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Nursing Student Moral Development in Preceptorship:

Socializing for Authentic Caring Engagement

in Nursing Practice

by

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ABSTRACT

Moral behaviour is the foundation of civil societies, and actions that impart goodness are necessary for the welfare of others and the evolution of humanity. In nursing education, preceptorship is a teaching/learning approach whereby learners are individually assigned to staff nurses in the clinical practice setting, to promote the socialization of nursing students into the nursing profession, and the acquisition of professional values and identity (Billay & Myrick, 2008; Myrick, Yonge, & Billay, 2010). The purpose of this grounded theory study was to explore the process of nursing student moral development in clinical preceptorship. The sample consisted of undergraduate nursing students, registered nurse preceptors, and faculty members from a large university in Western Canada. The results of this study indicate that nursing student moral development in preceptorship is shaped by a socialization process, whereby preceptors and faculty members engage students in constructing identity, exploring the experience of patients, creating meaning of practice encounters, becoming social agents, and reconciling moral issues in practice. As students navigate their way through these processes, they adopt caring behaviours that shape their nursing practices. The implications of this study for nursing education and preceptorship include: promoting pedagogical strategies to stimulate personal exploration of nursing and moral identity; recognizing the significance of care theory and an ethos of care; creating safe spaces in nursing programs to promote discussion of personal experiences, with the intent to facilitate reflection, appreciation of diverse perspectives, values clarification, creating meaning, and reconciling moral issues;

facilitating peer support in practice; and identifying the significance of moral emotions and personal ways of knowing as processes both for creating meaning from experiences, and acting as catalysts for action in practice.

PREFACE

This thesis is an original work by Jill Vihos. The research project, of which this thesis is a part, received research ethics approval from the University of Alberta Health Research Ethics Board Panel B, "Undergraduate Nursing Student Moral Development in Preceptorship: A Grounded Theory Study", No. Pro00035097, 2/21/2013.

DEDICATION

To John, for always believing in me and encouraging me to follow my ambitions. You have introduced me to adventure, creativity, and flexibility. Having you as a husband has truly made me a better person. Thank you for your patience and love and for helping me to be "good."

To Nikolas and Johnny; always be good to each other and those around you. Always hold steadfast to your aspirations and ideals, and treat others as you wish to be treated. Lead your lives by those standards, and you will find rewards.

To my Mom and Dad, whose support made this possible. You always pushed me to do my best and to persevere. I am grateful to have been the beneficiary of your advice and guidance. To this day, I always strive to wake up every day with a smile and to be kind to others.

To the greatest nurse I have known: my late grandma, Ethel Morrison. Her celebrated nursing career was reflected both in her achievements and in her practice. Receiving the Gold Medal in Nursing at Calgary General Hospital in 1937, and practicing as a district nurse in Northern Alberta during the early 1940s, reflected her dedication to the advancement of the nursing profession. Her greatness was truly embodied in her character. Her thoughtful consideration and open-minded acceptance of others, attentiveness, and true caring were the embodiment of a great nurse. I was truly fortunate to have her as a role model in my formative years. I would be remiss if I did not mention my grandpa, Sanders Morrison, who demonstrated the valuable life lessons of courage in taking chances and living life to the fullest. I have been so privileged to have a family who have truly "blessed my heart."

Last, in remembrance of my dear little four-legged friend, Buddy. You were with me when I began my journey into the nursing profession, and almost saw me to the end of this great project. In the spirit of authentic caring, you were always there, unconditionally, to attend and respond to me with true affection. John, Nikolas, Johnny and I truly miss you, and we know that God is taking care of you with great love.

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CHAPTER 1:

INTRODUCTION

Sommerville's (2006) question "Why should we be moral?" (p. 197) is of significance because, as she explained, if humans reject the notion of imparting goodness into their actions, the considerable majority of individuals would be living in a world in which they do not want to live. Adopting morals is defined as the act of being concerned about doing what is right or wrong. As nursing is a practice discipline, the study of moral reasoning is significant, for nursing actions always impact patient health outcomes. Nursing education programs are foundational in developing the moral reasoning abilities that nursing students require for future practice.

Of the few research investigations that have been conducted to explore the relationship between nursing education and nursing student moral reasoning, the majority have been quantitative. In these studies, most researchers have imported research instruments developed in non-nursing disciplines. This approach has led nursing scholars to critically question the reliability and validity of these investigations. Hence, there is a need to conduct qualitative studies to identify moral development processes applicable to nursing students.

The results of this study, which was conducted to explore nursing students' moral development in preceptorship learning experiences, provides insight both into nursing student professional development and into the significance of pedagogical strategies in undergraduate nursing programs.

In both the 20th and 21st Centuries, there has been a pervasive trend in the health sciences to adopt extrinsically-based ethics approaches that recognize ethics as a construct external to the practitioner. Understandably, ethical codes derived from deontological and principle-based ethical theory have been developed for professional nursing practice, for the purpose of protecting patients. However, it may be time to redirect ethical discourse in nursing towards ethics as a construct internal to the practitioner, while preserving those principles designed to protect care recipients. The surgeon-philosopher, Miles Little, suggested that the conduct of health care professionals in the past was simply governed by morality. However, health care professions have increasingly adopted and implemented "legalized ethics" to govern conduct, with the purpose of giving ethics necessary authority (Sommerville, 2006).

Great focus has been accorded to ethical rules and guidelines, yet the recognition of the individual has been lost. "Know thyself" was the foundation of morality for Socrates (Hauser, 2006). Socrates' notion of morality entails individuals knowing who they are as people, and searching both for meaning and for their places in the world. In nursing, one could propose that moral practitioners are those who know themselves as individuals in practice.

Problem Statement

To date, investigations into the moral reasoning of nursing students have been primarily quantitative, conducted using measurement tools borrowed from other disciplines. Increasingly, nursing scholars have questioned the reliability and validity of these investigations, inasmuch as their results have reflected lower

than average moral reasoning scores in nursing student populations. There is an increasing need to conduct qualitative research studies with nursing student populations, to acquire both understanding of moral development processes and to develop curricular strategies that foster moral growth in nursing students. Preceptorship relationships, whereby nursing students work with nurses in one-to-one relationships, have been proposed as a pedagogical strategy that can impact nursing students' moral development (Andersen, 1991; Myrick, Yonge & Billay, 2010).

Purpose of the Study

The goal of this study was to explore the processes that shape the moral development of undergraduate nursing students in the context of their preceptorship experience.

Research Questions

1. What are the basic psychosocial processes of moral development in the preceptorship relationship?
2. What are nursing students' perceptions of morals?
3. What are nursing students' conceptions of how their moral development is shaped by the preceptorship experience?

CHAPTER 2: REVIEW OF THE RELATED LITERATURE

The foundation of nursing practice is the act of "doing good" to promote optimal health outcomes in patients. In nursing, investigating how thought processes translate into actions, and how practitioners render autonomous decisions consistent with professional standards and codes of ethical conduct, can provide insights into moral behaviour. Within philosophical discourse, the challenge of mobilizing thought into action is grounded in the mind-body-spirit relationship. Nursing students enter formal education with established personal values and moral orientations that invariably shape their perspectives, meanings and actions in practice. However, researchers have found that the moral development and ethical decision-making abilities of nursing students change throughout the course of their nursing education (Auvinen, Suominen, Leino-Kilpi, & Helkama, 2004; Duckett et al., 1997; Duquette, 2004; Felton & Parsons, 1987; Haywood, 1989; Johnston, 1994; Nolan & Markert, 2002; Wehrwein, 1990). As the moral domain of nursing practice is embedded in human interaction, it is important to examine pedagogical approaches that cultivate moral development in undergraduate nursing education. Accordingly, nursing education has included practices to instill professional values and facilitate exploration of ethical frameworks for use in nursing practice.

To explore the current state of knowledge of nursing student moral development, I conducted an integrative review of the literature prior to initiating my study. The purpose of this literature review was to a) provide a rationale for conducting this study and justifying the research approach; b) demonstrate that

the study had not already been carried out; and c) reveal how the phenomenon has been studied to date (Dunne, 2011). Ganong's (1987) ten-stage framework was used to guide the review. The following questions were used to guide the review:

1. How is the moral development of nursing students described in both the nursing and allied health literature between 1985-2011?
2. How is the moral development of nursing students evaluated in oth the nursing and allied health literature between 1985-2011?
3. How is the relationship between nursing education and the moral development of nursing students described?
4. What new knowledge related to the processes of moral development of nursing students has emerged in both the nursing and allied health literature between 1985-2011?

A primary search strategy was conducted using both health and education computer databases including: Medline, CINHAL, Scopus, Web of Science, Embase and ProQuest Dissertations. English journal articles published between January 1985 and December 2011 were sampled. Inclusion criteria consisted of: (1) theoretical articles and descriptive research studies including qualitative and quantitative methods; (2) articles retrieved in a computer search using key terms including values, morals, ethics, decision-making and nursing education. A secondary search of reference lists in each article was conducted to identify additional articles related to the four guiding questions. Relevant papers were identified beginning with a title search, followed by an abstract analysis and lastly a manuscript review. For each study extrapolated, Critical Appraisal Skills Program (2004) tools were used to evaluate study rigor. A total of 118 papers including research studies, scholarly articles and doctoral dissertations were accepted for integration in the review.

Professional Orientation: Values, Morals, and Ethics

In Western society, the notion of moral development comprises moral sensitivity, moral reasoning, moral commitment and moral action, culminating in a "good" outcome (Duckett et al., 1992). In nursing, a "good" outcome is reflected in safe, competent effective care that benefits the patient and is congruent with professional and ethical standards. The notion of a "good" nurse is consistent with Aristotelian virtue ethics (Sellman, 2007). Aristotelian moral virtues include courage, temperance, justice, self-respect and liberality, developed by practice until they are ascertained as behaviours (Lavine, 1984). The foundation of "good" nursing is safe, competent and ethical care, acquired in nursing education through theory, practice and professional socialization. Within the nursing literature, theoretical articles and research studies addressing ethics and related concepts are abundant; however,, terms such as "moral reasoning" and "ethical decision- making" are often used interchangeably (Omery, 1989; Parsons, Baker & Armstrong, 2001).

The Canadian Nurse's Association (2008) defines values as "standards or qualities that are esteemed, desired, considered important or have worth or merit" (p. 28). In nursing, core values include caring, respect for persons, and attentive presence to conceptualizations and propositions (Cody, 2006). Thus, values are socially constructed, embedded in institutions, and influence actions. Furthermore, values are dynamic and contain cognitive, affective and behavioural components that influence social behaviour (Rognstad, Nortvedt & Aasland, 2004). As values influence action, awareness of the interplay among personal,

professional and organizational values can lead to greater understanding of one's moral orientation in nursing practice.

Morals are concerned with the principles of right and wrong, and conforming to socially-constructed standards of rightness, to impart "good" into actions. Morals are often referred to as virtues, with a view to "doing good." A central assumption of moral development is that individuals are guided by moral principles, which include respect for the dignity, values, and rights of others (Felton & Parsons, 1987). In nursing practice, moral behaviour can include advocating for patients, respecting individuals' autonomous decisions, and maintaining confidence in the nurse-patient relationship (Tabak & Reches, 1996). Ethics is a branch of philosophy encompassing right conduct and the good life. While the study of morals involves notions of right and wrong, ethics theory provides structural frameworks and established social and legal obligations for addressing moral issues. For example, killing is morally wrong, but a lawyer has an ethical commitment to defend an individual accused of murder.

Many professional nursing organizations use the terms ethics and morals interchangeably in their ethical codes. However, not all nurses and philosophers employ this usage (Canadian Nurses Association, 2008). Within the nursing literature, there is a lack of clear agreement as to the meaning of the term *nursing ethics* (Volker, 2003). Applying ethics to health care situations is complex, since it is not possible to explain ethical behaviour using only one construct (Duckett et al., 1992). Ethical frameworks encompass systematic problem solving, professional codes, legal imperatives, government law, and hospital protocols.

However, religious affiliation, socialization, personal ideals and moral perspectives all influence behaviour.

In nursing, moral behaviour is demonstrated by actions based on actual decisions made to address ethical issues in practice (Numminen & Leino-Kilpi, 2007). To date, scholarly articles and research investigations of nursing students' moral development encompass three processes: moral thought, moral decisions and moral action. Moral thought is shaped by personal values, culture, gender, ethnicity and professional values. Moral decisions are influenced by factors such as experience; understanding of ethics theory and frameworks for ethical decision-making; codes of ethics; professional standards; and organizational values. Finally, moral action is guided by socialization, role emulation, altruistic motivation, self-realization, social expectations, and caring. Rest (as cited in Duckett et al., 1992) describes a four-component model of the process of moral action: 1) moral sensitivity, which is demonstrated by cognitive-psychosocial processes; 2) moral reasoning; 3) moral commitment or motivation; and 4) moral action. In this model, moral action encompasses psychological attributes, interpersonal communication abilities, and social perspective-taking, which is influenced both by socialization and role-modeling (Coverston & Rogers, 2000; Duckett et al., 1992; Scott, 2006; Swider, McElmurry & Yarling, 1985). Currently, the examination of nursing student moral development reflects the use of theories derived from other disciplines. Consequently, there is a need to conduct further research for the purpose of developing theories of moral development that are applicable to the nursing profession.

Historical Perspectives on Moral Development in Nursing Education

Acquiring a moral foundation in nursing practice must emerge from a clear understanding of the ideal of nursing (Packard & Ferrara, 1988). While the terms morals and ethics are often interchangeable in the nursing literature, several studies do illustrate the relationship between ethical decision-making and moral behaviour or action (Han & Ahn, 2000; Johnston, 1994; Oberle, 1995; Rodney et al., 2002; Wehrwein, 1990).

Nursing education is the foundation whereupon professional values and ethical frameworks are learned (Andersen, 1991; Moore, 1991; Pang & Wong, 1998). The purpose of integrating ethics theory into education is threefold: 1) to advance nursing student's critical reasoning abilities for resolving ethical situations in practice; 2) to provide students with formal knowledge of ethics theory; and 3) to offer frameworks for clarification of ethical conflicts in practice (Parsons, Barker & Armstrong, 2001). In the first Nightingale schools of nursing, developing both intellect and character was the guiding philosophy of nursing education. The Aristotelian notion of doing just acts and imparting "goodness" in one's relationships served as the foundation for moral development (Bunkers, 2000). Furthermore, moral orientation was grounded in Christian virtue ethics emphasizing charity, humility, devotion, and serving others out of compassion, with no reference to self-interest and self-realization (Rognstad, Nortvedt & Aasland, 2004). As a pedagogical strategy, Nightingale introduced readings in the humanities to foster nursing student's understanding of morals and ethics (Bunkers, 2000; Sellman, 1997).

In the late 20th Century, nursing educators identified a significant deficit in ethics content in nursing curricula, as well as a lack of material resources such as nursing-specific textbooks and scholarly writings, to address ethical decision-making in nursing practice (Fry, 1989; Kennedy, 1989; Killeen, 1986; Thompson & Thompson, 1989). In the decades following the introduction of Nightingale schools of nursing, attaining rote knowledge and mastering practical psychomotor skills came to be viewed as priorities in curricular development, superseding the moral and social development of nursing students (Clay, Povey & Clift, 1983).

In the 1980s, rapid advances in science prompted nurses to examine the relationships among technology, professional values guiding practice, personal ideals guiding systematic problem solving, and legal imperatives (Dunn, 1994). Role ambiguity with regard to ethical decision-making arose among health care professionals, resulting from the use of technology in practice. Furthermore, over the course of the 20th Century, Western values shifted from humility, solidarity, and selfless devotion toward freedom and individualism (Rognstad, Nortvedt & Aasland, 2004). Collectively, these changes prompted nurse educators to increase curricular ethics content, to develop their students' abilities to apply systematic ethical decision-making when encountered with ethical dilemmas in practice (Cassells & Redman, 1989; Fry, 1989; Oddi & Cassidy, 1994; Woodruff, 1985). Pedagogical strategies such as lectures on ethics theory, interprofessional education, reflection, and role modeling were thereby introduced.

Pedagogical Strategies and Moral Development: Classroom and Clinical Practice

Consistent with the logical positivist philosophies guiding curriculum development in the 20th Century, early strategies to address ethical decision making in nursing education were grounded in the assumption that moral behaviour and ethical decision making could be taught (Clay, Povey & Clift, 1983). To evaluate ethics theory in nursing education, studies were conducted to investigate the relationship between ethics courses and moral/ethical decision-making outcomes. These investigations were conducted for the purpose of evaluating teaching strategies such as delivering lectures on ethics theory (Cassidy & Oddi, 1988; Cassidy & Oddi, 1991; Felton & Parsons, 1987; Gaul, 1987; Hembree, 1988), use of case studies (Davis**,** Ota, Suzuki & Maeda, 1999) and reflection (Doane, Pauly, Brown & McPherson, 2004).

The nursing literature contains evidence that ethics theory was introduced in baccalaureate nursing programs in the mid-1980s. The purpose of offering ethics theory was to provide nursing students a framework to facilitate understanding of their professional obligations to patients, and to guide them through ethical issues arising from the use of medical interventions in practice (Dunn, 1994). At this time, providing lectures on ethics theory was the predominant pedagogical strategy used to teach ethics to nursing students. Researchers have identified positive correlations between nursing students' knowledge of ethics theory and perceived levels of increased professional autonomy (Cassidy & Oddi, 1988;1991). This finding could indicate that

knowledge of ethics theory enhances a nursing student's sense of personal responsibility for actions (Cassidy & Oddi, 1988).

Researchers have identified positive relationships between engaging in ethics courses and increased levels of ethical/moral reasoning (Duckett et al., 1997; Felton & Parsons, 1987; Frisch, 1987; Haywood, 1989; Hembree, 1988; Johnston, 1994; Krawczyk, 1997). However, rote instruction of ethics using a lecture-based approach does not impact the personal values of nursing students (Cameron, Schaffer & Park, 2001; Eddy, Elfrink, Weis & Shank, 1994) and no significant correlation has been found between the acquisition of theoretical knowledge in formal ethics courses and the positive ethical growth of undergraduate nursing students (Evans & Bendel, 2004; Kennedy, 1989; Wehrwein, 1990). Nursing scholars have asked the question, "is it possible to teach practical wisdom and excellence of character?" (Begley, 2006).

A predominant criticism of the exclusive use of lectures to teach ethics is that learning is an individual process. Reliance on behaviourist models of education may interfere with knowledge construction and autonomy (Evans & Bendel, 2004). Although formal courses serve to increase an individual's knowledge of ethics, this does not necessarily mean that person will be a moral practitioner (Parsons, Barker & Armstrong, 2001). In a comparative study of nursing students and registered nurses, nursing students demonstrated greater knowledge of ethics theory. However, nursing students were less likely to act as patient advocates, to maintain confidentiality, and to report mistakes (Tabak & Reches, 1996).

Reflecting on practice experiences can help students to understand the relationship between ethical situations and professional standards, and to gain meaning from these experiences (Arries, 2005; Weisberg & Duffin, 1995). For some nursing scholars, including Begley (2006), Doane et al. (2004), Scott (1995) and Sellman (1997), reflection has a strong connection with virtue ethics because it promotes analysis of personal values, emotion, and perceptions in moral decision-making, leading to action in practice. Engaging in reflective practice can promote identification of and differentiation between personal and professional values (Martin, Yarbrough & Alfred, 2003; Nolan & Smith, 1995; Pang & Wong, 1998; Pask, 1997; Weis & Shank, 1991).

Professional knowledge can also be gained through praxis (Pang & Wong, 1998). Identifying personal experiences and applying philosophical frameworks to analyze and understand practice encounters cultivates moral behaviour in nursing students (Cameron, Schaffer & Park, 2001; Holt & Long, 1999; Lemonidou et al., 2004; Park et al., 2003). Introspective self-examination has three purposes with regard to moral development: 1) to prevent learners from engaging in self-deception, by fostering awareness of possible contradictions between one's behaviour and one's feelings; 2) to help learners ascertain a greater self-understanding, which may be obscured by environmental factors; and 3) and to help learners understand the feelings of others in difficult situations (Pang & Wong, 1998).

