AN ABSTRACT OF THE DISSERTATION OF

Juanita M. Joy for the degree of Doctor of Education in Education presented on April 13, 2000. Title: The History of the Associate Degree Nursing Program at Portland Community College.

Abstract Approved: _____
Larry Roper

This study describes the historical development of the Associate Degree Nursing Program at Portland Community College by women faculty leaders in a male-dominated organization. In-depth interviews of eleven participants were transcribed and analyzed. The participants gave a very rich description of this nursing program—thus describing its culture. Six themes were identified: the use of power, governance, informal networks, work ethic, psychological climate, and external influences. A review of the literature affirmed that these topics are conceptually related. Thus, three constructs were reviewed: the use of power, organizational culture, and associate degree nursing education.

What this means in terms of a historical study is for one to look at the whole. The influence of prior events upon contemporary social events is still a dynamic issue. Insight into how or why decisions have been made in the organization's past, can illumine contemporary decision making. Past decision

making can be viewed both within the historical context and through the contemporary lenses of the use of power in the workplace, organizational culture, and associate degree education. Being aware of the cultural context, both from the broader social perspective and from the microcosm of the organization or the immediate work group, allows insights through these more refined lenses.

The History of the Associate Degree Nursing Program at Portland Community College

by

Juanita M. Joy

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APPROVED:

Major Professor, representing Education

Director of School of Education

Dean of the Graduate School

I understand that my dissertation will become part of the permanent collection of Oregon State University libraries. My signature below authorizes release of my dissertation to any reader upon request.

Juanita M. Joy, Author

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Finally, I extend my deepest appreciation for the love and support of my family and friends who saw me through this process.

I dedicate this work to those who have come before, those working now, and to the students for whom we all work. It is a privilege to serve all of you.

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The History of the Associate Degree Nursing Program
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Chapter I: Introduction of the Problem

Introduction

Organizations are richly steeped in their own traditions, values, and history. Profoundly influenced by the developing leadership, the organization—through its human members—soon comes to form its own culture (Schein, 1985, Aycan, 2000). Over time, and within its history, the way of doing business is subtly imbued with the legacy it has both created and endured in the evolution to contemporary times. A problem that exists today is that institutional memory is buried within habit and it is not overtly recorded nor considered relevant to contemporary decision making. As founders retire, memories fade while others—including new members—carry on. The consequence is that, all too soon, we have little understanding of our history. Without the benefit of insight to understand the dynamics that shaped current policies and practices, we have scant understanding of what was done to create success. At the same time, because of "historical amnesia" (Evans, 1998), we know little or nothing of the errors made nor the lessons learned from them. Without a more complete understanding of our history, we have lost the rich depth that understanding our heritage provides.

Portland Community College (PCC) has a published accounting of the historical roots of the college (Guernsey, 1989). The history of the nursing program within this college, however, is only referenced briefly. Exactly how the associate degree nursing program was created within five years of the inception of the college has remained a mystery. How did a very small group of women accomplish this in the middle of a rapidly growing institution otherwise led and administered by powerful men? It is this discovery that this research seeks to answer.

Purpose of the Study

Understanding differing realities of the history of an organization is a critical component of an institution aspiring to become a learning organization. Insights gathered in deciphering the past enriches and broadens the perspective of today and for the future. The nursing program at Portland Community College has no written history and only incomplete, haphazard oral reports of its past. Therefore, the purpose of this study is to document the history of the PCC Nursing Program as seen through the lenses of retired teaching faculty. The intent is not to look at a particular model of a nursing program, rather it is to understand and describe the experiences of the individuals who lived its history. This study has relevance to contemporary decision making through greater understanding of the historical evolution of program practices, policies, and outcomes.

Background/Context

The nursing program in this study refers to the registered nurse (RN) associate degree in nursing (ADN) program at Portland Community College in Portland, Oregon. Underlying assumptions and values include a positive value placed on community college learning, nursing education, recollections of retired faculty, and a greater understanding of historical context. Limited information is available regarding the history of the nursing program at Portland Community College. While historical studies exist documenting the lifespan of individual diploma nursing programs, an identified gap exists in research studies of associate degree nursing program development and evolution. There is no historical research study of similar associate degree nursing program development and evolution in Oregon.

Starting with a Department Chair and two faculty in 1966, and ending with a faculty population of twelve in July, 1999, eighty-two full-time faculty have taught in the nursing program during the past thirty-three years. The study population consists of twenty-six retired PCC Nursing Program faculty and one faculty "retired" from the program after sixteen years to another position within the school (but not yet retired). The first president of the college (retired) is also included in the study. These nursing faculty retirees are part of seventy full-time faculty who left their teaching positions within the PCC Nursing Program since its inception in 1966. The researcher has had a

professional relationship with approximately one-third of the retirees, which eases entry of the subjects into the study and poses a risk for researcher bias.

Access to the target population and its history is both informal and official. Informal access occurred through the retired nursing faculty cohort unofficial monthly luncheons. Official access occurred through public documents both internal and external to the institution.

The primary research tool was the researcher's use of self—assuming a learner role and practicing personal and professional skills in observation, listening, and communication. The intent was to understand a social reality from each participant's point of view.

Central Research Focus

The purpose of this study is to describe the development of the nursing program by women faculty leaders at Portland Community College (in a male-dominated organization).

Rationale for the Study

This study is important to determine the impact of its history on contemporary decision making within the nursing program at Portland Community College. The history is innately steeped in program tradition —reflecting the sum of organizational, program, and professional values—which create its unique culture. In turn, this has shaped policies,

procedures, and the general way of doing business. As time goes on, original values and the rationale for decision making gets lost in the frenetic pace of the day-to-day routine.

This study is important due to the development of what came to be a flagship program within the college (Guernsey, 1989) by a small group of women nurse leaders in a male-dominated organization. The founding members of the program have retired; the history is a cacophony of stories passed down to those that have followed, along with dusty accreditation reports, random artifacts saved by department packrats, and other once important papers now buried and forgotten in bulging file cabinets. Historical records—doomed to good housekeeping—have been reduced to "must save" documents, which themselves risk being purged with the next accreditation cycle. A perfunctory and sketchy history of the department has been lost in welcoming comments and a flurry of papers. New members are welcomed to the department with pounds of papers—information about the college, the faculty handbook, department policy, procedure, and rules, curriculum committee agenda, course syllabi, the student handbook, schedules, clinical information, and related classroom notes. New members, thus oriented to the department, are also introduced to its culture through the ritual of handling a mountain of papers. Nowhere is the history of the nursing program highlighted as a significant piece of information to factor into current departmental decision making.

Understanding the dynamics that have shaped current policies and practices gives insights that can be evaluated against contemporary standards for decision making. Understanding what was done to create success, as well as understanding past errors, provides lessons for current program faculty and staff. A depth of knowing of our heritage—instead of a superficial awareness—provides a richness that lends itself to improved decision making. While the history of the nursing program is briefly referenced in an informal history of the college, exactly how it was created within five years of the birth of the college has remained a mystery. Insights gathered in deciphering the past enriches and broadens the perspective of today and for the future. It is this insight—seen through the lenses of those individuals who lived it—that has relevance.

Limitations

1. The population in this study was confined to persons (primarily nursing faculty) who had direct experience with the nursing program at Portland Community College.
2. The sample population was small and non-representative of all community college nursing faculty.
3. Conclusions from the study are only applicable to the nursing program at Portland Community College and cannot be generalized to other populations.

Definition of Terms/ List of Acronyms

American Nurses Association (ANA): A national organization representing all nurses in the United States.

Associate Degree in Nursing (ADN): A degree in Nursing from a two-year or community college. The ADN graduate takes the same licensure examination to become a registered nurse (RN) as the BSN graduate. This degree is often awarded as an Associate of Science Degree.

Baccalaureate Degree in Nursing (BSN): Awarded as a Baccalaureate of Science degree in Nursing from a four-year college or university. The BSN offers additional depth of nursing content beyond the ADN degree in areas such as nursing administration, nursing research, and community health. The BSN graduate takes the same licensure examination to become a registered nurse (RN) as the ADN graduate.

Clinical: see Practice Sites

Clinical Instructor: Refers to a registered nurse (RN) whose role as nursing faculty is education of students at a hospital, clinic, or other "real-world" setting. The educational institution determines if the clinical instructor is also a didactic instructor. At Portland Community College, all of the full-time nursing program (Master's prepared) faculty are also clinical instructors: an additional clinical instructor (minimum qualification is a baccalaureate degree in nursing) supplements clinical coverage.

Diploma Program: (Diploma School of Nursing) This form of nursing education is based in historical roots from the Nightingale era of nursing. It is also called hospital-based nursing education. Originally nursing students, working for subsistence wages, compromised the largest workforce within the hospitals where they learned as they worked. The majority of diploma programs had closed their doors by the mid-to-late 1960s, giving way to nursing education within institutions of higher learning. The diploma graduate took the same licensure examination to become a registered nurse (RN) as the ADN or BSN graduates.

Graduate Equivalent Determination (GED): Equivalent to a high school diploma.

Inductive Research Approach: Constructing a picture that takes shape as the researcher collects and examines each piece of the data (Bogdan and Biklen, 1998, p. 6-7).

Leader: According to Bennis and Mische (1995) the effective leader has the following skills and abilities: creativity, visionary influence, a solid knowledge of the business, credibility achieved through a track record, exceptional people skills, impeccable character, and excellent judgment (p.9).

LEGS: An acronym for Learning Experiences Guide for Students. A self-paced program of study for nursing students. Especially popular in nursing education in the 1970s.

Licensed Practical Nurse (LPN): One who gives general nursing care under direct supervision of a registered nurse, licensed physician or dentist. LPNs are educated in one-year vocational programs. In 1999, all LPN programs in Oregon are contained within RN Associate Degree programs in a ladder concept; that is, students may exit after one year and be licensed as an LPN, or continue to complete the RN program (OSBN, 1998). Not all ADN programs offer an "LPN exit." PCC does not. (Approximately 90% of Oregon LPNs continue in their education and become RNs.) Previously, an LPN may have obtained a fundamental nursing education and training through military experience (as a medic) followed by additional educational requirements. Therefore, the LPN did not take the same full curriculum as one who did not have the military medic background experience. In some states this title is called a licensed vocational nurse (LVN).

Long-term Care (LTC): A health care facility for the chronically ill where nursing care is provided. An older term used was "nursing homes;" this facility now cares for a broader clientele than the frail elderly, providing a wide array of health services.

LPN Exit: As described above with the term LPN, LPN programs are now within (some) RN ADN programs in a ladder concept. The LPN exit is when, at the end of one year, the student may exit the program with all

academic requirements completed to meet the licensure requirements as an LPN.

Masters of Science Degree in Nursing (MSN): Awarded from a four-year college or university. The MSN allows specialization in a wide variety of nursing arenas such as nursing education, nurse practitioner, nurse midwifery, nurse anesthetist, specific clinical specialities, and more.

National Council Licensing Examination (NCLEX): Tests created by the National Council of State Boards of Nursing for RN and LPN candidates.

NCLEX—RN: An examination administered to those who have completed a program of study culminating in a degree in nursing. Once candidates pass the exam they are licensed as an RN. The exam is given by each state's Board of Nursing, which regulates nursing licensure. There is also an NCLEX—PN licensing practical nurses.

National League of Nursing (NLN): An accrediting agency for schools of nursing in the United States.

Nurse Practitioner (NP): Registered Nurses with specialized graduate (Master's) level study. They are licensed by the state (and commonly meet national certification standards) to independently provide primary health care within their specialty area (Family Nurse Practitioner, Pediatric NP, and others). They may prescribe medications from an approved formulary (OSBN, 1998).

Oregon Nurses Association (ONA): A part of the American Nurses Association representing the nurses of Oregon. Referred to in archival data as Oregon State Nurses Association.

Oregon State Board of Nursing (OSBN): A state agency which regulates nursing education and licensure, and determines the scope of practice for each of the roles of nursing (nurses aide, LPN, RN, nurse practitioner). Each state has a Board of Nursing.

Organizational Culture: A basic set of assumptions that have proven successful and are adopted by a given group as it learns to deal with internal and external problems and are therefore taught to new employees (Baker, 1994, page xxii). These basic assumptions and beliefs operate unconsciously to fashion an organization's view of itself and its environment. They are learned responses to a group's problems of survival in its external environment and its problems of internal integration. . . . [Thus] culture is a learned product of group experience and is, therefore, to be found only where there is a definable group with a significant history (Schein, 1985, p.7).

Portland Community College (PCC): One of 15 two-year colleges in the state of Oregon. The nursing program, which is the focus of this study, is at Portland Community College.

Portland Public Schools (PPS): Also referred to in archival data as PPSD (Portland Public Schools District).

Power: The potential ability to influence behavior, to change the course of events, to overcome resistance, and to get people to do things that they would not otherwise do. Politics and influence are the processes, the actions, the behaviors through which this potential power is utilized and realized. (Pfeffer, 1992, p. 30).

Power—Coercive Power: This form of power is based on the belief of one person that another person will administer punishment if the desired change in behavior does not occur. It is the opposite of reward power. (Kalisch and Kalisch, 1982, p. 8).

Practical Nurse (PN): Those persons who are in the educational process toward becoming an LPN. By passing a state examination they become licensed (an LPN). In nursing education the terms PN and LPN are often used interchangeably with the understanding that the PN can only become an LPN after completing required course work and passing the state licensing examination (NCLEX—PN).

Practice Site: A location or situation in which nursing experience with actual patient/ client individuals or groups is obtained. Applies to various levels of nursing students. This may be a hospital, clinic, long-term care facility, hospice, home health, or any other community setting where nursing care is delivered. Referred to by nursing faculty participants as "clinical."

Pre-clinical: A term used in archival data referring to didactic or classroom instruction before the student went to the clinical (practice site) setting.

Registered Nurse (RN): After graduation from a school of nursing and passing a specific state licensure examination (NCLEX—RN), the title RN is then granted. Graduates of diploma, ADN, and BSN programs all take the same RN licensure examination. RNs administer general nursing care. They give medications and treatments prescribed by physicians, nurse practitioners, or others empowered with this authority, and may supervise other nursing assistive personnel (such as LPNs and Nurses Aides).

Student Success Program (SSP): A cluster of student services created to increase both the enrollment and successful completion of the nursing program by high risk populations. In 1994, a Health and Human Services (HHS) grant (co-authored by this researcher), funded $456,000 (over three years) for increased support of academically and financially disadvantaged pre-nursing and nursing students.

Organization of the Study

Chapter I presented the introduction, problem statement, central research focus, rationale, limitations and definitions of the study. Chapter II is a review of the literature related to the identified themes of power, governance, informal networks, work ethic, psychological climate, and external

influences. These themes are integrated into a review of the literature about power, organizational culture, and associate degree nursing. The research design and methodology of the study are discussed in Chapter III. Chapter IV presents the findings from the data collected. Chapter V summarizes observations derived from the data and suggests implications based upon those observations.

Chapter II: Review of the Literature

Introduction

This study investigates the experiences of a group of people who were directly involved in the creation and evolution of the associate degree nursing program at Portland Community College. Through in-depth interviews, the words of the participants were elicited to learn about their backgrounds, how they became involved with this nursing program, the changes they observed or participated in, and the challenges they faced. The goal was to identify factors which may have influenced the way decisions were made.

The literature review and identifying themes were both done through the final or synthesization stage of this research. Initial identification of themes was deemed premature by Bogdan and Biklen (1998) when they asserted that "You are not sure what literature is relevant at the beginning stages of a study, since the literature depends on the themes you (discover and) discuss" (p. 68). The process for literature review after data collection was therefore guided by the themes that were revealed.

The themes which emerged from the data were power, governance, informal networks, work ethic, psychological climate, and external influences. None of these themes existed in isolation from the others. An initial review of the literature confirmed an inherent relatedness of these themes (DeLaune and Ladner, 1998; Pfeffer, 1992; Schein, 1992) when seeking to describe the

development of the nursing program by women faculty leaders. The theme of power (specifically, of power in the workplace) related both directly and more subtly with the issues of governance and informal networks (Lunneborg, 1990; Pfeffer, 1992; Steinem, 1992). Psychological climate, work ethic, and informal networks, as well as the use of power, related to the literature of organizational culture (Pfeffer, 1992; Schein, 1992; Senge, 1990). Lastly, governance, work ethic, and external influences were addressed in the literature of associate degree nursing education (Ashley, 1976; DeLaune and Ladner, 1998; Schorr and Zimmerman, 1988; Ulrich, 1992).

Like any profession, nursing has its own culture and sub-cultures (as does education and nursing education), its own group norms related to work ethic, and external influences unique to the profession. In addition, these themes were not only present, but they were mutually inclusive as well.

For these reasons, the literature review focused on three constructs: the use of power (specifically, power in the workplace), organizational culture, and associate degree nursing education. The first group of literature reviewed, about the use of power, has been written mostly during the last fifteen years. The second group, which reviews the literature about organizational culture, also occurs primarily over the last ten to fifteen years. The third group, about associate degree nursing education, has a literature span of approximately fifty years, from the writings of Mildred Montag (1951) to contemporary nursing authors.

This multi-disciplinary approach to considering the identified themes is validated by Miles and Huberman (1994), who assert:

> On balance, we believe that a knowledgeable practitioner with conceptual interests and more than one disciplinary perspective is often a better 'research instrument' in a qualitative study: more refined, more bias resistant, more economical, quicker to home in on the core processes that hold the case together, and more ecumenical in the search for conceptual meaning (p. 38).

Literature Review of the Construct

The Use of Power in the Workplace

Etymologically, the word "power" comes from the Latin verb "potere", meaning "to be able." "Thus in the simplest terms, 'power' is the ability to affect something or to be affected by something . . . ; the hallmark of power is effectiveness" (Kalisch and Kalisch, 1982, pp.1-2). Everyone uses their personal power—in some manner, and on some level—to guide the direction of their lives, including at their place of work (DeLaune and Ladner, 1998; Katzenbach, 1995). Pfeffer (1992) has written extensively on the use of power in the workplace. He describes both the use of power and those who use it.

> Power has been defined as the ability to overcome resistance, to get others to do what you want. Inherent in this definition of power is the assumption that disagreement is one of the constant realities of the social world. . . . Power, therefore, is exercised in situations in which there is conflict. . . . Because [of this] one of the personal attributes of powerful people is the willingness to engage in conflict with others (p. 176).

The link between leadership and power is thus made. Leaders, then, are those who are willing to use their power to manage conflict and/or to influence change (Ansley and Gaventa 1997; Beatty, 1998; Bolman and Deal, 1991; Kalisch and Kalisch, 1982; Kouzes and Posner, 1990; Pfeffer, 1992.) Conflict is an inevitable part of life. While it is not rare for one to prefer to avoid conflict, not all conflict is "bad." In fact, "Leaders . . . must be prepared for conflict. Passionate disagreement about hard questions is a sign of a robust democracy" Ansley and Gaventa (1997, p. 53).

