

Why Are Nurses Leaving? Findings From an Initial Qualitative Study on Nursing Attrition

The nursing shortage remains problematic, yet research with nurses no longer in clinical practice is scarce. The purpose of this study was to understand the factors influencing the decision of registered nurses (RNs) to leave clinical nursing. A phenomenological research design was chosen to reveal the complex phenomena influencing the RNs' decisions to leave clinical nursing practice. Interviews were conducted with RNs who were no longer practicing clinically.

In the United States, nursing workforce projections indicate the registered nurse (RN) shortage may exceed 500,000 RNs by 2025 (American Association of Colleges of Nursing [AACN], 2010; Cipriano, 2006; U.S. Department of Health and Human Services, 2002). In 2008, the national RN vacancy rate in the United States was greater than 8% (AACN, 2010). Evidence suggests experiences as a newly licensed RN directly impact individual perceptions related to the profession (Cowin & Hengstberger-Sims, 2006). An estimated 30%-50% of all new RNs elect either to change positions or leave nursing completely within the first 3 years of clinical practice (AACN, 2003; Aiken, Clarke, Sloane, Sochalski, & Silber, 2002; Cipriano, 2006; Cowin & Hengstberger-Sims, 2006). While an abundance of data exist regarding the RN who stays at the bedside, few studies have explored the perceptions of the RN who decides to leave clinical nursing. Understanding factors associated with RNs' practice decisions is the first step necessary in developing effective nursing-retention strategies.

Purpose

The purpose of this study was to identify the factors influencing the decision of RNs to leave clinical nursing practice. Nurses who had elected to leave clinical nursing were interviewed at the setting of their choice. Previous clinical nursing experience included a variety of clinical practice settings. For this study, the term *clinical nursing* is defined as providing direct patient care in the hospital setting.

Background

Limited data exist about individuals no longer employed in nursing; no literature was found about the perceptions or decision-making processes of RNs no longer in clinical practice. A review of the literature was conducted searching nursing, medical, labor, and psychological/sociological databases. Years of search ended with 2007, the year of the interviews. A broad search began with GoogleScholar[®] and was narrowed to include CINAHL, MEDline, PsycINFO, and LexisNexis. Several issues concerning practice decisions are associated with the current nursing shortage, including job dissatisfaction (Aiken et al., 2002; Buerhaus, Donelan, Ulrich, Norman, & Dittus, 2005), an aging workforce coupled with increased demands (Auerbach, Buerhaus, & Staiger, 2007), and problematic relationships among members of the health care team (Aiken et al., 2002). While these factors may lead to increased nursing attrition, they have not been explored from the perspective of the former RN. A thorough examination of RNs' perceptions regarding the decision to leave is necessary. Thus, the purpose of

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In a descriptive correlational study of new RNs (n=187), investigators found up to half had considered leaving nursing within the first year. By the third year, almost one-third of the new RNs had left nursing or decreased work hours to part-time (Cowin & Hengstberger-Sims, 2006). Lafer (2005) hypothesized the substantial loss of nurses from patient care is correlated directly to suboptimal working conditions, stressors placed on RNs, and low economic benefits compared to other industries.

For a complete understanding of why RNs leave clinical nursing, a thorough review of RN perceptions regarding the decision to leave clinical practice is needed. Achieving this understanding requires awareness of reasons RNs have elected to leave clinical nursing. The review of literature found limited research about nurses who no longer practice clinically. Takase, Maude, and Manias (2005) noted research is needed concerning reasons RNs elect to leave clinical practice; this topic has been overlooked repeatedly in development of nursing policy.

Methodology

The decision to leave clinical nursing often is conceptualized as one influenced by multiple factors that compound over time. A phenomenological research design was used to provide an in-depth understanding of nurses' decisions to leave clinical practice. Because the focus of the research related to the perceptions of the RNs, and because no definitive research exists about this phenomenon, an interpretive, qualitative study was deemed appropriate. Interpretive hermeneutic phenomenology, with its intent to give meaning to the experience, was the ideal choice to guide this study (Benner, 1984; Heidegger, 1962; Lincoln & Guba, 1985; Patton, 2002).