Nurse educators play vital roles in facilitating nursing students' awareness of ethical situations, and in helping them to understand their experience of ethical

encounters in practice (Doane et al., 2004). Encouraging nursing students to reflect on personal ethical dilemmas in practice, and to engage in critical analysis thereby developing multiple perspectives on nursing practice, can be integral to identifying moral attitudes (Pang & Wong, 1998; Pask, 1997). Reflection can evoke self-awareness and promote altruistic motivation, given than self-concern and concern for others are considered equally valuable in moral conduct (Rognstadt, Nortvedt & Aasland, 2004). Reflecting on one's personal perceptions, world view, and affective response to situations in practice, can nurture moral development in nursing students.

Shaping Moral Development in Clinical Practice: Role Models and Professional Socialization

In nursing education, clinical practice is a vital part of curriculum. Therefore, evoking moral development includes engaging the learner both in the classroom and in the clinical practice settings. In addition to the use of reflective practice to promote moral growth, Pang & Wong (1998) suggested that moral development is advanced when students are exposed to nurses who role-model virtuous behaviours in practice. Therefore, identifying with role models who recognize ethical dimensions of health care practice and demonstrate ethically desirable behaviours may influence nursing student moral development (Scott, 1995; 1996).

Professional socialization is the process whereby novice practitioners acquire professional values and standards, and adapt to group norms within the practice environment, to construct professional identity (Harz, 1993; Joudrey &

Gough, 1999; Rognstad, Nortvedt & Aasland, 2004; Wilson, 1995). As moral sensitivity impacts patient care, comprehension of the moral underpinnings of professional values in nursing practice is important (Packard & Ferrara, 1988; Scott, 1996). Role-modeling, role repetition and interaction within a professional reference group can help to clarify professional roles and identify norms of professional ethical behaviour, supporting nurse autonomy, patient advocacy and accountability (Joudrey & Gough, 1999; Kelly, 1992; Moore, 1991).

Researchers examining the relationship between professional values, ethical decision-making, and moral behaviour in nursing students, have found that professional socialization, professional values and interprofessional collaboration facilitate students' awareness of ethical dilemmas, and the meanings thereof, thereby promoting moral development (Eddy et al., 1994; Joudrey & Gough, 1999; Kelly, 1992; Kelly, 1993; Moore, 1991; Schank & Weis, 1989; Sivberg, 1998; Tabak & Reches, 1996; Thoma & Rest, 1999; Weis & Schank, 1991; Wilson, 1995). As a pedagogical strategy, interprofessional collaboration can elicit greater understanding of the social expectations of practitioners, increase awareness of their roles, and promote greater understanding of moral development in the context of patient care (Scott, 1995).

Nursing scholars have also suggested adopting feminist and relational ethics as models for moral education in nursing (Beckett, Gilbertson & Greenwood, 2007; Bowman, 1995; Crowley, 1994; Gastmans, 1999; Joudrey & Gough, 1999; Lemonidou et al., 2004; McAlpine, 1996; Peter & Gallop, 1994; Pierce, 1997; Raines, 1994; van Hooft, 1999). Relational models, such as

Nodding's ethic of care, are grounded in the notion that individuals who are properly cared for by people who model social and ethical virtues are likely to develop these qualities (Noddings, 2002b). Noddings (2002a) suggests that individuals grow to define virtues such as respect, honesty, compassion, fairness, courage, self-discipline, cooperation, and responsibility within relationships. Accordingly, nursing students' moral orientation may be shaped by conditions such as interactions and relationships with others, notably nurses and nursing educators.

In the nursing literature, it is evident that professional socialization is an outcome of formal nursing education programs. Some scholars, including Schrock (1990) and Weis and Schank (1991), suggest that engaging in thoughtful analysis of the rationale for professional actions—using norms of professional conduct—and determining how to act morally based on professional knowledge and conscience, can promote nursing student moral development. Additionally, nursing students may encounter challenges as they are socialized into professional practice. These challenges include conflicts that may arise between what one views as "the right thing to" and the desire to maintain good relationships with group members (Cameron, Schaffer & Park, 2001). As nursing student socialization is a process that unfolds over the course of an entire nursing program, researchers have also investigated the relationship between moral development, advancing years of study, and previous clinical experiences.

Advancing Year of Study and Previous Clinical Experience

Nurse researchers have questioned the relationship between moral reasoning and previous professional experience such as prior exposure to clinical practice settings and the year of study in a nursing program (Arangie-Harrell, 1998; Auvinen et al., 2004; Duckett et al., 1997; Duquette, 2004; Felton & Parsons, 1987; Flaming, 2004; Ham, 2004; Haywood, 1989; Hembree, 1988; Johnston, 1994; Juujarvi, Pesso & Myyry, 2010; Kim, Park, Son & Han, 2004; Kim, Park & Han, 2007; Nolan & Markert, 2002; Thoma & Rest, 1999; Wehrwein, 1990). A significant number of researchers have reported that previous experience and an advanced year of study correlate positively with higher levels of moral reasoning (Auvinen et al., 2004; Duckett et al., 1997; Duquette, 2004; Felton & Parsons, 1987; Haywood, 1989; Johnston, 1994; Nolan & Markert, 2002; Kim, Park, Son & Han, 2004; Wehrwein, 1990).

As nursing students advance through formal nursing education programs, they progress in their ability to differentiate between when they would make a professional value decision, and the impact of the decision made (Duquette, 2004). Researchers have also found that advancing years of study in a nursing program correlate with higher levels of principled, moral reasoning (Felton & Parsons, 1987). Practical experience, acquisition of professional ethics theory, and role modeling by both teachers and nurses can collectively influence professional ethical decision-making. Therefore, the acquisition of professional values, norms and behaviours in nursing education can influence moral behaviours in nursing practice. Kim, Park, and Han (2007) reported that qualified

nurses demonstrated significantly higher idealistic and realistic moral judgment scores than nursing students. These positive correlations were largely attributed to practical experience in identifying ethical issues and participating in reasoning process to address moral dilemmas in practice.

Alternately, some researchers have refuted the relationship between previous nursing experience and the level of principled thinking (Ham, 2004; Hembree, 1988). In comparing ethical reasoning abilities between nursing students and experienced nurses, Ham (2004) found that experienced nurses had lower principle-level thinking scores than students. As researchers began to identify the numerous factors influencing moral development in nursing students, and contradictory study findings, varying quantitative methods to evaluate nursing student moral development emerged.

Quantitative Research Methodology in Studies of Moral Development in Nursing Students

Of the quantitative studies undertaken to investigate nursing student moral reasoning, researchers have applied designs such as:

- correlational survey (Chafey, 1989; Hilbert, 1988; Wehrwein, 1990)
- experimental case-control (Frisch, 1987; Gaul, 1987; Guice, 1992; Hembree, 1988)
- descriptive surveys (de Casterle, Grypdonck, Vuylsteke-Wauters & Janssen, 1997; Kennedy, 1989; Park, 2011; Tabak & Reches, 1996)
- demographic surveys (Eddy et al., 1994; Haywood, 1989; Mustapha & Seybert, 1989; Yung 1997)
- descriptive-exploratory (Johnston, 1994; Moore, 1991; Schank & Weis, 1989)
- descriptive quasi-experimental (McGovern, 1995; Turner & Bechtel, 1998)
- descriptive comparative (Duckett et al., 1997; Ham, 2004; Peter & Gallop, 1994)

- longitudinal (Arangie-Harrell, 1998; Kim et al., 2004; Kim, Park & Han, 2007; Sivberg, 1998)
- cross-sectional (Auvinen et al., 2004; Joudrey & Gough, 1999; Krawczyk, 1997)
- observational case-control (Evans & Bendel, 2004).

These studies employed measurement tools such as the Defining Issues Test (Arangie-Harrell, 1998; Auvinen et al., 2004; Chafey, 1989; de Casterle, Grypdonck, Vuylsteke-Wauters & Janssen, 1997; Duckett et al., 1997; Guice, 1992; Haywood, 1989; Hembree, 1988; Hilbert, 1988; Johnston, 1994; Kennedy, 1989; Krawczyk, 1997; Kim et al., 2004; McGovern, 1995; Mustapha & Seybert, 1989; Park, 2011; Sivberg, 1998; Wehrwein, 1990); and the Judgment About Nursing Decisions Test (Chafey, 1989; Gaul, 1987; Johnston, 1994; Kennedy, 1989; Kim, Park & Han, 2007; Moore, 1991; Turner & Bechtel, 1998; Wehrwein, 1990; Yung, 1997). Other quantitative instruments used to measure nursing students' ethical reasoning ability include the Nursing Dilemma Test (Ham), the California Critical Thinking Disposition Inventory (Evans & Bendel, 2004; Guice, 1992; McGovern, 1995) and the Ethical Behaviour Test (de Casterle, Grypdonck & Vuylsteke-Wauters, 1997).

Measurement Tools: The Defining Issues Test and the Judgment About Nursing Decisions Test

Use of the Defining Issues Test (DIT) to measure nursing student moral development has been supported, and Kohlberg's theory has been validated with samples of both male and female subjects, in dozens of countries over several decades (Duckett et al., 1992). Furthermore, repeated application of the DIT in nursing research promotes in-depth, comprehensive analysis of instrument

reliability and validity to support continuing use in studies of nursing student moral development. Nurse researchers have reported that the advantages of administering the DIT include: ease and speed of both administration and scoring; minimal dependency on verbal accounts, standardization, and high levels of reliability and validity (Chronbach's alpha 0.7-0.8); and integration of an inconsistency check to evaluate the reliability of an individual's score (Duckett et al., 1992). Lower than average moral reasoning scores in populations of nursing students have been identified in research investigations using the DIT (de Casterle, Grypdonck, Vuylsteke-Wauters & Janssen, 1997; McAlpine, Kristjanson & Poroch, 1997; Mustapha & Seybert, 1989; Oddi & Cassidy, 1994). Such findings have led researchers to question the applicability of the DIT as it relates to studying populations of nursing students (Baxter & Boblin, 2007; Oddi & Cassidy, 1994).

The DIT is based on Kohlberg's theory of moral development **(**Appendix A), a theory derived from investigating the responses of male adolescents to hypothetical situations (Baxter & Boblin, 2007). The DIT consists of six stories or ethical dilemmas, with twelve arguments representing different Kohlberg's stages attached to each story. First, participants evaluate the importance of each argument in resolving the dilemma. Second, participants select the four most significant arguments. Finally, participants rank them in the order of importance (Auvinen et al., 2004). A scoring system is then applied to calculate moral reasoning. This system includes: a score for each of Kohlberg's six stages; a P (principled reasoning) score based on the importance that a

participant assigns to item choice; and a D score which is based on empirical weights for each item and is derived from a scaling analysis of the data (Duckett et al., 1992). The difference in levels reflects the manner in which individuals organize and structure their social and moral world, and associated experiences (de Casterle, Janssen & Grypdonck, 1996).

Longitudinal data collected over two decades of replication studies, using the DIT across disciplines, reveals four consistent themes: 1) moral reasoning is primarily a cognitive process that advances over time from pre- to post-conventional levels; 2) development of moral reasoning does not progress as a result of age; 3) levels of moral reasoning tend to increase when individuals engage in formal education, or specific types of intervention programs; and 4) moral reasoning influences moral behaviour (Duckett et al., 1992). However, research investigations, in which the DIT has been applied to assess moral reasoning in undergraduate nursing students, have contained findings that are inconsistent with the aforementioned themes. Researchers using the DIT have found that cognitive processes associated with moral reasoning advance over time, when individuals engage in formal ethics courses (Arangie-Harrell, 1998; Felton & Parsons, 1987; Frisch, 1987; Haywood, 1989; Hembree, 1988; Krawczyk, 1997; Park, 2011; Wehrwein, 1990). Researchers have also found no correlation between formal ethics courses and moral behaviour, but nonetheless support the relationship between moral reasoning and advanced year of study (Johnston, 1994). Similarly, researchers using the DIT have identified positive correlations between an advanced level of nursing education and a higher degree

of moral reasoning, using Kohlberg's theory (Auvinen et al., 2004; Kim et al., 2004).

When using the DIT, a rigorous approach is essential for interpreting findings as evidence of sampling errors, inconsistent application of the DIT, use of abbreviated forms of the DIT, and incorrect interpretation of P scores have been found in studies of undergraduate nursing students (Duckett et al., 1992). Furthermore, attention to confounding variables, such as gender, is necessary when analyzing data (Duckett et al., 1992). Nurse scholars have therefore suggested that applying the Defining Issues Test (DIT) to investigate moral decision-making, in populations both of nurses and of nursing students, may be problematic as adult females represent the majority of the nursing demographic (de Casterle, Grypdonck, Vulysteke-Wauters & Janssen, 1997; McAlpine, Kristjanson & Poroch, 1997; Mustapha & Seybert, 1989; Oddi & Cassidy, 1994).

To measure ethical decision-making, the Judgment About Nursing Decisions (JAND) test was developed in the 1980s by Ketefian, in consultation with nurses. In response to reliability issues, the JAND has been revised over the past two decades. The JAND tool comprises six stories describing nurses in ethical dilemmas. Each story is followed by a list of five to seven actions addressing the scenarios provided. These established nursing actions are ranked according to criteria derived from the American Nursing Association's Code of Ethics. For each item, respondents evaluate each suggested action in three columns (identified as A, B, and C). In Column A, the respondent indicates whether or not the nurse should engage in the action by checking "yes" or "no";

these responses reflect understanding and valuing of ideal moral behaviour. In Column B, the respondent indicates if the nurse is likely to engage in the action by indicating "yes" or "no"; this item reflects perceptions of ideal moral behaviour. In column C, the respondent is given the opportunity to provide a narrative account of how the nurse in the dilemma would actually behave in the situation. Following administration of the JAND to research subjects, researchers score participants' performances using a predetermined scheme, assigning a score of 1 or 0 to each or the 39 items.

Measurement issues arising from the use of the JAND tool have included:

- the representativeness of ethical dilemmas used
- the content validity of the scoring scheme, with regard to differing representations arising from various contexts of nursing practice
- validity of the scoring scheme, as scores are predetermined and established by the author, and constraints in the work setting may preclude morally ideal actions
- the persistence of low-to-marginal reliability across studies, and the absence of specificity in reporting sample sizes used to obtain reliability coefficients
- ambiguity about which values pertain to which stage of the instrument development process
- limited reliability due to limited response options
- observed inconsistency in the ability of the JAND to discriminate among groups having different levels of expertise in nursing ethical dilemmas
- failure of factor analysis to support underlying conceptual dimensions
- limitations in using a code of ethics to evaluate practice, as codes are continually updated, and both nurse accountability and scientific basis of behaviour can evolve over time
- questionable validity (Cassidy & Oddi, 1991; Oddi & Cassidy, 1994).

Overall challenges in quantifying ethical behaviour, using hypothetical situations, are evident in studies where sample groups consistently score higher on measures of idealistic moral reasoning than on realistic moral action (Kim, Park & Han,

2007). This finding further supports the assertion that moral thought does not necessarily translate into moral action.

Measurement Issues: The Challenges of Quantifying Moral Development

Investigations applying the DIT, to measure moral development in samples of undergraduate nursing students, have largely resulted in reports of students at Stage 4 (de Casterle, Grypdonck, Vuylsteke-Wauters & Janssen, 1997; McAlpine, Kristjanson & Poroch, 1997; Mustapha & Seybert, 1989; Oddi & Cassidy, 1994). Kohlberg's Stage 4, or social system morality, focuses on social system and conscience maintenance. When applied to nursing, a Stage 4 score indicates that nursing students are primarily guided by professional norms, rules, and duties, and are unable to make ethical decisions based on their own moral principles. Based on these findings, there is a possibility that adhering to professional norms, codes of ethical conduct and a tradition of duty, all of which are endorsed in formal nursing education, has resulted in nursing students scoring at Stage 4. Hypothetically, actions consistent with Stages 5 or 6, namely autonomous moral behaviour, could be both positive and negative in populations of nursing students. For example, advocating for patients in situations of institutional restraint may lead to positive outcomes for both patients and nurses; however, abandoning ethical responsibilities, if one's personal values are inconsistent with patient's needs, could negatively impact a patient's health and safety.

There are limits to using solely rational models of ethical decision making in nursing practice, as ethical nursing practice is both a personal process and a

socially mediated one (Doane et al., 2004). Owing to the interpersonal nature of nursing, emotional elements of human experience and caring can influence moral behaviour (Arries, 2005; Crowley, 1994; Joudrey & Gough, 1999; McAlpine, 1996; Nolan & Smith, 1995; Peter & Gallop, 1994; Pierce, 1997; Raines, 1994; van Hooft, 1999). To address this problem, Carol Gilligan's ethic of care theory has been suggested as an alternative to evaluating moral development in nursing (Baxter & Boblin, 2007; Chally, 1990; Cooper, 1989; Harbinson, 1992; Martin, Yarbrough & Alfred, 2003; Oberle, 1995).

The major assumption of Gilligan's theory (1982) is that women construct moral problems differently than men, and are more likely to judge themselves on the basis of their capacity to care. Gilligan asserts that the primary moral issue for women arises from a conflict between the individual responsibility to care for oneself, and duty to care for others (Baxter & Boblin, 2007). Moreover, given that Kohlberg's theory evaluates moral decisions rather than moral actions, it is difficult to conclude that an individual's response to a hypothetical situation will translate into moral action in real-life situations (Callery, 1990). This challenges the accuracy of moral assessment, as case studies reflect *a priori* reasoning—that is, a judgment that has not occurred in reality. Correspondingly, research studies of moral development in female populations, using Kohlberg's theory, have indicated that the use of hypothetical situations to measure moral reasoning abilities in female populations is problematic; females demonstrate higher scores of moral reasoning when recounting real life events, rather than in hypothetical situations (Gilligan, 1982). The Ethical Behaviour Test (EBT) was adapted using

Kohlberg's theory, and further developed to examine both moral decision and actions specific to nursing practice, with a focus on the ethic of care (de Casterle, Grypdonck & Vuylstkek-Wauters, 1997). However, EBT scores reflect reasoning in hypothetical situations and there is little evidence of its use with samples of undergraduate nursing students. Overall, there is a need to continue to explore the process of moral development, and to develop appropriate tools for examining moral development processes in populations of nursing students. Ongoing development of measurement techniques can compliment existent tools without the bias of universally prescribed theories of moral decision-making (Crigger, 1994; Oddi & Cassidy, 1994).

To date, researchers have found that quantifying moral development in nursing students is challenging, owing to the multifaceted construct of ethical practice in nursing. Furthermore, given the difference between decision-making and action, the use of rank lists and hypothetical situations do not facilitate unprompted ethical thinking (Ketefian & Ormond, 1988; McAlpine, Kristjanson & Poroch, 1997; Oddi & Cassidy, 1994). Consequently, the variations and gaps in research on nursing students' moral behaviour present a need for both qualitative and quantitative methodologies to study moral development. Increasingly, researchers are using qualitative methods to explore nursing student moral development.

New Directions: Qualitative Research Approaches and Revisiting the Ethic of Care as Foundational in Moral Development

Over the past two decades, researchers have implemented qualitative methods to investigate nursing students' moral dispositions (Cameron, Schaffer & Park, 2001; Doane et al., 2004; Han & Ahn, 2000; Kelly, 1992; Kelly, 1993; Kelly, 1996; Lechasseur, Lazure & Guilbert, 2011; Lemonidou et al., 2004; Oberle, 1995; Pang & Wong, 1998; Park et al., 2003; Roberts, 1996; Rognstad, Nortvedt & Aasland, 2004). Qualitative research approaches have included grounded theory (Kelly, 1992; Kelly 1993; Kelly, 1996; Lechasseur, Lazure & Guilbert, 2011; Oberle, 1995), interpretive inquiry (Doane et al., 2004; Roberts, 1996), and phenomenology (Cameron, Schaffer & Park, 2001; Lemonidou et al., 2004; Pang & Wong, 1998; Park et al., 2003). Additionally, the use of mixed methods is apparent (Han & Ahn, 2000; Juujarvi, Pesso & Myyry, 2010; Rognstad, Nortvedt & Aasland, 2004). In these studies, researchers have identified significant relationships between ethical decision-making and professional socialization; the context of practice; caring; empathy; emotion; connectedness; decisions made to demonstrate balance between ideal action and realistic action; and the theory-practice relationship (Kelly, 1992; Kelly, 1993; Kelly, 1996; Lechasseur, Lazure & Guilbert, 2011; Lemonidou et al., 2004). Furthermore, researchers have identified relationships between nursing students' moral behaviour and their professional socialization (Kelly, 1992; Kelly, 1996; Lemonidou et al., 2004; Pang & Wong, 1998); role modeling (Pang & Wong,

1998; Roberts, 1996); and professional identity (Rognstad, Nortvelt & Aasland, 2004). None of these studies has examined the process of moral development in the context of preceptor-student relationships.

