruments. The reduced sample was used to calculate a Cronbach's alpha and descriptive statistics. A MANOVA was conducted with the oppression measures as dependent variables and educational level as independent variable using the randomized reduced sample of 66 nurses. No significant difference was noted between the two groups when answering the research questions: (1) Are there differences in the self-reported levels of oppression between the baccalaureate nurse and the associate degree nurse working in a hospital setting? (2) Does education level affect a nurse's self-reported assimilation into professional practice while working in a hospital setting? (3) Are there differing levels of self-reported marginalization between the baccalaureate and associate educated registered nurse working in a hospital setting? (4) Does the level of self-reported lateral violence differ between the baccalaureate and associate educated registered nurse working in a hospital setting?

In addition, a principle axis factor was conducted on the instrument developed to answer research question: (5) What is the validity of the hypothesized factors based upon the research literature- assimilation, marginalization and lateral violence? Eleven factors were identified. The factors were examined, and seven were identified that had at least three variables loading on the factor and rating above 0.4. The factors were the operationalized and labeled creating 7

subscales. The subscales identified were orientation, worth, assimilation, violence, autonomy, professional judgment, and competence. The subscales assimilation and violence validated the placement of five of the questions.

CHAPTER V

DISCUSSION

The purpose of this research was to determine if the BSN degree nurse self-reports a different level of oppression than the associate degree nurse. It has been suggested that nursing as a profession is oppressed (Brann, 2010; Dong & Temple, 2011; Pope, 2008; Roberts, 2010). An instrument was developed to measure the level of oppression as self-reported by bachelor and associate degree nurses and will be referred to as the Nursing Oppression Index (NOI). A principal axis factor was performed in the development of the NOI. Comparisons were made between the data from the NOI and the degree of education obtained by the RN completing the NOI. A MANOVA was performed to measure for statistical differences in the self-reported levels of oppression between BSN and associate degree nursing graduates. The research questions for this study were: (1) Are there differences in the self-reported levels of oppression between the baccalaureate nurse and the associate degree nurse working in a hospital setting? (2) Does education level affect a nurse's self-reported assimilation into professional practice while working in a hospital setting? (3) Are there differing levels of self-reported marginalization between the baccalaureate and associate educated registered nurse working in a hospital setting? (4) Does the level of self-reported lateral violence differ between the baccalaureate and associate educated registered nurse working in a hospital setting? (5) What is the validity of the hypothesized factors based upon the research literature—assimilation, marginalization, and lateral violence?

In answering the first four research questions involved in this study, there were no significant differences between BSN and associate degree nurses' self-reported levels of oppression, or any of the subgroups (assimilation, marginalization, and horizontal violence). The fifth research question was an exploration of the NOI questions developed. Questions 1 through 4 were based on the original hypothesized constructs based on the literature (assimilation, marginalization, and lateral violence). The following is a summary of the findings answering each question.

Research Question 1: Are there differences in the self-reported levels of oppression between the baccalaureate nurse and the associate degree nurse working in a hospital setting? To address this research question, a MANOVA was done using nurses' self-reported responses to an instrument (Appendix B). The hypothesis was that nurses with a bachelor's degree would self-report less oppression than associate degree nurses. The null hypothesis was not rejected because no significance was found. There was no significant difference between the variables within the overall oppression measurement. The MANOVA results found no difference between the educational groups in the self-reported levels of oppression.

Richard Shaull (1970) stated that there was not a nonaligned educational process and education either brings about conformity or becomes the promoter of freedom. The neutral results of this research present an interesting proposition. If Shaull was correct and there are no neutral results from an education, than graduates in clinical nursing may have been taught to conform. If one assumes Shaull was incorrect, the results may be environmental. This researcher makes no judgments about the effectiveness of educational preparations, only that the results of this study present no difference in the self-expressed level of oppression within this environment.

Research Question 2: Does education level affect a nurse's self-reported assimilation into professional practice while working in a hospital setting? To address this research question, a MANOVA was done using nurses' self-reported responses to an instrument (Appendix B). The hypothesis was that nurses with a bachelor's degree would self-report less difficulty with assimilation than associate degree nurses. The null hypothesis was not rejected due to lack of significance. No significant difference was found between the two independent variables within the overall oppression measurement. The MANOVA results equaled no difference between the educational groups in the self-reported levels of assimilation.

Freire (2000) suggested that new members, once assimilated into an oppressive group, have learned behaviors required from the dominant group. In a study by Wolfe et al. (2010), nurses in acute care nursing were found to have adopted the cultural attitudes of the environment and abandoned nursing core values in favor of assimilation into the environment. This study found no difference in the self-expressed assimilation between the two educational groups. It could be suggested that the nurses have fully assimilated into the environment and have no difference in the experience; however, that would disagree with the assumption that education cannot be a neutral process.

Research Question 3: Are there differing levels of self-reported marginalization between the baccalaureate and associate educated registered nurse working in a hospital setting? To address this research question, a MANOVA was done using nurses' responses to an instrument (Appendix B). The hypothesis was that nurses with a bachelor's level of education would self-report less marginalization than their associate level coworkers. The null hypothesis was not rejected because no significance was found.

Freire (2000) stated that oppression seeks to marginalize a group so they have no control over their environment, and that education must address this issue. This study found neutrality between the educational groups. Again, no assumptions can be made about the educational value, only that the lack of difference signifies that there may something education may gain from further exploration into this subject.

Research Question 4: Does the level of self-reported horizontal violence differ between the baccalaureate and associate educated registered nurse working in a hospital setting? To address this research question, a MANOVA was done using nurses' responses to an instrument (Appendix B). The hypothesis was that nurses with an associate degree level education would self-report nursing environments to be more laterally violent than their bachelor level educated co-workers. The null hypothesis was not rejected because no significance was found. There was no notable difference between the two educational levels within the overall oppression measurement. No significance was noted between the mean in the reduced sample of respondents. The MANOVA found no difference between the educational groups in the self-reported levels of horizontal violence.

Purpora et al. (2012) stated that a change in the social structure of hospitals may be needed to address the issues of horizontal violence (2012). Juxtaposed to this statement, Thobaben (2011) stated that nurses were educated to be "subservient and dependent" (p. 477). Environments and education may both contribute to horizontal violence within nursing environments. This study did not find a difference between the educational groups and therefore has no answer as to which statement might be truer.

Research Questions 5: What is the validity of the hypothesized factors based upon the research literature—assimilation, marginalization, and lateral violence? Seven subscales were

identified. The subscales assimilation and lateral violence validated the placement of five of the questions. Assimilation and lateral violence were discussed in length. The remaining five subscales were orientation, worth, autonomy, professional judgment, and competence.

