

**“You have to rely on everyone and they on you”:  
Interdependence and the team-based  
rural nursing preceptorship**

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**Abstract**

**Purpose:** A photovoice study was conducted to construct a narrative of teaching and learning to nurse in rural settings as seen through the eyes of nursing students and their preceptors. This article explores the rural context of team-based preceptorship; that is, how interdependence characterizes the quality of the transition from student to professional support networks, and in particular how professional, team-based networks function in rural settings.

**Methods:** Photovoice is a participatory research method wherein participants document their lived reality through photography, and supply narrative context to the photographs through group discussion. Four students and their four preceptors, based at health care sites in rural Western Canada, were supplied with digital cameras with which they took over 800 photographs over a

ten-week preceptorship course. Preceptors and students were active participants in generating the thematic data analysis.

**Findings:** The central thesis of this project was that rural nurses bring a strong sense of community ethos to clinical practice. One aspect of this community ethos was the importance of the rural health care team in precepting a nursing student. Students experienced a transition from their urban, school-based networks to rural-based, professional networks; preceptors and the interdisciplinary team supported students through this transition. As students gained independence from the university and emerged from their student status, they were integrated into the rural interdisciplinary team and community, greatly facilitating their transition to graduate nursing practice.

**Conclusions:** More than any other single aspect of rural nursing, we feel teamwork (and community ethos, by extension) is the key to promoting rural preceptorships and rural careers. This model for preceptorship has implications for selecting rural placements and may be transferable to other settings. Ultimately, this knowledge can be used to strengthen student placements in rural areas with implications for the recruitment and retention of nurses in rural areas.

**Keywords:** Photovoice, Rural Preceptorship, Participatory Research Method

**“You have to rely on everyone and they on you”: Interdependence and the team-based rural nursing preceptorship**

Since the earliest days of its establishment by nursing coordinators, preceptorship has encompassed a variety of models (Myrick & Yonge, 2005). Widely used in a number of countries to aid the transition of senior undergraduate students to professional practice, it is

traditionally defined as a one-to-one relationship between a staff nurse and a student during an intense, time-limited clinical experience, with a member of the nursing faculty supporting the process of student learning and evaluation (Udlis, 2008). While it is traditional for one or two nurses to precept a student in any clinical area, some students have been precepted by non-nurses, and others by specialized teams. Typically one team member serves as the primary contact person as required by the educational institution. In rural settings, where all disciplines work together, it is not unusual for the entire health care team to oversee a nursing student, even if only one or two team members are designated preceptors (Sedgwick, 2011). Because the one-to-one relationship is recognized as the gold standard for the preceptorship model (Luhanga, Billay, Grundy, Myrick & Yonge, 2010), the implications of team-based preceptorship may be highly context-dependent. This article explores the rural context of team-based preceptorship; that is, how interdependence characterizes the transition from student-based support networks to professional ones, and in particular how professional, team-based networks function in rural settings. We emphasize the importance of team cohesion, and of student integration with the greater rural community, to a successful preceptorship experience.

### **Background**

The rural setting is advantageous for nursing students on a number of accounts. The ‘expert generalist’ nature of rural nursing (Bushy & Bushy, 2001) fosters a wide range of competencies and clinical experiences, and the kinship-like, community bonds around and within rural health care teams constitute an informal, psychosocial support network (Hegney, McCarthy, Rogers-Clark, & Gorman, 2002; Kulig et al., 2009). These networks are welcoming places for students, not least because rural health care teams are eager to recruit new nurses in an era of critical staff shortages (World Health Organization [WHO], 2010), and/or create advocates for rural

specialization. Students who do undertake rural preceptorships are typically longstanding rural insiders, often from the communities where they choose placement, although this does not invalidate the importance of prior, contextual training in rural nursing (Edwards, Smith, Courtney, Finlayson, & Chapman, 2004). Research has also shown that the choice of clinical practicum placement prior to graduation influences a nurse's choice of practice setting (Charleston & Goodwin, 2004; Edwards et al., 2004), and moreover, that positive preceptorship experiences in rural settings are associated with intention to practice in smaller settings (Coyle & Narsavage, 2012). Due to the fact that many students face relocation from urban centers to rural communities to pursue these opportunities, financial assistance or assistance in-kind can be crucial to the success of a preceptorship (Neill & Taylor, 2002; Yonge, Hagler, Cox & Drefs, 2011; Yonge, Ferguson & Myrick, 2006). These measures are among the recommendations adopted by the WHO (2010).