Caring is a foundational, normative concept in the ethics of the nursing profession, and a fundamental element of moral behaviour (Gastmans, 1999; Kelly, 1992; Kelly, 1993; Kelly, 1996; Oberle, 1995). As a moral imperative, caring is considered an integral component of holistic practice. Caring is demonstrated by actions such as sensitivity and concern about another's wellbeing; identifying ethical obligations governing action; understanding the meaning of "goodness"; motivation to impart "good" into action; and the ability to reflect on one's actions (Joudrey & Gough, 1999; Kelly, 1992; Lechasseur, Lazure & Guilbert, 2011; van Hooft, 1999). While care is a cultural construct, awareness of multicultural moral and ethical values; variations in expressions; and processes and patterns of demonstrating care; are necessary to make meaningful care judgments and to take meaningful care actions (Pang & Wong, 1998). Studies of nursing students' perceptions of professional ethics have indicated that caring is fundamental to ethical nursing practice, and a lack of accountability or failure to accept responsibility for one's actions could reflect uncaring, unethical practice (Kelly, 1992).

In nursing student populations, researchers have found positive correlations between caring, perceptions of professional ethics, and socialization processes (Joudrey & Gough, 1999; Kelly, 1992; Kelly, 1996; Lemonidou et al., 2004; Pang & Wong, 1998; Peter & Gallop, 1994). Researchers have further

found direct associations between students' conceptualizations of caring practice and the pursuit of "doing good" as an essential component of ethical behaviour (Doane et al., 2004; Joudrey & Gough, 1999; Kelly, 1992; Kelly, 1996; Lechasseur, Lazure & Guilbert, 2011; Pang & Wong, 1998). Empathy, caring and emotion have been associated with nursing student moral development; they arise as the student develops awareness of personal values, when empathizing with patients (Lemonidou et al., 2004). Given that role modeling is fundamental to doing good in the context of patient care (Myrick, Yonge & Billay, 2010), further examination of student moral growth, in the context of the preceptor-student relationship, may lead to new understandings of moral development in nursing.

In nursing education, upholding the value of care presents a "moral horizon" of imparting goodness into action. (Rodney et al., 2002). In health care, advances in science and technology have led to a wholesale adoption of biomedical ethical frameworks, which place emphasis on curing rather than caring. This acceptance has lead to marginalization of the value of fundamental virtues associated with both nursing practice and moral being (Rodney et al., 2002). Greater recognition of the importance of caring as a moral imperative in nursing education may lead to new realizations in nursing research, education and practice. Consequently, identifying educational strategies to both uphold and nurture caring behaviours can facilitate moral development in nursing students.

Embracing the Theory-Practice Relationship in Moral Development

The educational philosopher, Dewey, found that although objective frameworks may assist individuals to guide decision making in ethical situations, it is difficult to generalize and prescribe similar actions in all cases (Doane et al., 2004).

Increasingly, researchers are using qualitative methodologies to explore the processes whereby ethical decision-making translates into moral action in nursing students (Baxter & Rideout, 2006; Cameron, Schaffer & Park, 2001; Flaming, 2004; Han & Ahn, 2000; Lechasseur, Lazure & Guilbert, 2011; Lemonidou et al., 2004; Park et al., 2003; Rodney et al., 2002). Qualitative explorations of moral reasoning have found that students use critical and reflective thinking abilities, when applying ethical principles and rules learned in theoretical practice (Cameron, Schaffer & Park, 2001; Han & Ahn, 2000; Lemonidou et al., 2004; Park et al., 2003).

Professional values, context, culture, and professional socialization are all factors influencing moral action in undergraduate nursing students (Baxter & Rideout, 2006; Flaming, 2004; Lemonidou et al., 2004; Pang & Wong, 1998). Nursing students assign primary importance to beneficence, justice, dignity, autonomy, and respect to guide actions in practice; however, unit culture can be a barrier to moral action, as students are in a persistent state of vulnerability due to their lack of professional experience (Lemonidou et al., 2004). Nursing students reported knowing which actions were ethically correct in many situations, yet being unable to mobilize these actions (Lemonidou et al., 2004). Given that

nurses are role models for nursing students, unit culture can have a significant impact on nursing students' moral development, as they judge the appropriateness of nurses' actions in practice (Flaming, 2004; Lemonidou et al., 2004). Students experience powerlessness and guilt when they do not speak up to address questionable behaviours in practice (Kelly, 1993). Further investigation of the link between theoretical and personal notions of "good," and the ability to impart this knowledge into action, is required.

A critical awareness of workplaces promoting and rewarding bureaucratic and institutional values and behaviours, as opposed to those based on patient-centered needs, may lead to greater awareness of moral action (Hendel, Eshel, Traister & Galon, 2006; McAlpine, Kristjanson & Poroch, 1997). While nursing students perceive personal and professional values as more important than organizational values when making decisions (Hendel, Eshel, Traister & Galon, 2006; Pinch, 1985), bureaucratic role discrepancies negatively impact these students' actual ethical behaviour (Numinnen & Leino-Kipli, 2007; Swider, McElmurry & Yarling, 1985). Consequently, investigating the processes and phenomena that induce nursing students to engage in actions reflecting post-conventional moral reasoning, may facilitate understanding of nursing student moral development.

Implications for Research

In undergraduate nursing student populations, researchers have found that moral satisfaction arises from actual good practice (Flaming, 2004; Lemonidou et al., 2004). To understand moral development in nursing students, further

research into the relationship among moral reasoning, ethical decision making, and moral action in nursing practice, is required (Duckett et al., 1997; Moore, 1991; Wehrwein, 1990). New knowledge may be generated through investigating additional sources of ethical values; the processes whereby pre-reflective notions of "right" arise from socially learned perspectives; the phenomena of ethical thought as an innate behaviour; and processes whereby moral reasoning and ethical decision-making lead to moral action in practice (Hauser, 2006; Joudrey & Gough, 1999; McAlpine, Kristjanson & Poroch, 1997).

As role modeling shapes nursing students' moral development, qualitative research into the basic psychosocial process therein, within the context of the preceptorship relationship, may lead to greater understanding of how this shaping takes place. To date, the literature reveals no findings on the relationship between preceptorship and nursing students' moral development. A investigation therein, in the context of preceptorship, would add to nursing theory development; serve as a basis for further investigation of moral development in nursing students; and illuminate the role of pedagogical strategies in nursing student moral development in the clinical environment. These findings may help to guide curriculum development in undergraduate nursing programs.

Moral behaviour is foundational to nursing practice. Within nursing, the concepts of values, morals and ethics are inextricably linked. Therefore, investigation of the relationship among thought, decision-making, and action may promote greater understanding of moral behaviour in nursing practice. In nursing education programs, pedagogical strategies to facilitate moral development

prepare practitioners to impart "goodness" into their actions in professional practice. Approaches such as reflection on practice; narrative pedagogy; case studies; and interprofessional learning; can facilitate moral development in nursing students (Arangie-Harrell, 1998; Durgahee, 1997; Duquette, 2004; Evans & Bendel, 2004; Felton & Parsons, 1987; Frisch, 1987; Haywood, 1989; Krawczyk, 1997; McGovern, 1995). Studies on nursing student moral development reveal methodological issues such as the predominant use of quantitative measurement tools adapted from other disciples; the use of surveys, in quantitative studies, evaluating responses to hypothetical situations rather than reality; and the increased need for qualitative studies to measure the process of nursing student moral development. The literature on nursing student moral development fails to differentiate between the concepts of moral reasoning, ethical decision-making, and moral behaviour in clinical practice. Additionally, there is a need to identify processes of nursing student moral development, as well as theories of moral development that are applicable to nursing practice.

A integrated, qualitative method, exploring the processes involved in the moral development of nursing students, and identifying variables influencing that moral development, may lead to a greater understanding of moral behaviour in nursing. Evaluating educational strategies to promote moral action, particularly the socialization process of preceptorship, can lead to enhanced understanding of moral development in nursing. Greater attention to the process of moral development in nursing has the potential to shape the future of professional practice.

CHAPTER 3: METHOD

Study Design

I used a grounded theory (qualitative) research approach, following Glaser and Strauss's (1967) method, to develop a substantive theory of the basic psychosocial processes shaping the moral development of nursing students during their clinical preceptorship course. Grounded theory is both a research methodology and a method of qualitative research design, used to develop theory on the basic psychosocial processes that guide individual action (Glaser & Strauss, 1967). Methodology comprises the study of method, epistemology, and theories of science underpinning a research design, and recommendations on how research should proceed; whereas method in research comprises logical sequencing and systematic techniques that can be used in a particular study (Campbell & Bunting, 1999; Milliken & Schreiber, 2001). In qualitative inquiry, researchers use grounded theory with the aim of developing an explanatory framework and establishing theory, rather than describing individual experiences (Glaser, 2001; Wuest & Merritt-Gray, 2001).

Research Questions

The following research questions provided direction for this study:

1. What are the basic psychosocial processes of moral development that occur in the preceptorship relationship?
2. What are nursing students' perceptions of morals?
3. What are nursing students' conceptions of how their moral development is shaped by the preceptorship experience?

Grounded Theory Methodology

The epistemology underlying grounded theory derives from symbolic interactionism, whereby human knowledge is realized through social activity (Milliken & Schreiber, 2001). Consequently, the goal of grounded theory is to uncover hidden meanings, to develop a theory about how individuals conduct their actions (Glaser & Strauss, 1967; Milliken & Schreiber, 2001). The foundational assumption of social interactionism is that people act toward things based on the meanings they assign thereto, and these meanings are derived through the process of interacting with others (Milliken & Schreiber, 2001). By shaping and directing their actions through relationships with others, individuals create both shared and unique meanings (Milliken & Schreiber, 2001).

Symbolic interactionism draws from pragmatism, a philosophy wherein ontological and epistemological problems are evaluated by discovering the practical consequences of action (Warms & Schroeder, 2009). The foundational principles of pragmatist philosophy include the interdependent relationship between theory and practice; the use of prior experience, or practical knowledge, to promote action; the notion of truth as relative; and the belief that social understanding arises from people's experiences and interpretations of the world they inhabit (Pursely-Crotteau, Bunting & Draucker, 2001; Warms & Schroeder, 2009). Grounded theory thus reflects pragmatist philosophy insofar as it focuses on psychosocial processes, social structural processes, and the structural conditions that influence individual's actions.

Symbolic interactionism focuses on the construction of meaning through the basic psychosocial processes of human interaction and action (Glaser, 1978; MacDonald & Schreiber, 2001). Grounded theory is based on three central tenets of symbolic interactionism: a) Human beings act toward things on the basis of the meanings that these things have for them; b) the meaning of objects derives from social interaction; and c) meaning is derived through an interpretive process (MacDonald, 2001; Pursely-Crotteau et al., 2001). In grounded theory, the researcher's role is to "examine socially constructed meanings that form the participants' realities and the behaviours that flow from those meanings" (Milliken & Schreiber, 2001, p. 180). In nursing, grounded theory methodology can help researchers address epistemological issues, such as the knowledge that nurses use to provide nursing care, and the private ways of knowing that nurses come to realize (Kikuchi, 2009).

The ontology, or nature, of nursing is grounded in the commitment to alleviate problems in society (Reed, 2009). Reed proposed that the reality of nursing emerges from the continuous dialogue between theory and practice, which is mediated by nursing research. In both pragmatist philosophy and grounded theory methodology, theory is viewed as a process, not a perfected entity (Glaser & Strauss, 1967). Therein, theory informs nursing practice, and questions arising in practice are potential research questions that can give rise to new theory. Theory for a practice discipline can provide conceptualizations to guide the everyday practices of professionals, and support that profession's purpose; grounded theory methodology is thus congruent with the goals of

nursing knowledge development (DeKeyser & Medoff-Cooper, 2009; Reed, 2009; Varcoe & Doane, 2009).

If nursing can be considered a human science, grounded theory is congruent with the ontology of that human science, insofar as it considers human beings unitary wholes in continuous interaction with their worlds, and active participants in social life (Mitchell & Cody, 1999). The goal of a human science is to explore the meaning, values, and relationships of lived experience (Mitchell & Cody, 1999). Grounded theory can generate findings in support of ontological discourse in nursing, to address whether reality exists or whether it is constructed (Leddy, 2009). In human science, subjectivity is viewed as central to human experience, and objectivity is viewed as a human creation (Mitchell & Cody, 1999). Human science preserves the possibility that universal, natural truths may exist, while acknowledging that ontological questions may be treated scientifically to attain knowledge, which exists phenomenally through lived experience (Kikuchi, 2009). Addressing the nature of reality in nursing is necessary, because the nature, scope, and object of nursing knowledge all shape thought, which in turn leads to action (Kikuchi, 2009). As a practice, nursing is a way of doing, with the goal of engaging in good actions that lead to well-being (Reed, 2006). Therefore, exploring the basic, human psychosocial processes pertaining to well-being in nursing can produce beneficial knowledge both for nursing practice and for nursing purpose.

The use of grounded theory methodology in nursing inquiry presents an opportunity for the development of nursing-specific theories to guide practice.

Pragmatist values such as respect for others; the value of an individual's subjective reality; consideration of both practical and ethical consequences of action; tolerance for alternative perspectives; applying previously learned knowledge and prior experience to everyday situations; and plurality of thought; are consistent with contemporary nursing philosophy (Warms & Schroeder, 2009).

Grounded Theory Method

As a qualitative research method, grounded theory design is based on the idea of theory as process, and the discovery of theory from data using constant comparative analysis and constant verification, to fit the phenomena being investigated, or adequately explain the phenomenon of interest (Glaser & Strauss, 1967). While rigor can be contentious in qualitative research, grounded theory includes processes to ensure the accuracy of the results. In grounded theory research, credibility is demonstrated through:

- ensuring methodological congruence by engaging in consistent and continuous joint data collection, coding, and analysis to generate theory and enhance the validity of the study findings
- ensuring that the data are relevant to the emerging theory by engaging in constant comparative analysis
- demonstrating theoretical sensitivity by maintaining a reflexive researcher diary both to control researcher bias and to gain theoretical insight into the emerging data
- ensuring that the sample is theoretically relevant to meet the criteria for generating theory
- guaranteeing that the purpose of the study is congruent with the resulting theory of interest
- increasing the scope of the emerging theory by comparing the narratives of different types of groups (Glaser & Strauss, 1967).

To allow data to emerge, and to prevent the researcher from imposing existing frameworks, hypotheses and other theoretical ideas on the data, Glaser and Strauss (1967) advised against conducting a detailed literature view at the beginning of grounded theory studies. For this grounded theory study, however, a literature review was required to receive ethics permission from the University. Furthermore, conducting a literature review was necessary a) to provide a rationale for conducting this study and justifying the research approach; b) to demonstrate that the study had not already been carried out; and c) to reveal how the phenomenon has been studied to date (Dunne, 2011). To demonstrate that I was not imposing any potential bias derived from the preliminary literature review, I maintained an audit trail of operational memos, analytical memos, and a reflexive researcher diary to reveal my thought processes and decisions throughout this study. Glaser acknowledges that literature plays an important role in the later stages of grounded theory study, as it demonstrates how the study builds on and contributes to extant knowledge within the field (Dunne, 2011). Moreover, a literature review that complements the developing grounded theory is required to demonstrate academic honesty (Dunne, 2011).

In grounded theory design, reliability is maintained during the phases of data collection and analysis a) by ensuring the appropriate use of the constant comparative method for the data analysis; b) by using codes to identify themes that arise from the data collected; c) by ensuring adequate exposure in the field, to guarantee that data saturation is reached; d) by understanding the themes that arise from the data; and e) by generating a theory that can be transferred to similar

phenomena (Glaser & Strauss, 1967). Saturation helps to develop the maximum number of diverse properties of a category; saturation is reached when the researcher is unable either to identify new properties—or to develop further properties—of a category from additional data (Glaser & Strauss, 1967). When researchers reach a theory, they further reappraise it for logical consistency, clarity, parsimony, scope, integration, fit, and work (Glaser & Strauss, 1967).

Rationale for the Selection of Grounded Theory

Grounded theory seeks to understand the individual's basic psychosocial processes, in the context of relationships and social environments. Therefore, a grounded theory approach was congruent with the aim of this study—to develop a substantive theory reflecting the basic psychosocial processes underlying preceptorship, thereby promoting the moral development of nursing students. Furthermore, grounded theory generates theory rather than testing existing theories. As a grounded theory is derived from data, it can be applied to a substantive area, from which it emerges to explain the behaviours therein (Glaser, 2001; Glaser & Strauss 1967). In this study, the phenomenon in question was the process of moral development in the nursing student–preceptor–faculty member relationship.

While both substantive and formal theories can be generated using a grounded theory approach, the aim of this study was to develop a substantive theory of nursing students' moral development, in the context of the student–preceptor–faculty member relationship. A substantive theory must be generated before a formal theory, because substantive concepts and hypotheses must emerge

first. This process allows the researcher to be objective and faithful to the data, while avoiding theoretical bias (Glaser & Strauss, 1967). Furthermore, the development of a formal theory was beyond the scope of this study, insofar as the study sample was limited to nursing students, preceptors, and faculty in a one-semester, senior practicum in the nursing program.

I used the grounded theory approach on account of the variety of approaches it affords (Glaser & Strauss, 1967). The primary focus of this study was to gain an understanding of the moral development of nursing students, within the nurse-preceptor-faculty member relationship. Glaser's (2001) coding schemes ensure greater flexibility in identifying categories and their properties, without forcing data into set coding schemes such as those proposed by Corbin and Strauss (as cited in Glaser, 2001).

Setting

I conducted this study with nursing students, faculty members, and registered nurse preceptors who participated in a fourth-year, undergraduate clinical preceptorship course in the Faculty of Nursing at a large, western Canadian university. In this clinical practicum course, nursing students are placed with nurse preceptors at various clinical agencies. The population for this study included nursing students, nurse preceptors, and faculty members who were currently participating—or had recently participated—in preceptorship assignments.

The Clinical Preceptorship Course

In this clinical preceptorship course, undergraduate nursing students engage in 340 hours of clinical practicum, under the direct supervision of a preceptor, with faculty member facilitation. The course aims to consolidate learning by engaging students in the management and care of patients, in an assigned clinical setting, preferably an area of special interest for the student. The course is delivered over a continuous block of time, and in a variety of nursing practice settings. Students practise under the supervision of registered nurses—or designated preceptors—who foster the students' independence in organizing and delivering nursing care. Students are required a) to participate in a continuous learning experience in their designated clinical setting, under the direct guidance of a registered nurse, and in situations that facilitate transition to the graduate nurse role; b) to develop a plan that will facilitate learning in the assigned clinical setting; and c) to coordinate and/or provide care for a patient assignment equivalent to the capacity of a newly graduated nurse. The objectives and terminal outcomes for the preceptorship course require students to demonstrate independence:

- in providing competent nursing care to patients in a clinical environment
- in managing health promotion and prevention strategies, using advanced therapeutic communication skills, health counseling skills and teaching and learning principles
- in engaging in evidence-based practice
- in integrating knowledge into clinical practice
- in integrating knowledge of primary health care into practice
- in displaying self-directed learning and critical thinking in practice.

Student Role

In this preceptorship course, students assume the role of active, self-directed learners in a designated clinical setting. Students are required to fulfill

the course objectives and adhere to codes of conduct at the university, agency, and professional levels. In the preceptorship relationship, students are expected to communicate actively both with their preceptors and with their faculty members, and to demonstrate receptivity to feedback, coaching, and evaluation. Students are required to demonstrate initiative, and willingness to participate, in learning opportunities that will enhance their knowledge in the clinical practice setting. As students become more familiar with the preceptorship setting, they are expected to practice with an increasing level of independence. As self-directed learners, students assume responsibility for their own learning; ask questions of their preceptors; and seek guidance to obtain the knowledge and attributes necessary to provide safe, competent, and ethical nursing care.