The research question for this study was, "What is the experience of RNs who leave clinical nursing?" Investigators conducted semi-structured interviews with nurses

Table 1.
Interview Questions

1.	What does the term <i>bedside nursing</i> mean to you?
2.	How do you define the role of the bedside or clinical nurse?
3.	Can you explain the relationship that existed between you as the RN and your patients?
4.	Can you talk about the reasons or a situation that may have brought you to the decision to leave bedside nursing?
5.	Can you think of a situation that exemplifies the relationships that you had with your co-workers while providing direct patient care?
6.	Have you found career fulfillment in your current position?
7.	Can you describe what you would require to return to the practice of clinical nursing?
8.	Why did you decide to participate in this research?
9.	Is there anything else you would like to share with me?

who left clinical practice. The questions used to guide the interviews are presented in Table 1.

Methods

Sample selection and recruitment. Purposive sampling was used for recruitment (Patton, 2002). Inclusion criteria consisted of licensed RNs with a minimum of 1 year of clinical practice and no clinical practice in the last 6 months. RNs with more than 1 year of experience were chosen as they could provide information about the factors leading to their decision to leave clinical nursing; investigators' assumption was that the decision to leave clinical practice was not related specifically to the initial shock of becoming a RN (Benner, 1984). RNs in supervisory or education roles were excluded, as were licensed practical nurses or other health care workers who self-described as *nurse*. RNs who allowed their professional licensure to lapse were excluded, based on the belief they may no longer identify themselves as nurses and thus may differ from nurses who maintain licensure yet do not practice clinically. RNs who were asked to surrender licensure by their state boards of nursing also were excluded.

Data collection and analysis procedures. After institutional review board approval was received from Georgia State University, study participants were recruited. Recruitment was done through the snowballing technique (Patton, 2002).

Currently practicing RNs at various hospitals in the southeastern United States were contacted by the primary investigator and asked if they knew nurses no longer in clinical practice. The email described the study, and asked for these nurses' help in recruiting potential participants. Telephone contact was made with each potential participant prior to the interview process to ensure study criteria were met. All recruitment was done over the telephone. An effort was made to not limit recruitment to one hospital, but to contact all known non-practicing RNs who might be willing to participate in the study. After providing a brief description of the proposed study, the investigator determined a mutually convenient time and location for the interview. Written informed consent assured nurses' participation in the study was voluntary, anonymity would be provided (to the fullest extent available), termination of the interviews was allowed at any time, and consent was obtained prior to the first interview. To maintain confidentiality, participants used a pseudonym during the interview.

Ten semi-structured interviews were conducted in 2007. All interviews were audiotaped and field notes were made during the interview process. Interviews were transcribed verbatim, and the recordings were compared with the transcription to ensure accuracy. Participants also received copies of their transcripts to review for accu-

racy. Upon review of the transcripts, participants were given the opportunity to meet again with the researcher to clarify any issues they deemed important. Interpretation was ongoing during this time, with the underlying purpose to identify why RNs decided to leave clinical nursing. Transcriptions first were reviewed as a whole with a basic interpretation derived. From there, the use of hermeneutics allowed the researcher to probe further into the contextual meanings present in the interviews (Geanellos, 2000). Interpretive analysis was shared with research colleagues to ensure appropriate interpretations were being made. As analysis continued, ideas and major themes were identified. These themes were paired with like themes and recorded appropriately, and supporting documentation coded. Themes emerged from the transcripts as analysis continued. When a new theme would appear, previous transcripts were reread to determine if that theme was identified in previous interviews. During analysis, the research team searched for all possible meanings related to the decision to leave nursing to ensure a complete analysis of the data.

Results

Sample. The majority of the participants were female (n=8, 80%), Caucasian (n=7, 70%), and ages 40-49 (n=7, 70%). RNs practiced in a variety of clinical settings, with 50% working on medical-surgical nursing units. Years of clinical practice ranged from 1 to 18 (M=6.5, SD=5.1), and number of RN positions ranged from 1 to 6 (M=2.4, SD=1.4). The majority of the participants had practiced in the southeastern United States (n=7, 70%). Demographics are summarized in Table 2.

Data analysis. Nurses reported many positive aspects to practicing clinically. They identified interactions with patients and families as being emotionally satisfying, and the loss of this interaction as their biggest regret since leaving practice. Many RNs stated they “felt guilty” about no longer practicing clinically, and many nurses cried during the interviews.