Findings and the Present Nursing Literature

Since the early 1800s, nursing has been reported by some as oppressed (Gordon, 2005; Joel & Kelly, 2002). Registered nurses cannot make independent decisions about the patients in their care without physician approval (Gordon, 2005). Dong and Temple (2011), in their analysis of oppression in nursing, suggested that nurses have an active part in nursing practice in regard to how oppression is addressed within the profession (Dong & Temple, 2011). Nurses need to evaluate how oppression is viewed within the profession. This study examined how self-expressed levels of oppression were viewed when differing educational levels exist (baccalaureate or associate degree). No difference was found between the two educational groups and their self-expressed levels of oppression. Oppression in nursing may not necessarily be recognized by those who are oppressed because they have conformed to a set of norms determined by the dominant group, but this does not mean it does not exist (Dong & Temple, 2011).

In 1876, Packard argued against nursing education, stating that there was no need for nurses to understand anything above completion of tasks assigned by physicians (Packard, 1876). The *New York Times* reported in the early 20th century that nurses received too much education and should be overseen by physicians (Thompson, 1906, page XX). Presently, graduates are expected to meet entry level requirements for professional practice (Hartigan et al., 2010). Nurse educators prepare nurses for entry level practice. A gap exists between what nurse educators believe is a practice ready nurse and the clinical representation of a practice ready nurse (Van

Herk et al., 2011). Relations between new and established nurses have a direct effect on the new nurse's ability to assimilate into practice environments (Thrysoe et al., 2012). This may be a direct result of the new nurse's non conformity to the dominant group. Some nurses struggle to assimilate into the work setting (Hartigan et al., 2010; Hayes et al., 2010; Peterson et al., 2011). Experienced nurses may have absorbed the cultural attitudes within acute clinical environments and abandoned nursing core values (Wolff et al., 2010). There is a gap between the practice readiness and educational preparedness of new graduate nurses (Hartigan et al., 2010; Star & Edwards, 2010; Wolff et al., 2010). Experienced nurses also encounter difficulties assimilating into new nursing positions (Dellasega et al., 2009). The existence of difficulties experienced by new and experienced nurses suggest the issue may be more environmental and cultural than previously examined. This research would suggest that there is no difference between the way associate degree and BSN graduates self-express assimilation into nursing clinical hospital environments.

The possible stifling of nurses by more powerful physicians has been suggested as a theme in nursing (Churchman & Doherty, 2010; Higgins & MacIntosh, 2010). In a study focusing on physician perpetrated abuse toward nurses in operating rooms, culture and hierarchy were listed as contributing factors (Higgins & MacIntosh, 2010). Higgins and MacIntosh described a nurse reporting being labeled a troublemaker when reporting a physician and defending a peer. Once this nurse conformed to the culture of silence within the operating room, she stated she was re-admitted into the group (Higgins & MacIntosh, 2010). In another study exploring nurses' willingness to challenge doctors' practice in an acute care hospital, medical dominance in the workplace discouraged nurses from challenging doctors' practice and acting as patient advocates (Churchman & Doherty, 2010). In this study, no difference in the self-reported

level of marginalization was noted between BSN and associate degree nurses. This suggests that marginalization may be related to a common experience in clinical nursing, or interactions between physicians and nurses have changed over the years. New studies are needed to determine if this is a correct assumption, because this researcher found no studies addressing the subject.

Horizontal violence is a significant issue in nursing and is directly linked to issues of oppression (Roberts, 2010; Roberts et al., 2009). Modern hospitals are areas where nurses are at risk for horizontal violence (Purpora et al., 2012). There was no significant difference in the BSN and associate nurse self-reported levels of horizontal violence. All the participants within this research were employed in a hospital environment. Among 175 hospital staff registered nurses, Purpora et al. (2012) reported a positive relationship between the beliefs of the oppressed self and horizontal violence. The study describes the incidence of horizontal violence among staff RNs and tested hypotheses about the social origins of the behavior. The quantitative study by Purpora et al. (2012) suggested a change in the structuring of hospital hierarchy to truly address horizontal violence in nursing. Roberts (2010) suggested that lateral violence remains a significant issue. The results of this research suggest that there is no difference in the way education affects the nurse's experience of lateral violence at the bedside within a hospital environment.

Factor Analysis

Initially, instrument questions and factors were developed based on the professional literature (assimilation, marginalization, and lateral violence). In an effort to determine the validity of the instrument an exploratory factor analysis (principal axis factor) was conducted after data collection. An EFA method ascertains the major dimensions of a concept through an

investigation into the correlations within identified variables (Kline, 1994). The original factors were assimilation, marginalization, and lateral violence, which were identified using the professional literature and identified prior to data collection. After data collection, items from the instrument were loaded onto a factor matrix, and rotated to create a clearer loading pattern. Seven variables loaded with a cumulative variance of 64% which means that these variables accounted for 64% of the total variance. Assimilation and violence were consistent with the instrument developed and have been discussed. The other five identified factors included orientation, worth, autonomy, professional judgment, and competence.

Orientation issues can be observed as nursing graduates continue to struggle in transitioning into the professional nursing environments (Peterson et al., 2011). Within the hospital environments, new nurses experience high turnover rates and job stressors (Duchscher & Myrick, 2008; Higgins & MacIntosh, 2010). The nursing orientation into a hospital environment may be increasingly difficult due to the stressors that are present. Items Q4#6, Q4#7, Q4#8, Q4#9, and Q4#10 were included in the assimilation portion of the instrument (Appendix F). Item Q2#4 was included in the marginalization portion of the instrument.

Worth may be an issue to be explored within nursing. Nurses are kept from receiving due credit for recovering patients (Duchscher & Myrick, 2008; Roberts et al., 2009). The medical hierarchy continues to view the nurse as an accessory to the physician (Brooten et al., 2012; "Power struggle between docs, nurses go public", 2010). The lack of credit sharing may have an effect on the nurses' perception of worth. The worthiness of a nurse has been defined by the helpfulness offered to physicians (Holyoake, 2011). Items Q2#1, Q2#6, Q2#9, and Q2#5 are included in the marginalization portion of the instrument (Appendix F). Item Q4#2 was included in the lateral violence portion of the instrument.

Autonomy of nurses includes the ability to make independent decisions. In the early 1900s, nurses were trained to "make the doctor feel that she is exerting every effort to have his treatment, not hers, intelligently followed" (Buhler-Wilkerson, 2001, p. 100). Any decisions about patient care have to be carefully constructed because nurses can be prosecuted for practicing medicine without a license (Gordon, 2005). The nurse's ability to make independent decisions is an issue of care delivery. Nursing quality care is directly linked to a nurse's control over bedside practices (Castner et al., 2013). Items Q2#3, Q2#8, and Q2#2 are included in the marginalization portion of the instrument (Appendix F).