Faculty Member Role

In this preceptorship course, faculty members actively facilitate the preceptor relationship, guide students in their learning, support both students and preceptors, and assess students to ensure that they achieve the terminal outcomes of the course. Faculty members integrate curriculum philosophy into practical experiences to facilitate learning outcomes. To foster active, involved, and independent learning, faculty members ask questions, whereby students discover what they do not know or understand, and determine what they need to learn. Faculty members also encourage students to synthesize information and think critically through modeling, coaching, and promoting reflective practice.

By engaging students in reflective, critical thinking, faculty members challenge them to question their personal assumptions, and help them to identify

multiple perspectives and possibilities with respect to given situations and topics. Faculty members are also expected to create a climate of trust within the preceptorship relationship, by acting as liaisons between students and preceptors, supporting students and preceptors, and modeling compassionate, honest, accountable behaviour. Faculty members are responsible for arranging meetings with preceptors and students, as necessary, to discuss the latter's growth and performance. When preceptors have concerns about students' clinical performance, faculty members support and guide the preceptors. Furthermore, faculty members act as resources for preceptors in the evaluation processes.

Preceptor Role

In this preceptorship course, preceptors develop one-to-one relationships with nursing students, to establish trust and safety while the students are learning. The preceptors engage in a variety of roles: model, teacher, facilitator, guide, and guardian. Through their professional interactions with patients, nurses, interprofessional team members, and families, preceptors act as role models for students vis à vis critical thinking, problem solving, decision making, compassion, and ethical behaviours. As teachers, preceptors share their knowledge and skills with students, and provide feedback on the students' performance and knowledge. Preceptors facilitate learning by collaborating with students, and by providing resources, encouragement, and feedback to help them independently identify their personal learning needs. As guides, preceptors assist students in linking theory to practice and in giving them opportunities to practice new knowledge and skills. As guardians, preceptors foster supportive and positive learning environments.

Sample Recruitment

I recruited the participants for this study using various approaches. First, I advised the clinical preceptorship course coordinator of my study's approval, and my plan to work with faculty, preceptors, and students participating in the preceptorship course. I attended a large-group, student orientation on the first day of the clinical preceptorship course, to notify students and faculty about the preceptorship study. Furthermore, I emailed student information letters about the study (Appendix B) to faculty members participating in the course, and posted them on the students' web site.

On the same date, I attended a preceptorship conference to inform registered nurse preceptors about the study. To reach those preceptors who did not participate in this workshop, I gave information letters (Appendix C) to faculty members to distribute to those individuals. To protect the anonymity of the participants, the information letters included my contact number and email address, so that the study volunteers could contact me directly.

At first, it was challenging to recruit volunteers for the study. Approximately one month after I addressed the student group and emailed the faculty members, I had recruited only two faculty members as participants. I therefore emailed the faculty members again and posted a second message to the course website to notify students, and repeated this procedure several weeks later. As a result I eventually recruited four faculty members and five students. As each volunteer approached me about participating in the study, we mutually arranged a date and time for our initial interview. In these intial interviews, I explained the

concept of informed consent, received participants' written consents (Appendix D), and collected demographic data (Appendix E).

I selected faculty members currently teaching the preceptorship course, and supervising students placed at my study location. I also selected nursing students currently taking the preceptorship course, placed at my study location.

Over the first seven weeks of the preceptorship course, only one registered nurse preceptor volunteered to participate in the study. Clauses in the Freedom of Information and Protection of Privacy Act limited my ability to collect personal information to contact the preceptors. Therefore, I followed up with faculty members to enquire whether any preceptors who had received information letters were willing to participate. I also contacted the appropriate official at the Faculty of Nursing, who subsequently contacted the professional practice leaders in two participating health agencies, regarding the preceptorship study. I subsequently posted information letters (Appendix C) on multiple care units for approximately seven weeks, to notify registered nurse preceptors about the study, but no volunteers came forward. The preceptorship workshop coordinator then sent emails to registered nurses, who had participated in the preceptorship workshop at the beginning of the course, to advise them of the study. Two more preceptors volunteered to participate after having received correspondence from the preceptorship workshop coordinator. A fourth preceptor volunteered seven months after ethics approval; this preceptor was actively involved in the preceptorship course, albeit with a new cohort of students. As with the procedure for the faculty and student participants, we mutually arranged a date and time for

the initial interview, at which I explained informed consent, received the participant's written consent, and collected demographic data.

I selected both experienced and inexperienced registered nurse preceptors, who were either currently precepting students or had precepted them within the past year, in a clinical practice location where I conducted the study.

Sample

I recruited a final sample of 13 participants for this study, including five nursing students, four registered nurse preceptors, and four faculty members; and I conducted a total of 36 interviews. Table 1 illustrates the number of interviews per participant.

With two exceptions owing to lack of availability, all participants engaged in two interviews each lasting 30-60 minutes, plus a third, member-check interview.

Table 1

Number of Interviews per Participant

Student	Faculty	Preceptor
01: Two interviews + 1 member-check interview	01: Two interviews	01: Two interviews + 1 member check interview
02: Two interviews + 1 member-check interview	02: Two interviews + 1 member-check interview	02: Two interviews + 1 member-check interview
03: Two interviews + 1 member-check interview	03: Two interviews + 1 member-check interview	03: Two interviews + 1 member-check interview
04: Two interviews + 1 member-check interview	04: Two interviews + 1 member-check interview	04: One interview
05: Two interviews + 1 member-check interview		

Demographic Information

Table 2 shows the participants' demographic information. Of the student sample, four participants were female and one was male. Four students undertook preceptorship placements in acute care settings, and one student undertook a community placement. For four of the students, this program was leading to their first degree. Only one student held a prior degree. All faculty member participants were females with graduate degrees. All preceptor participants were females with baccalaureate degrees in nursing. Three preceptors practised in acute care settings and one practised in the community.

Table 2

Participants' Demographic Information

	Age	Gender	Previous education
Students (n = 5)	20-29 years (n = 4) 30-39 years (n = 1)	F (n = 4) M (n = 1)	No previous degree or diploma (n = 4) Previous degree or diploma (n = 1)
Faculty members (n = 4)	40-49 (n = 1) 50-59 (n = 3)	F (n = 4)	Graduate degrees (n = 4)
Preceptors (n = 4)	20-29 (n = 1) 30-39 (n = 2) 40-49 (n = 1)	F (n = 4)	Nursing degrees (n = 4)

Ethics Approval

The Health Research Ethics Board Committee Panel B granted approval to conduct this study. To ensure the participants' confidentiality, I replaced their names with numerical codes on the audio recordings, written transcripts, demographic data collection records, and field notes. I stored the written consent forms and demographic data in a locked cabinet, placed the digital audio recordings in electronic files, and encrypted them on a password-protected

personal computer. I also stored both the digital audio recordings and the hard copies of the transcripts in a locked cabinet, separate from the written consent forms. I will retain the transcripts and other data in a locked cabinet for seven years.

Data Collection and Analysis

In this study, I collected data through one-to-one, semistructured interviews with the participants, and read associated literature on the topic of moral engagement. Additionally, I kept field notes, operational memos, analytical memos, and a researcher diary, to gain insight both into my activities and into my thought processes as the researcher.

Data analysis involved assessing the interview data, the analytical and operational memos, and the researcher's diary. In grounded theory, analysis occurs in two phases: substantive coding and theoretical coding (Glaser, 1978). Glaser and Strauss (1967) defined *coding* as a core analytical process that involves organizing the data and comparing and labeling newly created categories. The coding process occurred in two respective phases: substantive and theoretical (Glaser, 1978).

I used a variety of data sources to develop the substantive theory for this study. In grounded theory, interviews are the core source of data, directed by the emerging theory (Schreiber, 2001). I conducted semi-structured interviews at a mutually determined date and time, through a mutually determined mode of communication. The first interviews were the longest, averaging 51 minutes (47-66 minutes); the second interviews averaged 41 minutes (31-48 minutes); and the

third, member-check interviews lasted 13-20 minutes. I engaged 11 participants in three interviews, another participant in two interviews, and the remaining participant in one interview. Of the first and second interviews, 19 were face-to-face, 2 occurred via FaceTime and 4 via telephone. I conducted the 11 member-check interviews via telephone.

Initially, I used an interview guide with two open-ended questions for all participants (Appendix F). Limiting the initial interview guide to two open-ended questions is consistent with grounded theory method. Glaser and Strauss (1967) advise that initial decisions guiding data collection should not be based on a preconceived theoretical framework. Moreover, data collection is controlled by the emerging theory. The goal of collecting data in interviews is to follow the data emerging from participant narratives, rather than forcing the data (Glaser & Strauss, 1967). To ensure that I was not imposing my interview structure or biases in the interviews, I concluded each interview with the question, "Is there anything further that you would like to share, that you feel is related to the topic?" (Schreiber, 2001). With each subsequent interview, I formulated new questions that I derived from the emerging data. The second interviews contained questions emerging from transcription and line-by-line coding of the first interviews, along with general questions that arose from other participant interviews. The interview questions (Appendix F) therefore progressed from general to specific over the course of the study (Schreiber, 2001). In generating new questions, I was mindful of the need to keep them general and not force the data (Glaser & Strauss, 1967).

Consistent with the grounded theory approach, data collection and analysis occurred simultaneously; I used constant comparison to identify concepts, develop coding schemes, and reach data saturation. These processes led to the developing theory.

Data Management, Organization, and Analysis

I used a manual approach to managing the emerging data. To start, I immediately transcribed the digital audio recordings into Microsoft Word, following each interview. This process facilitated instant and continuous data analysis. To enhance reliability, I played the tape recordings simultaneously with the first reading of the transcript to identify possible errors in transcription. Furthermore, I read the transcripts multiple times to ensure my theoretical immersion in the data (Glaser, 1978).

I started the open coding procedure by analyzing the transcribed data line by line, and assigning line-by-line codes. I labeled each line-by-line code with the participant's pseudonym, and line numbers. As the open coding evolved, I assigned substantive codes to each line-by-line code. I then repeated this process for all of the interviews. Consistent with the grounded theory method, I conducted a constant, comparative analysis of the data by comparing the substantive codes, emerging from each subsequent interview, with those from previous interviews. To identify theoretical codes, I created a Word document containing all substantive codes emerging from the nursing students, faculty members, and registered nurse preceptors' interviews. The substantive codes emerging from the data included, but were not limited to: a) communicating and

building the preceptorship relationship; b) student as novice; c) transition; d) definitions of morals; e) definitions of ethics; f) personal values; g) creating meaning in the preceptorship relationship; h) professional responsibilities; and i) unit culture. I assigned each substantive code an alphanumerical code to identify the population from whom the substantive code emerged. This process also helped ensure saturation, lest I had overlooked new codes requiring further investigation. Additionally, the visual lists helped me ascertain whether or not the data from each population fit and worked mutually. Using the list of substantive codes, I initially identified two theoretical codes and grouped the substantive codes under each theoretical code category. The two theoretical codes were: a) distinguishing personal identity in practice, and recognizing the humanity of others; and b) identifying moral encounters in practice, and creating meaning of these instances through dialogue and ways of knowing. After further in-depth analysis, I determined four core categories, within the substantive code groups, reflecting the process of nursing student moral development in preceptorship. These four categories were: a) distinguishing nursing and moral identity; b) learning to recognize the patient's experience; c) identifying moral encounters and creating meaning of those encounters; and d) becoming a social agent and reconciling moral issues in practice.

To identify the substantive theory underpinning the core variable—moral development in preceptorship—I met with my supervisor to map concepts and to identify the basic psychosocial processes therein.

Theoretical sampling. In grounded theory, theoretical sampling involves concurrent data collection, coding, and analysis, to determine which data to collect next, in developing an emerging theory (Glaser, 1978; Glaser & Strauss, 1967). This process of data collection is controlled by the emerging theory (Glaser, 1978). During the data collection and analysis, I continually engaged in constant, comparative analysis to determine whether the new data fit with the previous data, and to determine where to follow new data. For this study, I recruited a purposive sample of nursing students, faculty members, and nurse preceptors. This sample was theoretically relevant to the investigation of nursing students' moral development in preceptorship. The sample moreover enriched theoretical sampling in its use of different population groups, to generate diverse themes, and to illuminate similarities and differences within the code group data (Glaser & Strauss, 1967). Similarities among the comparison groups helped to verify the usefulness of the codes and to substantiate the data therein, whereas their differences illustrated the diversity of the data collection within the code groups (Glaser & Strauss, 1967). Glaser and Strauss emphasized that researcher attentiveness to similarities and differences is vital in discovering themes that arise in code groups, and in developing an emerging theory.

Substantive coding. In qualitative research, coding is used to find as much data as possible about a phenomenon of interest (Richards & Morse, 2007). In grounded theory research, data are coded using *in vivo codes* or words that occur in the data (Richards & Morse, 2007). In this study, substantive coding included phases of open coding and selective coding.

Open coding. I derived the open codes from actual events, definitions, and meanings in the text of each participant's narrative. Open coding "opens up" the data to identify concepts that fit the data (Richards & Morse, 2007). In the open coding phase, I conducted a line-by-line analysis, coding the data in as many ways as possible, and reviewing the line-by-line codes to identify concepts, patterns, or events. Subsequently, I progressed to a substantive coding process, which involved naming each line-by-line code using a word or phrase to reflect the meaning or theme inherent in the line-by-line code. This process reflected theoretical sensitivity in that the emerging codes were grounded in the participants' descriptions of their experiences with preceptorship. Theoretical sensitivity is fundamental to grounded theory research; attention to participants' narratives and the data establishes the credibility of the findings (Glaser, 1978; Walker & Myrick, 2006). During the open coding phase, I constantly compared new data with existing data to identify emerging, substantive codes and their properties; to ensure the integration of substantive code groups common to faculty, preceptors, and students; and to determine if new codes were emerging in the data. Overall, I identified 72 substantive codes.

Selective coding. Once open coding was complete, the selective coding phase began. I considered the line-by-line coding complete and organized the coding process around substantive codes. In this study, substantive codes related to the basic, psychosocial process of nursing students' moral development in the preceptorship relationship. The constant, comparative analysis of substantive codes continued until I recognized that there were fewer major changes to the

substantive code groups. I concluded that I had reached data saturation when no further properties emerged from the constant, comparative analysis of subsequent incidents and the existing substantive codes. I then met with my supervisor to integrate the data into a central hypothesis, and to generate a substantive theory of nursing students' moral development in the preceptorship relationship. I integrated the data using theoretical codes (Glaser, 1978).

Theoretical coding. In the theoretical coding phase, I analyzed the relationships among the substantive codes to form conceptualizations and to generate themes that led to theory development (Schreiber, 2001). In this study, theoretical coding involved writing the theory by processing the coded data, memos, and theory (Glaser & Strauss, 1967; Myrick, Yonge, & Billay, 2010). Additionally, I used constant, comparative data analysis to test the relevance of the substantive codes, and to verify the data and the emerging theory. During theoretical coding, I tested emerging hypotheses through comparison with the existing data, and through new theoretical sampling (Glaser & Strauss, 1967; Schreiber, 2001). The substantive codes groups common to faculty, preceptors, and students included but were not limited to: a) personal values; b) engagement in preceptorship; c) personal identity and personhood in practice; d) nursing identity; d) moral identity; e) courage; f) recognition of the patient's experience; g) previous experience that shaped the preceptorship; h) support systems; and i) the creation of meaning in preceptorship. I consistently scrutinized line-by-line codes and substantive codes emerging from the data, to identify gaps and the need

for further data collection, thereby ensuring that I had reached saturation of the substantive code categories.

The accuracy of my findings was further supported by the emergence of a negative case (Glaser & Strauss, 1967). The negative case—that is, an alternate hypothesis—serves to affirm the credibility of the research findings. The pursuit of the negative case, emerging from the data, helps readers to understand how researchers obtain their theory from the data (Glaser & Strauss, 1967). In this study, my goal was to generate themes around a core variable or process reflecting the basic, psychosocial process of nursing students' moral development through preceptorship experiences. The core process of nursing students' moral development was found to be *socializing for authentic caring engagement in nursing practice*. In this study, the negative case reflected a deviation from this process; one nursing student's socialization did not facilitate authentic engagement in practice, owing to the fact that the student was unable to live out his or her personal identity in practice.

To further affirm the credibility of their findings, it is essential that researchers demonstrate awareness of their roles as instruments in developing grounded theory (Richards & Morse, 2007). As the principal investigator, my interest in nursing students' moral development arose from my practice both as an educator and as an administrator in undergraduate nursing education programs. For the past 10 years, I have worked in nursing education with undergraduate students. My work has encompassed clinical-, laboratory-, and classroom teaching of students in varying nursing baccalaureate programs and years.

Students' narratives in clinical journals, describing the challenge of translating what they deemed "the right thing to do" into action, have sparked my interest in this topic area. Furthermore, the socialization of nursing students into a group emerged as a phenomenon of interest during my Master of Nursing program.

In this study, I maintained researcher credibility through memos and a reflexive diary. Both the memos and the diary served as an audit trail to demonstrate my thinking, observations, and experiences in the process of collecting data.

Memoing and maintaining a researcher diary. Over the course of this study, I maintained both analytical and operational memos. Memoing is a research technique that involves recording notes about operational processes, analytical insights, and interpretations that arise during data collection. I maintained operational memos to create an audit trail of details, including the rationale for the research design, descriptions of the research, data-collection processes, and my sampling decisions (Birks, Chapman, & Francis, 2008; Cooney, 2011). My operational memos were helpful because they chronicled the research process and illuminated the advantages or limitations to procedures such as the sample recruitment, data collection, and analysis.

I wrote analytical memos that served both as an audit trail to demonstrate my approach to analyzing and generating theory, and a tool to help me extract meaning from the data (Birks et al., 2008; Cooney, 2011). My analytical memos included narratives on my interpretation of the data that I collected and analyzed; summaries of excerpts from works by various authors whom I deemed supportive

of the emerging findings from my data; and potential hypotheses and theories emerging from the data. Memoing helped to clarify my thinking about nursing students' moral development in preceptorship, as I became more aware of my subjective perspectives on the research process (Birks et al., 2008). Ultimately, memoing is an effective strategy to enhance rigour (Cooney, 2011).

In addition to memos, I maintained a research diary to chronicle my personal thoughts over the course of the study. A research diary establishes the comprehensiveness and credibility of the research findings, insofar as diaries demonstrate researchers' awareness of how their position impacts their relationships, both with the research participants and with the data generated (McCabe & Holmes, 2009). The insights arising from documenting my personal awareness during the research process encouraged me to reflect on methodological coherence, accurate representation of participant narratives, and consistent presentation of evidence. Engaging in these reflexive processes enhanced the study's rigour.

Rigour

Rigour is defined as the process required to ensure the detail, accuracy, trustworthiness, and credibility of the results in a scientific inquiry (Holloway & Wheeler, 2010; Koch & Harrington, 1998). In grounded theory, rigour is essential as researchers transform participants' narratives into more abstract and theoretical concepts (Holloway & Wheeler, 2010). Holloway & Wheeler (2010) suggest the following criteria to assess rigor in qualitative research studies: a) credibility, b) dependability, c) confirmability, and, d) authenticity.

Credibility

A significant threat to the credibility of findings can arise from incorrect or incomplete data (Holloway & Wheeler, 2010). In this study, the measures that I used to demonstrate validity or credibility included: a) ensuring methodological coherence with the grounded theory design, by engaging in consistent and continuous joint data collection, coding, and analysis to generate theory; b) ensuring that the data were relevant to the emerging theory, by engaging in constant comparative analysis; c) exercising theoretical sensitivity by maintaining a reflexive researcher diary, analytical memos, and operational memos, both to monitor my bias and to gain theoretical insight into the emerging data; d) ensuring that the sample of undergraduate nursing students, faculty members, and registered nurse preceptors was theoretically relevant, to meet the criteria for generating a substantive theory of the process of nursing students' moral development in preceptorship; e) affirming the purpose of the study—to investigate the basic, psychosocial processes in nursing students' moral development in preceptorship—was congruent with the emergent theory, namely *socializing for authentic caring engagement in nursing practice*; and f) increasing the scope of the emerging theory by comparing the narratives of the nursing students, preceptors, and faculty members (Glaser & Strauss, 1967).