An organizational leader may or may not be in an official position of authority. While power can be granted through a position within an organization, one does not need to be granted official authority to exercise power in the workplace. Life experience as well as age, gender, and acculturation, shape individual styles in using personal power to manage conflict and to influence decision making in the workplace.

Kalisch and Kalisch (1982) relate power to the field of nursing with the statement that "The struggle for power is a pervading feature of politics; thus politics in general as well as the politics of nursing requires the learning of power" (p. 9). They continue with the assertion that "Traditionally, nurses have been subjected to a great deal of coercive power, much of which was enforced by elaborate rituals and exact codes of conflict" (p. 9). The use of power in nursing is socially reinforced in nursing education. DeLaune and Ladner (1998) illustrate this point in their nursing text by stating, "Power that is

effective is power that is shared" (p. 222). They continue their discussion about developing power by informing this professional audience that "In addition to advanced practice nursing, other avenues for nurses to achieve power include knowledge, competence, caring, and affiliation" (p. 224). The professionally acculturated and imposed limits to the use of power are implied in the statement "share power and resources (including knowledge) with others, admit when a mistake is made because it demonstrates trustworthiness and honesty, [and] avoid power struggles" (p. 225). Do business texts—especially those written for a predominantly male readership—dispense the same advice, especially to "avoid power struggles"? None that this researcher has noted.

Pfeffer (1992) identifies multiple indicators of power. They include: reputational (ask others who has power); representational (note which political subdivisions are represented in critical organizational roles or positions); control over resources (including salary and salary differential), information, or formal decision making authority; observable consequences; and symbols of power such as physical office space, recognition, membership to special groups, and use of organizational resources. Caution must be used in the interpretation of the indicators of power. Power does not look the same in different cultures or sub-cultures—including within professional work groups such as the nursing program at PCC.

Paulo Freire (1993) vividly described the culture of education in his book Pedagogy of the Oppressed:

> There is no such thing as a *neutral* educational process. Education either functions as an instrument that is used to facilitate the integration of the younger generation into the . . . present system and bring about conformity to it, *or* it becomes 'the practice of freedom,' the means by which men and women deal critically and creatively with reality and discover how to participate in the transformation of their world (p. 16).

Freire passionately wrote to a reduction of social barriers through education—a philosophy this researcher demonstrated in her background and experience when she wrote (reflected in Chapter III) that "education is freedom." Disbursement of power, according to Freire, was often attached to education as a form of social rank and a reflection of economic strength. Sub-cultures—such as the educational and nursing communities—have often reflected elitism and snobbery among their own ranks based on perceived differences in social rank and economic strength. Unfortunately, these perceptions have become part of its culture, passed along to subsequent generations until the cycle is interrupted. In a large beautiful book, for example, about the history of nursing (Donahue, 1985) the space that was given—in its 509 pages—to associate degree nursing was two small paragraphs. (The practical nurse was not even listed in the appendix!) Surely the PhD nurse author had been schooled enough to understand the profound impact of ADN education—even if only to acknowledge the sheer number

(80%) of nurses educated in the thirty years since its inception (before her publication date) (Curran, 1987). The researcher reflected upon her own professional heritage and experiences supporting ADN education as she interpreted this as example of elitism and cultural snobbery within the profession. The researcher had the benefit of self-awareness that the author did not disclose.

Freire urged the development of personal awareness and insight as well as open dialogue to learn how another thinks, learns, and interprets the world. Heinrich and Witt (1993) commented on "a model . . . of 'emancipatory nursing education' [developed by Hedin and Donovan] that built on Freire's model of oppressed group behavior" (p. 120). They continued, asserting that "the medium is the message. . . . 'Freeing education' is values explicit and proceeds from the assumption that facilitator and participant share an egalitarian relationship. The result of sharing power is that autonomous learning is encouraged and reciprocal communication is valued" (p. 120). A commitment to an egalitarian stance, even if adopted as a personal (adult) stance, has likewise been learned as part of an acculturation process, whether professionally or socially. Unfortunately, the use of personal power, especially for egalitarianism and respectful dialogue, has not been universally taught—especially to children—as Steinem (1992) attested:

> But not until sometime in my thirties did I begin to suspect that there might be an internal center of power [that] I was neglecting. Though the way I'd grown up had encouraged me to

> locate power almost anywhere but within myself, I began to . . . pinpoint its beginning within—my gender and my neighborhood training notwithstanding . . . I had been raised to assume all power was outside myself (p. 22).

Steinem developed a strong argument that the use of personal power (or its lack), as a part of social acculturation, was prescribed differently between the genders. Noddings (1995), an educator, also examined this issue of learning within a cultural context. She explored Rousseau's view of education and pointed out the disparity of the male (Emile) learning to think for himself while his female counterpart was socialized to "do what convention prescribed" (p. 18). What Noddings did not elaborate on was the social context and acculturation that Rousseau himself was part of. Besides writing about education, Rousseau also wrote about the social contract whereby each member of society agrees, through socialization (even if they are not fully aware of it), on common rules of behavior. In this context, one willingly channeled personal power for the benefit of a greater good—as in obeying rules of the road. Perhaps this circles the reader back to both Steinem and Noddings if one asked "Who determines the rules of the road?" An egalitarian society would appear when the "entire education of women [is] relative to men" (Noddings, p. 18). The use of personal power—manifested by thinking for oneself—has been socially assigned diametrically and reinforced in the process of educating our children. Bullough (1990) looked at the legacy of socialization about the use of personal power and how it has impacted nursing

through the "traditional masculine belief of the inferiority of the female" (p. 5). She related this to the social context in which modern (often labeled "professional") nursing was conceived:

> The major way a woman in the nineteenth century coped . . . was to play a role in which she could demand respect—that of a lady. . . . Ladies (not women) were believed to be made of finer fabric. . . . Florence Nightingale was very much a lady . . . and her concern with the poor, the ill, the wounded and the sick was very much a proper concern for a lady. Ladies however, *spoke* about issues; while Nightingale mixed with the sick and wounded and went where no proper lady had ever gone before. In effect, she violated the gender norms of the day and threatened male power. Very much aware of her threat to men, she continually emphasized that she was doing only what a proper lady should do—extending the role by accepting what society said women were especially qualified to do. Her most symbolic action in this respect took place at the Scutari Hospital when, after her services were rejected by the surgeons and officers, she withdrew her nurses and simply sat with them in the hospital until she was asked to help. Quite simply, ladies did not go where they were not wanted. . . . It was only by acting as a lady that she was able to accomplish what she did (Bullough, 1990, pp. 5-6).

Nightingale held the special position of a woman born into a wealthy family. Lillian Wald—founder of the famous Henry Street Settlement in New York City—was raised in a similar financially comfortable family. Recall that Freire noted power was often attached to social rank and economic strength. Fitzpatrick (1990), describing Wald's contributions, reinforced this: "With the sponsorship of well-established wealthy Jewish benefactors . . . Wald established a Nurses' Settlement Home. . . . Likewise, she optimized her contacts to gain access to the wealthy and powerful who were in a position to

support her projects" (p. 94). Both Wald and Nightingale became outspoken in voicing the issues they were passionate about. Certainly having economic security allowed freedoms—free use of personal power—that one struggling to feed a family could little afford to voice.

Gilligan (1993) also wrote of the social barriers between the genders. In her study of women's development she, like Freire, also negated any global neutrality in the learning of social roles between the sexes. She described sociocultural oppression which prevented women from using their power and limited their personal and professional development. Not unlike the display of values and beliefs in the organizational culture, the use of power—or limitations of its use—once imbued into children, becomes self-imposed, a topic of personal conflict, or an area of conscious consideration for personal and/or professional development (Gilligan, 1993). Gilligan described a common dilemma experienced by one subject in her study: "Because [she] sees the acquisition of adult power as entailing the loss of feminine sensitivity and compassion, she construes the conflict between femininity and adulthood as a . . . problem" (p. 97). The message reflected that, in order to be successful (especially professionally), a woman must relinquish a measure of her femininity, perhaps even emulate male behavior.

Becoming equals—after being socialized differently—required a unique personal history which deviated from the social norm or it took relearning another way of being (Belenky, Clinchy, Goldberger, and Tarule, 1997).

Belenky, Bond, and Weinstock (1997) described a discussion group established in the mid-1970s for this purpose:

> [This group was] where the women could talk with each other as equals . . . . Being one among equals seemed to be a watershed experience for most of the women. All too often they had been confined to the bottommost rungs of the social hierarchy. They often spoke of amazement that others were coping with similar problems, which was of the greatest importance, since it suggested that many of the women's problems were a function of the social arrangements that devalued and excluded women (especially mothers and the poor). Previously, the women assumed the difficulties they faced were due to their personal inadequacies—a paralyzing assumption that left most without hope (p. 65).

In summary, the literature review of the construct "the use of power in the workplace" defined "power" as the ability to get others to do what you want. The point was made that issues of disagreement or conflict are the precipitating stimulus for the use of power. Pfeffer (1992) contributed a description of what power looks like through the identification of specific "indicators." Freire (1993) pointed out that there is no such thing as a "neutral" experience. Education—not unlike other arenas in life—held *both* the opportunity to enforce an elitist or class system social power structure and the opportunity to empower oneself to be free from rigid social controls. Although Noddings (1995) looked at the disparate social legacy which Rousseau described, Heinrich and Witt (1993) made egalitarianism and respectful dialogue sound possible. Gilligan (1993) viewed power from the perspective

of gender socialization. She posited what Steinem (1992) affirmed—that women learn as children to limit their use of power.

Organizational Culture

Fifty years ago the word "culture" was commonly used to refer to literature and the arts. This same term was used less often by anthropologists to refer to characteristics unique to members of a specific social group. It has evolved to contemporary times within the business literature to describe the culture of an organization. Through much of the century, any group of business owners and workers—with rare exception—was limited to working within a geographic area. Advances in technology promoted global exchange both through travel and through global communication. These opportunities have advanced awareness of "other," awareness of another person's way of thinking and doing business—another's culture. This insight has afforded the recognition of culture within any group of people—including those working in the same organization. As Schein (1992) explained the development of culture, the application to organizations became apparent:

> The most useful way to think about culture is to view it as the accumulated shared learning of a given group, covering behavioral, emotional, and cognitive elements of the group members' total psychological functioning. For shared learning to occur, there must be a history of shared experience, which in turn implies some stability of membership in the group. . . [It] somehow implies that rituals, climate, values, and behaviors bind together into a coherent whole. This patterning or integration is the *essence* of what we mean by "culture" (p. 10).

Beckhard and Pritchard (1992) described the culture of a work group as a "set of values (what is good or bad) and assumptions (beliefs about human nature) that distinguishes a particular organization from others. [It includes] norms (ground rules for behavior) and artifacts (such as who gets the corner office) that guide actions in the organization" (p. 46). Schein (1992) identified multiple categories which describe culture:

1. Observed behavioral regularities when people interact: the language they use, the customs and traditions that evolve, and the rituals they employ.

2. Group norms: the implicit standards and values that evolve in working groups.

3. Espoused values: the articulated, publicly announced principles and values that the group claims to be trying to achieve.

4. Formal philosophy: the broad policies and ideological principles that guide a group's actions toward stockholders, employees, customers, and other stakeholders.

5. Rules of the game: the implicit rules for getting along in the organization, "the ropes" that a newcomer must learn to become an accepted member, "the way we do things around here."

6. Climate: the feeling that is conveyed in a group by the physical layout and the way in which members of the organization interact with each other, with customers, or with other outsiders.

7. Embedded skills: the special competencies group members display in accomplishing certain tasks, the ability to make certain things, that gets passed on from generation to generation without necessarily being articulated in writing.

8. Habits of thinking, mental models, and/or linguistic paradigms: the shared cognitive frames that guide the perceptions, thought, and language used by the members of a group and are taught to new members in the early socialization process.

9. Shared meanings: the emergent understandings that are created by group members as they interact with each other.

10. 'Root metaphors' or integrating symbols: the ideas, feelings, and images groups develop to characterize themselves, that may or may not be appreciated consciously but that become embodied in buildings, office layout, and other material artifacts of the group. This level of culture reflects group members emotional and aesthetic responses as contrasted with their cognitive or evaluative response (pp. 9-10).

Culture, thus social in nature, is developed in groups of people and is communicated to new members of the group through these means. The sharing of common behaviors impart its cultural practices to a group (or subgroup within it), hence creating its cultural identity (Beckhard and Pritchard, 1992; Bruner, 1996; Cohen, 1998; DeLaune and Ladner, 1998; Maccoby, 1999; Pfeffer, 1992; Schein, 1992; Vaughan, 1992). Each group therefore creates its own cultural milieu. All individuals of any society are simultaneously members of multiple social groups or roles. Professionals are members of a culture that is unique to their training while also being members of their social and other communities. Consequently, it is the combination of social and professional mores which guide behavior. Even though the culture of a group is dynamic and ever-evolving, cultural change occurs slowly (Carnegie, 1991;

DeLaune and Ladner, 1998). The culture of an organization thus includes newer actions blended with the legacy offered from its history. Many assert that the culture of an organization can be consciously shaped by the leadership (Amey and Twombly, 1991; Bennis, 1999; Bennis and Goldsmith, 1997; Bennis and Mische, 1995; Schein, 1992; Vaughan, 1992). Deming cautioned against the use of one (or several) specific tactics (such as slogans) to change the environment; rather the leader should delve deeper to identify what keeps any one behavior persisting (Walton, 1986).

Just as social groups developed a cultural identity, members of a profession created a culture unique to itself. Kaiserswerth Hospital (where Nightingale received four-months of training in caring for the ill) also taught ladylike behavior to the local peasant girls learning nursing skills (Hegge, 1990). The customs and traditions, norms, rituals, and shared meanings—ways that the culture of a group makes itself apparent—are noted in the following description of the nursing student's uniform:

> [The] uniform reflected the fashion of upper-class married women of the day. It included a floor-length blue-gray tailored dress, a white bibbed apron, a long black shawl, and a white bonnet tied under the chin and with a double row of ruffles surrounding the face. The bonnet served the important function of allowing nursing students to walk alone in public. Unmarried women, identified by their head coverings, were not allowed to walk unattended through the village. The uniform afforded the students protection and respectability as they walked throughout the village to care for patients in their homes (Hegge, 1990, p. 74).

In addition to wearing prescribed attire, nurses (predominately female) were socially and professionally trained to reply to the physician (predominately male) with an attentive and prompt "yes, sir!", to rise from their chairs when the physician entered the room, and—contrary to social custom of the male offering his seat to a lady—to relinquish their chairs for the physician to use (Kalisch and Kalisch, 1982). Ulrich (1992) points out the legacy of Florence Nightingale through her writings and speeches. Nightingale—the mother of modern nursing—influenced by the culture of her era (the mid-1800s), imbued her values to the profession in these words:

> Do you think I should have succeeded in doing anything if I had resisted and resented? Is it our Masters command? Is it even common sense? I have been even shut out of hospitals into which I had been ordered by the Commander-in-Chief—obliged to stand outside the door in the snow till night—been refused rations for as much as 10 days at a time for the nurses I had brought by superior command. And I have been as good friends the day after with the officials who did these things—have resolutely ignored these things <u>for the sake of the work</u> (Ulrich, 1992, p. 55).

"Early in its formal organization, nursing accepted a passive role in physician-nurse relationships. Florence Nightingale wrote that the chief qualities doctors expected in nurses were 'devotion and obedience' . . . . [She also] lamented [that] this definition would do just as well for a porter. It might even do for a horse" (Pillitteri and Ackerman, 1993, p. 113). Nightingale—as well as other (subsequent) nurse leaders (Lavinia Dock, Lillian Wald, and others)—also belonged to the unique culture of the wealthy. Inherent in

Nightingale's behavior was the actual use of her personal power in dealing with an overtly male-dominated organization—the hospital.

Nightingale directed nurses' behavior with the value of hard work in her statements: "As for myself, I am so weary and heavy laden . . ." (p. 51); "always take . . . your *monthly* [italics added] day off;" and "I have toiled my way . . . " (Ulrich, 1992, pp. 82-86). Nursing education was eighty-one hours per week, fifty weeks a year (Pillitteri, 1991). Nearly one hundred years later nurses were still carrying this legacy. Only eight percent of hospital nurses were working "just" an eight hour shift, and less than fifty percent of nurses had two weeks of vacation time while fourteen percent had none at all; all this for $70 to $90 in monthly pay (Curran, 1987). Thus the professional culture of nursing evolved from shared experiences, which were then taught to subsequent generations through professional socialization. These included the values of hard work and doing whatever it took to get the job done within the cultural confines of the day.

In summary, the literature review of the construct organizational culture looked at the contemporary use of the anthropological term that describes characteristics unique to members of a specific social group. "Culture" refers then, to the accumulated shared learning (a history of shared experience) that is seen only through the behaviors of the individuals in the group. The values, behaviors, and climate of an organization or other group—the way culture is

seen—coalesce into a coherent whole that is the essence of its culture (Schein, 1992).

While individuals may be members of a specific organization or professional group, they are also members of other social groups. Thus each individual brings the gestalt of their sub-cultural memberships into each of their life experiences. The culture of nursing was described in the context of the era of its inception—its legacy imprinted upon the profession. The dynamism and slow evolutionary nature of cultural change was made evident.

Associate Degree Nursing Education

"The history of nursing is as old as the human race; the trained nurse a recent discovery" (Donahue, 1985, p. xvi). Florence Nightingale is considered the mother of modern nursing since 1856 when—during the Crimean War—Nightingale and her cadre of thirty-eight nurses reduced the military hospital death rate from forty-two percent to two percent (Burns, 1999, p.95; Donahue, p. 238). Nightingale also subscribed to the notion of *educating* people to become nurses instead of family or interested others simply nursing the sick as they had watched the others do. Thus, in 1860 she started the Nightingale Training School for Nurses—the first organized program for teaching nursing (Donahue, p. 248).

As in the Crimean War, the American Civil War (1861-1865) also dramatized the need for trained nursing care. Although some hospitals did

exist in the larger cities, they were very different from the contemporary model. Often the "hospital" was a combination of almshouse, prison, and infirmary; and the few haphazardly trained nurses had not gained their experience from formal training programs. (Donahue, 1985). Even after the birth of the Nightingale model of nursing education, the first trained nurses often received little classroom preparation as the aggregate of their training was completed in an apprenticeship. Baer (in Schorr and Kennedy, 1999) describes both the training and employment of the first graduates:

> [Three] formal training [programs] for nurses in the United States began in 1873 . . . followed . . . by training schools in hospitals all over the nation. . . . Each . . . admitted women for a two-year course of study (later three) that qualified them, upon graduation, to work as trained nurses in the private homes of the sick. Known as private duty nursing, this was the main form of employment for the first fifty years of nursing in America. Because pupil-nurses performed the nursing work in hospitals, these institutions had no need to hire more than a few supervisory graduate nurses . . . (pp. 99-100).