Professional judgment issues exist within environments in which nurses practice. Organizational issues, the hierarchy within medical practice, and the role of nurses continue to be unsupported by management (Clark & Springer, 2012). A nurse makes a professional judgment about patient care and must defend that position by obtaining physician support. Nursing decisions are challenged by physicians (Gordon, 2005). Nurses describe lesser collaboration than do the physicians (Brooten et al., 2012). Items Q2#7, Q2#11, and Q2#9 are included in the marginalization portion of the instrument (Appendix F).

Competence relates to a nurse's ability to perform within the environment. Some physicians accuse nurses of negligence or incompetence in front of patients (Higgins & MacIntosh, 2010). Higgins and Macintosh reported that one nurse stated," If a doctor says something against a nurse, who do you think they (administration) is going to believe?" (p. 323). The nurse is not considered knowledgeable and independent without physician agreement. When a physician disagrees with a nurse's assessment, the ordered treatment overrides the nursing knowledge. Castner et al. (2013) stated that nursing care quality is directly related to nurses' control over bedside practices. Items Q4#1 and Q4#13 are included in the assimilation

portion of the instrument. Item Q6#11 is included in the lateral violence portion of the instrument (Appendix F).

Based upon the EFA, seven factors were identified. The final instrument is available (Appendix B). The seven variables loaded as factors were assimilation, lateral violence, orientation, worth, autonomy, professional judgment, and competence.

Limitations

Limitations of this study include instrument development and lack of variability in the hospital where data were collected. The instrument developed was only used in one study, using the CVI. Content validity of an instrument ensures the items actually represent the domain of content (Polit et al., 2007). The CVI is one of the most commonly utilized methods within nursing research to validate a tool (Polit et al., 2007). The tool item with the word "violence" within the question may be misinterpreted. All the nurses included in this study came from within the same clinical hospital. Nurses in differing environments may report different levels of oppression. The research limitations include environmental and instrument limitations.

The term violence may have differing meanings. The question, "I have been afraid of violence at work" was validated but may not be specific enough to clarify violence at work. Violence has many different types and may be directed from somewhere other than peers. This instrument aimed to measure horizontal violence, so this question may limit the effectiveness of the results.

Instrument development is a limitation within this research. In this research, the instrument was developed using CVI. A factor analysis was completed using the results of this initial use of the NOI. Likert-type scales are considered interval or quasi-interval meaning that a factor analysis performed on such data are usually successful in measuring constructs (Floyd &

Widaman, 1995). The further development of the tool may yield different results based on the data sets obtained.

Application of the Results

The development of a quantitative tool to measure oppression within nursing environments created a step toward giving educators a measure of the present state of nursing oppression. The measurement of oppression within a hospital environment evaluated the present state of oppression within a hospital environment. The NOI may be used to determine levels of oppression in differing environments, and should be used to further the understanding of the oppression existing among registered nurses. This understanding can translate directly into the preparation of nurses for registered nursing practice. The development of social science assignments integrated into the existing BSN curriculum could develop more consciousness of oppression in nursing graduates. Freire (2000) wrote about the ineffectiveness of the teacher "banking" information within the minds of students. He believed that education should be a freeing experience where the mind becomes awakened into a new consciousness. Nursing education can use information like this dissertation to begin to pull apart the experiences in clinical nursing and prepare new graduates for the challenges within nursing environments. Nursing education that includes the information of social consciousness may engage students in a way that prepares them for the realities while partnering with them to enact change at the bedside. Freire (2000) stated,

> They are at one and the same time themselves and the oppressor whose consciousness they have internalized. The conflict lies in the choice between being wholly themselves or being divided; between ejecting the oppressor or alienation; between acting or having the illusion of acting through the actions of the oppressor; between being speaking or being silent, castrated in their power to create or re-create, in their power to transform the world. This is the dilemma of the oppressed which their education must take into account. (p. 48)

The expansion of this type of research may present a different view of oppression in nursing practice. This study suggests that the experience in clinical hospital environments related to oppression is the same for both BSN and associate degree nurses. The realization that no difference might exist between nurses with additional education is a call to action for educators. Freire (2000) believed that education should somehow change the way a person perceives the world and it should be a "practice of freedom" (p. 79). The answers to why there is no difference may lie in the very roots of historical beginnings of nursing as a technical field. These results should be used to expand the educators understanding of oppression within hospital environments, and encourage critical reflection.

Future Research

This researcher examined the phenomenon of oppression to see if a difference in self-reported oppression existed between nursing entry-level educational groups. Suggestions for future research should include further testing of the tool. A quantitative instrument has been developed to measure self-reported levels of oppression; another study of this kind was not located in the literature. Because this is a single study using a newly developed instrument, studies are needs to explore the usability of the NOI. Additional studies are needed to address reproducibility and further explore construct validity of the instrument developed, before strong recommendations can be made about its use.

Exploration into hospital and other nursing environments may be needed. In a study including 168 hospitals, Aiken et al. (2003) recognized the differences in hospital environments. There may be a significant difference between teaching hospitals and other environments. The hospital used in this study was not an academic teaching hospital. A significant difference in levels of oppression within differing environments may exist.

Further uses of the NOI should be explored. This instrument may be successfully used to measure the levels of marginalization, assimilation, and lateral violence within registered nursing environments. The NOI may give a picture of the internal workings within a nursing environment to assist management in improving the existing conditions within their nursing environments. Investigations may also include new versus experienced nurses; and nurses who are changing jobs and entering into a new hospital environment. Future research could determine if the NOI is a usable tool to gain understanding of nursing environments related to the levels of assimilation, marginalization, and lateral violence existing.

Conclusion

This study developed the NOI, which is an instrument to quantitatively measure the self-expressed level of nursing oppression within a hospital system. The NOI was utilized to explore the differences in self-expressed levels of oppression between BSN and associate degree nursing graduates within a hospital environment. No difference was found between the self-expressed levels of the two educational groups. A final exploration of the NOI, used a Principal Axis Factor to explore the questions created. Seven factors were identified, and the placement of five questions were validated. This dissertation study was most influenced by an article by Matheson and Bobay (2007) entitled, "Validation of Oppressed Group Behaviors." Within the article, readers are challenged to study the dimensions of oppression outside of isolation and sort out the truth of the existence of oppression by creating a tool to measure Freire's (2000) oppression model.