In grounded theory studies, constant, comparative analysis enhances the credibility of the study findings: a) in checking the evidence as frequently as possible; b) in verifying the conceptual categories and properties, by constantly comparing the data; c) in reducing bias, by demonstrating the diversity of the data

through comparing incidents with other incidents, or with properties of a category, to identify as many similarities or differences as possible; d) in ensuring that the abstractions from the data are accurate, and e) in increasing generality or explanatory power, by constantly comparing the similarities or differences in facts, to generate the properties of the categories (Glaser & Strauss, 1967).

To ensure for methodological congruence, I met with my supervisor following the initial two interviews. I demonstrated my data transcriptions and how I identified line-by-line codes and assigned substantive codes to these line-by-line codes. At this time, my supervisor appraised my data analysis to confirm that I was correctly adhering to open coding processes. I met again with my supervisor after completing my second set of participant interviews to demonstrate the substantive codes codes that I had identified and how I had regulated the coding process around selective code groups. My supervisor reviewed the data, and together we scrutinized the data to identify potential gaps and need for further data collection. Together, we identified that data saturation had been reached and my supervisor directed me to conduct member check interviews. Following the member check interviews, my supervisor and I met to initiate the theoretical coding process. Together, we analyzed connections between substantive code groups and integrated data from my analytical memos to uncover the substantive theory of nursing student moral development in preceptorship that was *socializing for authentic caring engagement in nursing practice.*

To further demonstrate the credibility of my study findings, I conducted member-check interviews with 11 of the 13 participants, to verify my transcriptions and analysis of their interviews. Given that researchers can potentially impose their own ideas or distort the meaning of participants' narratives, it is important both to listen to participants and to allow them to confirm their accounts (Holloway & Wheeler, 2010). Member checking, or member validation, is a strategy to ensure the trustworthiness of research (Holloway & Wheeler, 2010). Member checking helped me to determine whether my findings were compatible with the participants' perceptions; to correct errors I might have made in the data transcription and interpretation; and to assess my understanding and interpretation of the data. It further gave participants the opportunity both to recognize the meaning that they afforded their narratives, and to challenge my ideas (Holloway & Wheeler, 2010). For each member-check interview, I created a summary of the participant's two interviews by extracting each line-by-line code.

I conducted all of the member-check interviews via telephone. I began with the rationale for the member check, explaining that the interview would begin with a summary of our interviews. I invited each member to stop me at any time, if he or she felt that I had made an incorrect interpretation, and to provide corrective feedback. Upon completing the introductory clarification, I proceeded to read my summary. I then asked the members if the summaries were accurate, if anything needed to be revised, or if they had anything to add or clarify. I

recorded each member-check interview to ensure that I had accurately captured each member's feedback.

To further enhance the credibility of the research findings, I analyzed the data for negative cases, or data that did not easily fit with the developing theory (Glaser & Strauss, 1967; Holloway & Wheeler, 2010). Identifying the negative case stimulated my thinking and led me to explore whether my conclusions were appropriate. The core, basic, psychosocial process in this study was socializing for authentic caring engagement in nursing practice. One participant reported being unable to genuinely engage with her preceptor in practice, because her values in practice were different. This dissonance led to disengagement from practice, inhibiting the participant's ability to live out her personal identity and find authentic meaning in preceptorship. The absence of engagement in the preceptor-student relationship compelled this participant to seek alternative strategies to understand her practice and her moral development over the course of the preceptorship; one strategy was to seek affirmation from a family member who had helped to shape the participant's moral identity. All other participants reported active engagement in the preceptorship triad, and the ability to live out their personal identities in nursing practice to find meaning therein.

Dependability

Dependability relates to the consistency and accuracy of the study findings (Holloway & Wheeler, 2010). In this study, I established dependability by ensuring congruence with the grounded theory method, during the phases of data collection and analysis; this entailed using the constant, comparative approach to

the data analysis, and using of codes to identify themes emerging from the data collected. Furthermore, I established dependability through adequate exposure in the field, thereby ensuring data saturation. Saturation aids in developing as many, diverse properties of a category as possible; it is reached when the researcher can develop no further properties within a category (Glaser & Strauss, 1967). Achieving data saturation facilitated insight into, and understanding of, the themes related to nursing students' moral development in preceptorship. These themes, which arose from the data, led to a substantive theory—*socializing for authentic caring engagement in nursing practice*—that can potentially be transferred to similar phenomena. I also assessed this theory by asking eight questions proposed by Glaser and Strauss (1967; Appendix G). To further establish the dependability of my findings, I maintained an audit trail—comprising a researcher diary, field notes, and memos—to demonstrate how I made decisions in the research process, to reflect my researcher self-awareness, and to promote theoretical insight.

Confirmability

Confirmability entails demonstrating that the researcher's prior assumptions or preconceptions have not biased the findings (Holloway & Wheeler, 2010). In this study, I established confirmability through an audit trail of operational and analytical memos, illustrating my path through the research, my development of constructs and themes, and my interpretations thereof. Additionally, I exercised theoretical sensitivity in following the emerging data. During the semi-structured interviews, I asked general, open-ended questions and

ensured that my questioning path followed the participants' responses; this process allowed data to emerge, rather than forcing it according to my presuppositions. Moreover, my analytical memos and researcher's diary promoted consistent scrutiny of my thoughts and feelings, thereby ensuring that I did not bias either the emerging data or the research process.

Authenticity

Authenticity is achieved when the research strategies are appropriate to accurately report the participants' responses; it encompasses the principles of fairness, ontological authenticity, educative authenticity, catalytic authenticity, and tactical authenticity (Holloway & Wheeler, 2010). In this study, I demonstrated my understanding of the social context of the participants' practice both by exercising flexibility in arranging the interviews and by being aware of questions that might elicit troubling emotions. I made all participants aware of my willingness to travel to conduct face-to-face interviews with them, and to let them choose the date and time. I also offered participants the option of being interviewed via FaceTime or by telephone, if these modes of communication were more convenient for them. The nursing student participants worked full-time with their preceptors, managed course assignments, worked at paid employment, and maintained their personal commitments; I was therefore sensitive to their willingness to commit time to the study.

I was also mindful that the faculty-member participants had additional commitments such as course requirements, other employment responsibilities, and personal obligations. Regarding the challenge of recruiting preceptor volunteers,

I interpreted the scarcity of willing participants as reflective of the multiple commitments in their practice as registered nurses. Registered nurse preceptors must balance the dual roles of precepting students and fulfilling professional obligations to patients and colleagues in their clinical practice; additional time to participate in a research study can therefore be a challenge. I appreciated all the participants' willingness to volunteer their time for the study.

Morals encompass values, emotions, and identity; I recognized that related topics of inquiry could evoke deep personal feelings and reactions from the participants. Some of the student participants' interview questions related to personal identity in nursing practice, areas of fit, and enjoyment in practice; these questions could provoke anxiety if the students were not fully engaged in their clinical areas, or if they were questioning their selection of nursing as a profession. Therefore, I exercised sensitivity in asking questions, and held back on certain lines of inquiry. Likewise, I recognized that faculty members and preceptors' moral issues in practice or preceptorship could evoke strong emotional reactions. Qualitative research requires researchers to construct and communicate the experiences of their research participants; demonstrating ontological, educative, catalytic, and tactical authenticity was therefore vital.

Ontological authenticity. Ontological authenticity entails that research will help participants and readers understand their social world and humanity (Holloway & Wheeler, 2010). In this study, I ensured ontological authenticity by using substantive codes such as *understanding institutional constraints, identifying with patients, and identifying with students*. Each group of

participants identified institutional constraints on their own thoughts and actions, and on the thoughts and actions of nurses in practice. Nursing student, faculty member, and preceptor cohorts all recognized the importance of understanding the patient's experience of nursing care, and of appreciating the multiplicity of perspectives that individual nurses, patients, families, and health care team members bring to health care practice. Furthermore, each cohort acknowledged the relevance of their personhood in practice; the personal attributes, values, and notions that shape their professional practice; and how these concepts have been influenced.

Educative authenticity. Educative authenticity relates to the participants' improved way of understanding people through the research process (Holloway & Wheeler, 2010). In this study, educative authenticity was reflected in the substantive themes relating to the cohorts' understanding of each other's experiences: the patient's experience, the student's experience, the preceptor's practice, and so on. The participants' improved understanding both of their own and of others' basic, psychosocial processes of moral development was reflected in substantive codes such as:

- preceptors helping students to create meaning in practice
- faculty members helping students to create meaning in practice
- peers helping to create meaning in practice
- nursing students creating personal meaning in practice
- faculty members creating personal meaning in practice
- preceptors creating personal meaning in practice.

Catalytic authenticity. Catalytic authenticity entails that research enhances the participants' decision making. In this study, catalytic authenticity

was evident in the second set of interviews. I began these interviews by asking "What have you been thinking about with regard to the study topic since our first interview?" Initially, some participants reported that they had not reflected on the topic of moral development, but most had done so. Evidence of reflection on moral development became evident in the course of these interviews, even from participants who reported no reflection on the topic. The nursing student participants had reflected on maintaining professional conduct, on striving to be aware of undesirable behaviours towards others, and on ensuring that they would not bring these actions to their future practice as registered nurses. The faculty members and preceptors had reflected on how they had pedagogically engaged nursing students regarding morals and ethics, and on learning to be more attentive to the experiences of all members of the preceptorship triad.

Tactical authenticity. Tactical authenticity entails that research should empower the participants (Holloway & Wheeler, 2010). Tactical authenticity was evident in the nursing students' reports of advocating either for themselves or for others, and of finding the courage to bring voice to their concerns. In the second set of interviews, I encouraged the nursing student participants to reflect on the moral issues, involved in preceptorship, that they had described in the initial interviews. In describing their process of working through these issues, the participants identified various forms of advocacy, such as: addressing moral issues that they were initially fearful to bring forward to their preceptors; actively addressing the behaviours of other nurses that they considered negative; and taking pride for remaining true to their personal values and beliefs in who they

wanted to be as nurses. The preceptors reported feelings of accomplishment and pride in being preceptors, knowing that they had helped students, and made a difference by contributing to their nursing education. This finding is consistent with Myrick and Yonge's (2004) observation that preceptors consider the preceptorship experience as rewarding and a privilege.

Knowledge Dissemination and Transfer Strategies

I will condense the findings from this research study into a submission to *The Journal of Nursing Education*, a high-impact, peer-reviewed nursing publication showcasing original articles, with the aim of promoting the teaching-learning process, curriculum development, creative innovation, and research in nursing education. Alternatively, I will consider both *The International Journal of Nursing Education Scholarship* and *Nurse Education Today*. Additionally, I will prepare a scholarly presentation of the findings and present abstracts at conferences such as the annual Canadian Association Schools of Nursing and the International Congress of Nursing.

CHAPTER 4: FINDINGS AND DISCUSSION

Socializing for Authentic Caring Engagement in Nursing Practice

In this study, *Socializing for authentic caring engagement in nursing practice* emerged as the basic psychosocial process promoting undergraduate nursing students' moral development in preceptorship. *Socialization* (1991) is defined as a continuous process whereby an individual acquires a personal identity and learns the norms, values, behaviours, and social skills appropriate to his or her social position. *Authenticity* (1991) is defined as true, genuine, or real. In the context of human relations, authenticity is the state of being true to one's self, character, or spirit. *Socializing for authentic caring engagement in nursing practice* reflects the pedagogical, personal, and professional processes, occurring within the student–preceptor–faculty member relationship, that shape nursing students' moral development in their preceptorship course. In nursing programs, a central goal of preceptorship is the professional socialization of nursing students, through pedagogical and social processes such as role modeling, value orientation, professional-group interaction, and clinical practice (Billay & Myrick, 2008).

In exploring the basic, psychosocial process shaping nursing student moral development in preceptorship, it was assumed the students began their clinical practica with awareness of their moral identities. The core variable, *socializing for authentic caring engagement in nursing practice*, illustrates how the pedagogical relationship shaped two significant attributes of nursing student moral development: nursing students distinguished their personal identities in practice,

while recognizing the humanity of others; and students derived meaning from moral encounters, which in turn led to action and reconciliation of moral encounters in practice.

Conceptual Diagram: Socializing for Authentic Caring Engagement

Three conditions were associated with the substantive theory of *socializing for authentic caring engagement in nursing practice*: 1) how participants defined the key concepts of morals, ethics and moral development; 2) how participants engaged to build the preceptorship relationship among student, preceptor and faculty member; and 3) caring. Together, these three conditions converged to support the process of *socializing for authentic caring engagement in nursing practice.*

The substantive theory of *socializing for authentic caring engagement in nursing practice* comprised four key categories: 1) distinguishing nursing and moral identity; 2) learning to recognize the patient's experience; 3) identifying moral encounters and creating meaning of those encounters; and 4) becoming a social agent and reconciling moral issues in practice. Each category encompassed ambient conditions. *Distinguishing nursing and moral identity* entailed: finding one's "fit" with a practice area; defining the "good" nurse; harmonizing personal values in practice; integrating previous experiences; learning from others in the preceptorship; reconciling visions of nursing with the reality of practice; and assimilating into practice cultures. As nursing students engaged in the processes of recognizing, affirming, and refining both nursing and moral identity, they progressed to *recognizing the patient's experience*. *Identifying moral issues in*

practice and creating meaning of practice encounters entailed: identifying moral encounters both in practice and in the preceptorship relationship; dialoguing with others to create meaning in practice; and engaging in personal ways of knowing. Safe spaces and support systems were also essential in creating meaning. As students derived meaning from practice encounters, they proceeded to reconcile and take action to address practice encounters. *Becoming an advocate and reconciling moral issues in practice* entailed: rational and emotional processes leading to action; learning to be proactive; developing relational insight to socially navigate practice environments; and reconciling moral encounters in practice.

In this study, the four key processes of nursing student moral development in preceptorship emerged in the context of caring relationships. Accordingly, care theory was thus found to be supportive of nursing moral development, as it unfolded in the context of preceptorship relationships. Caring relationships—with faculty members, preceptors, peers, other nurses in practice, and other support systems—were safe, ethical spaces for nursing students to create meaning from their encounters, and moral issues in practice. Dialogue with others was foundational to distinguishing nursing and moral identity, recognizing the patient's experience, identifying moral encounters in practice, becoming a social agent, and reconciling moral encounters in practice. When students discussed moral encounters with others, they realized their own unique personal ways of knowing to create meaning. Concomitantly, as preceptors engaged students in professional socialization, students learned to acknowledge the unique processes

of rational, emotional, and relational knowing, to socially navigate their practice environments. *Socializing for authentic caring engagement in nursing practice* thus emerged as the basic psychosocial process of moral development in preceptorship (Figure 1).

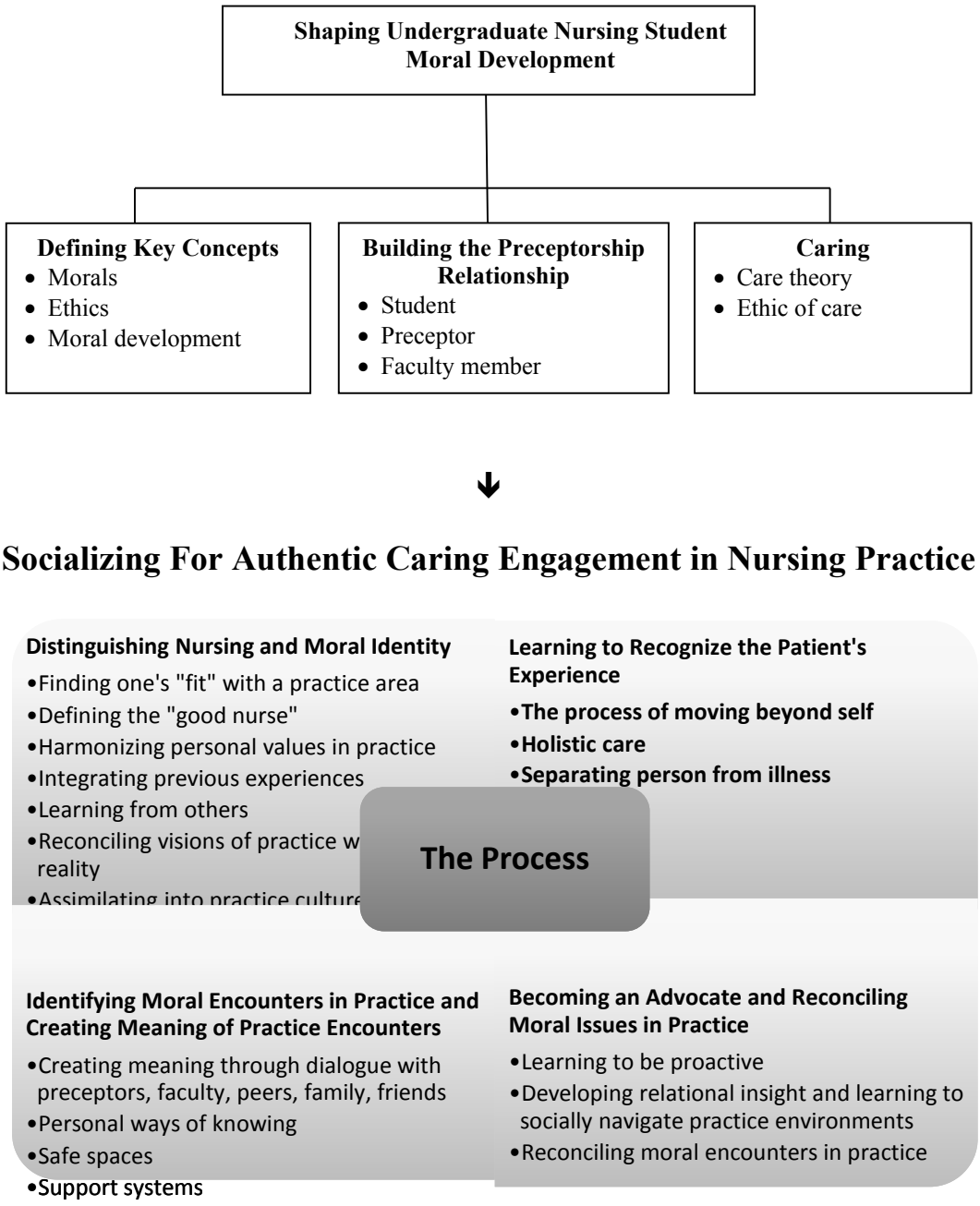

Figure 1. Undergraduate nursing student moral development in preceptorship: socializing for authentic caring nursing practice.

Socializing for Authentic Caring Engagement in Nursing Practice: Conditions that Shape the Process

In this study, three conditions were found to shape the process of *socializing for authentic caring engagement in nursing practice*: 1) How participants defined the key concepts of morals, ethics and moral development; 2) How participants engaged to build the preceptorship relationship among student, preceptor and faculty member, and; 3) Caring.

Defining Key Concepts: Morals, Ethics, and Moral Development

Initally, I asked all participants to share their perspectives regarding morals, ethics, and moral development. These various perspectives served as a foundation. The key perspectives shared by students were: morals as a set of values that determine conduct; morals as right or wrong, shaped by personal values that develop during upbringing and through relationships; morals as individual, varying among people; and the existence of morals in everyday life. Faculty members shared the following perspectives: morals as concepts of right or wrong that direct action; morals as individual and personal, shaped by one's values; morals as embedded in "the everyday"; morals as behaviours and actions; and morals as influenced by upbringing and education. The preceptors shared the following perspectives: morals as individual and personal; morals as shaped by upbringing; morals as integrated into everyday life; and morals as associated with behaviour. Table 3 summarizes the participants' perspectives.