While researchers of preceptorship have typically focused on individual nursing students and preceptors, or on the student-preceptor-faculty triad, this focus has lately shifted to the teaching and learning context, and the interdisciplinary environment in which the preceptorship experience takes place. For example, in a survey of eight students, Webster et al. (2010) found it was important for their respondents to feel part of a team. Nursing students enrolled in a senior, undergraduate rural nursing course in West Virginia cited the opportunities to practice as part of an interdisciplinary team, and to interact with students of other health professions, as one of their most valuable learning experiences (Coyle & Narsavage, 2012). Sedgwick (2011), using focus groups and interviews, found that rural, interdisciplinary team members were always open to informing students about their roles and responsibilities, upon request; furthermore, if the preceptor was a team player, the student was more likely to be welcomed and supported by the

other disciplines. In an ethnographic study, Sedgwick, Yonge and Myrick (2009) found that nursing students undertaking rural preceptorships were eager to become team members and readily disclosed information about themselves to gain acceptance. Furthermore, in both their orientation to the rural setting and the evaluation of their performance, these students gained a new appreciation of team effort.

In the current study, we employed photovoice to construct an account of rural preceptorship through the eyes of senior undergraduate nursing students and their rural preceptors. In this article, we explore the contributions of the rural health care team to preceptorship, and the effect of rural context on the one-to-one preceptor-student relationship.

### **Method**

Photovoice is a participatory research method wherein participants document their lived reality through photography and supply narrative context to the photographs through group discussion. Our participants took photographs of their experience, removed the ones they did not want to share with the researchers, then explained to the researchers which ones they had chosen and why. This process occurred at the midpoint and endpoint of each student's ten-week practicum. The justifications for photovoice are: 1) it fosters participant reflexivity; 2) it enables the communication of tacit knowledge through images and narrative; and 3) its end products—such as exhibits, photo-essays and online slideshows—are more accessible to stakeholders and policymakers (Wang & Burris, 1997). Our primary aim was to construct the story of teaching and learning for students and preceptors in rural settings.

### **Context**

The context for this project comprised rural health care sites and the unique characteristics of rural practice, which we have defined as autonomous practice indicative of smaller centers;

complexity of work; distance from the educational institution and supervising faculty involved; limited access to educational experiences and resources; and difficulty in recruiting nurses to the setting (Bushy & Bushy, 2001; MacLeod, Kulig, Stewart, Pitblado, & Knock, 2004; Yonge et al., 2006). We selected this setting with the challenges of rural nursing and the uniqueness of the rural environment in mind, while recognizing the need to enhance rural preceptors' development as clinical educators. Six rural sites—four acute care- and two community-based—were selected across two Western Canadian provinces, based on students' chosen placements; it was understood however, that each of the six sites differed in their rural contexts. These contextual differences were considered in the analysis of data, and added to the breadth and complexity of the narratives derived from each site.

### **Ethics**

We obtained ethical approval from our respective university research ethics boards, rural acute and community care sites where the research was conducted, and the regional health authorities overseeing these sites. As the nature of photographic data renders participant anonymity problematic (Harrison, 2002), we obtained signed permission from all persons taking or appearing in photographs for their use. Pseudonyms have been used in the presentation of the study findings.

### **Recruitment and Orientation**

At our invitation, clinical instructors in two Western Canadian undergraduate nursing programs recruited four senior nursing students undertaking rural preceptorships, along with their four rural preceptors. Mindful of bias, we took care to select only participants with whom we had no prior academic or professional relationship, and assured these individuals they would be free to withdraw from the study at any time. Students were approached by the clinical

instructor, not a member of the research team, who in turn invited their preceptors to participate. Our sample comprised four senior undergraduate nursing students: one female and one male in Alberta, one female and one male in Saskatchewan. Their four preceptors (all female) comprised two acute care RNs in Alberta, an acute care RN and a home care RN in Saskatchewan. All the participants were Caucasian. We equipped these primary participants with inexpensive digital cameras, theirs to keep upon the conclusion of the study and encouraged them to share the cameras with friends, family, and other health care team members to maximize photographic coverage of each rural site.