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APPENDIX A

Questions- Literature Alignment

Questions -Literature Alignment

Assimilation. In this study, assimilation refers to the inclusion of new nurses entering into nursing environments, including orientation and acceptance of new graduates and/or experienced nurses into the culture of professional nursing practice. (25 questions)	
Original Question	Statements from the Literature
Nursing is task oriented.	New graduates experience a conflict between the professional values in nursing and the task oriented job requirements in professional nursing (Feng & Tsai, 2012; Thrysoe et al., 2012).
Professional nursing values are important.	New graduates experience a conflict between the professional values in nursing and the task oriented job requirements in professional nursing (Feng & Tsai, 2012; Thrysoe et al., 2012).
Nursing professional values are easily incorporated into nursing tasks.	New graduates experience a conflict between the professional values in nursing and the task oriented job requirements in professional nursing (Feng & Tsai, 2012; Thrysoe et al., 2012).
Nurses value the orientation process.	New graduates experience a conflict between the professional values in nursing and the task oriented job requirements in professional nursing (Feng & Tsai, 2012; Thrysoe et al., 2012).
From the first day here, l felt included in my working environment.	Relations between new nurses and established staff can have a direct effect on the new nurses' assimilation (Thrysoe et al., 2012).
New staff is welcomed as an important part of the team from the first day.	Relations between new nurses and established staff can have a direct effect on the new nurses' assimilation (Thrysoe et al., 2012).
Nurses have to prove themselves.	Relations between new nurses and established staff can have a direct effect on the new nurses' assimilation (Thrysoe et al., 2012).
Experienced staff value new graduates as a valuable resource.	Relations between new nurses and established staff can have a direct effect on the new nurses assimilation (Thrysoe et al., 2012).
The relationships between experienced staff	Relations between new nurses and established

and new graduates are very supportive.	staff can have a direct effect on the new nurses assimilation (Thrysoe et al., 2012).
Nurses like to orient new staff nurses.	Relations between new nurses and established staff can have a direct effect on the new nurses assimilation (Thrysoe et al., 2012).
Nurses like to orient new graduate nurses.	Relations between new nurses and established staff can have a direct effect on the new nurses assimilation (Thrysoe et al., 2012).
The transition into this nursing area was easy.	Relations between new nurses and established staff can have a direct effect on the new nurses assimilation (Thrysoe et al., 2012).
As a new graduate, the values I learned in nursing school were very important.	While being orientated as a new graduate, "discrepancies exist between the values of new graduates and their experienced co-workers" (Wolff et al., 2010, p. 190).
Experienced nurses value nursing judgments.	While being orientated as a new graduate, "discrepancies exist between the values of new graduates and their experienced co-workers" (Wolff et al., 2010, p. 190).
Nursing values are universally important.	While being orientated as a new graduate, "discrepancies exist between the values of new graduates and their experienced co-workers" (Wolff et al., 2010, p. 190).
The values I learned in nursing school helped me perform well here as a nurse.	While being orientated as a new graduate, "discrepancies exist between the values of new graduates and their experienced co-workers" (Wolff et al., 2010, p. 190).
My role as a nurse is to be compliant.	Current new nurse graduates are taught nursing is a profession and are prejudiced against the demands of the patriarchal healthcare systems (Wolff et al., 2010).
My obligation to nursing is to the profession.	Current new nurse graduates are taught nursing is a profession and prejudiced against the demands of the patriarchal healthcare systems (Wolff et al., 2010).
As a nurse, I am not subservient to the healthcare systems.	Current new nurse graduates are taught nursing is a profession and prejudiced against the demands of the patriarchal healthcare systems

	(Wolff et al., 2010).
I value critical thinking as a professional nursing skill.	Current new nurse graduates are taught nursing is a profession and prejudiced against the demands of the patriarchal healthcare systems (Wolff et al., 2010).
As a new nurse, adjusting to the demands of nursing work environments was easy.	Assimilation into professional practice is exacerbated in acute care situations where nurses are frequently required to make complex nursing decisions, work long shifts and balance rapid patient admission and discharge (Hartigan et al., 2010; Hayes, Bonner, & Pryor, 2010).
This work environment is easy to adjust to.	Assimilation into professional practice is exacerbated in acute care situations where nurses are frequently required to make complex nursing decisions, work long shifts and balance rapid patient admission and discharge (Hartigan et al., 2010; Hayes, Bonner, & Pryor, 2010).
Adapting to this nursing environment was a difficult transition.	Assimilation into professional practice is exacerbated in acute care situations where nurses are frequently required to make complex nursing decisions, work long shifts and balance rapid patient admission and discharge (Hartigan et al., 2010; Hayes, Bonner, & Pryor, 2010).
Becoming familiar with this nursing environment is difficult because of the rapid patient turnover.	Assimilation into professional practice is exacerbated in acute care situations where nurses are frequently required to make complex nursing decisions, work long shifts and balance rapid patient admission and discharge (Hartigan et al., 2010; Hayes, Bonner, & Pryor, 2010).
As a new staff nurse here, transitioning to the workload was easy.	Assimilation into professional practice is exacerbated in acute care situations where nurses are frequently required to make complex nursing decisions, work long shifts and balance rapid patient admission and discharge (Hartigan et al., 2010; Hayes, Bonner, & Pryor, 2010).
Marginalization. In this study, marginalization refers to the ability of nurses to make independent decisions of care based on their licensure. (20 questions)	
Questions	Statements from the Literature
Physicians value my critical thinking skills.	Physicians are seen as having the only customary judgment making authority (L. K.

	Matheson & Bobay, 2007).
I need permission from physicians to do my job.	Within the healthcare team, permission to proceed is obtained from the physician (L. K. Matheson & Bobay, 2007).
I work for doctors.	Physicians are the dominant group in healthcare (L. K. Matheson & Bobay, 2007).
My supervisors value nursing judgment.	All groups in healthcare are less valued than physicians (L. K. Matheson & Bobay, 2007).
I have decision making autonomy.	Physicians are seen as having the only customary judgment making authority within the healthcare system (L. K. Matheson & Bobay, 2007).
Physicians always make the final decision.	Physicians are seen as having the only customary judgment making authority within the healthcare system (L. K. Matheson & Bobay, 2007).
Nurses have decision making autonomy.	Physicians are seen as possessing the only customary judgment making authority within the healthcare system (L. K. Matheson & Bobay, 2007).
I am encouraged to participate in rounding as an equal partner.	There is a misconception that the dominant group is more competent than other groups (Breault, 2003).
My professional opinion matters.	The dominant group is more competent than the subservient groups (Breault, 2003).
Physician orders are the guidepost for nursing practice.	A power struggle between physicians and nurses creates the idea that physicians define nursing practice (Mantzoukas & Jasper, 2004).
I am valued for my professional nursing skills.	A power struggle between physicians and nurses creates the idea that physicians define nursing practice (Mantzoukas & Jasper, 2004).
Patients value my independent judgment.	A power struggle between physicians and nurses creates the idea that physicians define nursing practice (Mantzoukas & Jasper, 2004).
Nurses can perform care independently without physician approval.	A power struggle between physicians and nurses creates the idea that physicians define nursing practice (Mantzoukas & Jasper, 2004).