As compared with the faculty and student perspectives on morals, a distinguishing characteristic of the preceptors' perspectives was their emphasis on

the professional responsibility to adhere to ethical codes, and their obligations to respect patients and do them no harm. The applied nature of the preceptors' definitions can be attributed to the immediacy of living out their relationships with patients in practice. Although the students were immersed in full-time preceptorship practice at the time of the interviews, their tendency to define morals in a more philosophical, less pragmatic way is perhaps related to the transition from student to graduate nurse, and the

Table 3

Participants' Perspectives

	Nursing students	Faculty members	Preceptors
Morals	Morals as: • a set of values that determine conduct • right or wrong and shaped by personal values that are developed during ones upbringing and through individual and varied among people • existing in one's everyday life	Morals as: • notions of right or wrong that direct action • individual, personal and shaped by one's values • embedded in "the everyday" • behaviours and actions • influenced by upbringing and education	Morals as: • individual and personal; morals as shaped by upbringing; integrated and everyday life; associated with behaviour • professional responsibility to adhere to ethical codes • obligations to respect and not harm patients
Ethics	Ethics as: • synonymous with morals • unsure of differentiation between morals and ethics	Ethics as: • synonymous with morals	Ethics as: • following policies and procedures • acknowledging the obligation to respect and protect patients
Moral development	• Moral development in nursing program: dynamic process of seeking understanding and knowledge leading to independent practice • Moral development in preceptorship: using their experiences to reflect on	• Students progressing in their ability to recognize moral issues and appreciate perspectives on others in practice • Ability to question	• Students learning about themselves Students learning their responsibilities in practice • Practicing ethically • Developing a sense of what is right and wrong

	Nursing students	Faculty members	Preceptors
	personal performance, care provided to patients, multiple perspectives that patients and nurses bring to care, professional responsibilities to others to guide one's own future practice • Ability to identify moral issues in practice • Analyzing practice encounters with one's value system Analyzing personal practice and practice of others with one's value system	practice and seek rationale for the actions of themselves and others • Dynamic process • Continual engagement	
			(table continues)
	• Being open-minded to others perspectives • Being reflective • Being able to bring a voice to concerns in practice • Being able to understand the uniqueness of patients and others in practice		

developmental stage of a novice nurse in practice. Furthermore, the preceptors found morals harder to think about and define.

Given that the terms *ethics* and *morals* are often used interchangeably in the nursing literature, I asked all participants to define ethics. Student and faculty participants described ethics as synonymous with morals, and reported using the terms interchangeably. Students were unsure of the difference between morals and ethics, whereas faculty members were aware of philosophical debates addressing the difference between these concepts. By contrast, preceptors described ethics in pragmatic terms: adhering to policies and procedures, and acknowledging the obligation to respect and protect patients.

The students differentiated moral development in preceptorship from moral development throughout the nursing program. They considered the latter a dynamic process of seeking to understand, and of knowledge leading to independent practice. Preceptorship, however, entailed using their experiences as a means for reflection on their personal performance; on the care they provided to patients; on the multiple perspectives that patients and nurses brought to care; and on their professional responsibilities to others to guide their own future practice. As with the term *morals*, students regarded moral development as unique to each person. Despite the students' perception that the individualized approach to learning in preceptorship fosters personal moral development, two preceptors did not agree. Common themes emerging from the students' descriptions of moral development included: identifying moral issues in practice; analyzing practice encounters with value systems; analyzing personal practice and the practice of others against their own value systems; being open minded about others' perspectives; being reflective; being able to voice concerns in practice; and understanding the uniqueness of patients and others in practice.

Faculty members defined students' moral development as the evolution of students' ability to look beyond their own needs and appreciate the perspectives on others in practice. The faculty viewed preceptorship as a means of teaching students' to explore their personal value orientations in practice; to question the practice of others; and to analyze the rationales for their own and others' actions. One faculty participant suggested *continual engagement* as a more appropriate,

less conclusive term than *development*, insofar as the latter implies that something has been reached.

The preceptors likewise defined student moral development as a process in which students learn about themselves and their responsibilities in practice, learn to practice ethically, and develop a sense of right and wrong. For the preceptors, moral development entailed students reflecting on practice to understand who they were as practitioners, to understand the uniqueness of their patients, to evaluate the appropriateness of their actions, and to guide future practice. One preceptor described moral development as a potential challenge for students, because they are expected to follow others rather than to be leaders. Collectively, the differences and the commonalities across student, faculty and preceptor definitions establish the value of further exploring the concept and processes of moral development, within the context of preceptorship. The unique perspectives of each group proved the importance of exploring how students, preceptors and faculty members endeavored to build the preceptorship relationship.

Building the preceptorship relationship: The preceptorship process. Preceptorship is integrated into the curriculum to socialize learners into their professional roles. Professional socialization begins early in nursing education, as students are introduced to practice environments in clinical courses. The preceptorship course represents a phase of socialization in nursing students' education, characterized by their transition from the student role of to that of graduate nurse (Myrick, 1988). In preceptorship, preceptors, faculty members, peers, and members of the nursing team all influence nursing students'

socialization into independent nursing practice. As the students in this study entered their preceptorship, preceptors and faculty members were central in establishing the conditions necessary for the students to engage in preceptorship practice.

Faculty members and preceptors described their roles as supporting students, facilitating their acquisition of the necessary knowledge and skills required for safe, competent practice in preceptorship, and creating safe spaces for students to discuss and explore moral issues in practice. Faculty members and preceptors' descriptions of the conditions they established to socialize students exemplified pedagogical strategies—such as modeling and dialogue—embodying an ethic of care (Noddings, 2002a; 2002b).

As students requested clinical practice placements in areas of personal interest, their preceptors were attentive to their individual learning, needs and interests (Noddings, 2002a). One-to-one relationships allowed the preceptors to pay more attention these individual learning styles, experiences, and needs. One student explained:

> I would say that this past preceptorship has been the clinical where I have spent the most time dwelling. I have had other experiences, and I think part of that was, the other experiences were only six weeks long. There are other students on the units, so the focus isn't solely on you, and you aren't paired individually with one other person. But in this preceptorship . . . you always have that one person there for support. That changes it as well. Then you always have somebody to ask those questions that pop into your head right away. You don't have to wait, or collaborate with the rest of the students; it's just one on one. I think that that helps, because the focus is more on you, and you get more individual attention. (Fedra, Interview #2, Lines 486-483, p. 11, 2013)

The consistent support and attention of one or two nurses, who immediately responded to a student's needs, reflected a philosophy congruent with care theory. When the preceptors identified, attended, and responded to students' needs, the students experienced care. Relationships based on care and trust are necessary for individuals to understand virtuous behaviour (Noddings, 2002a; 2002b). This is the priniciple of preceptorship, contingent on a positive, trusting preceptor-student relationship. If the relationship is not harmonious, the conditions necessary for the students to feel cared for might not exist. By contrast, a cohesive, trusting, and caring preceptor-student relationship can improve nursing students' moral development in preceptorship (Myrick & Yonge, 2004; Myrick, Yonge, & Billay, 2010; Myrick, Yonge, Billay, & Luhanga, 2011). It is therefore essential for students, preceptors and faculty to build a steadfast relationship promoting effective preceptorship experiences.

Students. The students stressed the importance of building professional relationships with their preceptors from the start. During interviews, the students identified qualities essential to the development of cohesive preceptorship relationships, such as demonstrating mutual respect; understanding the preceptor as a person; acknowledging the preceptor's level of experience and approach to clinical practice; understanding the student role; and communicating with their preceptors. Four students stressed the importance of self-awareness in the student-preceptor relationship, explaining how that relationship was enhanced when they and their preceptors expressed their awareness of their own behaviours.

The students all described their relationships with their preceptors as harmonious or "good." One student remarked: "I think we have a good relationship. We're the same age, and I don't know if that is weird to me or weird to her. I don't think that is an issue. She just started nursing earlier. So, maybe that makes us get along a bit better" (Agapi, Interview 1, Lines 218-222, 2013). Another commented: "I thought it was great . . . It was very supportive, I felt very comfortable with her. She was understanding . . . it was a really nurturing, therapeutic relationship" (Meropi, Interview #1, Lines 210-225, 2013).

With the exception of one student, the participants felt comfortable discussing practice issues with their preceptors. Most students felt comfortable bringing their concerns forward, although some felt "brushed off" by their preceptors at times. One student explained:

> I feel like she may have brushed it off a bit. I don't know if she thought it was me overdoing it, or overdramatizing it. Or if she thought it might be the patient that might be explaining it to me that way because I don't know why because I am a student, I don't know. (Agapi, Interview #1, Lines 259-264, 2013)

Another student added:

> I think I was kind of brushed off, but I think if there would have been something it would have been investigated further. So, I just don't feel comfortable waiting around for something bad to happen. (Xeni, Interview #1, Lines 267-271, 2013)

As time progressed, the students established and became increasingly engaged in professional relationships with their preceptors. Toward the completion of their preceptorships, the students came to view their preceptors as actively invested in their learning experience—taking time to teach clinical-practice competencies, clarifying their practice, ensuring time to debrief, and collaborating with students

to develop plans of action. The students also came to value their preceptors' experience and the cohesive, professional relationships they formed together. When observing their preceptors' practice within the nursing team, the students came to understand why their preceptors had been selected for their positions. Four students intended to adopt behaviours role-modeled by their preceptors, such as the acknowledgment and valuing of other perspectives; communicating clearly; working through differences with others; and making accommodations to ensure the nursing and interprofessional teams worked effectively. The students came to recognized the responsibility of being a role model in practice, knowing they themselves would become role models for others in the future. With the exception of one student, they all discussed moral concerns with their preceptors, once the student-preceptor relationships were established.

The students described open communication in their relationships with faculty members, who were responsive to their concerns. All students viewed the faculty members as support persons who could assist them in working through moral issues in practice. The students described their faculty-student relationships as more detached than their preceptor-student relationships, attributable to the structure of clinical preceptorships, wherein faculty members do not practice alongside students, as they might do in traditional clinical courses.

While all students viewed faculty as receptive to their moral concerns in practice, they were more likely to take these concerns to their preceptors. One student commented, "[my preceptor] was the one that I came out [and told] and I was, 'Oh, he is really upset, and he is really worried about his finances, and he is

a little worried about being sent home too early'"(Agapi, Interview #1, p. 6, 2013).

Another student added:

> On my unit we had to do 15-minute restraint checks for a patient who was confused. They [the patient] were in two-point restraints in bed, and every 15 minutes it [restraint check] was supposed to be done . . . This patient wasn't assigned to me, and after about 11 o'clock, and from about 7 to 11, there hadn't been any restraint checks done . . . I had noticed this at about 11:30 or so. So I did my restraint checks without waking the patient up, and circulation and everything with the restraints, and there was nothing previously recorded . . . I went back an hour later, and it was all filled out. So, either somebody had done those 15-minute restraint checks and had recorded them on an incorrect sheet or perhaps their personal data. But I had felt like they had just kind of filled it all in, just because nothing bad had gone on with the patient and they had just forgot to record them. So I just brought that up to my preceptor, who was also not assigned to that room, and we discussed what that meant for ethical practice, what that meant for routines on the floor, and how we have to make sure we are getting in those checks at the appropriate times. (Xeni, Interview #1, Lines 53-81, p. 2, 2013)

This response illustrates both the immediacy of the preceptor to the student, and the preceptor's ability to contextualize the student's concerns, owing to his or her understanding of how these concerns can emerge in practice. Some students identified moral issues related to observations of their preceptors' practice:

> Never once in the eight-hour shift she spent with us as a patient—and we just had the one patient—did he ask her why [her actions brought her to care]. He didn't ask anything. This was my very first shift, my very first shift with my preceptor, and I just wasn't sure. I thought back to myself, "My first question is, 'Why'?" That is what brought her in in the first place . . .Nothing, nothing was asked to the patient . . .There was a lot more things that I think could have been explored, and I never really asked my preceptor that night because, like I said, it was my very first shift. I don't know him; I was still feeling out the waters with my preceptor with my experience at that location. (Fedra, Interview #1, Lines 271-235, p. 5-6, 2013)

> I don't know if she has fatigue or if she doesn't care about some of these issues . . . She kind of pushes the responsibility to the doctor. "Well, the doctor ordered it; it is not my responsibility." I think that nurses have more responsibility than that to question their practice and the way things are going. I don't know if it is just, she has been working so long and she has stopped questioning things, or if she never really did. I'm not that sure. (Desponia, Interview #1, Lines 168-179, p. 4, 2013)

These students expressed the desire to question their preceptors about their rationales, either for their actions or for their lack therof. The students hesitated to discuss these moral issues with their preceptors, however, because they perceived that their practice values were not congruent with the preceptors'; they were thus afraid giving offence, resulting in an adversarial relationship. Bernstein (1996) suggests that pedagogical power relations arise between educators and learners. In teacher-learner relationships, power is evident within the boundaries that define knowledge. Consequently, power within pedagogical relationships can shape the meanings arising both from teacher-learner interactions and from identity. The students, believing their preceptors had power over their trajectories in the preceptorship course, thus hesitated to discuss certain moral issues with them. One student commented, "I haven't really voiced any of this stuff to her, because I have been having a lot of these feelings during this preceptorship about the [intervention], and some other stuff . . . and I don't want to antagonize myself against her, because I just want to graduate" (Desponia, Interview #1, p. 2, 2013). Another student remarked:

> I think that it truly was just that I know not only was it my first day with my preceptor, but it was also my preceptor's first day with me. And that person ultimately has control of me as their student, over how I am going to proceed through my program and my course. He's the one who has the however many years of experience in this specific role, therefore making him borderline expert in this area. Which is kind of like, who am I to

> question what his actions are? (Fedra, Interview #1, Lines 290-298, p. 7, 2013)

Just as students described how they developed relationships with their preceptors, preceptors established relationships with students in their own unique ways.

Preceptors. In building relationships with their students, preceptors expected the students to enter the preceptorship intending to learn, and willing to actively participate in new learning opportunities. They expected the students to be open communicators, to be honest, and to be receptive to feedback. All of the preceptors emphasized the importance of treating students with respect. They moreover described their faculty-preceptor relationships as cohesive, regarding faculty members as individuals able to support and guide students when required. In their most recent precepting experiences, no preceptors had required faculty intervention, either in their relationships with their students, or with student performance issues. One preceptor recalled a challenging relationship with a previous student, wherein a faculty member had offered guidance and support: "She was definitely there to sort of guide our relationship to make sure it was not terminated . . . I think that it was good that she got on our path so that we could make it work, and it did. So yes, I think she was huge in that role" (Evangelia, Interview #1, p. 12, 2013). Establishing relationships both with preceptors and with students was therefore a foundational role for faculty members.

Faculty members. All faculty members emphasized the importance of respect, openness and transparency between themselves, students, and preceptors, in building the preceptorship relationship. The faculty members perceived open

communication as essential to assessing learning and progress in the preceptorship course:

> Clinically, I oversee how their progression is coming. I communicate with the preceptors with regards to their patient loads, what kinds of activities they are able to do, what would you like to see them doing. But then my job is to facilitate the discussion of how that might look . . .Talking with the students, and I also talk with the preceptors about what they are seeing. I encourage them to have their first chat together, because I think those lines of communication are important—to talk to the person first. But if it gets to the point where this is not working really well, then I immediately go in, and we have a meeting with the three of us and try to hash out what each side is saying. We try to meet in the middle or have a compromise or whatever else. (Olympia, Interview #1, Lines 152-168, p. 4, 2013)

Faculty members also described their role as one of facilitating communication with both students and preceptors. One faculty member remarked: "There are hours of meetings: You talk to the student, you talk to the preceptor, get them together and say: 'This is what I'm hearing. This is what I think. What do you guys think? How are we going to move forward?' " (Alethia, Interview #1, p. 12, 2013).

In addition to routine site visits, faculty members communicated with students through blogs on the course website and reflective journal assignments. Students could also reach faculty members on their cell phones at any time. All faculty members highlighted the importance of trust and comfort in the faculty-student relationship, and described working to ensure students' awareness of their support:

> But the [student's] concern is, "Are you going to be there for me?" If this all falls apart, who is going to be there? That is the biggest one. I remember recently, one student said to me, "So even on the weekends when there is someone else on call, your telephone will be on?" So even though that student has never phoned me, she needed to know that the

> telephone would be on, that her primary source of safety was there, because she had no relationship with the person on call. (Elpida, Interview #1, Lines 418-433, p. 10, 2013)

For faculty members, trusting relationships with students ensured the latter could disclose or say anything to them without fear of reprisal. Faculty viewed disclosure as important in supporting students to ensure a successful learning process. They described student comfort and trust as necessary for open communication in the preceptor triad—important for their assessment of students' thought processes and learning needs, for the creation of new learning opportunities, and for the clarification of student learning and progress in the preceptorship:

> I have always said that things are very transparent. There isn't this, "Okay, well, I deal with this, and you deal with this." There are really shared responsibilities, . . . and that includes shared responsibilities with the student. So this isn't about, we come and fix whatever is not working, but the student can identify that [the issue]. I think we were very clear from both a preceptor perspective, and my perspective . . .I think these are really important pieces, so all of us have given very similar messages to the student. (Hermione, Interview #1, Lines 243-258, p. 6, 2013)

All faculty members regarded the evaluation process as a barrier to student openness, speculating that the students might refrain from expressing their thoughts candidly because the faculty members evaluated their performance.

Like the preceptors, the faculty also emphasized the relationship between students' attitudes and their openness to learning. "If they come in with honesty and readiness to learn, I think any preceptor is probably going to work wonders with them. But if you come in with preconceived ideas about that or [have] built

some barriers over time to make yourself feel safer, maybe that is where it runs into a little more trouble" (Olympia, Interview #1, p.16, 2013).

Another faculty member added:

> Quite often the big thing is, "This is where I want to do my preceptorship; this is where I really want to be. I want to get a job here, and if I can't get a job here, why did I do nursing?" This last group was really interesting because out of nine students—one went to [area], all the rest were in [area]—I don't think any of them . . . [were] sure that they would like it. So they actually went in there saying, "Never done it; let's give it a shot." A totally different attitude to "I must have this area. I came into nursing to be a [area of specialization] nurse, and that's my goal and that's my vocation." These guys said, "Let's give it a shot," and I think they were really open to anything. (Alethia, Interview #2, Lines 610-624, p. 14, 2013)

They believed preceptorship would be most beneficial to open-minded students with a readiness to learn. Faculty also identified barriers to student engagement in preceptorship, such as gaps between students' preconceptions and the realities of a practice area, or the assignment of students to areas they did not perceive to be a "fit" for them as individuals. "In the past I've had some students who have no idea . . . last semester, we had 12 or 13 students who wanted to go to [area]. Some of them had to drop out at midterm because they couldn't handle the scrutiny of the physicians. So they don't know themselves. If you knew yourself, you'd be able to pick the right area" (Elpida, Interview #2, p. 11, 2013).

As the preceptorship progressed, faculty observed students' growing comfort in practice. All faculty had to work intensively at developing relationships with the students because they did not see them as frequently:

> There is a big difference. They are almost intimate, the preceptor and the student: "She is just like my mother." They develop this relationship, maybe they are not friendships, but it is this close. It's a collegial working

> relationship that they enjoy. They have inside jokes. A good preceptor will have those sorts of things, or the student will feel free to say things to them that they wouldn't say to other people . . .I have to work at it, work at a relationship with the student, because I only see them four or five times. (Elpida, Interview #1, Lines 438-450, p. 10, 2013)

Faculty characterized their role in the faculty-preceptor relationship as supportive. They noted the importance of supporting and guiding preceptors in student assessment and evaluation, and in responding to issues that arose within the student-preceptor relationship. They supported the student-preceptor relationship when student performance issues arose, and when preceptors felt their students had disengaged from practice:

> I also want the preceptors to finish with them feeling that "I have done the best I can, and I still had a positive experience preceptoring. And I've had enough support from the faculty that I would not mind a couple of tips so that I can preceptor again." (Olympia, Interview #1, Lines 785-790, p. 18, 2013)

> I have to see part of my role as creating a space for them to reflect on who they are as a preceptor, as someone who is teaching, because that's not always something they identify with necessarily. We teach people, but students, practitioners are sometimes a little different. (Hermione, Interview #1, Lines 671-675, p. 15, 2013)

The faculty also emphasized their role in supporting students experiencing negative preceptorship relationships, and the importance in supporting them in these situations:

> By the time the student felt comfortable to tell me, it was a crisis situation. So I just feel morally caught, because you are only given one preceptor. If the unit is falling apart, the student has to be somewhere. We go over to our placement office and say, "This isn't working," or to the manager. They have no more staff to put them with while they are all fighting on the unit, is another thing . . . What you have to do is support the student and be there more often and talk with the student. But it is almost like you get paralyzed in, what do you do here when the whole system is falling apart? That is not happening everywhere, and most of the time it is good. But

> with the students who have a rotten preceptor, sometimes you are in there before they even come into shift or at the end of shift to see how it's going. (Elpida, Interview #2, Lines 276-292, p. 7, 2013)

> One of the students was told by her preceptor that he didn't think she was a good fit for the unit because of her attitude. When we talked about it, I tried to reinforce that she is a good nurse, she is a smart woman, she has every capacity to be a fabulous nurse (Olympia, Interview #1, Lines 751-755, p. 15, 2013).