As described above, the majority of the nursing programs were directed by hospitals where the more experienced students taught the newer, less experienced ones how to care for patients. The various levels of the unsalaried nursing students provided nursing care at a low-cost service to the institutions. "Between 1890 and 1900, approximately four hundred training schools for nurses were established. The absence of uniformity in content and length of program resulted in nurses with markedly differing abilities" (Schorr and Kennedy, p. 17). Haase (1990) elaborates:

> The civilian health care system was overwhelmingly private. . . . A distrust of government . . . seemed natural. . . . Each ethnic or religious group developed its own . . . system of hospitals. Public hospitals were most often associated with care of the poor and were thereby suspected of providing a lower quality of care. . . . The overwhelmingly private nature of the health care system explains in part the poor status of nursing education. . . . Most nurses were educated in three-year programs operated by the hospitals; each hospital, in short, produced its own nurses . . . [who] worked with the not insignificant assistance of the captive labor pool formed by the current crop of nursing students (p. 10).

While the hospitals were indeed a training ground for nurses, the needs of the hospital and its patients were of primary importance; the educational needs of the student nurses were incidental. A 1920 study recommended (in the Goldmark Report) that nursing education be independent of hospitals and that students no longer be used as a source of cheap labor (Donahue, 1985). Eventually hospitals began paying for nursing care and some universities began offering nursing education. These changes were not made quickly nor easily. A note in the May, 1930 American Journal of Nursing explains the relationship between hospitals and nursing education by the end of the 1920s:

> The amazing growth of schools of nursing, which have multiplied their number 143 times within the past fifty years, has come about not because the public wanted more nurses, but because the hospitals wanted more students. Hospitals run training schools . . . [and] it is cheaper to run a poor school than it is to employ graduate nurses. It is an extraordinary thing, but it seems to be a fact that hospitals regard the suggestion that they pay for their own nursing service as unreasonable. They have been receiving free service for so many years that they regard it as an inalienable right . . . (Schorr and Kennedy, 1999, p. 58).

The sentiment was echoed in the report of a 1931 study by the Women's Bureau:

> [The study] showed that trained nurses with less than five years experience had median earnings of $1650 [annually]. Teachers and secretaries did not average this until after ten years experience, and the bookkeeper and stenographer groups did not approximate this median until after fifteen years experience (Schorr and Kennedy, p. 64).

While the passage infers that nursing was well paid, the nurses, however, knew about the nisus seen ten hours a day, six days a week. Yet another thirty years showed little progress. "The Bureau of Labor Statistics figures for 1963-1964 showed the salary for general duty nurses at $4,500 [when] teachers were averaging $6,325, and secretaries were making $5,170 a year" (Schorr and Kennedy, p. 107). The issue of wage was beginning to be recognized as a legitimate issue.

> Another problem that nurses working in hospitals have historically faced is low wages. This condition is linked to the philosophy of Florence Nightingale, who held that nurses should draw satisfaction from being helpful, rather than from monetary compensation. [Thus] around the world, nurses have become mired at . . . low income levels (Schorr and Kennedy, p. 114).

In time ". . . the growing sense of social responsibility for health, the improved status of women in society, and the influence of the Nightingale concept, all contributed to the development of nursing education and improved nursing practice" (Donahue, 1985, p. 254). Nursing training programs developed academically to provide both theoretical information and practical experience. The hospital-based programs—which became known as diploma

schools of nursing—provided, in general, a sound educational background for nursing practice, although they did not offer an academic degree for several decades. The problem with diploma programs was the inconsistency of educational experiences between each of these hospital-based programs. Despite the fact that nurses could, by 1923, become registered (thus the title "registered nurse"—or RN) through individual state licensing examinations, "the first mandatory licensure law . . . did not take effect until 1949" (Donahue, p. 18). The intent of the licensure was to ensure a standard of nursing care and concomitantly, the standard of nursing education.

"By 1944-1945, the student nurses being trained in the nation's 1,300 hospital-affiliated schools of nursing (at the time, the backbone of nursing education) made up fully eighty percent of the total nursing work force in the nation's hospitals" (Haase, 1990, p. 2). While nursing continued to attract others to join its ranks, the students were predominantly single (unwed) females. As late as the 1960s, becoming married—or God-forbid, pregnant —was grounds for dismissal from nursing school. Exceptions were sometimes made if the student was in the last few weeks or months of the program (Haase, 1990). Once graduated, the attrition of nurses was high due to long hours and exhausting demands of the work, low pay, and the social expectation of stay-at-home wives and mothers. Although fewer women entered nursing (and there were fewer nursing programs) during the

depression of the 1930s, nurse shortages have nonetheless been an issue in nursing.

The unfortunate effects of war have always led to an established need for nurses in both military and civilian life. The need for nurses was great with the onset of World War II. A concomitant growth in the field of medicine also led to increased national need for nurses. Haase (1990) notes that "when the nation entered the war [(WWII) there was] little with which to attack disease except for quinine and for salvarsan to treat syphilis. [In addition,] a few vaccines had been developed and were in use" (p. 7). Haase continues quoting a physician who described, in 1980, the profound changes in medicine during the era of WWII:

> These events were simply overwhelming when they occurred. I was a medical student at the time of sulfanilamide and penicillin, and I remember the earlier reaction of flat disbelief concerning these things. We had given up on therapy a century earlier. . . . We were educated to be skeptical about the treatment of disease. Overnight we became optimists, enthusiasts. The realization that disease could be turned around by treatment was a totally new idea (p. 7).

As advances in medical care grew, the need for nurses grew both in number and in skills. The shortage grew to crisis proportions: "by 1944, the American Hospital Association (AHA) reported that twenty-three percent of the nation's hospitals were being forced to close beds, wards, and operating rooms because of the lack of nurses" (Haase, 1990, p. 3). Public awareness was growing along with the need for nurses. The first federal support (and

incentive) for nursing education was created with the 1943 Nurse Training Act (also called the Bolton Act), which established the Cadet Nurse Corps (DeLaune and Ladner, 1998; Donahue, 1985; Haase, 1990; Schorr and Kennedy, 1999). (Incidentally, the founding chairperson of the nursing program at PCC was educated through the Cadet Nurse Corps.) The following year "Roosevelt issued the Second Bill of Rights, with the clear implication that the federal government should underwrite each person's right to a job, an education, food, and medical care" (Haase, p. 9). While nursing education continued to be offered independently by some universities, the hospital-based diploma schools remained the primary training ground for the majority of American nurses. In a collegial effort, some of the diploma programs became affiliated with a college where their nursing students took courses for academic credit (Haase, 1990). Some hospitals that offered diploma programs applied to their state boards of higher education for permission to award an academic degree in nursing. While permission was never granted, it sparked debate within the nursing profession around the question of higher education. The 1948 Publication of Nursing for the Future by the National Nursing Council for War Services—better known as the Brown Report—recommended that education for nursing belonged in colleges and universities, not in hospitals. "In fact Brown criticized hospital-based programs as inadequate and authoritarian" (Haase, 1990, p. 16).

The advances in technology were accompanied by a growing public appreciation of, and incentive for, the acquisition of knowledge. While a small portion of the population was acquiring advanced degrees, the wants and needs of the American people were more pragmatic. The uniquely American invention—the community college—grew from the two-year transfer curriculum (reflected in the name 'junior college') to meet community needs. Baker (1994) explains:

> Programs and services for adults—for the continuing education of workers in the skilled trades, technical occupations, and the allied professions—and courses and programs of general interest and value to personal and corporate development of the local community have always been the distinguishing features of community and junior colleges. Still it was after World War II . . . that this function grew to prominence . . . [providing] higher education with a flexibility and adaptiveness to local social needs (pp. 13-14).

The emphasis on education, advances in technology (specifically in medical care), and a profound nurse shortage set the stage for a breakthrough in nursing education. Mildred Montag, a doctoral student at Columbia University in New York, conceptualized the integration of community colleges with nursing education. Associate degree nursing education was piloted at seven community colleges in 1952 by Montag as an experimental project. The graduate of this program was to be a nursing technician, who would have narrowly defined functions—different from the collegiate nurse graduate. Although it was later, in 1965, when the American Nurses Association (ANA) published a paper stating that all nursing education should take place in

institutions of higher learning, the organization recommended two levels of nursing practice: professional and technical. The professional nurse would have a baccalaureate or higher degree, the technical nurse would have an associate degree, and the technical nurse would work under the direct supervision of the professional nurse (DeLaune and Ladner, 1998; Donahue, 1985; Haase, 1990; Schorr and Kennedy, 1999). Donahue (1985) elaborates:

> [A] significant innovation in nursing education occurred with the development of associate degree programs in community colleges. These schools exhibited a phenomenal growth, but their nursing programs evoked a great deal of controversy. It was felt that this community college connection equated nursing education with vocational training at a time when a professional status was being sought for nursing (p.380).

This perception, however, while periodically fueled to remain a hot debate in nursing education—has not in fact, been clinically noteworthy. Nurses working side by side in the clinical setting recognize one another as professional nurses generally unaware (or unimpressed) by educational level. Because of the emphasis on collegiate education, a paid work force, and new emphasis on the advances in medicine, the plethora of diploma schools—the backbone of nursing education for three-quarters of a century—phased themselves out. (By 1965, most diploma programs had closed.) Contemporary nursing education is offered, predominantly, by associate degree programs as well as four-year institutions.

Informal History of the Nursing Program at PCC

In 1948, the Board of Education for Portland Public School District #1, approved the Practical Nurse Course. Created as a section in adult education, Guernsey (1989) asserts "one of the college's flagship programs in nursing was [now] launched" (p. 10). The course was offered by the Portland Public Schools in cooperation with the State Department of Vocational Education and the Oregon Nurses Association (ONA). The first class was held at the Girls Polytechnic High School (Portland, Oregon) in September 1949. The class had nineteen students and two nursing faculty (with an annual salary of $3,100) who provided theory, laboratory, and clinical instruction (Oregon State Board of Nursing, 1952).

The continuity of all of the students attending the same classes contrasted vividly with their clinical experiences. Not unlike the diploma programs, the practical nurse (PN) student—in a pink-and-white uniform, white stockings and the school cap—worked forty hours a week, in the same hospital that employed them, as part of the training. Four participating hospitals—St.Vincent, Good Samaritan, Emanuel, and Providence—agreed to give clinical experience (the students were paid a clinical stipend rate from 40¢ to 75¢ an hour) to any of their employees who became members of the class. The students thus had a dual relationship with the hospital as both their employer and as their clinical preceptorship host facility. "The plan for the PN

course was set up [so that] each hospital [took] care of their own former employees" (Oregon State Board of Nursing, 1954, p.2). The students were clinically supervised (primarily) by the RN staff in local hospitals. This created problems for the nursing faculty, as each hospital had different expectations and requirements (Oregon State Board of Nursing, 1954). Dolan, Fitzpatrick, and Herrmann (1983) point out a common problem: "heavy demands on the wards made it impossible for all students to attend their class" (p. 207).

Not unlike the fragmentation of the clinical experiences, the Practical Nurse Program was not housed in any one place. The nursing content was taught at Couch School while the nutrition component continued to be taught at Girls Polytechnic High School. The Program Coordinator used the offices in the Benson Annex where the Practical Nurse records were kept; the instructor's office was in the classroom (Oregon State Board of Nursing, 1954). This remained an issue until the Sylvania campus was constructed nearly twenty years later. In the interim, the director and the faculty had their offices in the Adult and Vocational Education Building at 515 Northeast Fifteenth Avenue in Portland. Later, another large classroom was being used at the Failing School (OSBN annual Survey Report, 1961).

The OSBN Survey Report of 1954 also noted that the program had "great difficulty" in finding properly prepared faculty. The following year the first nursing faculty that would in fact, later retire from PCC, was hired. She turned the program around by instituting many positive changes—from curricular

changes to improved relations with clinical facilities. This same faculty member, who never held an official leadership role, was credited as being "instrumental in course improvements" (OSBN annual Survey Report, 1955).

The practical nursing program—with a faculty of four in 1960—was still in the Adult Family Life division under the umbrella of the Adult and Vocational Education Department of Portland Public Schools. In 1961, forty years after Portland's Public Night School had become the Vocational and Adult Education Department of Portland Public Schools, it changed to Portland Community College. [Chapter 602 of the 1961 Oregon Statutes was the enabling legislation establishing community colleges in Oregon and for providing financial reimbursement from the state (Guernsey, 1989, p. xv).] When PCC was formed, a PN program at Forest Grove was subsumed within the district. This meant that, besides multiple physical sites of operation, PCC also had two separate PN programs operating at the same time.

The head nurse at Providence Hospital, with a passion for new ideas and opportunities, also served as President of the Board of Nursing. The new college president had heard of this nurse. At the same time, he was aware of the practical nursing (PN) program at the college and its ability to meet a community need for vocational training. Wanting the college to be on the leading edge, in 1965, with the ADN movement gaining momentum, a wife who was trained as a nurse, and a recent hospitalization, the president looked for someone to start the first ADN program in the state. Clark College, across

the river in Vancouver had already started an ADN program. (An informal history of its program asserted that they were the fifth ADN program nationwide.) Associate degree nursing education was spreading across the country as quickly as the community college movement. By 1963 there were 4,927 students enrolled in ADN programs nationwide (Emerson, 1965, p. 15). PCC did, in fact, become the first ADN program in the state of Oregon. [See Appendix D: Oregon Community College ADN Programs.]

The PCC president approached this nurse leader because of her connections with the Board of Nursing and asked if she would help set up the ADN program. The first department chair of the ADN program at Portland Community College thus started in 1965—the same year that the American Nurses Association (ANA) issued its first position paper on nursing education—recommending that it take place in institutions of higher education. In addition to the chair, two nursing faculty who had already proven themselves capable in the PN program, were moved into the ADN program to write the curriculum and to assist with the development of the program. (These three women all became participants in this study.)

In the fourteen months between her start date and that of the first class, the ADN Chair contacted others (primarily those in California) who had already started an ADN program. Familiar with Montag (1951) and her work, she arranged to meet with Montag personally. Montag had a direct influence on the PCC program. Not only had those in nursing education heard of her but,

as one of the participants of this study said, "She was like a saint or something. She was fantastic." Another recalled that Montag presented "a program on the ADN [so we] spent the summer with her." Armed with an understanding of ADN education and Montag's encouragement, the faculty wrote the curriculum while the Department Chair negotiated clinical sites. After completing the application, together they made a presentation to the Board of Nursing for approval to start the PCC ADN program. The first class of the ADN program started in January of 1967; the next class was admitted in the fall of 1967. From then on, the students began [only] in the fall.

PCC now had two levels of nursing education—the PN program and the ADN program. Thus the ADN joined the PN program to compete with other nursing programs in the Portland metropolitan area for student clinical placement sites—in both acute (hospital) and long-term-care (LTC) settings. (In 1966, there were ten local nursing programs: ADN: PCC, and Clark College in Vancouver, WA; LPN: PCC, Chemeketa, and Clark College; Diploma: Good Samaritan and Emanuel Hospitals; and BSN: OHSU, University of Portland, and Walla Walla—affiliated with Portland Adventist Hospital—Healy, 1999). The PCC LPN students, in the community for twenty years, were both accepted and welcomed as the hospitals saw these students as their employees. One of the participants explained how, in understanding the local nursing community, the faculty first opened up new clinical sites for the PN students, "then [the department chair] would move us out and put the

ADN students in. I became creative in finding new clinical sites for [the] LPNs." At the same time, a faculty person was hired to both teach in the LPN program, and to write and implement a new curriculum that provided behavioral learning objectives. This was significant in that it changed the clinical focus by moving the student from being a hospital employee—under the direction of hospital personnel with faculty only visiting and advising—to their clinical experiences' being directed and instructed by program faculty. This represented the final break from the control that hospitals had over nursing education since the days of Florence Nightingale.

Nursing has always been dynamic. The changes occurring were sometimes exciting, sometimes stressful, and occasionally unwelcome. After the 1965 ANA position paper (again, stating that all nursing education should take place in institutions of higher learning), many, and eventually all, of the diploma schools—alma mater to a majority of Portland area nurses—closed. A theme restated multiple times from those who had been on the front line was the resistance of nurses in practice to ADN education. It was new and it was very different. In many ways the ADN program symbolized the death of how many local nurses had received their hospital-based training as a diploma graduate. Like the development of community colleges, these programs were in response to social need. There was a growing shortage of nurses.

The response of the nursing community was not the extent of pragmatic concerns. The use of common space remained an issue for the ADN program

like it had been for the PN program. The Failing School building (later named the Ross Island Center) had twenty-two classrooms which were shared by all. Anecdotal stories have been told about nursing faculty office space as simply a desk in the ladies' restroom and of classes held in hallways, on the auditorium stage, and in a boiler room. For a year or two, the PN program was housed at the old School of Nursing building at Providence Hospital. In 1970 it moved back to Ross Island, where it remained another two years until the Health Technology Building was completed (in 1972) on the new Sylvania campus.

Students became increasingly aware of personal, educational, and professional choices. By 1970—the same year the nursing program was first given National League of Nursing (NLN) accreditation and the year after the first ADN class (of twenty-four) graduated—many of the PN students (in a program still separate from the ADN program) wanted their academic credits accepted as they continued toward their ADN degree. A participant explained that, in order to create internal congruency between the two programs, the faculty "decided that there was a core of knowledge that was common to [both the] ADN and PN so in the fall [of 1971] we started a pilot project with twenty ADN students and twenty LPN students who became the 'core' students." The ADN program decided to pilot, and subsequently adopted, the published LEGS (Learning Experience Guides for Nursing Students) curriculum. While one participant described its use as keeping pace with current educational

practices, another explained that "we were tired. Here we had to deal with how we were going to integrate the PNs into our curriculum. This seemed like something that would work, and we just didn't have the time or the staff to go through a whole curricular revision." One thing the LEGS curriculum did was to prompt a landslide of changes. A participant described the process as well as the changes:

> Also at this time individualized self-paced learning, based on behavioral objectives, was becoming the popular instructional model. . . . [We] had been reviewers of a new individualized learning system that was being published ('LEGS') and felt the leveled, self-paced learning activities would be the perfect curriculum for our 'core' students. Thus started: small group discussion (no lectures), General Assembly; advisor/advisee conference and group; sign-up and preparation for learning activities; individual viewing of audio-visual materials; clinical objectives with demonstrated preparation; and pass-no pass grades.

The "core" referred to the course work required in the PN program that was also required in the ADN program. Regardless of the reason for initiating this curriculum, the success of the core pilot program led to the faculty decision to adopt LEGS for the (new) ADN curriculum. This effectively provided the common ground for articulation between the PN and the ADN programs. This curriculum allowed for an LPN exit after completion of a particular level of the LEGS curriculum and resulted in the elimination of a separate PN program. Although the integration of the PN program into the ADN program was stressful for both students and faculty, the decision had

been made: the PN program was now gone as a separate entity and the 'LPN exit' came into existence.