Nurses are ALWAYS required to follow doctor's orders.	A power struggle between physicians and nurses creates the idea that physicians define nursing practice (Mantzoukas & Jasper, 2004).
I am encouraged to communicate with physicians.	Doctors and nurses do not communicate well (Tschannen & Kalisch, 2009).
Doctors listen to me.	Near errors and mistakes occur because nurses and doctors do not communicate (Tschannen & Kalisch, 2009).
Communication here is excellent.	A common issue between nurses and doctors is a lack of communication (Tschannen & Kalisch, 2009).
Nurses use a hidden form of communication when speaking with physicians.	Nurses communicate with doctors in a manner that does not challenge the hierarchy (Churchman & Doherty, 2010).
Nurses can challenge physician orders.	Nurses communicate with doctors in a manner that does not challenge the hierarchy (Churchman & Doherty, 2010).
Nurse communication is done by making physicians think it is their original idea.	Nurses communicate with doctors in a manner that does not challenge the hierarchy (Churchman & Doherty, 2010).

Lateral Violence. In this study, horizontal violence refers to any acts of aggression or perceived aggression from one nurse to another. This includes lateral violence as an interchangeable term. (18 questions)

Questions	Statements from the Literature
Nurses here are mean to each other.	Nurses have been found to be cruel to one another (Thobaben, 2011).
I have witnessed physical violence between staff members while working as a nurse in this hospital.	Nurses have been found to be harsh to one another (Thobaben, 2011).
I have been afraid of violence at work.	Nurses working in hospitals are at risk for horizontal violence (Purpora et al., 2012).
As a nurse, you have to defend yourself.	Nurses working in hospitals are at risk for horizontal violence (Purpora et al., 2012).
Sometimes, I am afraid of other nurses at work.	Nurses working in hospitals are at risk for horizontal violence (Purpora et al., 2012).

Backbiting never happens here.	Nurses working in hospitals are at risk for horizontal violence (Purpora et al., 2012).
Sabotage is a real threat to my nursing license.	Nurses working in hospitals are at risk for horizontal violence (Purpora et al., 2012).
I have seen nurses call each other nasty names.	Nurses working in hospitals are at risk for horizontal violence (Purpora et al., 2012).
I have been a victim of horizontal violence.	Nurses working in hospitals are at risk for horizontal violence (Purpora et al., 2012).
As a nurse, I have kept my professional opinion to myself for fear of retribution from other nurses.	Nurses working in hospitals are at risk for horizontal violence (Purpora et al., 2012).
I feel accepted by my peers at work.	Lateral violence in nursing has been discussed as bullying, horizontal violence, workplace violence and most recently workplace aggression (Becher & Visovsky, 2012; Hayes et al., 2010; Sheridan-Leos, 2008; Stevens, 2002; Townsend, 2012).
Workplace violence is just part of being a nurse.	Lateral violence in nursing has been discussed as bullying, horizontal violence, workplace violence and most recently workplace aggression (Becher & Visovsky, 2012; Hayes et al., 2010; Sheridan-Leos, 2008; Stevens, 2002; Townsend, 2012).
I have refused to work with someone at this hospital.	Nurses display horizontally violent behaviors (Sheridan-Leos, 2008, p. 401).
As a nurse, I can refuse to orientate new staff.	Nurses display horizontal violent behaviors (Sheridan-Leos, 2008, p. 401).
Nurses listen to each other.	Modern hospitals offer a very challenging environment for the new nurse in which to acclimate (Duchscher & Myrick, 2008).
Nurses have to be aggressive sometimes.	Horizontal violence can take the form of workplace aggression (Rodwell & Demir, 2012; Thobaben, 2011; Townsend, 2012).
Nurses here are accepting of one another.	Horizontal violence can take the form of workplace aggression (Rodwell & Demir, 2012; Thobaben, 2011; Townsend, 2012).
As a new nurse, I felt welcomed immediately.	Modern hospitals offer a very challenging environment for the new nurse in which to

acclimate (Duchscher & Myrick, 2008).

APPENDIX B

Final Instrument for Study

Nursing Oppression Index

You are being asked to take part in a research study. We are asking you to take part because you have been identified as a licensed registered nurse. Please read this form carefully and ask any questions you may have before agreeing to take part in the study. What the study is about: The purpose of this project is to determine if the bachelor degree nurse reports a different level of oppression than the associate degree nurse. What we will ask you to do: If you choose to continue and take the proceeding survey, it will take you about ten minutes or less to complete a short demographics and a 1-5 Likert scale questionnaire. I promise…that's it!

Risks and benefits: I do not anticipate any risks to you participating in this study other than those encountered in day-to-day life. There are no benefits to you. Nursing is a very demanding profession and I hope to learn more about nurses and the implication of increased education.

Compensation: You will get no compensation from completing this survey. You may get the satisfaction of having had the opportunity to contribute to an important assessment within your nursing environment.

Your answers will be confidential. The records of this study will be kept private. In any sort of report we make public we will not include any information that will make it possible to identify you. Research records will be kept in a locked file; only the researchers will have access to the records. Paper records collected will be entered online and destroyed as soon as entered. Online collection will utilize a system that requires a password and no information will be collected that will specifically identify you or your hospital.

Taking part is voluntary: Taking part in this study is completely voluntary. You may skip any questions that you do not want to answer. If you decide not to take part or to skip some of the questions, it will not affect your current or future relationships. This study is not part of your regular employment and participation/ not participating will not affect your employment or your relationship with your employer. A generalized summary of results will be provided to the hospital, but no information will be provided to individual supervisors and your employment should not be affected. If you decide to take part, you are free to withdraw at any time. If you have questions: The researcher conducting this study is Sheila Montgomery. Please contact me with any questions you have. If you have questions later, you may contact Sheila Montgomery at 205-965-3883. You can reach my dissertation chair (Prof. Houser) at rhouser@ua.edu. If you have questions about your rights as a person taking part in a research study, make suggestions or file complaints and concerns, you may call Ms. Tanta Myles, the Research Compliance Officer of the University at (205)-348-8461 or toll-free at 1-877-820-3066. You may also ask questions, make suggestions, or file complaints and concerns through the IRB Outreach Website at http://osp.ua.edu/site/PRCO_Welcome.html. You may email us at participantoutreach@bama.ua.edu.