Wang and Burris (1997) emphasize the importance of a ‘facilitator,’ namely a community expert who 1) liaises between the researchers and the participants; and 2) directs group discussions in which participants supply context for their photographs. Members of the research team took on this role, being familiar with the rural health care context as clinical instructors and preceptorship coordinators. The facilitators were responsible for conducting site orientations as well as moderating the midpoint and endpoint discussions.

Following consultation a professional medical photographer regarding key ethical, legal and cultural considerations, our facilitators led open-house orientations at each research site. These orientations were tailored to promote the participation of as many members of the health care team and rural community as possible, while maintaining ethical standards for visual research methods. The orientations covered topics such as camera operation, basic photography skills, consent procedures and power dynamics within photography (Wang & Burris, 1997). We asked our participants to consider themselves photojournalists in their workplaces and communities, with the prerogative to document whatever they felt was relevant and be as

creative as they desired. Digital technology would enable participants to review and delete photographs they did not wish to share with us.

### **Data Collection, Analysis and Rigor**

Two stages of data collection took place: a four-week acclimation period, followed by a further four weeks of more intensive exploration of themes emerging from a midpoint discussion (Wang & Burris, 1997). As the research design was participatory, participants were responsible for selecting which of the photographs taken would be included as data, according to their discretion. During the discussion sessions, participants made comments suggesting that they had been selective of which photographs to include; use of digital technology greatly facilitated participants' discretionary judgment as it allowed them to take numerous photographs and to delete them easily prior to sharing the images. By the end of the ten-week preceptorship, the participants had provided the research team with over 800 digital photographs.

A discussion session followed each phase of data collection. To facilitate group discussion and participatory analysis, the photographs taken by participants were compiled into PowerPoint slide shows. Facilitators guided midpoint and endpoint discussions with open-ended questions such as, "What do we see here?" and "What does this photo mean to you?" Afterwards, recordings of these discussions were transcribed for analysis. Preceptors and students took part in data analysis as they collaborated with the facilitator to select meaningful photographs; contextualized the photographs through narrating the selected photographs; and codified the images through identification of relevant themes, issues or theories that emerged from their photographs (Wang & Burris, 1997). This dialogue is central to the photovoice methodology and occurs best in a group setting, where both individual and collective meanings can be elicited. With the aid of qualitative research software, NVivo8, we developed thematic categories through



the coding of transcripts and images.

A third and final session was conducted at each site, wherein we presented the overarching thematic findings, including images taken at the other sites, to participants as a PowerPoint slideshow. This provided validation of the themes and gave participants the opportunity to expand on their previous commentary and to substantiate the data from other sites. These discussions were also recorded and transcribed and the transcripts were used to further refine and conceptualize the thematic categories. The long-term, in-depth engagement with these participants and their rural sites, including the multiple, collective conversations, produced a rich and rigorous dataset.

### **Findings**

The central thesis of this project was that rural nurses bring a strong sense of community ethos to clinical practice. One aspect of this community ethos, here explored in detail, was the importance of the entire rural health care team in precepting a nursing student. Throughout the preceptorship, students experienced a transition from urban-based networks, formed during their nursing program, to rural-based, professional networks; preceptors and the interdisciplinary team supported students through this transition. As students gained independence from the university and emerged from their student status, they were integrated into the rural interdisciplinary team and community, greatly facilitating their transition to graduate nursing practice.

#### **Transitioning to Rural Support Networks**

One of the more compelling patterns to emerge was the students' common experience, upon commencing their rural practica, of being cut off from their accustomed urban, school-based support networks. "I had one phone call with my [clinical instructor] on my final evaluation after Emergency," said Becky (student), "but that was the only contact I got." Becky's

rural preceptor was particularly irked by this situation: “I think the student would have liked to hear [from the faculty person]. That would have been nice. Just because [students are] so used to hearing feedback.” Remoteness from peers was another aspect of the students’ perceived rural isolation. “You [get] used to doing clinical groups [with] other students, and you can complain about the instructor, or complain about the person that you had to be with that day, or what really went excitingly well,” Becky remarked. “Here it was like, ‘well, I can’t talk to my boyfriend because it’s confidential, and he won’t care or understand what’s going on.’ So yeah, I found it comforting to talk to the other nurses, but it would have been nice to brag to other students.” For nursing students unaccustomed to the periodic stresses of acute care, peer support was hardly a trivial matter, as Becky hastened to add. “I know one student saw [an] infant code; it was her first day and she was traumatized by it. She really took it hard, and she had no one really to talk to except for the co-workers.”