The LEGS curriculum was set up to let students self-pace, or progress at their own speed of learning. The concept of self-pacing was tempered by the reality of scheduling labs and discussion groups (class) and students meeting similar clinical expectations to which their peers were held accountable. Therefore students self-paced (with individual exceptions) within two or three units of one another. More than one comment was heard from the faculty who had taught during this time that "the students could be self-pacing as long as they went fast!"

As mentioned previously, PCC had two separate PN programs operating at the same time. One was the original PN program created under Portland Public School District #1 Night School; the other was a PN program at Forest Grove (affiliated with Tuality Hospital). When PCC was created through the 1961 legislation that created community colleges, Forest Grove was enveloped in the district as a satellite campus. Thus, it became a second and separate PCC practical nursing (PN) program. At the time that the LEGS curriculum was initiated, the Forest Grove students were combined with the Sylvania students for program and curricular continuity. They were also symbolically united by *all* PCC nursing students (the PN and the ADN) wearing the same uniform. Eventually—in the mid 1970s—the Forest Grove Program

moved to the Rock Creek campus, which in turn had moved to the Sylvania campus by 1985. (PCC has several campuses: Sylvania, Rock Creek, Cascade, and Southeast, plus other satellite work sites.)

The transition to the LEGS curriculum in 1972 was the impetus for major curricular changes—besides the collapse of the PN program into the ADN program. A student who entered in the fall of 1972 recalled that on admission "we could either do LPN or RN [track]". Didactic content, previously in a large hall lecture format, became small group class discussion. The whole process of testing—self-paced formative post-testing congruent with the educational model that LEGS represented—soon evolved to include more formal summative testing. Within a couple of years, two summary examinations and a final test were added. (The educational strategy of both formative and summative testing has persisted as an integral component of the nursing program.) Also in 1972, the testing center was opened. Its use persisted until 1999, when the post-tests (renamed "quizzes") were made electronically available through the use of an on-line software program by the name of WebCT.

The nursing skills lab, a critical component of nursing education, also changed when LEGS was adopted. One participant explained:

> Previously to LEGS most of skills lab occurred in the first two terms of [both the] PN and ADN programs and were mainly by the see-one-do-one method. When we started LEGS there was a heavy focus on lab practice skills with accompanying AV [audiovisual] materials. Since the focus in the pilot LEGS was on

> mastery, we decided we should have testing on skills and develop criteria for each skill that needed to be demonstrated. A year later we set up the first med lab for second year. The purpose was to prepare students to give 'team medication.' Second-year had designed a 'team leading' experience for second year students modeled after the team nursing approach to patient care that was being used by most hospitals at that time.

Another participant commented that if she had one word to sum up that time, it would be "change." The nursing program remained dynamic. In 1974—the year of five new faculty hires—another faculty member due to retire instead wrote a proposal for the use of "tv" (videotaping) to teach simulated problem-solving. The use of video was very effective and has persisted as a teaching tool still in use at PCC. Not every tool of technology, however, was effective. Willing to work with the earliest computer, a faculty in the nursing program worked with staff in the computer department to design a system of tracking student progress through the program. A summer was spent "writing computer codes for every learning and testing activity in the LEGS curriculum . . . which generated a computer record for each student of all the learning experiences they had participated in." The faculty filled out stacks of computer cards. An idea easily implemented today, it was ahead of the technology of the time. The computer printout did not approach a fair trade for faculty time. Perhaps remembering this, some faculty were later reluctant to embrace computer technology until it became truly "user friendly."

As time went on, all components of the program underwent evolutionary change: prerequisites, math and English placement tests, and more. Eventually the LEGS curriculum became outdated. The faculty rewrote sections of the curriculum to keep the program up-to-date. By 1979-1980, consultants were hired to help with leveling clinical objectives. This prompted a total curriculum revision—again written by the nursing faculty. Faculty involvement and personal ownership of the curriculum—the program itself—remained evident. The department was effective: the PCC Nursing Program received and maintained national and state accreditation; graduates consistently received high scores on the RN licensing exam (often the highest in the state, occasionally the highest nationally); and as importantly, the graduates performed well clinically as new novice nurses (a reputation which has persisted).

The program had its first change in leadership in seventeen years when, in 1983, the founding department chair was appointed to the position of division dean and a faculty member became the nursing program director. Fiscal changes occurred: the funding boom of the mid-1960s through the 1970s tapered off. The budgetary realities caused a review of the practice of the nursing program offering like classes on two different campuses.

Previously, the students attending the PCC Nursing Program at the Rock Creek campus were integrated with the ADN students at the Sylvania campus through the curricular changes associated with the LEGS teaching

format. The shared experience was limited geographically, however, by a distance of ten miles. In addition, the Rock Creek students were often identified as those students who were planning to take the "LPN exit" rather than completing the full ADN curriculum. 1985, the Rock Creek campus of the nursing program was moved and—for the first time since the inception of the college—all PCC nursing students were fully integrated into the ADN program at the Sylvania campus.

Aware of ongoing changes in education and in nursing, the program was vigilant to maintain the currency of its curriculum. In 1986, a member of the faculty took a year long sabbatical from teaching to prepare a draft of a revised nursing curriculum. On a regular basis, the most recent of the curricular revisions were presented to the faculty as a whole. A discussion ensued between all members of the faculty—often animated, occasionally heated, and nearly always with mutual warmth and respect. The ideas generated in these meetings were taken "back to the drawing board" until the new curriculum was complete—a product which used all of the faculty's strengths and ideas to truly reflect faculty ownership of the curriculum. The new curriculum, aligned with current nursing theory, was centered around health promotion and client (not "patient") empowerment for self-care through the life-cycle instead of a more traditional medical model of a disease-focused approach.

The most significant change brought about by this revision, however, besides abandoning the LEGS format, was—through re-sequencing the didactic content—the elimination of the LPN exit. This decision was made by looking at trends in nursing, nursing education, and the needs of the community served. (Most of the ADN programs in the state have maintained the LPN exit.) This new curriculum was implemented in the fall of 1986.

At the end of that academic year—in June 1987—the program was awarded continuing accreditation (from the State Board of Nursing) through 1991. In 1990 the State Board of Nursing used PCC nursing students to pilot the computerized adaptive testing of the NCLEX (RN) examination that it eventually adopted (in 1994).

In addition to changes in leadership, the pioneering faculty—who had not only seen the evolution of the original PN program, but the inception, development, and growth of community college and ADN education—were also retiring. In 1990, the last working member of the original ADN faculty (once part of the PN faculty), retired. A second faculty person moved into the role of program director in 1991, then—following a seeming "tradition"—to that of division dean (in 1994).

In 1989, the nursing Student Success Program (SSP) was created to increase both the enrollment and successful completion of the program by minority populations. Congruent with PCC organizational goals, funds were given to the idea. In 1994, this researcher, along with another department

member, wrote ("day and night" for several days) a proposal for a Health and Human Services (HHS) grant of $750,000—awarded in full but dispersed at $456,000 (due to HHS budgetary cutbacks)—for increased support of the SSP over the next three years. The grant was designed for academically and financially disadvantaged pre-nursing and nursing students. Although the SSP was now expanded to meet the needs of all students who met the criteria, the students served remained predominantly students of color. The services provided through the HHS grant started in the fall of 1995 and were offered during three academic school years. Even though the grant funding ended in June of 1998, one faculty member has continued to be given some release time to offer support to high-risk students. The peer student note-taker, and the parallel support, and pre-nursing courses have persisted—congruent with the philosophy of student mentoring (Daloz, 1989).

Interest in computers had led to the development of the Multimedia Center (MMC: a computer media lab) a decade earlier when a faculty member wrote a Fuld grant for startup. It soon evolved into a joint adventure shared by the dental department—to be used mostly by the dental program. In addition to time and physical logistical challenges, computer technology had evolved profoundly without a significant increase in MMC services. The State Board of Nursing had changed from pencil and paper exams to the computerized adaptive testing for the NCLEX (RN) examination. Technological needs grew but physical space remained finite. In 1997 the researcher and another

department faculty member co-authored a Fuld grant (awarded $15,000) for additional computer equipment in the nursing video lab as a means to increase nursing student access to computer learning media.

In addition to these changes, the nursing department saw another significant change when the faculty—historically relegated to "leftover" office space and housed in multiple locations—were geographically united as one faculty. Although all of the nursing faculty had been on the Sylvania campus in the Health Technology (HT) building since its construction in 1972, they were located in an upstairs-downstairs split. Half of the faculty shared space with the physical education (PE) department on the lower level, while the other half of the faculty and the program director were housed upstairs, in the nursing department office. To be united, they were relocated to the lower level—losing any windows which looked to the outside world—and the PE department moved into the former nursing department office.

After the department relocated in 1994, the third of three department chairs (now called the program director) moved into the role of division dean. Didactic content was kept current by faculty who, besides teaching full-time (and whose personal calendars reflected working more than the contractually stated responsibility), worked as nurses and nurse practitioners, took classes, served on committees or boards, and attended professional meetings—mostly in their "spare time," during the summer, or other times off. Faculty commitment to ADN education and creativity in meeting program outcomes

has been consistent amidst the dynamism of both nursing and nursing education. (A chronological list of events is available in Appendix C.)

Conclusions

A review of the literature confirmed both the relatedness of the themes which emerged from the data (power, governance, informal networks, work ethic, psychological climate, and external influences), and the grouping of the themes into three major areas (the use of power, organizational culture, and associate degree nurse education). The literature review of the construct "the use of power in the workplace" defined power as the ability to get others to do what you want. The point was made that issues of disagreement or conflict precipitate the use of power. Power, manifested by different indicators (Pfeffer, 1992), is created and enforced by a social power structure (such as class or gender socialization). Likewise, the culture of a group is developed through a shared history of shared values and behaviors (as well as other indicators) created as an adaptive response in problem solving. This pattern is taught to new members, thus acculturating them to the group. Drucker (1989) points out that when an organization "deals with the integration of people in a common venture, it is deeply embedded in culture" (p. 229). The common venture inherent in "modern" nursing education began with the influence of Florence Nightingale, who integrated a more formal education with practical, hands-on training. The hospital-based diploma programs

provided the mainstay of nursing education for nearly three quarters of a century. The disparity between diploma programs culminated in the Brown Report (National Nursing Council for War Services, 1948), which recommended that nursing education be removed from the control of hospitals—known for exploiting nursing students as a cost-free labor force. The emphasis on education, advances in technology (specifically in medical care), and a profound nurse shortage set the stage for the creation of associate degree education.

Chapter III: Research Design and Methodology

Introduction

Contemporary understanding of organizations includes an understanding of human interactions. Each person in the organization has a unique set of skills and a unique perception and understanding of the organization. This study explored one community college nursing program from the perspective of multiple people who had a working knowledge of it. Understanding the social world from the point of view of participants in it and being attentive to the social context in which events occurred and have meaning are indications for the use of qualitative research methods. Bogdan and Biklen (1998) relate qualitative research to historical studies:

> Historical research is concerned with finding and evaluating observations of past events. Its goals are to describe accurately what transpired and to clarify relationships among events, people, and the like. Once past events have been described, historical studies often attempt to explain the reasons for these developments and to evaluate the significance of the occurrences (Rubin and Rubin, 1986, p. 57).

Data collection occurred through in-depth interviews of retired nursing faculty and a past college president, and through examination of public and personal documents as well as other materials (such as photographs and memorabilia). The approach is primarily inductive. Seidman's (1991) scholarly work on interviewing was referenced throughout this process. A list of interview topics and questions was developed to illuminate incremental

changes and the shared history of the nursing faculty at PCC. The purpose of this study is to describe the development of the nursing program by women faculty leaders at Portland Community College (in a male-dominated organization).

Rationale for Interpretive Research

Unlike quantitative research, which holds the goal of demonstrating cause and effect, interpretive research seeks to describe. Erickson (1986) identifies the key feature of interpretive research as "central research interest in human meaning in social life. . . . The issue of using as a basic validity criterion the immediate and local meanings of actions, as defined from the actor's point of view, is crucial in distinguishing interpretive [from other types of research]" (p. 119). Therefore, this study focuses attention on the perceptions and experiences of the participants. Lincoln and Guba (1989) note that the nature of reality is often multiple, constructed, and holistic. The best way to know another's experience, and to understand their perceptions and thoughts about those experiences, is to talk with them. The interview, a tool of interpretive research, provides a format for this exploration; talking with multiple individuals offers insight to the same events from different perspectives. Seidman (1991) discusses interviewing:

> At the heart of interviewing research is an interest in other individuals' stories because they are of worth. . . . The purpose of interviewing is not to get answers to questions, nor to test

> hypotheses, and not to 'evaluate' as the term is normally used. . . . At the root of in-depth interviewing is an interest in understanding the experience of other people and the meaning they make of that experience (p. 3).

This attention on the perceptions and experiences of the participants is the focus of qualitative research (Locke, Spirduso, and Silverman, 1993) and the reason for choosing this methodology. The researcher use of self is the research instrument. Strategies employed to minimize the effect of researcher bias and to maximize reliability and validity are summarized by Miles and Huberman (1994):

> To us, some markers of a good qualitative researcher-as-instrument are:
>
> - some familiarity with the phenomenon and the setting under study
> - strong conceptual interests
> - a multi disciplinary approach, as opposed to a narrow grounding or focus in a single discipline
> - good "investigative" skills, including doggedness, the ability to draw people out, and the ability to ward off premature closure (p. 38).

Ansley and Gaventa (1997) discuss research, the act and the relevance not only to institutions of higher learning, but to society itself. They comment on the experiences of college faculty as often "cut off [from people with] no conduits through which to receive information [or to] build relationships with people and problems" (p. 51). They also state, "We see social capital as consisting of connections between and among groups and

individuals—connections built incrementally through shared histories of activity and interchange" (p. 51).

The Researcher

An interpretive (qualitative) research design uses the researcher as the principal data collection "instrument." Personal background, experiences, and commitments—the tacit knowledge that the researcher holds about community colleges and nursing—necessarily impacted and interacted with the research. In order for the reader to understand the researcher's perspective about the study and how those relationships with the participants affected the research, a description of the researcher's background and experience is presented.

Background and Experience

The researcher was born and reared on a farm in Iowa. She interacted with the health care system early as a pediatric patient born with correctable health problems. The researcher never interpreted these experiences as particularly traumatic. Although very young, the health care she received somehow influenced her toward a career in nursing. From an early age, the researcher recognized the value of caring nurses and, especially, the joy of being healthy.

The researcher's relationship with education was shaped by her mother and maternal aunt who were both teachers, and by her own early educational

experiences. The researcher liked learning, and school was a positive experience. In addition, her parents lived true to their belief that education was not confined to the walls of a classroom but to life itself. Twice, the researcher missed school to take extensive car trips to experience and understand how other people live. Her parents, proud of the benefits and heritage of country life, also recognized limited experiences and opportunities for themselves and their children. They moved from the farm to Phoenix, Arizona. As both a family member and as a grade school student now living in the Southwest, the researcher studied the desert, the peoples of the desert, and all who were drawn there. Characteristics of different tribes of Native Americans indigenous to the Southwest fascinated her. An understanding and appreciation of human diversity grew.

After a couple of feeble starts, her mother held her first job outside of the home since she had married. She worked for General Electric, soldering chips onto the first computer boards. The experience which altered her mother also shaped the researcher as she listened to animated dinner conversations describing both expanding technology and human possibility. Her parents encouraged their children to seek a college education, something they themselves had not had the opportunity for. When the children grew older, the researcher's family moved to California, where higher education held a reputation for being the best in the country.

The researcher completed high school and started college in the late 1960s amidst campus protests against "the establishment" or ways of doing things because "this is how they always have been done." The Vietnam War was a profound influence that taught her generation ("the baby boomers") that the way things had always been done was not working. One or two of the 100 classmates and many other members of her peer group died in Vietnam, and untold others were traumatized. Children no more, their lives were forever altered. Everything was open for evaluation and change. Science and technology exploded with new discoveries to which the common person soon had access. The women's movement appeared on the heels of civil rights. This was the social context in which the researcher entered college and her nursing education. The researcher graduated from nursing school married, eager, well trained, ready to earn a professional wage, and to help buy their first home. Her college degree, and that of her spouse, ensured these choices. Education provided a higher standard of living, new freedoms and new choices, and shaped her value that "education is freedom."

The researcher worked as a nurse in a variety of settings: high risk obstetrics, medical-surgical nursing, intensive care and coronary care units (ICU and CCU), and clinics. She returned to school for an even broader choice of professional roles by obtaining a Master's in Nursing (MSN) with a specialty advanced practice degree as a Family Nurse Practitioner (FNP). The researcher worked both in hospital (in-patient) settings as an RN and in out-

patient settings (clinics) as a nurse practitioner. In addition to her paid positions, the researcher volunteered to teach expectant parent childbirth classes, family planning classes, CPR (cardiopulmonary resuscitation) and a course she created and named "Healthy Responsibility." The researcher knew that she enjoyed teaching. In 1985, she joined the faculty of Portland Community College to teach nursing. While the original core of the three faculty who founded the program had retired, some who watched its inception and others who had joined early in the program's development and growth were still there. The researcher was welcomed into the faculty to share the common goal of creating good nurses.

As she learned about the department in which she worked, the researcher would occasionally hear the comment, "I wonder what they were thinking when they set it up this way!" One of the few faculty who witnessed the early days would say, "Well, that was done like that because . . ." and a story was told. A new understanding lent tolerance and insight into the past, that allowed the faculty to go on with current decisions and the work before them. The researcher remembered thinking, "Someone should write this down." As she witnessed members of both the second and third generations of the PCC Nursing Program faculty retire, a renewed commitment to document the history led to this research. The researcher's involvement in the nursing program at PCC is overt. Researcher bias is inherent in this type of qualitative research and must be acknowledged. Methods to minimize the

impact of researcher bias are discussed in-depth later in this chapter in the sections respectively titled, "Participants" and "Data Collection."

Theoretical Beliefs

The researcher's beliefs support an interpretive research design. These beliefs include the following: a) that reality is socially constructed and ever-changing; b) that multiple realities exist and are constructed through interactions with others; and c) that humans communicate what they know through symbols, the most common of which is language (Falk, 1995). The research goal was to gain entry into the conceptual world of the participants. The researcher believed that the best way to explore the phenomenon being investigated was to ask those who had direct experience with the nursing program at PCC about their perceptions and to listen to their responses.