❍ Yes, I agree to participate (1)

- ❍ No, I decline participation (2)

If No, I decline participation Is Selected, Then Skip To End of Survey

What was your original degree upon entering into nursing?

- ❍ Associate Degree (1)
- ❍ Baccalaureate Degree (2)

How many years have you practiced as a Registered Nurse?

- ❍ Less Than One Year (1)
- ❍ 1-3 years (2)
- ❍ 3-5 years (3)
- ❍ 5-10 years (4)
- ❍ More than 10 years (5)

What is your highest degree in nursing earned to date?

- ❍ Associate Degree (1)
- ❍ Baccalaureate Degree (2)
- ❍ Graduate Degree or Above (3)

If Graduate Degree or Above Is Selected, Then Skip To End of Survey

Where are you presently employed?

- ❍ Intensive Care Unit (1)
- ❍ Intermediate Care Unit (2)
- ❍ Floor Nursing (3)
- ❍ Pre-Operative Area (4)
- ❍ Operative Area (5)
- ❍ Emergency Room (6)
- ❍ Other (7) _____

Please answer the following questions related to your present nursing position by marking a box, rating the questions using the scale below. Likert scale: 1= Never, 2= Seldom, 3=About Half the Time, 4 =Usually, 5= Always

Q2 Section 1

My supervisors value nursing judgment. (1)	❍	❍	❍	❍	❍
I have decision making autonomy. (2)	❍	❍	❍	❍	❍
Nurses have decision making autonomy. (3)	❍	❍	❍	❍	❍
I am encouraged to participate in rounding as an equal partner. (4)	❍	❍	❍	❍	❍
My professional opinion matters. (5)	❍	❍	❍	❍	❍
I am valued for my professional nursing skills. (6)	❍	❍	❍	❍	❍
Patients value my independent judgment. (7)	❍	❍	❍	❍	❍
Nurses can perform care independently	❍	❍	❍	❍	❍

without physician approval. (8)					
Doctors listen to me. (9)	❍	❍	❍	❍	❍
Communication here is excellent. (10)	❍	❍	❍	❍	❍
Nurses can challenge physician orders. (11)	❍	❍	❍	❍	❍

Q4 Section 2

Professional nursing values are important. (1)	❍	❍	❍	❍	❍
Nursing professional values are easily incorporated into nursing tasks. (2)	❍	❍	❍	❍	❍
Nurses value the orientation process. (3)	❍	❍	❍	❍	❍
From the first day here, l felt included	❍	❍	❍	❍	❍

in my working environment. (4)					
New staff is welcomed as an important part of the team from the first day. (5)	❍	❍	❍	❍	❍
Experienced staff value new graduates as a valuable resource. (6)	❍	❍	❍	❍	❍
The relationships between experienced staff and new graduates are very supportive. (7)	❍	❍	❍	❍	❍
Nurses like to orient new staff nurses. (8)	❍	❍	❍	❍	❍
Nurses like to orient new graduate nurses. (9)	❍	❍	❍	❍	❍
Nursing values are	❍	❍	❍	❍	❍

universally important. (10)					
The values I learned in nursing school helped me perform well here as a nurse. (11)	❍	❍	❍	❍	❍
As a nurse, I am not subservient to the health care systems. (12)	❍	❍	❍	❍	❍
I value critical thinking as a professional nursing skill. (13)	❍	❍	❍	❍	❍

Q6 Section 3

Nurses here are mean to each other. (1)	❍	❍	❍	❍	❍
I have witnessed physical violence between staff members	❍	❍	❍	❍	❍

while working as a nurse in this hospital. (2)					
I have been afraid of violence at work. (3)	❍	❍	❍	❍	❍
As a nurse, you have to defend yourself. (4)	❍	❍	❍	❍	❍
Sometimes, I am afraid of other nurses at work. (5)	❍	❍	❍	❍	❍
I have seen nurses call each other nasty names. (6)	❍	❍	❍	❍	❍
I have been a victim of horizontal violence. (7)	❍	❍	❍	❍	❍
As a new nurse, I felt welcomed immediately. (8)	❍	❍	❍	❍	❍
As a nurse, I have kept my professional opinion to	❍	❍	❍	❍	❍

myself for fear of retribution from other nurses. (9) Workplace violence is just part of being a nurse. (10) I have refused to work with someone at this hospital. (11)	❍ ❍	❍ ❍	❍ ❍	❍ ❍	❍ ❍

APPENDIX C

The University of Alabama IRB

Office for Research

Institutional Review Board for the
Protection of Human Subjects

THE UNIVERSITY OF
ALABAMA
RESEARCH

May 20, 2014

Shelia Montgomery
ESPRMC
College of Education
The University of Alabama
Box 870231

Re: IRB # EX-14-CM-070 "Oppression in Nursing: Does Education Level Make a Difference?"

Dear Ms. Montgomery:

The University of Alabama Institutional Review Board has granted approval for your proposed research.

Your protocol has been given exempt approval according to 45 CFR part 46.101(b)(2) as outlined below:

(2) Research involving the use of educational tests (cognitive, diagnostic, aptitude, achievement), survey procedures, interview procedures or observation of public behavior, unless:
(i) information obtained is recorded in such a manner that human subjects can be identified, directly or through identifiers linked to the subjects; and (ii) any disclosure of the human subjects' responses outside the research could reasonably place the subjects at risk of criminal or civil liability or be damaging to the subjects' financial standing, employability, or reputation.

Your application will expire on May 19, 2015. If your research will continue beyond this date, complete the relevant portions of Continuing Review and Closure From. If you wish to modify the application, complete the Modification of an Approved Protocol Form. When the study closes, complete the appropriate portions of FORM: Continuing Review and Closure.

Should you need to submit any further correspondence regarding this proposal, please include the assigned IRB application number.

Good luck with your research.

Sincerely,

[redacted]

Director & Research Compliance Officer
Office for Research Compliance
The University of Alabama

358 Rose Administration Building
Box 870127
Tuscaloosa, Alabama 35487-0127
(205) 348-8461
FAX (205) 348-7189
TOLL FREE (877) 820-3066

Informed Consent Document

(This form will appear in electronic and paper formats)

You are being asked to take part in a research study. We are asking you to take part because you have been identified as a licensed registered nurse. Please read this form carefully and ask any questions you may have before agreeing to take part in the study.

What the study is about: The purpose of this project is to determine if the bachelor degree nurse reports a different level of oppression than the associate degree nurse.

What we will ask you to do: If you choose to continue and take the proceeding survey, it will take you about ten minutes or less to complete a short demographics and a 1-5 lickert scale questionnaire. I promise…that's it!