The rural nurse preceptors who took part in the study were sympathetic to this predicament, and spoke of their constant mindfulness with regard to their preceptees’ psychosocial wellness. “I always made sure what she looked like,” said Margot (RN), Becky’s preceptor; “Is she having a good day, or is she dragging her butt out the door?” More important, the preceptors endeavoured to pull their students into the social fabric of the rural workplace, which they characterized as open and collegial. Angelina (RN) said, “We have social night ... open to everybody in the hospital. On Friday nights at [the pizza place], everybody gets together. It’s a drop-in; if you want to come, you come.” A crucial element of this camaraderie was the common, community bond shared by all staff members, which tended to undercut any traditional hierarchies. “Some of the doctors we call by their first names, because that’s what they’ve

requested,” added Angelina. “They know us; they are [part of the community]. . . [Two of the doctors] have farms here; they have cattle and stuff.”

For their part, the students—even those from rural backgrounds—were struck by the democratizing, community ethos of the rural health care team. “In [the city], we never really got to talk to the physio [therapists], or occupational therapists, or social workers, and here... everyone works together. It’s really refreshing.



Figure 1: “[The doctors] know us...[They] have farms here.”

The doctors aren’t intimidating.... It’s not a hierarchy,” remarked Becky (student). Tellingly, one of our onsite photovoice discussions was attended by the hospital administrator, who had taken an interest in the student’s progress and even assembled the staff for his group photo. “You helped me get that all organized,” Peter (the student) marveled. This young man was clearly gratified to have the personal attention of a busy administrator.

### **Working Together and for Each Other**

The most pertinent aspects of community ethos, vis-à-vis teaching, were mutual trust and regard amongst members of the health care team. Preceptors implicitly trusted their colleagues to help guide and evaluate the students, resulting in a broader preceptorship experience. In one instance, unforeseen circumstances necessitated a switch in personnel: “I was sick. *I* was a

patient... so that's why... [Peter] got some good experience with a *really* experienced preceptor” (Angelina, RN). More often, preceptors delegated their colleagues in the effort to optimize the students’ time:

If I have six nights in a row—nights can be quiet here, or they can be action-packed—I won’t make my student work for six nights. I will ship them everywhere else... we had [her] in just about every area of the hospital. Just to give them some variety, so that on those slow days, you’re not just sitting doing nothing. You’re still gaining lots of skills in other areas. (Donna, RN)

Putting the students’ needs first was a recurrent theme in preceptors’ remarks. Becky’s preceptors, who had earlier expressed frustration with the lack of faculty involvement in her preceptorship, repeatedly went out of their way to track their students’ progress amongst the entire team:

I hear what’s going on and [I] know where she’s going, but know I need some examples [for the assessment], so then [my colleague] says, ‘well don’t worry about it, I’ll write in what I want and then you write in what you want,’ and I said, ‘oh sure, that’ll work you know.’ So, [the] poor [student] has got all these people that have evaluated her. She had two instructors, two preceptors in her first mental health [practicum] and now she’s got two more of us, so we’re all going to be adding to this very thick assessment. (Sarah, Home Care RN)

One of Sarah’s photographs stood out as a symbolic projection of this attitude: the entire home care team gathered in their office for a photo with her student Becky, whom they sat in the center of the group.

Extensive feedback, and experience with multiple situations across an entire hospital, are invaluable assets for senior nursing students facing imminent licensure examinations—something the preceptors, themselves practicing nurses, did not forget. The students acknowledged that this onslaught of information was initially overwhelming, but they quickly grew to appreciate their preceptors' willingness to hand them off to colleagues. Becky spoke gratefully of the “crash course on wound care products” she received from the hospital specialist one afternoon.