The Participants

Key Participants

The researcher selected eleven participants from those who had a working knowledge of the nursing program at Portland Community College. Interpretive inquiry often focuses in-depth on a relatively small number of participants, selected purposefully (Patton, 1987). While this number was larger than originally planned, it had the benefit of offering insights from multiple perspectives. Miles and Huberman (1994, p. 267) quote a historian:

"Bias in a primary source is to be expected. One allows for it and corrects it by reading another version. . . . Even if an event is not controversial, it will have been seen and remembered from different angles of view by different observers" (p.19).

The choice to work in a community college was made by these individuals before they become participants in this study, so a convenience sampling strategy was used to choose the participants from an identified group of people who had worked at or with the nursing program at Portland Community College during the time of its inception and development (Patton, 1987).

Volunteering after hours at the annual alumni fund-raiser phone bank, the researcher mentioned the study to a retired faculty member. She learned that a social cohort had been formed of the retirees who had worked in the nursing program in its early years. Many of them met for lunch once a month. Since this retiree would see this cohort in a few days, the researcher asked her to inform the retired faculty cohort of this research. The researcher also asked the retiree to gain permission, individually, from cohort members, for access to their names and telephone numbers so the researcher could contact them regarding this research. Consent was given and the researcher was mailed a list (with telephone numbers and addresses) of this twenty-one member cohort. In reviewing archival data, the researcher identified others who had retired or left, as well as those who had been involved with the

program in its inception or development. The group was much larger than expected. In order to narrow the sample down to a manageable number, the researcher surveyed the members of the original retired faculty cohort list. In this preliminary survey, demographic data were requested, open ended survey questions were asked about the history of the nursing program, and interest in being interviewed was solicited. In addition, the researcher also identified five faculty characteristics that would help focus the study. The characteristics were:

- the willingness to be interviewed,
- first hand experience or knowledge of the development of the nursing program at PCC,
- physical ability to tolerate being interviewed for one to one-and-a-half hours,
- the ability to reasonably remember past events, and
- a willingness to share personal interpretation or significance of past events and decisions.

The ideal sample size was originally determined to be between four and six participants. Because of personal involvement in the program as a faculty member, the researcher wanted a broad base from which to triangulate the data and as a means to offset researcher bias.

The responses from the preliminary survey revealed that twelve of the twenty-one were willing to be interviewed. Three people qualified the yes with

comments such as "if I am around—I'm traveling;" or "yes, but I think there are better people for you to talk with;" or "it depends." Three people said, "no;" one person did not respond to that question; and five did not return the survey. Although the nursing faculty had preponderantly been women, the researcher decided that the sample should reflect both genders. The male participant was the only male faculty member to retire from the program. While he did not have knowledge of the inception of the program, he afforded a unique perspective. Thus the target sample of nine consisted (at this point) of eight females and one male, all of whom were Caucasian.

All of the participants in the study either had taught in the nursing program at PCC or had an active role in its administration. Participants were not selected solely on their role within the program, however. The researcher ideally wanted to interview both those who had taught on the first-year teaching team as well as those who had taught on the second-year team. She also wanted participants who had been in faculty, department, and leadership roles. As it turned out, the sample was mixed in many dimensions.

A number of the preliminary survey respondents (four) included the comment "be sure to" talk with the one who was always involved in any curriculum revisions and was an unofficial leader of the department. Several respondents to the preliminary survey made mention of the woman who had been the second department chairperson. Although "retired" out of the department but elsewhere in the organization, she had been directly involved

with the department for sixteen years. The researcher felt it was important to interview this woman for her insights into its history. The sample size thus grew by one to a total of ten. In the process of conducting the research interviews, the researcher was encouraged by more than one participant to interview the man who was college president when the nursing program was being developed, as he had exerted great influence over its beginning. While the researcher did not have a solid rationale to stray from the retired nursing faculty prototype that described the research participants, it made sense from the perspective of historical relevance. It also made sense, as his name arose in the interviews. The sample size was now eleven. Fourteen people were on the interview list—twelve retirees (including three tentative participants), the second department chair with a sixteen-year history with the department but not a "retiree" *per se*, and the past president of the college. Not knowing how or where the rest of the interviews would take her, the researcher planned to interview the three tentative participants last or as a last resort. As it turned out, with a large sample of eleven participants, it was not necessary to re-contact them to solicit an interview. The researcher did use the data gathered from all of the retirees who responded to the preliminary survey.

The researcher was sensitive to issues of researcher bias. By expanding the survey sample to eleven participants, she was able to have five participants with whom she had never worked; four worked on an opposite

work team than she had; and one had been department chair her first two years at the college (twelve years earlier). The participants included the three original department members—the (organizing) department chair and two faculty members who wrote the first curriculum and taught the first class. The fourth participant was one of the founding members of the practical nurse program who watched the inception and creation of both the community college and the ADN program. She worked exclusively in the PN program until it was incorporated into the ADN program. The first college President and the one who initiated the inception of the ADN program was added to the interview list. As stated, four of the participants worked in the department during the same years that the researcher did, but they did not teach on the same team. A male faculty member was in this category. In addition to those the researcher had either not worked with or had not worked closely with, the researcher worked on the same faculty team with two of the participants. Although not involved in the startup of the program, one participant was included for her twenty-three year perspective. A different participant and the researcher last worked together eight years previously during the researcher's first (and participant's final) five years of teaching. The researcher no longer worked with any of the participants. (The list of participants is included in Appendix B.)

Two members had served as department chair; two had been interim chair; and all but one of the other participants had rotated into and out of being

a teaching team leader. While this sample of participants was larger than originally projected, the researcher felt multiple perspectives would provide strong triangulation to the data and balance as much as possible the fact that she had worked closely with two of the eleven participants. The individual tactics used in this study are discussed in data management. Miles and Huberman (1994) elaborate on triangulation however, by stating:

> We think of triangulation by data source (which can include persons, times, places, etc.), by method (observation, interview document), by researcher, by the theory, and by the data type (qualitative text, recordings, etc.). . . . The aim is to pick triangulation sources that have different biases, different strengths, so they can complement each other. . . . Perhaps our basic point is that triangulation is not so much a tactic as a way of life. If you self-consciously set out to collect and double-check findings, using multiple sources and modes of evidence, the verification process will largely be built into data collection as you go. In effect, triangulation is a way to get to the finding in the first place—by seeing or hearing multiple instances of it from different sources by using different methods and by squaring the findings with others if it needs to be squared with (p.267).

Entree

Access to the target population was both informal, through an after-hours annual alumni fund-raiser phone-bank, and official—via access to public documents, both internal and external to the institution and, minimally, through personal documents or memorabilia. Therefore, gaining entree to participants and access to documents was not difficult. A member of the retired faculty asked cohort members at a monthly luncheon for their consent (at the researcher's request) to give their names and telephone numbers for her to

contact them regarding this research. Seidman (1991) validated this approach stating, "Whenever possible, it is important to establish access to participants through their peers rather than through people 'above' or 'below' them in their hierarchy" (p.36). Consent was given, and the researcher was provided the (incomplete) list of retired nursing program faculty. A preliminary survey was conducted of the members on this list: demographic data were requested, open-ended survey questions were asked about the nursing program, and interest in being interviewed was solicited. Twelve of the twenty-one surveyed were willing to be interviewed. The researcher perceived that maintaining long-term accessibility to the participants might be a potential problem due to advanced age and potential or actual ill health. For this reason, timeliness, and for gaining insight into the process of this research, the researcher conducted a pilot interview of one participant. In the end, access did not prove to be a problem because of the persistence of the participants in this study.

Data Collection

Data collection, including the pilot interview, subsequent interviews, and document review took place from February 1998 to March 1999. The length of the study gave the researcher an opportunity to develop and test emerging ideas against additional data as the information was gathered. The goal of data collection was the acquisition of a body of data which described how a small group of women faculty initiated, implemented, and developed a growing

nursing program at one particular community college that was male-dominated in its administration.

Interviews

> Qualitative interviewers understand that one person's experiences are not intrinsically more true than another's. If the interviewer discovers four different versions of the same event, it doesn't necessarily mean that one of the interviewees is right and the other three are wrong. They may all be right, reflecting different perspectives on what happened or observations of different parts of an event. People looking at the same event may understand them differently (Rubin and Rubin, 1986, p. 10).

The researcher's professional training has included family therapy, group dynamics, and other forms of therapeutic communication (including active listening.) An astute use of self necessitates awareness of the influence one's presence and conversation. Even so, there is no such thing as an unbiased researcher (Holstein and Gubrium, 1995; Miles and Huberman, 1994). Methods to minimize the impact of researcher bias are: (1) profiling the researcher (as done elsewhere in this document), (2) triangulation of data, and (3) peer debriefing through the use of an expert rater panel answering, "What dominant themes occur in the stories of those interviewed?"

In-depth interviews were used as the primary method to collect information about participants' perceptions of their experiences with the nursing program at Portland Community College. Data collection took place through three phases of the open-ended interview: a preliminary survey; the

interview itself; and talking with the participants after they received a proof copy of the interview transcript. The preliminary survey requested demographic data, asked open-ended survey questions about the nursing program, and sought to identify potential participants. The researcher contacted doctorally prepared nursing faculty (including a person—once a faculty member, later a nursing program chair, and now retired—from another community college). Preliminary survey content and potential interview questions were all discussed. This was done to receive feedback about both the wording and the content of the survey questions. In addition, this was another way to offset researcher bias. As a result of these conversations and enriched by a discussion with her major professor, the researcher modified the draft preliminary survey and the interview guide. As the preliminary surveys were returned and read, the researcher called each of the survey respondents who volunteered to be interviewed for the study. After she introduced herself, the researcher explained the research, answered any questions, discussed informed consent and confidentiality, and, finally, made appointments for the interviews.

Next, face-to-face interviews were conducted in a location that was as private, comfortable, and convenient for the participants as possible. All but one of the interviews were conducted in the participant's home. The other was conducted in a quiet booth of a local restaurant. At the beginning of the interview, the researcher introduced herself, talked about her background,

discussed the study, and answered any participant questions. Participants were also given time to read and sign the letter of consent (see Appendix A). This part of each interview lasted for five to ten minutes. Then, with participant consent, the tape recorder was turned on (with as little fanfare as possible), and the interview began. The audio taped interviews were transcribed verbatim by a professional transcriptionist using the word-processing software program WordPerfect.

The interviews lasted from sixty to ninety minutes each. The first portion of each interview focused on the participant's background and reviewed or clarified any of the responses to the written survey. During the next portion of the interview, the researcher asked the participant how they became involved with the nursing program at PCC, what it was like initially (when they first knew it), and any changes and challenges they noted during the time they were involved with the nursing program.

The researcher used a variety of questions that elicited opinions, perceptions, reactions, background, and feelings. Because of her association with the nursing program, the researcher exerted extra effort to define the focus of the interview and to avoid guiding participant responses. The researcher also realized that the use of a tape recorder might initially inhibit the participants. Therefore, the recorder was set up as unobtrusively as possible.

The open-ended format allowed for freedom and flexibility within each interview, enabling the researcher to modify and adapt questions based upon what happened within the context of each interview. While guiding the focus of the interview, the researcher also listened seriously to the participants and the stories they told. "The active interviewer encourages contextual shifts and reflections. The respondent is not treated as a judgmental dope, . . . but is heard to speak of life in relation to diverse substantive and perspectival contingencies" (Holstein and Gubrium, 1995, p. 55). The researcher assumed the stance that there was a lot that she could learn from them.

Before the end of each interview, the researcher referred briefly to the Interview Guide (see Appendix E), which served as a checklist to ensure that relevant topics were discussed and that as much data as possible was gathered from the participant. This consistency and use of "relevant queries" helped ensure research reliability (Miles and Huberman, 1994). Field notes were taken as a methodological tool. Bogdan and Biklen (1998) validated this with the statement, "Qualitative researchers guard against their own biases by recording detailed fieldnotes that include reflections on their own subjectivity" (p. 34).

The interviews were completed over several weeks. After each interview (in addition to sending thank-you notes) the researcher immediately dubbed the tape and broke the tabs out of the cassettes so the interview was protected from inadvertent erasure and destruction. Fieldnotes were written

and personal comments were recorded in a research journal. While the researcher personally transcribed the pilot interview, a professional transcriptionist was used for the remaining interviews. The original interview tape was given to the transcriptionist, and the researcher kept the duplicate copy. While each tape was being transcribed, the researcher again listened to the taped interviews, read over any transcripts that she had to date (including the one from the pilot interview), and reviewed the fieldnotes—all before proceeding to the next interview.

In spite of familiarity with the equipment and testing it prior to each interview, technical difficulties did occur. With one interview, the recorder refused to turn on. After tinkering with it for a few minutes, the researcher started the interview by taking detailed fieldnotes. After ten or fifteen minutes, another attempt was made to start the tape recorder. It worked! On another occasion, two interviews were scheduled in the same day. As it turned out, these two participants did not live far from one another, and the time scheduled between the interviews was ample and relaxed. It was logistically convenient. The recorder worked in the "test, test" just prior to the interviews, the spool turned and required both tapes to be turned over mid-interview. A few days later when the researcher was working with the interview tapes, she realized that *nothing* had been recorded for *either* of the two interviews. The researcher reviewed her fieldnotes. They provided enough detail that she

could enlarge upon her notes while the interviews were fresh in her mind. The researcher pondered the situation and decided not to reschedule with these participants. They had been interviewed. The researcher continued with the interviews of the other participants. Luckily, there were no further mishaps with the tape recorder.

The third phase of the open-ended interview occurred when the researcher talked with the participants after they received a proof copy of the interview transcript. After the researcher received a transcript, she made a duplicate as a working copy and corrected any (very few) mis-transcribed words or phrases as she again listened to the tape recorded interview. She also deleted any "um's" from the written transcript. The researcher then gave participants the "proof copy" transcript of their interview. They were asked to read it and to note any errors, confusion, or misunderstanding that seemed to exist in the transcript. The changes that the participants asked to be made to their transcript included a misquoted or misspelled name, and one participant added five or six explanatory comments to the transcript. The researcher incorporated participant driven changes to the transcripts. She also created a one-sentence statement of any discussions she deemed irrelevant to the study (i.e., participant briefly digressed to discuss spouse's health concerns). While the original transcript remained intact, this proofed and edited draft now became the transcript copy that the researcher worked from as she looked for themes.

Document Review

The Oregon State Board of Nursing (OSBN) provided photocopy access to accreditation reports from 1987 to 1997. Oregon State Department of Archives provided similar access to comparable OSBN documents spanning the years from 1948 to 1987. Historical milestones and demographic data about the program, its faculty, and the administration were included in these official records. Other documents included: 1) record (grade) books provided by the participant in the pilot interview; 2) personal notes, photos, and documents of participants (primarily) and current members of the nursing faculty who volunteered materials; and 3) a "home video" of a nursing faculty retirement party held in 1991. The researcher used this information to learn more about the participants, to attach a date to various events, and to verify events—all for triangulation purposes and to lessen the risk of researcher bias.

Data Analysis

Data analysis began after the transcription of the first interview. The researcher continually reviewed the transcripts, searching for themes and patterns, trying to understand what was said as well as what had not been said. She listened to each tape again and again, listening for content as well as pauses, laughter, and vocal inflections. New perspectives and insights gained from this analysis helped fashion the next interview. For example, in

the pilot interview, the researcher was repeatedly encouraged to talk with both the official leader and with the one who apparently had been an unofficial leader. Understanding that "at the root of in-depth interviewing is an interest in understanding the experience of other people and the meaning they make of that experience" (Seidman, 1991, p. 3), the researcher decided to heed this advice. (At the same time—because of a close working relationship with one participant eight years previously—she expanded the number of participants in the study to reduce the risk of researcher bias.)

Because the researcher had interacted professionally with six of the eleven participants prior to the study, all of these other interactions could be considered data gathering too, as these—not unlike other professional experiences—influenced the researcher's thinking. (The six participants, identified above, retired—or left the department—in 1987, 1990, 1992, 1995, 1995, and 1997, respectively.) Interactions between the researcher and the participants—between their individual retirement dates and the time of the study—were limited to "retirement teas" and to one or two phone bank fund-raising "telethons." In addition, only two or three of the retirees attended these events. Nevertheless, the researcher controlled for researcher bias as much as possible by focusing on the data gathered specifically through the interviews, and not from data gathered through informal avenues. Thus, data analysis was limited to data from these eleven interviews (including the preliminary surveys) and archival public records.

As the researcher gathered the data, she utilized the constant-comparative method of data analysis. This means that archival data were read and notes were made of the chronological chain of events that created the nursing program at PCC. This resulted in the creation of a time line which was cross-referenced with each new piece of data to verify, correlate, and corroborate the data. "Designs of all qualitative studies involve the combination of data collection with analysis. . . . The constant-comparative method (Glaser and Strauss, 1967; Strauss, 1987; Strauss and Corbin, 1990) is a research design for multi-data sources . . ." (Bogdan and Biklen, 1998, p. 66).

The researcher repeatedly listened to the taped interviews both at home and in the car and read the transcripts multiple times making notes in the margin of her working copies (the original of each transcript was left intact). The researcher's intent was to understand the comments from the perspective of the participants. "Researchers in the phenomenological mode attempt to understand the meaning of events and interactions of ordinary people in particular situations. . . . What phenomenologists emphasize then is the subjective aspects of people's behaviors" (Bogdan and Biklen, 1998, p. 23). Denzin and Lincoln (1998) support this reflective process of sense making: "The constructivist or interpretivist believes that to understand this world of meaning, one must interpret it . . . to offer the inquirer's construction of the constructions of the actors one studies" (p. 222). Through this process

then, the themes slowly began to emerge. The researcher developed a list of the themes as she read each transcript. Upon reading each subsequent transcript, the list was added to; notes were made when another participant also commented on a theme. For example, the term "autocratic" was noted twenty-six times in the transcripts of the eleven participants. The list evolved into a checklist of themes cross-referenced by participant comments noted in the transcripted interviews (see Appendix G).

The themes which emerged from the data were power, governance, informal networks, work ethic, psychological climate, and external influences. None of these themes existed in isolation from the others. The review of the literature confirmed an inherent relatedness of these themes, as described in Chapter II, in the constructs of power, organizational culture, and associate degree nursing education.

Validity and Reliability

To maintain the trustworthiness of this study, the researcher kept a research journal, notes, and case files to describe how data were collected and how decisions were made throughout the study. Strategies to maximize reliability and validity summarized by Miles and Huberman (1994) are:

- some familiarity with the phenomenon and the setting under study,
- strong conceptual interests,
- a multi-disciplinary approach, as opposed to a narrow grounding or focus in a single discipline,

> • good 'investigative' skills, including doggedness, the ability to draw people out, and the ability to ward off premature closure (p. 38).

Internal validity is concerned with the question of how close one's findings are to reality, and whether researchers are observing what they think they are seeing. Within interpretive research, the researcher will always be interpreting the reality that is presented, which is the informants' perception of reality as they see it. Miles and Huberman (1994) explain: "The crunch question [is] truth value. Do the findings of the study make sense? Are they credible to the people we study and to our readers" (p.278)?