Risks and benefits: I do not anticipate any risks to you participating in this study other than those encountered in day-to-day life.

There are no benefits to you. Nursing is a very demanding profession and I hope to learn more about nurses and the implication of increased education.

Compensation: You will get no compensation from completing this survey. You may get the satisfaction of having had the opportunity to contribute to an important assessment within your nursing environment.

Your answers will be confidential. The records of this study will be kept private. In any sort of report we make public we will not include any information that will make it possible to identify you. Research records will be kept in a locked file; only the researchers will have access to the records. Paper records collected will be entered online and destroyed as soon as entered. Online collection will utilize a system that requires a password and no information will be collected that will specifically identify you or your hospital.

Taking part is voluntary: Taking part in this study is completely voluntary. You may skip any questions that you do not want to answer. If you decide not to take part or to skip some of the questions, it will not affect your current or future relationships. This study is not part of your regular employment and participation/ not participating will not affect your employment or your relationship with your employer. A generalized summary of results will be provided to the hospital, but no information will be provided to individual supervisors and your employment should not be affected. If you decide to take part, you are free to withdraw at any time.

If you have questions: The researcher conducting this study is Sheila Montgomery. Please contact me with any questions you have. If you have questions later, you may contact Sheila Montgomery at 205-965-3883. You can reach my dissertation chair (Prof. Houser) at rhouser@ua.edu.

If you have questions about your rights as a person taking part in a research study, make suggestions or file complaints and concerns, you may call Ms. Tanta Myles, the Research Compliance Officer of the University at (205)-348-8461 or toll-free at 1-877-820-3066. You may also ask questions, make suggestions, or file complaints and concerns through the IRB Outreach Website at http://osp.ua.edu/site/PRCO_Welcome.html. You may email us at participantoutreach@bama.ua.edu.

UNIVERSITY OF ALABAMA IRB
CONSENT FORM APPROVED: 5-20-14
EXPIRATION DATE: 5-19-15

Office for Research

April 3, 2015

THE UNIVERSITY OF
ALABAMA
RESEARCH

Shelia Montgomery
ESPRMC
College of Education
The University of Alabama
Box 870231

Re: IRB # EX-14-CM-070-R1 "Oppression in Nursing: Does Education Level Make a Difference?"

Dear Ms. Montgomery:

The University of Alabama Institutional Review Board has granted approval for your renewal application.

Your renewal application has been given exempt approval according to 45 CFR part 46.101(b)(2) as outlined below:

(2) Research involving the use of educational tests (cognitive, diagnostic, aptitude, achievement), survey procedures, interview procedures or observation of public behavior, unless:
(i) information obtained is recorded in such a manner that human subjects can be identified, directly or through identifiers linked to the subjects; and (ii) any disclosure of the human subjects' responses outside the research could reasonably place the subjects at risk of criminal or civil liability or be damaging to the subjects' financial standing, employability, or reputation.

Your application will expire on April 2, 2016. If your research will continue beyond this date, complete the relevant portions of Continuing Review and Closure From. If you wish to modify the application, complete the Modification of an Approved Protocol Form. When the study closes, complete the appropriate portions of FORM: Continuing Review and Closure.

Should you need to submit any further correspondence regarding this proposal, please include the assigned IRB application number.

Good luck with your research.

Sincerely,

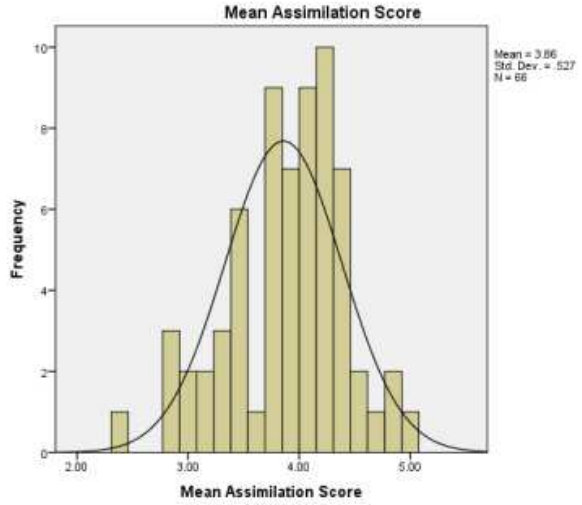
[redacted]

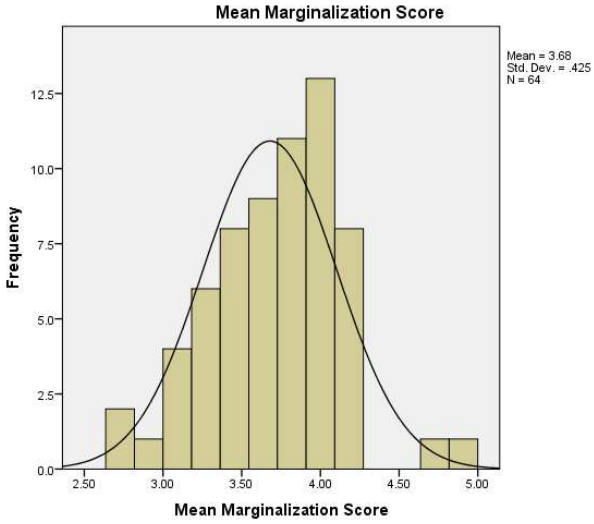
Director & Research Compliance Officer
Office for Research Compliance

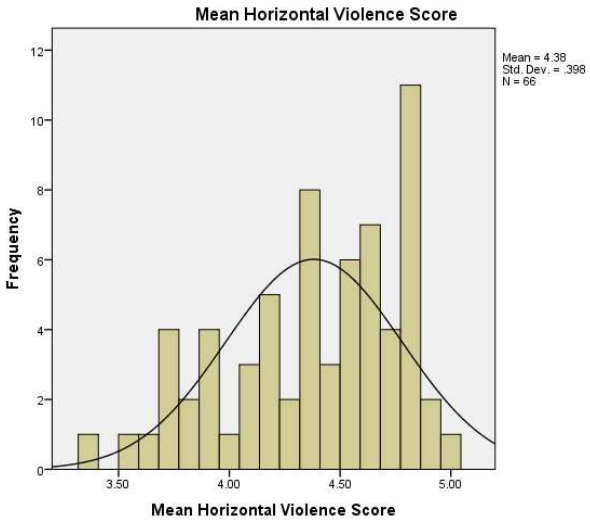
358 Rose Administration Building
Box 870127
Tuscaloosa, Alabama 35487-0127
(205) 348-8461
fax (205) 348-7189
toll free (877) 820-3066