Faculty members described preceptorship as the unfolding of a shared clinical practice, emphasizing the importance of the each member's commitment, within the preceptorship triad, to student learning:

> We had conversations prior [to clinical] of, "How are you going to approach it? Do you agree with more of a collaborative approach? Are we always going to be transparent with the student, and when would we not be transparent? So when do you need to activate me with instances?" I think that really helped in making the students able to read some of it, because we were more attuned to them as well. (Hermione, Interview #2, Lines 440-447, p. 10, 2013)

> [It is important to have] someone [who is] really open about "This is what I want to work at; this is what I want to get out of it." Then the preceptor has something to hang their hat on and say, "I can help you with that. I can't help you with the rest of it, but I can really help you with that." . . .It's like having someone teaching you to ski and having them follow you down . . .It is accurate; it is concrete. (Alethia, Interview #2, Lines 755-763, p. 17, 2013)

Support and recognition of students as individuals, by their preceptors and faculty members, enabled the students to live out their personal identities in their preceptorships. Meaningful efforts by students, preceptors and faculty members to build the preceptorship relationship led to active engagement in the preceptorship process. The very nature of preceptorship reflects a caring pedagogy that embodies care theory and a care ethic.

Care. Throughout the research process, all interview data reflected an ethic of care consistent with the findings of care theorists. Amongst ethical theories, Nodding's (2002a; 2002b) ethic of care—founded on the premise that individuals possess a universal desire to be cared for in positive relations with others—is most congenial to the data collected in this study. Noddings (2002a; 2002b) characterizes care both as a virtue and as a special quality of relationships, relating to obligations that arise when individuals feel they must respond to one another. Consequently, a central aim of a moral life is to identify, attend, and respond to the need for care.

Nodding's (2002a, 2002b) ethic of care, grounded in pragmatic naturalism, espouses the view that human beings are social animals who desire to communicate. While relatedness and caring are central to the ethic of care, deciding how to behave also requires reasoning (Noddings, 2002a; 2002b). Moreover, Nodding's ethic of care is profoundly relational and contextual, focusing on the moral agent, the recipients of the agent's acts, and the conditions under which the participants interact. Accordingly, Nodding's ethic of care offers a significant perspective both for nursing education and for clinical practice. Insofar as clinical nursing practice is founded on relationships among nurses, their patients, and their colleagues, theories emphasizing the complexities of human connections can enrich the understanding of ethical practice in nursing.

Moral education (Noddings, 2002a) is essential in that it focuses on the understanding of self and others. According to Noddings, a moral education encompasses pedagogical processes such as role modeling, reflection, dialogue,

practice, and confirmation. Learning strategies such as reflection evoke self-awareness, leading to ethical caring. This study afforded students the opportunity to identify role models in clinical practice—their preceptors, other nurses, and their faculty members—who evinced moral behaviours. During the preceptorship, faculty members and preceptors engaged students in personal reflection and debriefing, thereby helping them to create meaning from moral issues they encountered in practice.

In their preceptorships, the students engaged in caregiving activities, involving patients, in designated nursing practice settings. Noddings (2002) suggests that learners in authentic practice settings are motivated by goodness, inasmuch as they are compelled to acknowledge and validate the experience of others. In this study, nursing students were able to distinguish their personal identities in practice—and recognize the humanity of others—when they brought personal values to nursing care.

Moral practitioners are the anticipated outcome of nursing curricula integrating an ethic of care. In keeping with Dewey, the pragmatic theorist, care theorists have promoted education as a means of nurturing individual abilities to act critically and constructively, in the face of moral issues (Noddings, 2002a). Furthermore, an ethic of care fosters virtues, expressed as behaviours in particular situations (Noddings, 2002a; 2002b). Nursing preceptorship is one such pedagogical context, wherein learners' virtuous behaviours are nurtured through caring relationships—with patients, nurses, educators, peers, and interdisciplinary team members—in an authentic, clinical practice setting.

Defining key concepts, building the preceptorship relationship, and *caring* are central to nursing student moral development in preceptorship—here characterized as *socializing for authentic caring engagement in nursing practice.*

Socializing for Authentic Caring Engagement in Nursing Practice: The Key Categories

Four key categories emerged in *socializing for authentic caring engagement in nursing practice*: 1) distinguishing nursing and moral identity in nursing practice; 2) recognizing the patient's experiences; 3) identifying and creating meaning of moral encounters, and; 4) becoming an advocate and reconciling moral encounters in practice. Authenticity was vital to all these processes.

> I believe our most authentic selves are to be found in the complex interaction of knowing ourselves, relating to others, appreciating our place in the great web of all life, and seeing ourselves as part of the earth, the stars, the universe, and the cosmos. (Sommerville, 2006, p. 56)

Trusting, supportive relationships within the student–preceptor–faculty member triad underlay the students' moral development. In order for students to care authentically, they had to distinguish between nursing identity and moral identity.

1. Distinguishing Nursing and Moral Identity in Practice

Identity is connected to moral capacity, in that it helps individuals to interpret their actions and personal responsibilities (Hauser, 2006). Identity further entails recognizing how one is similar and dissimilar to others (Sommerville, 2006). Hauser suggests that a sense of self assists individuals to disconnect from their own self-interest, to contemplate others' experiences, and to

recognize that altruistic actions benefit others. Individuals thereby recognize that they must take responsibility for others' well-being.

Identity also enables unique ways of knowing—aesthetic, intuitive, and spiritual—and guides the exploration of meaning, purpose, and self (Sommerville, 2006). Through their moral development, the nursing students grew to validate their personal identities, construct nursing identities, understand the evolution of their moral identities, and recognize the humanity of others.

Authenticity entails remaining true to who we want to be—to our values, in other words—in our interactions and in our relationships (Taylor, 1991). In this study, the students' unique attributes included personal values, lessons learned from previous experiences, and the desire to practice in areas that fit their individuality. Authenticity in nursing practice is important because it reflects a genuine commitment to oneself, the nursing role, and the interests of patients who are receiving care (Myrick, Yonge, & Billay, 2010). Preceptors and faculty are models for students. Brookfield (2006) suggests that students value teachers who demonstrate openness, honesty, and congruence between words and actions.

The process of distinguishing nursing identity and moral identity in practice encompassed several ambient conditions: 1) finding one's "fit" with a practice area; 2) defining the "good" nurse; 3) harmonizing personal values in practice; 4) integrating previous experiences; 5) learning from others in preceptorship; 6) reconciling visions of nursing with the reality of practice cultures; and 7) assimilating into practice cultures. My initial interview data led

me to invite student, preceptor and faculty participants to share their perspectives on nursing and moral identity in the clinical preceptorships.

Nursing students. The student participants agreed that developing a nursing identity is a dynamic process, and that individual nurses ultimately create their own practices:

> One thing that I've definitely learned about nursing practice as a whole is that nursing school can offer you different learning experiences, and you can go seek out your own as an undergrad nurse or as a health care aide. But at the end of the day, you develop and cultivate your own practice . . . Ultimately, there are tasks as a nurse that we have to carry out and things that we have to do in order to cover ourselves in case something goes to court. But there are many, many different ways to carry out the same task, and there is a lot of different ways that different personalities can accomplish the same goal. So it comes down to your own personal practice, I guess. (Fedra, Interview#1, Lines 314-332 p, 7-8, 2013)

All student participants reported that preceptorship helped to shape, but not ultimately to determine, their nursing identities. In their view, preceptorship gave them an opportunity to observe their preceptors and other nurses in practice, and to select attributes to integrate into their own practices. One student stated:

> I'd like to think that I am absorbing most of the good qualities and aspects of her practice, because there is very many to choose from . . . But it is that little room with nursing as both a science and an art form, for your own personal style, and I think you pick up on a lot stylistic habits from your preceptor—how you interact with the patients, how you orientate patients to the unit, mannerisms at the bedside, and patient relationship mostly. (Xeni, Interview #1, Lines 527-539, p. 12, 2013)

Another reflected:

> I think that my preceptor was able to work through her differences, to work with other people and to accommodate other people so that things worked more effectively. And even the manager . . . the manager was totally role-modeling to everybody, and that is why they respected her so much. So I think that is something that I will take away as well. And just taking things in stride and knowing that there is more than one way to do

> something; just to be open—open to feedback and open to communicating with people, despite it maybe being difficult at times. (Agapi, Interview #2, Lines 338-353, p. 8, 2013)

Yet another remarked:

> Her unending kindness and her love for people, no matter how inappropriate their behaviour. Definitely advocacy was something that I picked up . . . She definitely was willing to fight for something if she believed that it was right and she didn't believe the patient was getting this. (Meropi, Interview #1, Lines 256-269, p. 6, 2013)

The students' acquisition of professional identity was grounded in their personal experiences and interactions with others (Cook, Gilmer, & Bess, 2003; Seacrest, Norwood, & Keatley, 2003). Although one goal of preceptorship was to facilitate independence in practice competencies, promoting independence was also necessary to help students explore and identify who they were in nursing practice. This finding is consistent with Habermas' (1971, 1973) theory of identity formation, wherein socialization, communicative action, and reflection on the relationship between oneself and one's environment, are combined to create subjective meaning and personal identity. Taylor (1991) endorses Habermas' perspective that dialogue and communication are foundational to identity formation and authenticity. Taylor explains that individuals become capable of understanding themselves and defining their identities through communication with others. In this preceptorship, as nursing students developed their identities and gained proficiency in nursing care actions, they also acquired an understanding of behavioural expectations, and internalized their social roles and symbols in their environment. As one student remarked:

> I think preceptorship has given me a lot more experience making moral/ ethical decisions than past practicum experiences, because we are practicing a lot more autonomously . . .You also absorb some qualities of your preceptor, and you try to choose the best qualities that you want to emulate in your practice as well. But I am sure, subconsciously, I'm picking up on things that I'll have to address and reassess myself later just to make sure that I am practicing ethically as well. (Xeni, Interview #1, Lines 649-668, p. 15, 2013)

Another stated:

> The common theme in my paper that I talked about was being able to be a great nurse, [which] would show that you actually want to learn, and having to adapt to the changing environment . . .I find when you challenge people, they are more than happy to give reasons for what they do, and then you have learned even more why things are the way they are. Then often they will reflect on the way they used to do things, and those types of things. But I think just being able to adapt to change and wanting to learn, and I hope that I never lose that. That's something that I have now, and I know that a part of it might be because I am so new and I have so much to learn. I hope that is something I can keep with me in my practice for as long as I am a nurse. (Fedra, Interview #2 Lines 656-690, pp. 15-16, 2013)

All students in the study agreed that preceptorship served to influence their preexisting moral identities and approaches to future practice. Several students remarked: "I would say that this past preceptorship has been the clinical where I have spent the most time dwelling" (Fedra-2, p. 11); and "It helped me become more compassionate and solidified morals that I have, such as not judging people, because I got to see where those people come from, and where their story starts" (Meropi-1, p. 13, 2013).

Throughout the interviews, the students gave various perspectives on which aspects of the preceptorship served to shape their moral identities. Two students did not think their preceptors had helped to shape their moral identities, because they did not believe the preceptors shared their practice values. These

participants identified the faculty-student relationship, the process of learning from other nurses in the practice area, and their direct engagement in practice as shaping their moral identity. By contrast, three other students described the preceptor-student relationship, and participation in practice, as influential in shaping their moral identities. These students also reported less engagement with their faculty members, however.

All students cited the importance of candid self-reflection, and remaining true to their values, as integral to shaping their moral identities. One student stated, "It's a really high calling to really improve upon your moral and ethical reasoning, because it involves, I think, a lot of self-reflection, and a lot of honest self-reflection as well" (Xeni, Interview #2, p. 5, 2013). Identity involves understanding how we are both like and unlike others (Sommerville, 2006). In developing moral identity in practice, the students actively scrutinized their preceptors and other nurses in the clinical environment, through "watching by example; watching how other nurses handle those situations, or kind of looking at how my preceptors handle those situations" (Fedra, Interview #2, p. 5, 2013). The students appraised the actions of preceptors and other nurses according to their personal values, and preconceived ideas, of what it means to be a nurse in a given clinical practice area. As the students explored and established their distinctive identities in practice, faculty members and preceptors alike offered unique perspectives thereon.

Faculty members' perspectives on nursing students. Like the students, the faculty members regarded preceptorship as an opportunity for students to

discover who they would become as nurses, and how they would provide care in the practice system. One faculty member described encouraging students to consider, "What is it that you would feel would get you ready to be the nurse that you imagined you would be? And that's the other piece we have to ask for, 'Who do you think you will be as a nurse?' because we all imagine that very differently" (Hermione, Interview #1, Lines 164-169, p. 4, 2013).

Another faculty member added:

> I talk to students about that and just say to them, "What kind of RN do you want to be? What kind of nurse do you want to be? You get to make a decision." . . .And [advise them to] "look at attributes that your preceptor has. Or look at attributes that your buddy nurses had, or a tutor has had. What do you want to take with you, and what don't you want?" And all of it is learning. (Alethia, Interview #2, Lines 95-106, p. 3, 2013)

Faculty participants also regarded preceptorship as an opportunity for students to learn about themselves, and about the personal attributes that shape them as nurses. As one faculty member commented, "I think the preceptorship is more than learning an area; it's getting to know yourself as a nurse: 'What are my strengths? What are my areas to work on?' . . . It gives them a chance to work at who they are" (Alethia, Interview #2, Lines 661-666, p. 15, 2013).

In the faculty members' view, preceptorship influenced students' nursing identities but did not ultimately shape them. Faculty members felt that nursing identity is shaped over time, through experience. All of the faculty members encouraged their students to reflect on relational, emotional, and other practice experiences in preceptorship, thereby thinking about what kind of nurses they wanted to be. One faculty member stated:

> We certainly do a lot of talking together, and that is one of the things that we do in our debrief session, is "What do you take away from this experience that you will carry on with you into your graduate role?" Inevitably, they will talk about things like this [critical behaviours toward colleagues in practice], and we will talk about "Okay, these are choices you are now going to make; how did it feel?" If it didn't feel so good and if they don't think that's an appropriate thing to do, then maybe that is what you take into your profession. (Olympia, Interview #2, Lines 407-420, pp. 9-10, 2013)

Overall, an integral role for faculty was to encourage students to explore their personal responses to social interactions, throughout the preceptorship, that in turn served to enhance their knowledge of themselves, others, and the nursing profession.

Given that preceptorship occurs primarily in settings selected by students themselves, it indicates or affirms who they are. Preceptorship fosters learning in authentic nursing practice environments (Manninen, Henriksson, Scheja, Silen, 2013) and affords students the opportunity to find affirmation in areas congruent with their values, aspirations, and personal lives. Conversely, students may feel challenged if they realize their visions of practice are not reflected in the reality of their experiences. All faculty members cited the search for identity, and fitting into practice, as moral issues for students. They observed that students search for identity and fit by assessing their levels of engagement, and their desire to make the most of their preceptorships. As one faculty member stated:

> I do find that I have students, when they come to me in [preceptorship course number], they realize that "I always thought this is the kind of nursing that I wanted to do, and this is so not what I want to do." That gives them difficulty in staying engaged and staying, finishing up the [preceptorship course number]. Some of them will withdraw because "this is just not a fit, and I can't do it" . . . Some of them will say, "I'm going to make the best of this. It doesn't matter what happens; this is a learning opportunity" (Olympia, Interview #1, Lines 344-356, p. 8, 2013)

Another faculty member commented, “They come into nursing because this is where they want to be, and if they don’t get this straightaway, ‘Why do this?’” (Alethia, Interview #1, p. 11, 2013).

When students became distressed by the incongruity of their visions of nursing practice with the realities therein, the faculty intervened to help the students complete their preceptorships. Such faculty intervention could entail increasing the frequency of their site visits, facilitating communication within the preceptorship triad, and “being there” to support the students.

As preceptorship usually occurs in areas selected by the students, the faculty members believed the students had already developed a sense of who they were, when they entered the preceptorship. As one faculty member commented: “Already making the choice of having gone into the practice came with some contemplation prior to this. This was not, ‘Oh, I am going to go into [area of practice].’ So there were clearly already some stories that came before” (Hermione, Interview #1, Lines 781-785, p. 18, 2013).

All faculty members agreed that nursing students came to the preceptorship with moral identities. Three faculty members viewed the preceptorship as shaping these identities. One stated: “I see it unrolling through . . . their willingness to really engage in the whole process of acting as if you are going to be a graduate nurse” (Olympia, Interview #2, p. 14, 2013). Others commented:

> I think it is a slow walk for them . . .I think they started seeing the patient. Whereas they didn’t see the patient before, they saw the skills and all the work that they had to do. And now they started bringing, they had all the knowledge, they had all the skills now they could start looking at the

> patient and evaluating everything that is going on. (Elpida, Interview #2, Lines 235-249, p. 6, 2013)

> Some of the ways in which we get to live with patients that are meaningful. I think some of the attuneness to that has shaped them and some of their moral identity. I think it also it has, if anything, accepting themselves for who they are. (Hermione, Interview #2, Lines 577-581, p. 13, 2013)

One faculty member did not agree: "I don't think it totally shapes them because they come into it with their own beliefs and ideals" (Alethia, Interview #2, p. 10, 2013).

All of the faculty felt moral identity was shaped by *harmonizing personal values, recognizing patients' experiences,* and *living one's identity in practice*; these processes occurred when students were endeavoring to assimilate into the practice environment. For those faculty members who viewed preceptorship as shaping nursing students' moral identity, key factors were learning to be attentive to patients' experiences, and learning to reconcile patients' decisions with one's own value system.

All faculty members agreed that students adapted their preceptorship learning to their future practices. One faculty member stated:

> Sometimes these things do not come out as an incident, these are ingrained in who we become as practitioners if we are thoughtful and attentive and to me it has been more trying to teach them how to be thoughtful and attentive both to who they are and also who, whatever we want to call people, patient, to just people, who they are. (Hermione, Interview #1, Lines 99-106, p. 3, 2013)

In the faculty members' view, preceptorship encouraged students to appreciate diversity, to question practice, to express their voices, and to discover practice areas where they could be advocates. One faculty member stated: "I

think, fundamentally, they are more comfortable. They are comfortable with the staff; they are more comfortable with agreeing and disagreeing" (Alethia, Interview #2, p. 6, 2013). Another faculty member commented:

> In reading all my students' journals this time around, I realize it doesn't come together until the end. Because almost all of them speak of, even in [4th-year clinical course], they could not center on anything but their skills. And they did that for their first half of clinical in [preceptorship course] also. And then all of a sudden, there was a difference, they felt secure, and then they could see the world and start having a voice. (Elpida, Interview #2, Lines 163-169, p. 4, 2013)

Like the students, faculty members considered learning how to develop and maintain relationships within the team to be a significant element of preceptorship. One faculty member remarked:

> They have also felt as a student, they are an integral member of the team. They weren't just overlooked, they weren't just asked because it is nice to ask, they really felt they have made a huge contribution. And they feel that nursing has made a huge contribution in that team and that's one of the highlights. (Hermione, Interview #1, Lines 821-826, p. 18, 2013)

Another commented:

> I think what it does is put them in the environment to give them opportunity to have the full nurse . . .I am part of the team. So from that perspective, it gives them the idea of what it is like to be a nurse in a practice team. (Olympia, Interview #1, Lines 300-304, p. 7, 2013)

Faculty members identified the nursing team, the unit, and its organizational culture as relevant to nursing students' moral development. All members concurred that the unit culture influences, nurtures and shapes learning.

Faculty members agreed that preceptorship encouraged the students to evolve as learners, to understand the cultures in which they practise, to identify normative behaviours and subcultures, and to recognize when cultural norms were

broken. Faculty members also concurred that behaviours on the unit are projected onto students, who decide in turn whether or not to integrate them into their future practices. The students' remarks were consistent with this belief.