Rodney, another student, recalled being “blown away” by the level-headed ability of one RN (not his preceptor) to turn an incoming motor vehicle accident (MVA) into a teachable moment:

[She said,] ‘We’ve got an MVA coming in... the ETA’s ten minutes. Let’s go into the Outpatient room. [We’ll] go step-by-step through the process of what we can expect to do in an MVA,’ and that’s exactly what we did. We did that twice— actually two or three times—and on top of that, after the situation, the nurse asked if there’s anything we could have done differently, and she got the whole team to debrief the situation.



Figure 2: "We're all going to be adding to this very thick assessment." (Sarah, RN)

Occasions such as this exemplified Donna's (RN) characterization of the rural preceptor role as that of 'quarterback' amidst an entire staff committed to precepting.

For the students, the most significant learning outcome was the experience of becoming a team insider. "If you're willing to work, you're fair, and you treat people well, you'll do well here," said Donna (RN). "It's a lot easier than you think, because people are willing to give you a chance, and [they] expect the best." Both preceptors and students characterized the process of student integration into the team as welcoming, particularly if the student demonstrated a favourable attitude toward work and team-oriented behaviors. Viewing a photograph of herself with two staff members, Shannon (student) remarked, "There's the girls working together. [It says] we're a team... because Maggie's an LPN [licensed practical nurse] but you don't consider her an LPN; she's part of your team. Sharon's a supernumerary so she's just a new nurse there." Shannon's words reflect a vital insight into frontline rural health care: designations are secondary. The staff treated her as an equal, and she responded in kind. Peter (student), whose

initial shyness prevented him from taking a picture of another person for several weeks, found himself acting as a de facto nurse on an evening when the hospital was short-staffed (another example of a rural frontline reality). This experience, borne of a crisis, proved transformative. “I tagged along quite a bit too closely at first,” Peter admitted, “but by the end you’re given a lot more freedom, so you have to learn how to rely on everybody, and they have to learn to rely on you.” For these students, the opportunity to develop their *own* sense of teamwork in practice proved to be the greatest incentive to return to rural health care as fully-fledged nurses. “You get a lot more support from the staff, and the physicians as well,” explained Peter. “I guess there’s that sort of bonding experience you have, you know, that maybe you wouldn’t have in other areas.”

### **Discussion**

For most students, a practicum is a decisive turning point in a program of study. If we take into account the isolation initially experienced by our participating students, a rural nursing practicum begins to resemble a crisis in its truest sense: a time of peak uncertainty and a liminal rite of passage. In the absence of classroom and peer support, these students had to make the intuitive leap, as Peter (student) expressed above, that teamwork is driven by mutual reliance.

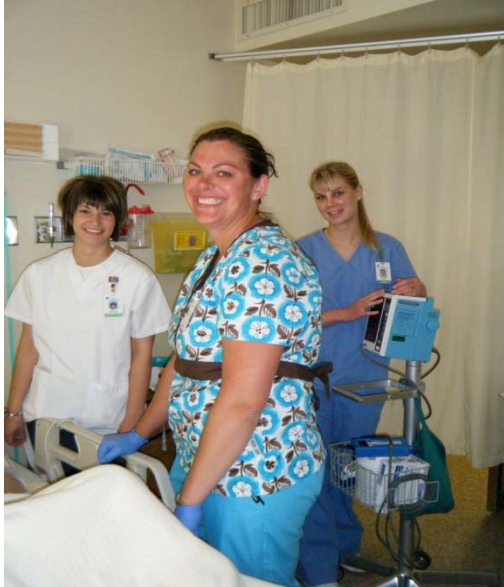


Figure 3: "There's the girls working together. [It says] we're a team. (Shannon, student)

Mills, Francis, and Bonner (2008) state that rural nurses “are motivated by a need to look after each other” (p. 602); the same could be said of rural populations in general, whose survival is predicated on such reliance. We submit that attuning a student into this community ethos is the signature outcome of a successful rural preceptorship, and the findings of other studies (Sedgwick, Yonge & Myrick, 2009; Webster et al., 2010) tend to support this viewpoint. Perhaps we should not be too quick to indict the faculty members who left their rurally placed students to discover this for themselves. The experience of being cut off from accustomed supports may have actually facilitated the growth of the preceptor-student relationship and fostered student independence from their instructors. This observation has been echoed in other studies of rural preceptorships (Sedgwick & Yonge, 2009; Yonge et al., 2006). While such rotations pose additional challenges to faculty involvement due to geographic distance from the university, this may also be a part of the natural progression of preceptorship; students and preceptors can be coached through this transition.