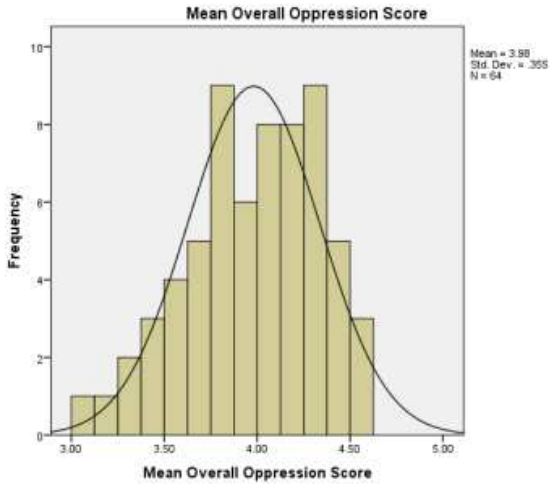
APPENDIX D

Histograms of Measures


Mean Assimilation Score
Mean = 3.86
Std. Dev. = .527
N = 66
Frequency
Mean Assimilation Score

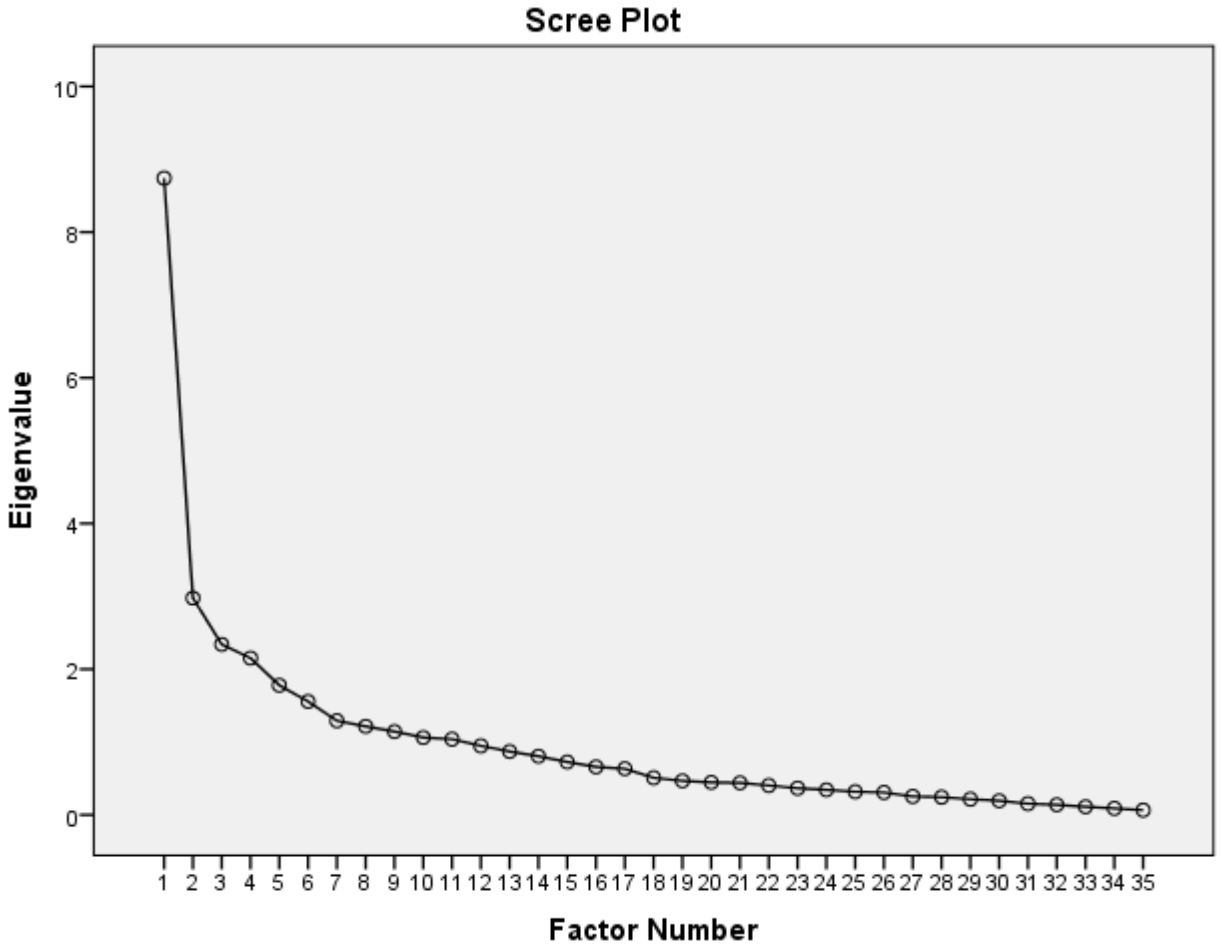

Mean Marginalization Score
Mean = 3.68
Std. Dev. = .425
N = 64
Frequency
Mean Marginalization Score


Mean Horizontal Violence Score
Mean = 4.38
Std. Dev. = .398
N = 66
Frequency
Mean Horizontal Violence Score


Mean Overall Oppression Score
Mean = 3.98
Std. Dev. = .355
N = 64
Frequency
0
2
4
6
8
10
3.00
3.50
4.00
4.50
5.00
Mean Overall Oppression Score

APPENDIX D

Scree Plot


Scree Plot
Eigenvalue
10
8
6
4
2
0
1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35
Factor Number

APPPENDIX F

Questions Factor Analysis

Orientation
Q4#6 Experienced staff value new graduates as a valuable resource.
Q4#7 The relationships between experienced staff and new graduates are very supportive.
Q4#8 Nurses like to orient new staff nurses.
Q4#9 Nurses like to orient new graduate nurses.
Q4#10 Nursing values are universally important.
Q2#4 I am encouraged to participate in rounding as an equal partner.

Worth
Q2#1 My supervisors value my judgment.
Q2#6 I am valued for my professional nursing skills.
Q2#9 Communication here is excellent.
Q4#2 Nursing professional values are easily incorporated into nursing tasks.
Q2#5 My professional opinion matters.

Autonomy
Q2#3 Nurses have decision making autonomy.
Q2#8 Nurses can perform independently without physician approval.
Q2#2 I have decision making autonomy.

Professional Judgment
Q2#7 Patients value my independent judgment.
Q2#11 Nurses can challenge physician orders.
Q2#9 Doctors listen to me.

Competence
Q4#1 Professional nursing values are important.
Q4#13 I value critical thinking as a professional nursing skill.
Q6#11 I have refused to work with someone at this hospital.