Lincoln and Guba (1989) identify strategies to establish trustworthiness. The ones most relevant to this study include: 1) triangulation of data; 2) member checks (in process and terminal); 3) a thick description; and, 4) the reflexive journal. Other methods include profiling the researcher at the onset of the study to clarify the researcher's assumptions and theoretical orientation and, lastly—after the interviews are completed—peer debriefing. These strategies were used to strengthen the validity and reliability of this study. The goal of these efforts is to minimize biases and errors and to increase the effectiveness of the use of self as the instrument of data gathering and analysis. Merriam (1988) echos the use of these strategies for ensuring internal validity and reliability as they apply to interpretive research.

Triangulation, or the use of multiple sources of information to verify the accuracy of data that has been gathered, was unique to this study as it related

to one particular community college nursing program. Public documents (primarily accreditation reports and, to a lesser degree, meeting minutes); informal conversations with current faculty and staff; and personal notes, documents, photos, and video from participants and current members of the nursing faculty, were used to triangulate sources of information. As the study progressed, the researcher cross-checked information gleaned from participant interviews with information from previous interviews as well as public documents.

The researcher asked participants to clarify any confusing information written in their survey response. After the interview was transcribed, she asked participants to review the transcripts. A follow-up call was made to discuss it with them.

Participants were given additional opportunities to respond to the study's data. Besides sending transcripts of their interviews to them for response, the researcher also sent them a copy of the informal history for them to review. She attached a personal note thanking them for participating in the study and asked them to contact her (a third time) to discuss the history and her findings—especially if any errors or incongruencies were noted. One retiree contacted the researcher noting both a typographical error and an incongruency (in one section a person's retirement date was misquoted, even though it was listed correctly elsewhere). The participant's attentive feedback was very much appreciated and the corrections were made.

To increase the trustworthiness of this study, the researcher kept a research journal, notes, and case files to describe how data were collected, and how decisions were made throughout the study.

Peer debriefing was utilized through the use of an expert rater panel. The three, whom the researcher referred to as the "readers," each offered a unique perspective. One reader, only socially familiar with nursing and with community colleges, held a master's in English literature and worked in a university setting. The second reader, familiar with nursing, had personal experience as a student (only) in both community colleges and universities. The third reader, familiar with community colleges, was not familiar with nursing. They all held master's degrees. None of the readers had worked at nor attended PCC.

The researcher asked the readers to answer the question, "What dominant themes occur in the stories of those interviewed"? A written guideline was provided (see Appendix F). While waiting for the readers' feedback as to the themes they identified from the transcripts, the researcher also read the transcripts for themes. She wrote directly on a working copy of the transcript, marking the passages that reflected a theme, critical event, or point of decision making. Notes were made in the margins. Once this was done, the researcher went back through the transcripts and created a "list of themes" as well as a "list of critical events."

Ethical Considerations

The purpose of the research and the privacy of the participants were considered both before and during the study. The researcher informed participants about the possible purposes and activities of the research, and also about any benefits or risks that were involved with their participation. Those who agreed to participate in this study were provided consent forms that were discussed individually with each participant prior to any data collection (see Appendix A). Secondly, in order to protect them from any psychological or social risk, the researcher maintained confidentiality by protecting the security of the preliminary surveys, audiotapes, transcripts, and fieldnotes. The data were kept in a secure location in her office at home.

Chapter IV: Findings

Introduction

In-depth interviews were conducted with a group of people who had first-hand experience or knowledge of the nursing program at Portland Community College. (Again, the purpose of this study was to describe the development of the nursing program by women faculty leaders at Portland Community College—in a male-dominated organization.) The sum of each of the eleven interviews created the essence of the data of this study. Qualitative research is defined by Burns (1989) as "studies in which: (a) an alternative to the positivist paradigm is used as the basis for the study, (b) words are considered the elements of data, © a primarily inductive approach to data analysis is used, and (d) [theme] development is the outcome of data analysis" (p. 44).

The researcher compiled the data—interview transcripts, written documents, and Field notes (which consisted of a variety of charts, tables, and electronic files)—listed below:

- The research journal.
- A list of the social cohort of retired nursing faculty—given to the researcher by a retiree.
- The preliminary survey.
- A log of preliminary survey responses.

- Field notes, which include telephone contact summaries.
- Correspondence to and from the participants.
- The informed consent form for participants (Appendix A).
- A list of research participants: by name and role description (Appendix B).
- The interview guide (Appendix E).
- Interview transcripts: original, proof copy, and reader copy.
- Document log: an alphabetized list of documents and data collected.
- Artifact log: a list of archival photos, letters, or other materials collected from the OSBN, PCC, participant, peer, or personal archives.
- A list (by name) of PCC nursing department and other staff—primarily nursing faculty teaching in the ADN program since the program was created. (The names were gleaned from the archival data and from the interviews. Non-nursing college administrators—and a brief description of their roles—were included since they were named in the data.)
- An informal history of the nursing program at PCC—summarized in Chapter II and in the Nursing Program History: A chronology of events from 1948 (when the LPN program was created) to 1999 (Appendix C). (These were written by the researcher to document the evolution of this particular nursing program, to make sense of the volume of data, and to anchor the sequence of key events in the mind of the researcher.)
- A list of Oregon community college ADN (and LPN) programs (Appendix D).
- Guideline to identify themes (Appendix F).

- A list of themes (identified in the transcripts) summarized in Themes-Participant table (Appendix G).

The researcher next searched the data for commonalities and patterns. Each item in the researcher's notes—at first written in the margins of the working copies of the transcripts—was simply listed or else it was languaged more succinctly (i.e., "power struggle" became power). A chart was created which cross-referenced a significant or meaningful issue with each of the participants to see how many of the participants mentioned any one issue. Feedback from each of the three peer reviewers of the transcripts was then added to the list of issues and synthesized into one chart (again, see Appendix G). After an insightful discussion with her advisor, the researcher characterized the data by the themes of power, governance, informal networks, work ethic, psychological climate, and external influences.

As the participants told their stories, both events and the meanings attached to them, were revealed. The participant retirees' relationships with students, peer faculty members, and official leaders—the interpersonal interactions—defined the internal structure of the nursing program, and concomitantly shaped its response to the external world. To better understand the development of the nursing program at PCC, each of these themes is described—in the participants words. Chapter V summarizes the researcher's observations from these findings.

The Data Characterized by the Theme:

Power

The researcher selected the theme "power" after noting that the word "autocratic" was used more than twenty-six times by ten of the eleven participants when they were asked about leadership style—particularly in reference to the leaders involved with the inception of the nursing program. In addition, the use of the word "tyrant" appeared once or twice. The use of personal power, especially during the development and the first two or three years of the nursing program at PCC, was simultaneously one of autonomy—"We could do whatever we wanted [with the curriculum and how the program was set up]"— and one of being controlled by others. An administrator had their "hands in everything; We had to have our I's dotted, and our t's crossed; I always liked to fight for the underdog, and that's what we were; and, Of course we had to do whatever they said."

Symbols and issues of power were also discussed by the participants: "We were women—they gave the money to the men's things; They stuck us anywhere—at one time I think two or three of us had an office in the women's bathroom; We held classes on the stage; I was determined that we weren't going to be on campus in our whites [nursing uniforms]—I wanted us to blend in with everyone else on campus." The theme "power" (specifically, power in

the workplace) is therefore reflected in these comments by the participants. Pfeffer (1992) added insight to the topic of "power" when he wrote:

> Diagnose power by observing its consequences. Power is used to take action, and one way to determine who has power is to observe who benefits, and to what extent, from organizational actions, particularly decisions or actions that are contested. . . . Even the more influential, who have fared well in the contest for resources, have little to gain by making their success public. It is considered unseemly to boast, and more important, if others see how well you are faring, they may unite against you, or at a minimum, demand some of the spoils. Thus, it is often the case that the results of organizational influence are kept secret, which make diagnosing power by this means more difficult (Pfeffer, p. 59).

Thus, the women in these interviews (the study participants) gave voice to the concepts Pfeffer (1992) enumerated when they described both interpersonal relationships and the symbols of power.

Governance

Because the participants had worked in the nursing program for several years, they had experienced more than one leader. As the leadership was described in the stories that were told, the participants also depicted professional autonomy, shared decision making, and participatory governance. The theme "governance" thus emerged from the data: "We were a team—she dealt with upper administration and outside agencies, while we wrote curriculum; and, Then we would meet and go over it and together figure out what some of our rules [department policies] were going to be." The participants, one after the other, described the organization (PCC)—which five

years earlier emerged, independent of Portland Public Schools—in which they worked: "We could do what we wanted, but only so far—the 'higher-ups' always had a thumb on us; We always knew who was boss; and, We had to get program approval, of course." The structure which governed them was described as hierarchical, with a very clear chain of command: the college president had (and exercised) the ultimate authority for decision making.

Informal Networks

Seven of the eleven participants brought up word-of-mouth hires and the value of other social and professional contacts: "I knew her from when I was working up on the hill; She and I went to high school together; I knew her from graduate school; I knew all the folks at the hospital; I had worked with them so I knew how they thought—that sure made it easier for us later; and, I recruited her to come teach with us—I knew her from where we had students."

Conversely, the existence of a "good-old-boys club" was mentioned as a place that was closed to them: "They would go out for coffee together (or sometimes lunch) almost every day while the rest of us had to work: By the time they got back, they had already hashed out a lot of things that we weren't even privy to—We didn't have a chance; We decided if they could have an 'old-boys club,' we could have one too (for women), so we got everyone

together about once a month at somebody's house (usually in the evening) to hash out everything that we were worried about."

Informal networks also played a crucial role in garnering acceptance with the nurses in the community, for they were the ones that facilitated (or hampered) student learning in the clinical settings. Because of the PN program's being in the community for nearly twenty years prior to the development of the ADN program, the faculty had well established relationships in the community. Nevertheless, bringing in the ADN was not an easy transition, as one participant explains: "The nursing committee did not want to see the ADN come in. That was the feeling—that we couldn't produce an RN in two years. The diploma nurse didn't think we could do it either because they had three years. It was a big controversy to have the program." At the same time, the nurses knew the faculty through the PN program—which was very well received in the hospitals. Eventually it worked because "We would talk with the head nurses and talk with the staff . . . It didn't take too long. [We did whatever we could to make it work.] That pleased them. . . that changed attitudes. They figured we were dedicated [and] eventually they were very supportive." Although only four participants mentioned informal networks, this appeared to be significant for faculty recruitment, as a display in the disparity of power by exclusionary lunches together, and in securing student clinical placement sites. These all led to the theme "informal networks."

Work Ethic

Seven of the eleven participants mentioned the heaviness of the workload. Both the expectation and the willingness to meet it reflected a strong work ethic which sacrificed personal needs to the needs of the department. "My God, it never seemed to end, we worked day and night; We had to do everything—we registered the students, we collected the money, we took money for their books, then we went and got them and brought them back for the students, and, we measured them for their uniforms: we did everything—that's all besides teaching them nursing, writing curriculum and test questions; We had to teach them everything; We taught the nutrition; and, We taught anatomy and physiology as we went."

With the work ethic bar set through expectations of long hours at no extra pay, a renegade participant found a way to cope: "I had to put it in my goals to go home after seven or eight hours. I put in my contracted time that I was supposed to work and now I had going home at a decent hour in my goals so they couldn't really say much to me about it." The implication is that one working "only" their contracted time was somehow slack in carrying their full workload. The demographic data revealed—through hire to retire dates—that the majority of the respondents (of the preliminary survey) retired as soon as they were eligible to do so. Commitment to the program through a work ethic expressed by consistently going "above and beyond," was thus—finally—abated by quitting at the earliest (benefitted) retirement date.

Psychological Climate

The participants provided a variety of insights and issues when describing the development of the nursing program at Portland Community College. More than one participant reported feeling "like a pioneer—we were doing things that hadn't been done before;" another reported "I think this was the most challenging and the most rewarding time of my career." Comradeship between the faculty was referred to more than once: "We were like one big, happy family." People respected one another for both their teaching and for their nursing skills. "She was so good about that; We had a lot of talent among us; I don't know why we had to get the 'sages from the East'—that's what we called them—when we had people right here who knew best what our program needed; She was a crackerjack nurse; and, She was good at talking with all those people from various agencies." There was a general pride in the program and the success of its graduates.

The tone of the program, while generally positive, also had its darker side: "We had to prove ourselves; They didn't think we could do it and it just made me more determined; I don't know how this happened, but people got paranoid after a while." Thus, the theme "psychological climate" is reflected in these anecdotal comments. In addition, the variation occurring in the psychological climate was revealed by accolades and negative comments alike.

External Influences

The last theme—"external influences" is reflected in comments participants made to describe the context of events or decisions. In Chapter II, the researcher described the advent of the ADN as both revolutionary and evolutionary: "The nurses at the hospital did not want to see it coming in. This was totally new; They were sure that nurses couldn't be educated in two years; The nurses [working in area hospitals] made it hard on us—the Oregon State Board of Nursing (OSBN), wasn't much better." Educational trends were revealed in comments like: "We used Bloom's taxonomy—that was what you used then; and Later (in the 1960s) self-paced programmed learning became very popular so we decided to try it." The topics evolved to broader social issues as well: "Well, you see, it was the 1960s; 'women's 'lib' [the women's liberation movement] was happening—more women wanted good careers; The civil rights movement was happening; We had students going to jail for protesting; Students were questioning us and what we were doing; and The drug culture was starting to happen—for the first time the board (OSBN) had to meet to talk about nurses who took drugs—it was unheard of."

Conclusions

Through their own words, the participants of this study reflected the themes of power, informal networks, governance, work ethic, psychological climate, and external influences. As they told about the development of the

nursing program at PCC, they described a tapestry in which one theme overlapped another—none existed distinctly unto itself. It is the combination of these themes that most fully describes how this small group of women created an associate degree in nursing program at PCC (itself legislated into existence only five years before the first nursing class). The researcher summarizes the findings through the observations described in the next chapter (Chapter V).

Chapter V: Summary and Implications

Introduction

This study sought to describe the development of the associate degree nursing program by women faculty leaders at Portland Community College (in a male-dominated organization). The researcher became interested in understanding the history of the nursing program after hearing comments in faculty meetings such as "I wonder why (or how) they ever set it up this way." From that point forward, the topic remained a curiosity until, finally, the researcher embarked on a journey to discover the secrets nearly forgotten in the institutional past.

Personal involvement in the nursing program (as a member of the faculty) prompted the researcher to be alert to her own personal filters when examining the history. She sought ways to minimize researcher bias (as described in Chapter III).

This chapter is organized into four sections. The first presents the observations generated from the data. The second section contains the implications derived from the observations. The third section, identifies some limitations of the study. The fourth provides some suggestions for further research.

Observations

Through their stories, the participants described what may have contributed to (or hindered) program development. The understanding was from the perspective of the ones who lived it. As described previously, analysis of the data revealed six major themes: the use of power (specifically, power in the workplace), governance, informal networks, work ethic, psychological climate, and external influences. A review of the literature affirmed that these themes are conceptually related. Three broad topic areas were then reviewed: the use of power, organizational culture, and associate degree nursing education. The observations made from this study are presented within these same three constructs. At first glance, it may appear that the use of power, organizational culture, and associate degree nursing education are unrelated, distinctly separate, entities. Ultimately, however, one does not exist separate from the others.

Observation: Power in the Workplace

The use of power may infer physical or fiscal strength, intellectual cunning, manipulative use of political contacts, or some combination of all of these. The participants of this study, however, demonstrated "power" simply by *using* their personal power to influence the development of the first ADN program in the state of Oregon. While this sounds simplistic by contemporary standards, the use of personal power is contextually unleashed or

constrained. In other words, the unique circumstances of the moment, combined with professional and sociocultural expectations of an era, shape the use of power.

The participants, predominantly female, were handed the legacy—of social and professional acculturation—to be submissive to their male counterparts. In 1963 Betty Friedan confronted the cultural notion that women (born in or before the 1940s) preferred to give away—or deny—their personal power, wanting instead for "the men to make the major decisions" (p. 14). While it is not the intent of this research to describe the history of female socialization, the nine female (of eleven total) participants were nevertheless imbued in a culture that believed it was more appropriate for men to have and to use power than it was for women to do the same.

In the days of its inception and during the time of the development of the associate degree nursing program at PCC, the institution offered positions of authority—and its concomitant official power—to men. This legacy was made evident not only in public accreditation reports, but in the symbolic displays of presidential and other photographs which recorded historical events. The participants reflected gender and power differences in their comments, often blurring the two. It is in this context that the phrase "male-dominated organization" has been used in this research study to reference the official authorities of the college at the time.

In addition to this, a broader social acculturation was reinforced through the professional training of nurses (predominantly female) to "obey" the physician (predominantly male) with absolute fidelity (Lippman, 1990). The fact that physicians (as well as hospital and college administrators) were predominantly male, reinforced male-dominated, hierarchical power structures that provided a legacy to contemporary nursing education. In other words, these female leaders were socially and professionally acculturated to subjugate their personal power to another. This is what made their use of power in this work setting so unique.

The broader context in which the participants worked established circumstances which subtly supported their use of personal power as they developed the associate degree nursing program at PCC. The community college was a new concept and PCC—newly legislated by the state of Oregon—was just getting started. In addition, the official leaders (who were male) had been busy jousting to determine the presidency of the college (Guernsey, 1989). Once named, the president of the college was undoubtedly occupied with the bigger picture—getting Oregon's first community college up and running.

The college president was on the lookout for revenue generating programs that met community needs through pragmatic vocational training. Not unlike others in higher education (Cohen and Brawer, 1989; Cross and Valley, 1974; Jarvis, 1993; Merriam, 1988), this was his personal educational

philosophy and he was thoroughly committed to it. He knew about the PCC LPN program (now viable—thanks to its nurse faculty leaders—as it entered its second decade of service). He wanted the college to offer this new nursing degree (the ADN). He had also heard of a woman who was well-connected in the nursing community and thought able to provide the leadership for the new ADN program. The goal was clear—hire the staff and develop an ADN nursing program.

Although he never lost touch with the nursing program to get progress reports or provide ongoing motivation, the president had many other issues and programs to command his attention. Not unlike home economics or similar female-dominated professions, the nursing program was a "women's thing." While more than one participant recognized the relative lack of value placed on the nursing programs, another recognized the benefit of "getting lost in the shuffle."

Once summoned to create this program, the nursing department chair and faculty were empowered with adequate funding while thus being sufficiently "left alone" to create the program as they saw fit. These founding mothers of the ADN program became "stewards" (Block, 1996) by taking complete responsibility for creating the program. They spent the time that was required to "do their homework."