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Table 2.
Demographic Characteristics of Participants

Age	
22-29:	1
30-39:	1
40-49:	7
50-59:	1
Gender	
Male:	2
Female:	8
Race	
Caucasian:	7
African American:	2
Latina:	1
Highest Level of Nursing Education	
ADN:	5
BSN:	5
Highest Level of Other Education	
BS/BA other field:	3
MBA:	1
Clinical Experience Setting	
Medical-surgical nursing:	5
Critical care nursing:	3
Psychiatric nursing:	1
Labor and delivery:	1
Was Nursing Your First Career?	
Yes:	5
No:	5
Currently Employed Outside the Home?	
Yes:	7
No:	3

to leave clinical nursing, three themes emerged: (a) unfriendly workplace, (b) emotional distress related to patient care, and (c) fatigue and exhaustion. *Unfriendly workplace* was evidenced by nurses reporting issues of sexual harassment; verbal or physical abuse from co-workers, managers, or physicians in the workplace; and/or consistent lack of support from other RNs. The second theme, *emotional distress related to the patient care*, was recognized when RNs spoke of the conflict they felt regarding patient care decisions.

Often this was marked by a perception that others ignored patient or family wishes. The third theme of *fatigue and exhaustion* was characterized by the frequent comments regarding overwhelming emotional and physical exhaustion.

Unfriendly Workplace

Unfriendly workplace was reported by all RNs in the study. Participants described being left alone or ignored as new RNs or being told to “toughen up” under the auspices of making them “better nurses.” They also relayed incidents of belittling confrontations, sexual harassment, or gender abuse with co-workers. RNs described perceived lack of support when they were new to the profession, and indicated this influenced their clinical nursing practice and their decisions to leave clinical practice.

Tony worked in a surgical intensive care unit and left after 2 years of clinical nursing. He described his experience as a nurse as “simply disappointing.” Tony noted, “Nurses feed on their own. When I would ask for help, I was ignored...It was like I was an inconvenience.” Tony felt alone and isolated as a new RN.

Tina worked on a medical-surgical unit after her initial orientation as a new RN. She had been working for approximately 2 months on the night shift when a patient care situation became chaotic and she went to find help. Two RNs were in the break room, and the others “couldn’t be found.” She said:

I was totally alone...one patient in what I thought was SVT, one pulling out all of his lines because he was disoriented, and one who really seemed to have a hard time breathing. The RNs in the break room said they would be there “in a minute.” I called the supervisor [for help], and she told me to find my mentor. I was...all alone, all the time. Yet I was responsible.

Tina left clinical nursing after 1 year. Both Tony and Tina indicated they consistently felt they were alone in their transition as RNs in an unfriendly workplace.

The theme of unfriendly workplace also was characterized by stories of gender abuse and sexual harassment. All participants shared

at least one incident of abuse in the workplace. They indicated the behavior generally was accepted as the norm on the units where these nurses worked, and they did not feel empowered to stop this cyclic abuse. John described a situation when, as a new nurse, he was working in an intensive care setting. During one of his routine trips to the medication room, a male colleague locked the door and began to shout to others, "The faggot is in the med room, come and get him!" John reported this type of behavior was viewed as a hazing ritual that continued for approximately 1 year after that first incident. This hazing stopped for one individual when a new nurse would join the unit, as the bully could focus on someone new. John talked about how the hazing just made him "sad" and over time "worn down." He saw similar behavior with slight variations repeated with all new RNs, with no one ever asking for it to stop. John indicated the manager was aware of the situation and in his opinion "turned a blind eye." John left nursing about 1 year after being locked in the medication room, but says he felt the purpose of this behavior was to "toughen up" and "make better" the new nurse. While some nurses may have "toughened up," John left nursing after slightly less than 2 years of practice, tired and disappointed in his chosen profession.

Participants also described situations of sexual harassment or hostile behavior from physicians. Melanie was a new RN working in labor and delivery when a physician began throwing medications and fluids at her while she was in a patient's room. When she reported the incident to the charge nurse, Melanie was asked, "What did you do to start it?" Melanie reported feeling abandoned rather than supported by her RN colleagues. She described the situation as "oppressive...you would get caught by these (physicians)...and it was supposed to be ok." What bothered Melanie more than the physical confrontation by the physician was the lack of perceived support from fellow nurses. She indicated it seemed as if she was working in a profession wherein nurses were not

willing or able to support one another. Melanie felt powerless and abandoned at work.