While prior contextual training of the sort advocated by Edwards et al. (2004) might have been welcomed by our participants, their remarks all pointed toward the implication that rural teamwork can only truly be understood through firsthand experience, and running a gauntlet of unpredictable situations. This is where the support of the preceptor, and indeed the entire health care team, became crucial in assisting students to navigate the uncertainties inherent in rural nursing. By its very nature, rural nursing practice enables a wide variety of learning experiences for students (Bushy & Bushy, 2001). Van Hofwegen, Kirkham and Harwood (2005) see this as a layering of clients in every stage of life, needing every type of care; interdisciplinary teamwork; and engagement with the community. Our findings show that these learning opportunities depend on the respect team members have for each other's abilities, regardless of discipline or designation. An overly possessive or mistrustful preceptor would have resulted in stretches of "just sitting doing nothing," as Donna (RN) put it. In this light, Sedgewick's (2011) observation that rural preceptors need to have rapport with other team members, for the good of their students, seems particularly relevant; in fact, the relationship the student has with the preceptor may act as the vehicle for integration into the team.

Nursing students can also do their part in optimizing the rural preceptorship experience. Being flexible, adapting quickly to different teaching styles and using this knowledge to seek out multiple learning opportunities all benefited our participants. That being said, these attributes can only proceed from a measure of confidence and trust in one's precepting nurse and the team surrounding that nurse. If our findings and those of others (Hegney et al., 2002; Kulig et al., 2009) are any indication, rural health care teams are the ideal crucible for the formation of such confidence and trust. More troubling is the instance of a student filling in during a staffing shortage. The preceptor-student—or team-student—relationship contains an inherent power

differential, and nurse educators perennially struggle to ensure that nursing students in clinical settings are not exploited as unpaid labor. For all the interdependence that may evolve over the course of a practicum, students remain vulnerable as novices, learners and outsiders. Nursing faculty and preceptors must therefore ensure that students are not placed in compromising positions. As gratifying as being treated as an equal may seem to a student at the time, it can erase gains in clinical nursing education, to say nothing of the potential ethical and legal consequences.

In a previous review of literature, the one-to-one preceptorship was submitted as an ideal model on account of its consistency; trust and safety within the learning space; preceptor availability; and individualized feedback (Luhanga et al., 2010). Had the learning experience in our study been restricted to the one-to-one relationship, however, the students would have been denied the depth and variety of health care teamwork. This is not to undermine the crucial role of the preceptor in closely monitoring the student's transition to their new support network; coordinating experiences with other team members; and acting as a clearing house for feedback and evaluation of student work.

### **Limitations**

The complexity of this teaching-learning experience suggests that this type of preceptorship model needs greater exploration, including its application in non-rural settings. Comparative research would be valuable in understanding the unique effects of the rural context on the preceptorship experience, and the extent to which these positive aspects could be transferred to other settings. The participant sample size was small which is appropriate for a qualitative study and for the entire study the participants generated over 800 photographs. A recent photovoice study completed by Leipert and Anderson (2012) had participants generating

144 photographs. The huge variation in the number of photographs between both studies creates questions about the photovoice method that need to be explored. As a method, photovoice requires more critique.

### **Conclusion**

Teamwork is the key to promoting successful rural preceptorships, for students and preceptors alike, whereby the latter rely on their colleagues to provide a meaningful experience for the former. The findings of this article show that rural health care teams provide a uniquely comprehensive clinical experience, socialize nursing students into the insider discourse of rural health care, and act as gatekeepers to the rural community at large. An implication for this study is that when rural preceptors are recruited, their working environment should also be assessed. More than any other single aspect of rural nursing, we feel teamwork and community ethos, by extension, is the key to promoting rural preceptorships and rural careers. Delivered with sufficient breadth and force, this message may help offset the staff shortages currently affecting rural health care sites across the globe.

### **Supporting Agencies**

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