The faculty took advantage of the funding opportunity to attend a summer session with Mildred Montag—the creator of the associate degree

nurse program. The participants were enthusiastic about this new form of nursing education and being a "pioneer" in getting it established. Their contacts in the community helped secure program approval from the state board of nursing (OSBN) as well as to secure student clinical placement sites. They used their professional expertise to develop the course work of the program.

Observation: Organizational Culture

Although not every group develops a group culture, any community of individuals that spends enough time together to create a shared history, acquires a group culture. "Group culture" applies to both the broader social culture and to social and professional sub-cultures—a combination which is unique to each individual.

The 1960s, the period of the development of this nursing program, reflected a heightened dynamism in a broader culture that was socially self-conscious: the normal ways of doing business were up for scrutiny. The community college movement was exploding as a national educational trend while other broader social concerns also offered a profound influence on the fledgling college culture. The civil rights movement—which would forever illuminate human rights issues—was a major element. In turn, this stimulated the women's liberation movement, advocating equal rights between the genders. In addition to higher education, there were accelerated changes in

health care technology and nursing education. Local opportunity was rich. These nurse leaders were then, historically positioned to be able to develop a nursing program independent of tradition: the broader culture was in flux, and the neophyte institutional culture had not yet established patterned mandates for behavior.

An organizational culture evolves then, when individuals work together—such as nurses, and nurse educators. The department chair and the faculty became co-creators of this nursing program. While one was "the department chair," the relationship between them, especially initially as the program was being formed, was collegial. Intuitively, they recognized that "leadership is essential but it does not have to be provided by a single person" (Bolman and Deal, 1991, p. 150). This lack of an established pattern of behavior allowed the research participants—the ones who developed the nursing program—both a deeper level of responsibility and a broader arena from which to draw their own solutions.

Although five associate degree nursing programs had been piloted under the tutelage of Montag (Montag, 1951), very few ADN programs had yet been established. The participants—truly pioneers—approached this task from a pragmatic stance. Together they learned by doing—a valuable experience for leadership skill development (Beatty, 1998; Bennis, 1999; Maxwell, 1999). They were creating a shared history solving problems together, an act which provides the framework for the culture of an organization.

At the same time that they had the opportunity to pioneer something new, the participants also brought with them their values of commitment, hard work, and the altruism characteristic of nursing. In time, these became part of the culture of the nursing program at PCC—all contributing to its standard for providing stellar associate degree nursing education.

Observation: Associate Degree Nursing Education

In 1966, federal support promulgated higher education in general, and nursing education in particular. Along with the bonanza of community colleges, associate degree nursing programs were also mushrooming across the country. The nurse shortage was acute, and technology—particularly medical technology—was creating even greater demands for (and upon) nursing. Concurrently, nursing education was trying to extricate itself from a preponderance of hospital-controlled diploma schools. The participants of this study created—"from the ground up"—the associate degree nursing program at PCC. The ADN program, as did its graduate, answered a social need. (The reader is reminded of the history of nursing education outlined in Chapter II).

At this time in its history, nursing was experiencing profound "growing pains." The profession was internally and externally mandating a change from the status quo—in nursing education, nurse salaries, and in nurse-physician relationships. In other words, broader social changes were permeating the sub-cultures of nursing and nursing education.

Not unlike other human responses to change, a few people (like the participants in this study) led the changes, some resisted, and yet others simply watched. In general, the local (and wider) nursing community did not know what to make of the new ADN. They had no experience with it (very few had). It certainly did not neatly fit into the well entrenched culture of nursing.

The resistance of the local nursing community was real. "A successful person is one who can lay a firm foundation with the bricks others have thrown at them" (David Brinkley, as quoted in Maxwell, 1999). Through personal tenacity and commitment as well as an in-depth understanding of associate degree nursing education, the participants were able to overcome the nurses fears and objections. They became ambassadors, emissaries, spokespersons, and conciliators for ADN education, and especially, for the program at Portland Community College. They delivered "fabled service" (Sanders, 1995.)

Implications

An understanding of the history of an organization provides the lens of sociocultural context through which to see organizational events. From this study, one can look at any point in the history of the associate degree nursing program at Portland Community College. Through the lens of power, for example, a sociocultural context can add insight to the dynamic interplay of circumstance and decisions made by these nurse leaders.

Likewise, one can look at the various cultures influencing this ADN program at any one point in time. On a micro-level, the (PCC) institutional culture understandably impacts the nursing program. Initially, it did so by the *lack of* a shared history in the earliest days of its evolution. The women were free of—perhaps even sheltered from—the mores (of both the culture of nursing and the broader social culture) which could otherwise proscribe their behavior as nursing faculty.

When seen holistically, the interplay between internal and external influences becomes apparent. Examples of external influence are abundant in this research ranging from the national nurse shortage, to the civil rights movement, and technological advances. Each of these events influenced the development of the nursing program at Portland Community College.

Using both the historical context and looking through the lens of the use of power, organizational culture, and associate degree nursing education, one may even observe which influence is more dominant at a given point in time.

As the program staff dealt with each of these issues, their experience became their history. For example, attitudes of the nursing profession toward the associate degree nurse—manifested by nurses in the community—shaped where and how clinical site selections were done.

Another example may offer insight into attitudes and values. For example, early (very early) computer technology was utilized for recording

student progression through the program. The mechanics of filling out the keypunch cards proved to be very time consuming and cumbersome. The result was "an atmosphere" ranging from cautiousness to disdain of computers. Fortunately, the culture of an organization is dynamic, allowing growth. With time and new experiences (with both new technology and new faculty) this perception of computers shifted. Without the benefit of insight into this experience—once imbued into the culture and thus rarely overtly articulated—one could only wonder why many of the faculty were recalcitrant to have personal computers put on their desktops.

Predictably, it is neither historical, internal, nor external observations, in themselves, which provide insight of "the truth." It is the combination of all these factors, blended yet again with current insights and decision points, that keep an organization healthy and growing—a "learning organization" (Kouzes and Posner, 1990; Senge, 1990;). It is the hope of this researcher that the lenses provided by this research both recognize and honor the legacy of a few far-sighted, and hard working nursing faculty, and offer insight to us—the leaders of today. With insight, we can thoughtfully shape our own histories through the patterns we create.

Limitations of the Study

The limitations of this study are:

- The population in this study is confined to persons (primarily nursing faculty) who had direct experience with the Nursing program at Portland Community College.
- By choosing to include only those who had first-hand experience or knowledge of the inception and development of the nursing program at PCC, others who knew of the program from broader nursing (or other) circles may have been screened out.
- The sample population was small and non-representative of all community college nursing faculty.
- Conclusions from the study are only applicable to the Nursing program at Portland Community College and cannot be generalized to other populations.
- The researcher only examined the perceptions of eleven participants, thus, the assertions can reflect only the experience of these eleven people.

Suggestions for Further Research

The observations framed in this chapter are presented as pertinent to the history of one community college. Hopefully, they will launch critical inquiry as the basis for future research studies. In addition to the observations presented, the study raises other questions for researchers interested in

nursing education in general and associate degree nursing education in particular. These include further research in:

- The history of the development of an ADN program within a college that—with sufficient history—had a well established organizational culture.
- The history of the development of other ADN schools of nursing—particularly in the Pacific Northwest.
- The factors contributing to faculty tenacity. (Thirty-two percent of the full-time nursing faculty stayed at PCC until retirement.)
- Factors relating to attrition of faculty by gender (male-female attrition differences.)
- Exploration in the differences of power structure between the ADN and the BSN schools of nursing.

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APPENDICES

Appendix A — Informed Consent for Participants

Title of Research Project: The Development of the Associate Degree Nursing Program at Portland Community College.

Investigators: Larry Roper, Ph.D. (541) 737-3626
Juanita Joy (503) 977-4056

Purpose of the Project: This study is designed to describe the history of the Registered Nursing Program at Portland Community College from inception to the present from the perspective of retired nursing faculty.

Procedures: I have received an oral and written explanation of the study and understand that as a participant in this study the following things will happen:

1. I will participate in a personal interview and I will be asked questions about the history of the nursing program at PCC as I recall it. I will be asked questions about what led me into nursing, what led me to PCC, and to describe the process or circumstances of events as I recall them. I will also be asked personal demographic data such as years of service at PCC.

2. I will be contacted after the interview by telephone or by personal appointment, to clarify information discussed during the interview.

Confidentiality: I understand that the names of current or past public employees are public information and that my name will be identified as having been a member of the PCC nursing faculty. I also understand that any information obtained from me during the interview will be kept confidential unless the investigator gets my permission to quote me. I will know what I am being quoted as saying. I can freely choose to have my comments be kept confidential. The only persons that will have access to this information will be the investigators. If questions or concerns arise, I feel free to contact Dr. Roper or J. Joy.

Voluntary Participation Statement: I understand that my participation in this study is completely voluntary and that I may either refuse to participate or withdraw from the study at any time without penalty.

Signature: My signature below indicates that I have read and understand the procedures. I give my voluntary and informed consent to participate in this

study. [The margins were adjusted on the participant copy to allow this informed consent to fit on one page.]

Participant Signature Date

Researcher Signature Date

Appendix B — List of Research Participants

Why Selected to Be a Participant
One of original members creating program, writing its curriculum. Retired in 1976 after 10 years. Researcher did not work with participant.
Pilot Interview; Oldest living participant. One of first faculty in PN program. Noted in OSBN reports as instrumental in revitalizing it. Saw transitions when ADN program started. Retired in 1976 after 21 years. Researcher did not work with participant.
Faculty member in PN program in early years. Worked in ADN program when it opened. One of original members creating program, writing its curriculum. Retired in 1978 after 15 years. Researcher did not work with participant.
First president of PCC Actively sought and promoted the inception of the ADN program at PCC. Retired in 1979. Researcher did not work with participant.
First department chair. Started program, got it up and running. Promoted to division dean. Left the department in 1983, retired in 1987 after 20 years (16 years as chair; 4 as dean). Researcher did not work with participant.
Faculty member, became the second department chair, became division dean and the first woman and only nurse to become dean of instruction. Left the department in 1987 after 15 years (to become dean). Researcher worked at the same time (1985-1987) but did not work closely with the participant.
Faculty member in PN program part-time 1957-1967; in ADN program in 1967. Retired in 1990 after 22 years. Researcher worked at the same time (1985-1990) but did not work closely with the participant. (Tape malfunctioned during interview).
Unofficial leader. Managed day-to-day working of department. Retired in 1992 after 25 years. Researcher worked with the participant (1985-1992).
A student in the first class of the ADN program. Became a faculty member years later. Retired in 1995 after 20 years. Researcher worked at the same time (1985-1995) but did not work closely with the participant.
One of four men who worked in the program and the only male to retire from the PCC program—in 1995 after 20 years. Researcher worked at the same time (1985-1995) but did not work closely with the participant.
Worked in ADN program as member of the "second generation" of faculty. Retired in 1997 after 22 years. (Tape malfunctioned during interview). Researcher worked on the same teaching team with the participant from 1995-1997.

Appendix C: Nursing Program History: Chronology of Events

Year	Events — Year Reflects Start of Academic Year
1948	**The LPN program was created** by the Adult and Vocational Education section of the Portland public schools. Approved by board of education school district #1 November 22, 1948 (OSBN). For women who were already working in hospital and want to get PN licensure. George Henriksen was the director and Jean Bloom the supervisor. The Publication of Nursing for the Future (known as the Brown report) recommended that education for nursing belonged in colleges and universities, not in hospitals. National Nursing Accrediting Service for nursing educational programs was established.
1949	On Jan 10, 1949 and Sept 12, 1949—19 and 31 students respectively began in the Practical Nurse course at Girls' Polytechnic High School. The first two faculty were Bertha Hussey and Bessie Witt.
1950	Portland advisory committee for PN training was organized June 1950. PN course changed from 9 mo to 12 mo starting in August. Mrs Geneva Pecore elected by school district to serve half time as hospital coordinator.
1951	37 have graduated from PN program to date. 35 licensed. Special Problems Committee (of community RNs) mentioned in OSBN report. Thirty applicants screened for class of 16. Mildred Montag authored book that was conceptual precursor to ADN education.
1952	1st OSBN survey report (after site visit). Jean Bloom is the supervisor of Adult Family Life Education. Myrtle Bartholomew is the instructor. Henrietta Doltz (faculty) ended 6 year reign as president of the OSBN Board.
1954	OSBN survey report of PN program. Issues: No course outline—created as went. Faculty turnover: 3 quit in 2 years; difficulty finding qualified faculty. Supervisor change from J Bloom to part-time (16 hour/wk) coordinator Myrtle Bartholomew (course instructor). No regular (planning) meetings. Nursing moved to Couch school classroom; Faculty office is a desk in the Couch school classroom. Student stipend $.75/hour. Same pink and white uniform (OSBN).

Year	Events — Year Reflects Start of Academic Year
1955	V.Hildebrand, RN, Oregon State Board Nurse Examiners assistant executive secretary, did PN site visits Nov 1954 and Nov 1955. Things stabilized from prior year. Becky Davis Larimer started teaching in the PN program. Lois Peyton is coordinator of the course. Special problems committee concerned with the selection, admission and withdrawal of individual students (OSBN).
1957	Wanda Fitterer started teaching part-time in PN program (until 1967). Chemeketa began its PN program.
1958	OSBN annual survey report: PN program expanded into 3 divisions 1) 12 mo day program, 2) 16 mo part-time evening program, 3) High school PN pre-clinical (didactic) and last semester covered in 13 months. Pre-clinical at Girls Polytech including lab and separate classroom space. Coordinators office at Multnomah Hospital.
1959	PN program committee meeting minutes revealed IQ testing being used for pre-admission screening of applicants.
1960	OSBN annual survey report; PN program now has 4th instructor. (The instructors are Henrietta Doltz, Becky Larimer, Margaret Simpson, and Ann Tomlinson). OSBN identified three main areas of improvement — selection policies, curriculum, better clinical supervision. Active advisory committee. Clark College started its ADN program, asserting it was the fifth ADN program in the nation.
1961	Legislation passed starting PCC (all Oregon community colleges). PPS School District #1 Vocational and Adult Education now became—as a separate operating unit—Portland Community College. Forest Grove PN program also part of the new PCC district.
1962	All pre-clinical [classes] had no patient contact prior to June62. (OSBN survey) Rose Christensen named as Providence Hospital employee liaison person with PN program. Three full-time faculty in program were Henrietta Doltz, Becky Larimer, and Martha Holland; MaryAnn LaSalle worked part-time; and Dorothy Harper was a temporary faculty member.

Year	Events — Year Reflects Start of Academic Year
1963	Joan Edwards, Carol Connolly started in PN program. Carol rewrote LPN curriculum. OSBN annual survey report: 100-130 students each year. New day class enrolled every 4 months; one eve class /year. High school class component discontinued. IQ score used in admission selection. Recommendations; more correlation between theory and clinical, school take more responsibility for clinical supervision, faculty keep abreast, give students more responsibility for own learning (outside study vs all provided in class). Four faculty (2 with program for several years; 1 hired 1961, 1 in early 1962. Faculty: H Doltz, Becky Larimer, Martha Holland, (all full time); Mary Ann LaSalle part-time, and Dorothy Harper temp. Student stipend $.75 hr. PN instructor salary $5580-$6060 12 month year with 4 week paid vac. JFKennedy was assassinated.
1964	PCC classes held at Failing School (later named Ross Island Center) and at Shattock School. First Nurse Training Act: allocated federal aid for nursing education.
1965	ANA published position paper on nursing education (should be in higher education vs hospital based). Rose Christensen started Nov 1. June Conway started full time (although hired "part-time" 1965-1969). Bob Zertana named acting director of Vocational Technical division at PCC (when George Henriksen retired).
1966	**The PCC RN (ADN) program is created**. It is the first ADN program in the state. Joan Peterson Edwards moved into the ADN program in July. She and Carol Connolly wrote the curriculum for the ADN program while Rose negotiated clinical sites. Together they made presentation to OSBN for approval of ADN program. Applications for the program went out in the fall. Applicants were screened and accepted for 1st class (to start January 1967). Clara Williams started in October in PN program.
1967	January 1967—the first ADN class started; Pat McCathern and Roberta (Robbie) Menicosy are students in that class. Later they both taught in the program. Hazel Hale started part-time. Dee Miller started. Wanda moved from being part-time PN faculty to teach full-time in the ADN program. Male faculty Klaus Shawnis died. Carol Connolly moved into ADN program; rewrote curriculum.
1968	Betty Calmettes-Foster started. Hazel taught part-time in the summer. LPN program moved to Providence Hospital 1968/9. The voters from 5 county areas approved the formation of a new college district which included the school districts of Portland and others. (OSBN). Chemeketa began its ADN program.

Year	Events — Year Reflects Start of Academic Year
1969	First class (of 24) graduated in Sept. Hazel Hale went from part-time to full-time (after completing MSN). Betty to 2nd year team. Joan is the nursing representative on the PCC faculty senate (1969, 70, 71). PCC purchased the Failing School and renamed it the Ross Island Center. US (still) engaged in Vietnam war.
1970	Pram Dahya started. The ADN program is given NLN accreditation. LPN program moved back to Failing School (Ross Island Center). Cascade Campus now part of PCC.
1971	June Conway retired. Shirley Anderson started part-time in the PN program (teaching clinical at Physicians and Surgeons) when Irene Cohen on emergency medical leave. Clara started in 2nd year; worked on pilot project with LEGS, combining LPN and ADN. Mt Hood CC began its ADN program.
1972	Health Technology building completed. Nursing program moved from Failing/ Ross Island to Sylvania. Shirley Anderson went from part-time to full-time (clinical and writing curriculum). Clarissa Farnsworth started. The ADN and PN programs are blended in a pilot for the LEGS curriculum. Clara 2nd year coordinator (until 1974). Nursing testing center opened (faculty ran it). Joan Peterson became Joan Edwards. Mariah Taylor (later a community leader as an NP) graduated from the ADN program; Colleen Caraher, who later worked in the nursing skills lab, started as a student in the ADN program.
1973	Betty Calmettes Foster quit (to remarry). Shirley Anderson to 1st year team (until 1978). Hired testing center monitor. Joan Edwards served on college human rights committee.
1974	Joan Edwards 'retired' and rehired to develop the video lab. Pat McCathern, Mary Blake, Carolyn Choi, Tim Miller, and Sherrill Moore started. Clara moved from 2nd year to coordinate 1st year. Tim to 2nd year. Hazel and Clara to NY NLN testing conference. Hazel and Clara set up first medication lab. Clara spent the summer writing computer codes for every activity—used until 1981. Lottery system cumbersome— devised admissions testing Math and English. Admissions office designated person just to handle nursing admissions (Eva Johnson). Nixon resigned re Watergate.
1975	Clara Williams acting department Chairperson (for the year). Betty Calmettes-Foster reapplied/ rehired. Forest Grove program moved to Rock Creek mid-1970s. Wanda took over video lab. Joan devised method for testing LPN skills in lab, videotaped, compared to test guides to evaluate students.