Alice, another participant, recalled a similar situation when she was working in a small, rural hospital. Some of the physicians commonly and purposefully intimidated nurses by making sexual innuendos:

I wouldn't call it sexual harassment...It was just part and parcel with what you dealt with when we were...in the hospital. But it happened, and it was accepted, and essentially word got around that if you make rounds with doctor so and so [you should] make sure you are on the opposite side of the bed. You just sort of, you dealt with it.

In both these cases, the nurses reported a perceived acceptance of this behavior by administrators. This acceptance was seen as even more debilitating than the harassment itself. The overwhelming lack of support felt by all the nurses in many different situations ultimately led to their decisions to leave clinical practice.

All RNs described situations in which managers simply did not address inappropriate behavior. This indifference and lack of support allowed a culture of horizontal hostility (HH) and bullying in the workplace. Many of these incidents occurred when the study participant was a new nurse, yet they were the reasons nurses cited for leaving clinical practice even years later. For many, this type of work environment was synonymous with clinical nursing and became the reason they would not return to clinical nursing practice in the future.

Emotional Distress Related to Patient Care

Overly aggressive treatment, lack of collaboration between physicians and staff, and lack of respect for patient and family wishes caused recurrent emotional distress among the interviewees. RNs reported situations in which heroics were performed "just as learning instruments," and families were asked to leave the room during procedures so they would not stop in-progress treatments that may have violated a patient's wishes at end of life. Nurses talked about going

home and crying, not only about the loss of their patients but also the loss of autonomy and respect as health care professionals in the institutions in which they worked. More importantly, they perceived a lack of support and understanding by managers and other RNs regarding these issues.

These actions caused many participants to question their professional roles. Rose talked about her work in the neonatal intensive care unit. Babies were sicker each passing year. Previously, they would have died almost immediately, but now were kept alive through advances in medical technology. Many times Rose believed this delivery of care was pointless.

We were playing God...keeping babies alive...causing undue hope for the parents, and all the while pretending like it was ok, when we knew, I knew, it wasn't...yet no one else seemed to agree with me.

As Rose continued to watch (and participate in) what she considered to be futile treatment, she began to perceive her situation as hopeless and her role as helpless.

Almost every nurse talked about the distress caused by inappropriate use of advancing technologies. Many believed prolonging life was prolonging suffering, and it did not represent the type of nursing they wanted to practice. None indicated a solution existed to deal with the perceived ethical problems. Many relayed stories of frequently crying at or about work. Nurses reported their feelings of hopelessness and emotional distress were associated with calling in sick, searching for another position, or considering leaving clinical nursing altogether. As Ruth said,

I remember near the end...I was crying, crying almost every day, even at work, and I turned to a co-worker and said, 'I just don't think it should be like this.' I mean, what kind of job do you have where you cry every day? That is when I knew, when I had to look for another job.

Ruth's story of crying epitomizes the experiences of many participants. The emotional burdens of nursing increased to the point that the only apparent solution was to leave clinical practice. For these nurses, a pattern first developed of

missing work, and then ultimately tendering their resignations when the stressors of providing care became too much.

Fatigue and Exhaustion

Working in an unfriendly workplace and being exposed to emotionally distressing dilemmas on a frequent basis was followed typically by insurmountable fatigue and exhaustion. Alice describes being “bone tired” the 6 months before deciding to quit. Olivia said she sometimes felt “too tired to go on” and “tired all the time.” Melanie stated she “bordered on burnout, all because I cared.” Increased absenteeism was common during this time as participants believed they simply “couldn’t do one more thing.” Others noted they purposefully would not answer the telephone for fear of being called into work. Alice stated,

You are always on. Thinking and working. And it is not that you are always on when you are there... You are on when you get home. It takes hours, sometimes days, to relax after a particularly bad day... I am paranoid about phone calls these days. I hated to answer the phone to say no, to not go in, but I hated to say yes, knowing what that phone call would mean.

Alice’s fear of phone calls simply underscored her overwhelming fatigue from constantly working, and feeling it was never enough. Knowing a telephone call could mean she would be asked to work on a non-scheduled day increased her inability to rest on her days off, contributing even further to her fatigue. When Alice went to work after being called in on her day off, she reported those days were always harder and more demanding because, inevitably, others were not at work as scheduled, or the patient census suddenly had taken a sharp increase. These were the days Alice said she simply “couldn’t do one more thing.” She reported being both emotionally and physically drained during these times, and her recovery from these incidents took longer each time they occurred.