Year	Events — Year Reflects Start of Academic Year
1976	Becky Larimer retired. Joan Edwards retired (again!). Clara worked on special research project. Clarissa helped with curriculum rewrite. OSBN began accreditation of nursing education programs. The Rock Creek (3rd) PCC campus opened. Clackamas CC began its ADN program.
1977	Clara 1st year coordinator again (until 1984).
1978	Carol Connolly and Clarissa Farnsworth retired. Alice Myers started. Hazel had 1 quarter sabbatical. Shirley to 2nd year. Tim 2nd year coordinator. PCC purchased the Southeast Center—the 4th PCC campus.
1979	Dr. DeBernardis, the first President of the college, retired; Dr. Anthony named his successor. Teri Mills started. 2nd year stopped using LEGS. Tim in 1st year (until 1983).
1980	Men allowed in OB at Providence for the first time—in a controlled situation. Clara still coordinator 1st year; also coordinated 2nd year. OSBN accreditation with no recommendations or stipulations.
1981	Clara acting chairperson 1981-1983 (while 1st year coordinator). Stopped using computer codes. Tim 1st year coordinator 1981-1983. Gov Atiyeh declared Nov15-21 "Week of the Associate Degree Nurse".
1983	Rose Christensen appointed Division Dean; Shirley Anderson named Department Chair. Therese Vogel started.
1984	Claudia Brewer Michel started. Clara SACC chair 1984-1986. NCLEX pass rate 100% (OSBN).
1985	Dr. Anthony retired as PCC president; Jim Van Dyke appointed as interim. Betty Calmettes-Foster retired. Susan Jacobs, Pam DeBoni, Stan Birnbaum, and Sue Aiken quit. Juanita Joy and Maurice McKinnon started. Tim Miller took a 2-quarter sabbatical to go to school. Chris Stott started as department secretary. Office remodeled to seal off the door (in the back of the office) that led to HT C11 classroom. Rock Creek program was integrated with the program at Sylvania. NCLEX pass rate 100%. Shirley Anderson and Liz Ruff lobbied (successfully) for passage of Oregon House Bill 2928 which prohibits OSBN from making any changes in entry level education or licensure without prior legislative approval. Historic!

Year	Events — Year Reflects Start of Academic Year
1986	Dr. Dan Moriarty named as the new President of PCC. Jessica Bailey started as Executive Dean of Sylvania campus. Colleen Caraher, Theresa Watts started. Linda Arlt started (1 year temp). Clara on sabbatical as major writer of new curriculum. Started requiring prerequisites. NCLEX pass rate 100% (OSBN). Teri Mills' son Ryan on cover of PCC 25th anniversary issue schedule of classes, along with two male ADN students.
1987	Board of Nursing certified continuing accreditation of PN/ADN programs through 1991. New curriculum accepted by board—and started (the 1st year without LPN exit). Liz Ruff Goulard started 7/1 as department chair. (Tim Miller was interim chair). Rose retired. Shirley Anderson became Associate (division) Dean. Carolyn Choi, Theresa Watts, and Donna Buck left. Linda Arlt rehired (1 year temp). Laura Rodgers started. Alice Myers SACC chair. Jessica Bailey quit. Alice Jacobson joined PCC. Eva Johnson is (still) the health professions admissions officer (OSBN).
1988	Ballot Measure 5 passed. Chris Stott quit/transferred out of nursing; Laura Kirk new department secretary. Colleen Keenan started part-time. Nursing Department door moved from in front of elevator to side by HT exit. Lorna Kern started. New curriculum implemented: end of LPN exit (OSBN). Tim 1st year coordinator 1988-1990.
1989	Mary Blake retired. Tonya Drayden and MaryBeth Yosses started. Linda Arlt started full-time. Colleen Keenan started as part-time secretary. June McCauslin started as testing center monitor. Gov Goldschmidt declares Feb 15 "Associate Degree Nurse Day". SSP (student success program) started. Started Holiday Giving Tree.
1990	Wanda Fitterer and Dee Miller retired. June left. Clarice Anderson and Kerry Pioske (1st as clinical instructor) started. Clara Williams became lab coordinator. Juanita Joy 2nd year coordinator (until 1995). Piloted CAT (computerized NCLEX) June/July (OSBN).
1991	Hazel Hale retired. MaryBeth and Clarice Anderson quit. Dana Striver started—clinical and lab (worked through Med Staffing 1989-1991). Jessie Hammond, Kerry Pioske, and Shirlee Snyder started. Shirley Anderson named Sylvania campus Dean of Instruction. Liz became Division Dean. Maurice interim program director 7/91. LPN bridge piloted (OSBN).

Year	Events — Year Reflects Start of Academic Year
1992	Clara retired. Priscilla Loanzon, Janet Mathews, Susanna Griffith, started. Kerry Pioske full-time faculty (completed MSN). Michelle Mattraw on board 2/1992-6/1992. Maurice McKinnon appointed program director. Laura Kirk left; Rosemarie Millet new department secretary. LPN bridge piloted. OSBN approved SACC changes in prerequisites (OSBN).
1993	Kerry Pioske quit.
1994	Kiar First and Michelle Schull (clinical) started. Maurice appointed Division Dean 12/1994 (Liz resigned to join Clackamas CC). Priscilla named department faculty chair (until Fall 1996; appointed as acting program director Wtr 1997 and Sp1997). Nursing office (and upstairs faculty) moved to 1st floor of HT. Rosemarie Millet left; Rita White new department secretary. Juanita Joy and Maurice McKinnon applied for and got 3-year SSP grant ($456,000 funded). Therese Vogel on sabbatical (to increase Spanish language skills and to work Virginia Garcia clinic. NCLEX exam became Computerized Adaptive Testing (CAT).
1995	Pat McCathern and Tim Miller retired. Tonya quit. (Therese moved to 2nd year to teach peds). Laura Rodgers quit Oct 1. Juanita Joy moved to 1st year. New faculty started: Peggy Sherer, Sandie Molloy, Michelle (for clinical) and Maurge Koch 11/95. Priscilla Loanzon appointed faculty chair half-time. Claudia became lab coordinator while Alice on sabbatical (to translate pain into multiple languages). Year 1 of SSP grant. NLN and OSBN Accreditation. Eva Johnson retired; Julie Walston new health admissions coordinator.
1996	Tom Blickle started part-time in lab. Michelle Shull Grove full-time (finished MSN). Year 2 of SSP grant. OSBN follow-up survey October 10. Maurice on sabbatical Wtr and Spr 1997 (1996-97SchYr). Betty Palmer appointed Acting Dean. Year 2 of SSP grant.
1997	Sherrill Moore retired. Michelle full-time. Nancy Hull started. Priscilla acting program director until Shelly Quint started 7/1997. Juanita Joy released half-time to be assistant to the Dean of Academic Services. Claudia on sabbatical (to work in OB/MCH). Year 3 of SSP grant. Rita White transferred out of department (to OSD). Colleen Keenan started as full-time department secretary. Julie Walston (health admissions) and Zonya Watts (SSP secretary) left. Debbie Imus started as part-time department secretary. Gary Perry new health admissions coordinator. Priscilla and Juanita applied for/got $15,000 Fuld grant for Nursing computer lab (in video lab). PCC sold Ross Island Center.

Year	Events — Year Reflects Start of Academic Year
1998	Pram Dahya retired. Shirlee Snyder and Kiar First quit. Wendy Sheldon, Verna VanDuynhoven, and Jeannette Kamp started. Ande Bowden started part-time in lab. New computers in lab with Fuld grant. Faculty sabbaticals: Jessie fall and winter (developed on-line physical assessment course); Juanita winter quarter (wrote nursing department history); Linda spring quarter (on-line class project). Debra Bittick clinical sub for sabbaticals. Priscilla Loanzon President of OCAP. Claudia SACC chair.
1999	Alice Myers retired. Michelle Grove and Sandie Molloy quit. Wendy Sheldon, Jeannette Kamp, and Verna left (did not reapply). Debra Bittick, Colleen Duncan, Becky Fahey, and Marcia Skinner started. Obtained lawyers bookcase for millennium display. Nursing Department History written/completed by Juanita Joy. Nursing Department quilt created (Teri Mills coordinated). Gov. Kitzhaber proclaims April 7 "Associate Degree Nurse Day."

Appendix D: Oregon Community College ADN Programs

Community College	location	CC since	ADN since	LPN since
Blue Mountain	Pendleton	1962	1977	1976
Central Oregon	Bend	1949	1967	1953
Chemeketa	Salem	1965	1968	1957
Clackamas	Oregon City	1968	1976	1967
Clark	Vancouver, WA	1933	1960	1952
Clatsop	Astoria	1964	1983	≥1964
Columbia Gorge (re PCC)	The Dalles	1989	—	—
Klamath (re PCC)	K. Falls	1996	—	—
Lane	Eugene	1964	1970	1965
Linn-Benton	Albany	1967	1970	never
Mount Hood	Gresham	1966	1971	≥ 1966
Oregon Coast (re Chemeketa)	Newport	1987	—	—
Portland CC	Portland	1961	1966	1948-1987
Rogue	Grants Pass	1970	1988	1974
Southwestern Oregon	Coos Bay	1961	1975	1961
Tillamook Bay (re PCC)	Tillamook	1981	—	—
Treasure Valley	Ontario	1962	1978	1962
Umpqua	Roseburg	1964	1974	19xx

Appendix E: Interview Guide

Background

Please describe your background and how you became interested in nursing:
• When did you become a nurse/ take your NCLEX?
• Do you think that you have benefitted from becoming an RN? If so, how?
• For what reasons did you choose your own degree (diploma, ADN, BSN) over another degree?
• Did you decide to get your MSN before or after you starting at PCC?
How did you come to be at the PCC Nursing Program?
• How did you find out about the job at PCC?
• How did you choose PCC?
• For what reasons did you choose to work with LPNs/ADNs vs BSNs or diploma students?
• What were some of your own goals, (both short and long term)?
• What were the largest obstacles that you have faced outside of school that impacted your job at PCC?

Daily Life

Describe for me your experience at PCC:
• Tell me about your first year at PCC — what was it like?
• How did it change from your first couple of years at PCC to your last couple of years?
• What makes PCC distinct or unique?
• What were some of the goals of the department that you remember?
• Did you ever have times where you seriously considered quitting (from PCC)? Why or how did you decide what to stay?
• Have you stopped out during certain quarters, or were you employed continuously? If you have stopped out, what are your reasons for doing so?
• Describe for me what kind of teacher or faculty that you were.
• Describe your relationship to students and staff—including faculty and administration.
• Did you spend time talking to faculty or staff on a regular basis after or outside of work?

Decision Making

Identify the key institutional figures the influence they had on the program:
• Who does the institution remember and why?

• What words come to mind that describe the style/model of leadership used?
• What means of communication/ information sharing were utilized?
What challenges did you face that leaders of other academic programs did not face?
• What major conflicts arose? How were they generally resolved?
How did decision making take place?
• Describe the process that was used to handle problems or to work through issues.
• Describe any rewards or motivations.
What were some of the things that caused controversy?
• What were some obstacles that caused problems for you or for the department?
Are there any other [Identify] specific events occurring within the nursing program that stand out in your memory?
Describe for me if you had any mentors or other supports. How were they beneficial to you?
Were there faculty, administrators or other staff that were particularly helpful?
Tell me what you remember about your experience of .....
What was your experience with how decisions were made?
Do you remember when you decided to ..... ?
Please discuss some of the reasons why .....
How did you feel after .....?

Suppose a grandchild was considering studying nursing. What advice would you give them or what would you tell them (about college, about nursing, and about how to succeed)?
Would you say that you identify with PCC and that you are loyal to it as an institution?
Have you changed as a result of your experience at PCC?
• In other words, if I knew you previous to your time at PCC, and I know you now, would I notice any difference in you?
Do you "see" things differently now that you have retired from PCC?
What haven't I asked that I should have asked?
What have I left out?
Do you have anything to add?

Appendix F: Guideline to Identify Themes

Thematic analysis focuses on identifiable themes and patterns of living and/or behavior. The first step is to collect the data. [Doing the interviews—done!] From the transcribed conversations, patterns of experiences can be listed. This can come from direct quotes or paraphrasing common ideas. A researcher describes the following as an example:

> A family was interviewed to get a better understanding of their experience with a juvenile justice system. The entire interview was transcribed. The first pattern of experience listed, was the process of the juvenile being arrested, and the different explanations from the various family members. The second pattern of experience listed was the attitude that each family member had toward the process (Aronson, 1992).

You will be helping me to identify the themes or patterns—things that you may see that I do not see. Researcher Aronson continues with comments on identifying themes:

> The next step to a thematic analysis is to identify all data that relate to the already classified patterns. [Write the theme in the margin by what the person said to lead you to identify this theme]. To continue the above example, the identified patterns are then expounded on. All of the talk that fits under the specific pattern is identified and placed with the corresponding pattern. For example, each family member somehow named their "attitude" while they were speaking. The father stated that he is "anti-statist," the mother said that she is "protective," and the son stated that "felt bad for what he had done" (Aronson, 1992).

This example means that at the end of reading the transcript, you then sit back and reflect for a moment and see if a pattern emerges for you—in this case there were a lot of things about attitude occurring in this family. Usually more than one theme evolves. Maybe others could in this example could be the coping strategies of each family member, or attitude about the juvenile justice system. <u>There is no right or wrong way to do this.</u>

Your feedback is important to me. I appreciate the time you are taking to contribute to this piece of research.

Appendix G: Themes—Participant Table*

Theme\Participant	#1	#2	#3	#4	#5	#6	#7	#8	#9	#10	#11
Power											
power issue		✔	✔	✔	✔	✔		✔	✔	✔	
autocratic			✔	✔	✔			✔	✔	✔	✔
paternalism			✔	✔	✔				✔		
tyrant				✔					✔		
1st department chair	✔	✔	✔	✔		✔	✔	✔	✔	✔	✔
1st college president	✔	✔	✔	✔	✔			✔			✔
female/female	✔		✔		✔						
male/female		✔	✔	✔	✔						✔
women in admin	✔	✔	✔		✔			✔	✔		✔
adm vs. faculty	✔	✔	✔	✔	✔	✔			✔		✔
treated differently		✔	✔	✔	✔						
symbols of Power		✔	✔		✔				✔		
Governance											
admin–other	✔	✔	✔	✔	✔			✔	✔		
leader personality	✔	✔	✔					✔	✔		
support-funds		✔		✔	✔			✔			
decision making	✔			✔	✔			✔	✔	✔	✔
open door policy		✔		✔	✔	✔			✔		✔
2nd program chair	✔				✔	✔	✔	✔		✔	✔
informal leader			✔	✔	✔	✔	✔			✔	✔

Theme\Participant	#1	#2	#3	#4	#5	#6	#7	#8	#9	#10	#11
Informal Networks											
networking	✔				✔			✔	✔		
hired word-of-mouth	✔		✔	✔	✔			✔	✔	✔	
Good Old Boys		✔	✔	✔	✔				✔	✔	✔
External Influence											
external influence	✔	✔	✔	✔	✔			✔	✔		✔
faculty union				✔	✔				✔		✔
technol/computer	—see nursing-specific to—										
men in nursing	✔	✔	✔	✔	✔		✔		✔		✔
cc formation	✔	✔						✔	✔		
other ComColl's				✔				✔	✔		
legislation			✔		✔				✔		
anti-ADN sentiment		✔		✔	✔	✔		✔	✔		
status of nursing	✔	✔		✔					✔		
OSBN infl/relat			✔	✔	✔				✔		
ClinicalSiteCompet		✔		✔	✔	✔	✔	✔			
pt rights/ lawsuits				✔					✔		
drug culture		✔			✔						
cultural mores	✔	✔	✔		✔	✔		✔			✔
community philos		✔							✔		
physical space		✔	✔			✔		✔			✔
Work Ethic											
commit. to program	✔	✔	✔		✔	✔	✔	✔			
worked hard	✔	✔		✔	✔	✔	✔	✔			✔
work extra–no pay	✔			✔	✔						
pride in Program	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔
board Scores/						✔		✔			✔

Theme\Participant	#1	#2	#3	#4	#5	#6	#7	#8	#9	#10	#11
'doing everything'	✔	✔							✔		
prior teaching	✔	✔		✔	✔		✔	✔			
curriculum exper	✔	✔	✔	✔	✔		✔				
teaching A&P etc	✔	✔		✔	✔			✔			
good at job	✔		✔			✔	✔	✔	✔	✔	
Psychological Climate											
pride in program	—see work ethic—										
psychologic climate	✔	✔	✔					✔		✔	✔
Innovation			✔	✔	✔			✔	✔		
pioneer spirit	✔			✔	✔			✔			
exciting times					✔	✔		✔			
conflicts	✔					✔					✔
Favoritism			✔			✔	✔	✔	✔		
deference2authority	✔	✔	✔	✔	✔		✔	✔			✔
autonomy	✔		✔	✔	✔	✔		✔	✔	✔	
support– psych		✔		✔			✔	✔			
relatBetwStaff	✔		✔		✔			✔		✔	✔
accolades 4 peers	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔
peer friendship	✔			✔	✔	✔	✔				✔
neg re peer	✔		✔		✔			✔	✔		
PN vs ADN staff	✔	✔	✔		✔	✔		✔			✔
upstairs/dwnstairs			✔		✔	✔	✔	✔		✔	✔
paranoia	✔			✔		✔	✔	✔	✔	✔	
sabotage		✔	✔	✔							✔
Montag Influence		✔		✔	✔			✔	✔		
students (+ / -)	✔	✔	✔	✔		✔	✔	✔	✔	✔	
diverse students	✔	✔		✔	✔				✔	✔	✔

Theme\Participant	#1	#2	#3	#4	#5	#6	#7	#8	#9	#10	#11
sexism		✔	✔	✔	✔				✔	✔	✔
traditional roles	✔	✔	✔			✔	✔		✔		✔
Resistance to Chg			✔		✔			✔	✔		
Change thrust upon			✔								✔
Work w/OtherDept		✔	✔					✔			
Nursing–specific to											
ADN inception-PCC	✔	✔		✔	✔			✔	✔		
curriculum	✔	✔	✔	✔	✔	✔	✔	✔			✔
various campuses			✔			✔		✔			✔
college reqmts	✔	✔		✔	✔		✔	✔	✔		
pre-requirement		✔		✔	✔		✔	✔	✔		✔
admission process	✔	✔		✔	✔	✔		✔			✔
grievances				✔		✔		✔	✔		
student attrition								✔			✔
Lab	✔	✔		✔		✔		✔			✔
video lab				✔		✔		✔			
LPN entry				✔		✔		✔			
LEGS	✔		✔	✔	✔			✔			✔
computer cards			✔			✔	✔	✔			✔
advisory committee		✔			✔						

* To protect the confidentiality of the participants, this chart is *not* cross-referenced with Appendix B.