Melanie’s story supported Alice’s descriptions:

If you are doing a good job, it is

mentally as well as physically exhausting, demanding... you are going to burn out, as no one supports you, stands by you... you are always working, always on your feet, always thinking. It doesn’t end... ever... your brain is always in overtime.

Melanie, like many of the RNs, felt she was always “on,” never having time to recuperate from the daily stressors of working as a bedside clinician.

Haley described the fatigue and exhaustion best when she noted nursing is a profession only another nurse understands. She said nursing simply cannot compare to other professions because, “After all, who is going to die if the weather man tells you it isn’t going to rain and it does?” One interpretation of this is that the constant vigilance required in clinical nursing frequently is overlooked and under recognized, providing holistic patient care is emotionally and physically demanding, and all demands increase exponentially when a lack of camaraderie exists. Alternatively, Haley felt totally responsible for her clients. She believed no one understood what she was experiencing; she was all alone. Many participants said nursing was simply “too much,” indicating the levels of stress and exhaustion ultimately drove them from clinical practice. Scholars have recognized emotional or mental fatigue, coupled with physical fatigue, may be representative of the syndrome of burnout (Maslach, 1982; Trossman, 2007; Vahey, Aiken, Sloane, Clarke, & Vargas, 2004).

Discussion

Study participants believed they had to leave clinical nursing practice; this was the only recourse for them in basically untenable situations. Most participants felt a lack of support in the workplace at many levels, and these RNs were most troubled when the lack of support arose from their peers. This also extended vertically to feelings that management and physicians did not support the RN in clinical practice.

For many years, HH and moral distress have been identified as pervasive problems that may lead to job dissatisfaction, nurse burnout,

and nursing attrition (Longo & Sherman, 2007; Murrells, Robinson, & Griffiths, 2008). Despite recognition of HH in the nursing workplace, the cycle of abuse has led some persons to leave a profession about which they were once excited. The moral dilemmas and conflicts encountered by many nurses have left such indelible marks on their perceptions of nursing that they hesitated to return to clinical nursing. Study participants originally believed they could make a valuable contribution through clinical nursing, yet they believed they never could return to nursing practice in that context. All the nurses expressed guilt about not working clinically, but none were willing to return to clinical practice.

A lack of support was documented initially by Kramer (1974) as a primary reason for nurses to leave professional practice. Lack of support, HH, and moral distress all have been documented subsequently as associated with job dissatisfaction and nursing attrition (Longo & Sherman, 2007; Patrick, 2000; Vahey et al., 2004; Young, Stuenkel, & Bawel-Brinkley, 2008). The findings from the current study also suggest retention efforts should focus on work environments, including recognizing and then eliminating HH and vertical indifference. The combination of these two elements ultimately led each interviewee to leave clinical nursing.

Limitations of the study include a relatively small sample size. Although participants reported differing levels of abuse, it is unknown if this finding would be replicated on a larger scale. The reason some RNs consider abuse acceptable in clinical practice also is unclear. Further research is needed to explore the power differential among RNs, its relation to perceptions of HH and vertical indifference, and its ultimate impact on nursing turnover or intent. No other research has explored RNs’ potential vulnerability or resiliency to perceptions of HH and vertical indifference. Full understanding of reasons for RNs’ departure from clinical nursing will enable nurse managers to implement effective strategies to retain current staff.

Nursing Implications

With increasing medical technology demands, increased acuity of patients, and the complex phenomena of the nursing shortage, retaining experienced nursing staff at the bedside is of utmost importance (Aiken et al, 2002). Medical-surgical nurses may benefit from a recognition that perceptions of the workplace appear to cause some RNs to leave nursing. Recognizing when colleagues appear to be distressed, frustrated, or socially isolated, especially as new RNs, may help retain future nurses. Effective mentoring programs that fully support the transition into nursing practice from both professional and social development perspectives may ease this transition, and assist in long-term retention strategies. Developing cultures that embrace diversity, have a zero tolerance policy for HH, and provide support networks for nurses experiencing emotional distress may enhance retention of the nurse in clinical practice.

This study provides broad conceptualizations of why nurses leave clinical practice. Exploring these concepts in more detail is necessary and will benefit every nurse, every patient, and every family, and ultimately improve quality of care. ■

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