The faculty took note that students reported normative behaviours on the unit, incongruent with their personal values of practice, or inconsistent with the professional practice values they had learned in the nursing programme. One faculty member stated: "We imagine as nurses we have the obligation to take care, but we can't live that out publicly because there is that institutional sanction around budgets. And so I think that with students that happens too" (Hermione, Interview #1, p. 5, 2013). Another added:

> We spend all our time and energy in this program teaching them these are the appropriate ways to do things, this is best practice, this is how you should be doing communication. Then they go out, and there is such a disconnect in some units, I think they do become very disillusioned. (Olympia, Interview #2, Lines 427-433, p. 10, 2013)

Faculty members observed that perceived, unprofessional nursing behaviours on the unit urged to students to reflect; to be self-aware; and to understand the practice environment, nursing practice in general, and their own identities as practitioners. Insofar as professional socialization entails learning normative behaviours for future practice, both the unit and the institutional culture directly influenced the students' moral development. While faculty members cited unit culture as shaping both nursing and moral identity, preceptors offered firsthand observations on the students' exploration of their identities within clinical preceptorship practice.

Preceptors' perspectives on nursing students. As with student and faculty participants, preceptors emphasized the importance of preceptorship for learning how to practise and for recognizing the significance of individuality in practice. The preceptors knew they were role models for their students, but they nonetheless expected them to approach care in their own ways. As one preceptor remarked: "I'm not there to change a person; I'm just there to help sculpt a nurse" (Evangelia, Interview #1, p. 11, 2013). The preceptors were mindful and accepting of students who approached care in slightly different ways, provided the students still gave safe, competent, and ethical care. Preceptors moreover encouraged students to be attentive both to their own and to others' practices, and to question whether or not their practices were the best. One preceptor stated:

> You need to know when to ask questions. I think a huge thing is knowing your own limits . . .I guess it goes back to properly taking care of your patient. If you don't know something, definitely ask. I think it is hard for students to ask questions. They should be comfortable when they are a nurse, to be able to do that. (Evangelia, Interview #2, Lines 143-149, p. 4, 2013)

Another remarked:

> I have only been there for [number of] years, so sometimes I go to my senior nurses too and [I ask them], "What do you think? What is up with this?" I think that was really good for him to see too, that it doesn't stop when you become a staff member. I'm always going to senior nurses and asking questions and opinions and things. I want to make sure that they [patients] are getting a thorough assessment. (Zisis, Interview #2, Lines 94-101, p. 3, 2013)

The preceptors described their role as helping students to grow as nurses. As one preceptor stated: "A huge thing is a willingness to learn, because that is what I am there for—not necessarily to impart all of my knowledge, but a huge chunk of it.

Not to necessarily shape them, but at least help them grow in their own nursing career" (Evangelia, Interview #1, Lines 435-439, p. 10, 2013).

Other preceptors added:

> To prepare them for their graduate role. Help them to develop a plan of care so that they can transition smoothly into the graduate role, rather than after graduation be very scared of coming to independent practice. I want them to be confident at the end of their preceptorship: "Hopefully I can manage this. I'll be able to do it on my own." That is what I feel you should be able to do by the end of preceptorship. (Parthena, Interview #1, Lines 151-158, p. 4, 2013)

> I like to see them grow, and if they show me confidence by the end, then I know that they are going to be confident in practicing. If they are confident doing what they are doing now, I think that they would be confident in their practice as well . . .It makes me feel good that I was able to help them out. (Kallopi, Interview #2, Lines 493-503, p. 11, 2013)

> I remember him telling me . . ."You made it not so scary, and you made it so I could ask you whatever I wanted to ask you. And I wasn't scared to ask you questions. And I was kind of excited by the end of it, to have the prospect of working there and working with you." . . . It makes me happy to help someone and know that they go from being totally terrified of a unit and of a specialty to being interested enough to want to work there. (Zisis, Interview #2, Lines 586-602, pp. 13-14, 2013)

Preceptors and faculty members' roles—supporting students and encouraging them to reflect on the preceptorship process—facilitated the students' personal understandings of nursing in the preceptorship area.

The preceptor participants agreed that, while the students arrived in clinical practice with established moral identities, preceptorship impacted those identities, albeit in a minor way. One preceptor stated:

> Everyone is going to have their own direction morally that they have been raised with but also there was a lot of discussion in my nursing school classes about morals and ethics and values and sticky situations and what would you do ifs and what would you do in that situation. I think by the

> time the preceptorship rolls around, the student probably has a good idea where they fall. (Zisis, Interview #1, Lines 235-241, p. 6, 2013)

All preceptors were aware that they were clinical practice role models; the students observed their individual practices and they in turn projected their practice values onto the students. However, the preceptors also observed that their students tended to adopt their technical competencies and priorities for care, rather than their personal attributes. All preceptor participants were aware of their own behaviours and how students might interpret them. They also recognized the influence of unit culture on students' moral development and learning. One preceptor endeavoured to avoid negative attitudes and conversations on the unit, when she was working directly with a student:

> You can only be positive so much, and eventually you get into your culture of the unit. If that's the mood [negative mood] of the day, it's the mood of the day. I try and not be like that, especially when there is a student . . .I feel like the student has years to learn about all that, they don't need to learn about that now. So definitely when I have a student, I'll try to switch the conversation to something else. (Evangelia, Interview #1, Lines 344-353, p. 8, 2013)

Three preceptors remarked that it was important to encourage students to become independent thinkers, rather than following others. Two preceptors agreed that moral issues were exacerbated when other nurses influenced students' thinking, rather than allowing the students to search for their own meanings. Students thus influenced may struggle personally and morally, unable to identify their values and personhood in practice encounters. Another preceptor participant observed that students tended to follow nurses' behaviours rather than make their own decisions:

> It is some students, it is not every student. They have the ability to identify it and go ahead. I think that when they develop in their program, sometimes, some students don't develop that quality, to be observant. So they like to do what is routine. "Somebody has done that before me, so I will just follow it" (Parthena, Interview #1, Lines 523-528, p. 12, 2013)

The preceptors' accounts genuinely reflected the students' socialization as they integrated the practices, norms, and attitudes of the practice environment into their own identities and practices. With regard to the student-preceptor relationship, all preceptors stressed the importance of creating an environment in which students felt accepted and supported in their learning. One preceptor stated: "I think they are trying really hard to do everything perfectly. And that is what they are nervous about, is to make sure they do everything perfectly. I try not to make them think that way" (Kallopi, Interview #2, p. 11, 2013).

The preceptors indicated that acceptance and support in the learning relationship were essential to students' self-awareness, and openness with their preceptors about moral issues. Yonge, Myrick, Ferguson, and Luhanga (2005) find that a positive learning environment facilitating openness, inquiry, and trust is necessary for effective preceptorship experiences. The preceptors in this study emphasized that the students' ability to identify and vocalize moral issues enabled the preceptors to help them to work through the issues. One preceptor recounted:

> We did a lot of reflection after each day. And I think that was good, because they could tell you what they saw and how it could be a totally different experience. I would see one thing, and they would be looking at something else. So, it was really neat to see how the same situation is viewed by two different people and what she took from it based on what I did was neat to see. (Evangelia, Interview #2, Lines 505-512, p. 12, 2013)

The preceptors regarded recognition and reconciliation of nursing and care challenges as a moral quality. Three faculty members concurred. Owing to the preceptors' daily immersion in the practice area, however, they tended to describe in more detail the students' need to learn the challenges of nursing, within the context of clinical practice. One preceptor stated:

> It was definitely evident that he understood the reasoning behind the compassionate care designation for this particular patient . . .He indicated to me that his family is religious, and he has an understanding of the concept that there are definitely different religious views . . .I definitely think he had the sense of why this was done, and if it done for a reason. (Zisis, Interview #1, Lines 258-272, p. 6, 2013)

Another remarked:

> We talked about it afterwards, about if she is not comfortable, she should not be doing it anyway. And, we have to follow along with what you feel, as well as what the parent wants. You have to balance them, and we had a long talk about it afterwards . . . I think that she would not give the [intervention] in that incidence after, because she felt very strongly about what was happening to the child and how it was affecting the child. So I think that was her resolution to the situation. (Kallopi, Interview #1, Lines 40-64, pp. 1-2, 2013)

As with the faculty members, the preceptors believed that students' understanding, both of patients and of practice contexts, significantly shaped their moral identities. In the faculty members and the preceptors' view, students learned to recognize the relationship between their personal beliefs, their patient's individual desires for care, and institutional values governing practice. The students thereby identified those practice areas best "fitting" them as practitioners.

a. Finding one's "fit" with a practice area: Students. In preceptorship, a student's choice of practice area reflects both personal identity and nursing identity. Ideally, students are assigned preceptorship placements in practice areas

of their choosing. The students in this study requested designated preceptorship placements for a variety of reasons: the fit of the placements related to other life commitments; their enthusiasm about the clinical practice areas and the types of care delivery; their passion for the practice areas; and previous, positive, fulfilling, learning experiences in their selected clinical areas. A given preceptorship placement—or area of practice—fit well if it was congruent with the student's vision for nursing, values for learning, and values for care delivery. A good fit also fulfilled the nursing responsibility to "be there" and help people: "Somewhere where I can go and feel like I am actually helping people and not doing things that are not helping them. So that is my issue right now . . .Am I really helping?" (Desponia, Interview #1, p. 4, 2013). Another student commented:

> I think that one of the things that you really need to look for is, is this the kind of patient that you can serve to the best of your ability? The work and the tasks are very important, but more so than that, it is the people, because everybody will define their health differently. You really have to be a nurse who can be there for the people of that unit rather than just doing the motions. It has to be somewhere where you can be engaged in your daily activities, because if you are not engaged in it, I think your personal involvement, personal motivation for being there, and doing a thorough job is quite decreased. You have low motivation to do great work because you want to be somewhere else. So you have to want to be there and want to be there for the people, a very important aspect for that fit. (Xeni, Interview #1, Lines 733-749, p. 17, 2013)

The students expressed varying perspectives on the fittingness of their preceptorship areas. Four students received placements in practice areas they had requested. One student was disappointed about her preceptorship placement because it was not an area of her choice. This participant expressed her commitment to making the most of her placement, but was unsure whether she

would continue to practice in the preceptorship area: "I don't know about [area] per se, but I think higher acuity somewhere on some unit . . . I liked it there; I enjoyed the experience there; but I wouldn't really say that I had a passion for it" (Agapi, Interview #2, Lines 542-548, pp. 12-13, 2013).

Upon completion of their preceptorships, three students considered their areas fitting. One student stated:

> I feel like in [area] you would never get bored. I don't feel like I would lose my skills. It is somewhere I could practice every type of nursing, whether it is oncology, pediatrics, mental health . . . So in [area], that would be one of the best places to be able to explore those areas. (Fedra, Interview #2 Lines 635-645, pp. 14-15, 2013)

Another remarked:

> It is what I want to do. I love helping people, and this is a way that I can help people and feel good about it. It is important to do something that you feel good about, and that will keep me going for a long time. (Meropi, Interview #2, Lines 243-246, p. 6, 2013)

The third student said that "it is a very good fit for me now just because I've become more accustomed to that specific unit and [area] in general. But yes, I think it is a pretty good fit for me" (Xeni, Interview #1, p. 16, 2013).

One nursing student was initially enthusiastic about her preceptorship, describing a rewarding, prior, clinical placement in her practice area. Upon completion, however, this participant was unsure if she would continue in that area of practice. Her perception of care delivery in the institution caused her to question its congruence with her personal caregiving values:

> Except for some of the ethical issues that I've had with the way things are done. If those issues weren't there and there were some changes made to the system, I would love to work there. But at this point I'm not sure if I

> am going to stay there after this. (Desponia, Interview #1, Lines 109-113, p. 3, 2013)

From the students' accounts of developing identity in preceptorship, it was evident that professional socialization and institutional norms bore on their personal values and actions in practice (Seacrest et al., 2003). Furthermore, as the students discovered their identities as nurses, seemingly ill-fitting preceptorship areas were instrumental in shaping their moral development:

> I just want to able to be the type of nurse [who actively questions practice]. I think it will come in time, not to be afraid to ask the doctor, "Why are we doing this? It doesn't seem necessary. These are the risks involved." And to openly discuss it with my colleagues, whether they have the same opinion or not. And just not to fear being ostracized for it. (Desponia, Interview #1, Lines 759-764, p. 17, 2013)

Learning where they could best meet the needs of patients helped the students to recognize their authentic and moral selves as professionals. One student stated:

> It helped me become more compassionate and solidified morals that I had, such as not judging people . . . I got to see where those people come from and where their story starts, which is most of the times in childhood where they've just gone through terrible, terrible things. So [with] the compassion and the empathy and my rule of not judging people, I really got to see why is it not good to judge these people. (Meropi, Interview #1, Lines 587-596, pp. 13-14, 2013)

Likewise, both faculty members and preceptors recognized that students were immersed in a learning process, enabling them to identify where they could best attend to the needs of patients, while remaining true to their authentic selves in practice.

Faculty members' observations of student fit. The faculty members asserted that a student's request for a preceptorship placement is significant,

involving values, previous learning experiences, and aspirations for practice. A noteworthy theme, in faculty descriptions of student fit, was group socialization and the need for students to assimilate into the practice culture. One faculty member stated:

> Some students are much more aware of the culture, and I have other units that the culture is so supportive of students. They talk about how the staff say: "Thank you. I'm glad you were here today; you were wonderful. Look where you were; look where you are now." It's not just their preceptor who tells them that; it is everybody that encourages them. So, if you were on one of those encouraging units, even if you were the weakest student, you would become much stronger. You would become a better person. (Elpida, Interview #2, Lines 401-410, p. 9, 2013)

Faculty members described group culture in the practice areas where students were socialized, as well as the unique cultures of different practice settings. Moreover, they viewed student fit with unit culture as a bilateral process. On the one hand, students discovered how to assess the unit culture, how to socially navigate that culture, and how to actively engage in the preceptorship; on the other, the practice area culture had to facilitate learning and accept the students as persons. One faculty member described it in the following way:

> In order for the student to fit, it is also what the preceptor brings. There is also this unit environment, and can you have the ability to—I don't want to say lay low, because that is not really true—do you have the ability to step back and just observe your environment and figure out how it works and then start to step into conversations? Do you go into it open enough that you watch and you listen and take your cues from your preceptor? Or do you go into it with a sense of "Well, this is who I am. You should accept me." I guess it is the sense of openness that the student comes to the unit with. (Olympia, Interview #1, Lines 735-745, p. 17, 2013)

Another faculty member remarked:

> If the unit culture allows bad manners and allows bullying behaviour, then the student in the preceptorship will be on edge. And she is more likely to

> either leave or, I think, project the same behaviour . . .Initially, the students will come in, and they are waiting for the hammer to fall. It's, "they are being nice; they are being nice. Well, wow! They are still being nice." At about midterm they have had good days and bad days. The preceptor says, "I couldn't even get myself organized." Well, that's interesting. They've given an opinion about something, so they are finding that if they have seen something that the preceptor hasn't and they come and say, "Oh, I saw this, and this is what was done," that their knowledge is valuable. They are much more comfortable. So if the environment is conducive to learning and these units are, then the preceptorship will be fine. (Alethia, Interview #2, Lines 297-312, p. 7, 2013)

Yonge et al. (2005) suggest that successful preceptorships are attributable to positive learning environments that foster support; facilitate openness, inquiry, and trust; and do not threaten. The faculty members viewed these cultural conditions as essential to students' safety and comfort in expressing their perspectives and concerns about practice.

Preceptors' observations of student fit. All preceptors agreed that it is vital for students to have a sense of their values, and to identify practice areas that fulfill their personal identities. In their most recent precepting experiences, the preceptors viewed their students as active learners who were making the most of their preceptorship. They viewed themselves as resources for students, anticipating that the students would engage enthusiastically in the learning process. One preceptor recalled a strained relationship with a former student, who preferred an entirely different care setting. In that instance, the preceptor helped the student by creating learning experiences similar to those in the area the student desired. The student, however, did not wish to engage in these learning experiences:

> It probably started on the first day. She basically said that she didn't want to be in the [area], so I found it really hard to engage her . . .I would try and give her experiences, but I'd still think, "Well, I guess she doesn't want to." I'd still try, [but] she'd often say no to different experiences; that was hard . . .I still tried because that is what she wanted to learn, and I can only teach as much as they want to learn, right? (Evangelia, Interview #1, Lines 77-90, p. 2, 2013)

This student's unwillingness led to a strained relationship, wherein the student was disconnected and the preceptor was frustrated at her inability to engage the student. Similar to the faculty members, the preceptors clearly understood the importance of student work, within the nursing team and the unit, to their preceptorship learning. One preceptor stated: "I think it helps their confidence. They don't feel that they are just a student, or just an extra person who happens to be there. They feel that they are part of the team. I think that helps them when they become a nurse" (Evangelia, Interview #2, Lines 246-252, p. 6, 2013). Other preceptors added:

> I think that is really important as a student to know, that as a staff member, I can't deal with that all by myself either. Someone else who has a lighter assignment, or an assignment that is doing better than mine is maybe could. "Could you just give that person something for pain? I have someone down the hall who is really in need of my assistance right now." So that's I think another big thing. (Zisis, Interview #2, Lines 122-129, p. 3, 2013)

> I expect them by the midterm to be taking a full load. Be able to manage, be able to prioritize, know how to manage the care, get things done, ask for whatever feedback you need to get. Not just the preceptor, but also the other members of the team, and work as a team with everybody. (Parthena, Interview #1, Lines 146-151, p. 4, 2013)

The preceptors also described student fit as it related to the balance between professional and personal preference. They concurred that it is important to practice in an area in which one is happy; otherwise, dissatisfaction leads to

disengagement, compromised patient care, and poor psychological well-being of the nurse. One preceptor described it this way:

> If you are not satisfied with what you do, if you dread every day, racing off you think, "I have to go to that place." And you don't like the people there, "I don't like the people there, I can't work with the people there, nobody likes me." That it is going to be emotionally disturbing, I wouldn't be happy. I would take all that is happening into my personal life. (Parthena, Interview #1, Lines 327-355, p. 8, 2013)

Overall, preceptors considered students' "fit" to be reflected in their personal satisfaction and active engagement in practice.

b. Defining the "good nurse." In developing their nursing and moral identity, the nursing students were aware of their personal and professional values. In their view, the nursing program helped them to develop their awareness of personal values, through individual reflection on their practices, and during group discussion about encounters and moral issues in practice. Additionally, they strove to integrate professional practice competencies, learned over the course of the nursing program, into their nursing practices. During the interviews, I asked the students to describe their personal perceptions of a good nurse, alluding to ideals of moral nursing practice. One student remarked:

> I think a good nurse is a nurse that is able to show caring and compassion for their patients, is able to go that extra step or anticipate that next action whatever it may be . . .A good nurse is getting the job done as expected or as in your description for your job. But I personally don't want to be a good nurse, I want to be a great nurse. I think that a great nurse would be someone who goes over and above and that truly, actually cares, more compassionate, and passionate about their job also. (Fedra, Interview #1, Lines 508-530, p. 12, 2013)

Another observed:

> Caring, communication with your co-workers, with the other members of the team, with your patients. How well you respond to patients' needs, how well you critically think when you're giving out medications. How well you anticipate things . . .I think a great nurse is a lot of things . . .She is a good nurse, my preceptor, but I think there are elements missing, but I think that is everybody. I don't think that we are going to be a great nurse all the time. I think there are days where we will be fabulous nurses, and other days when we will not be great nurses according to my definition or anybody's definition. (Agapi, Interview #2, Lines 305-329, pp. 7-8, 2013)

Another student remarked:

> Someone that provides quality care, standard quality care, like IVs and that stuff and does it proficiently. A good nurse will check-up regularly on a patient and spend time to talk to a patient and have a good attitude when going to work and try to have work and personal life not spill into patient interactions. Like say whatever you want in the break room, but when you go to deal with a patient they have the same attitude or a positive attitude in treating all people equally. (Meropi, Interview #1, Lines 601-610, p. 14, 2013)

The students' descriptions of a good nurse comprised common and distinctive qualities, important to each student. They unanimously described a good nurse as a caring individual who is knowledgeable; optimistic; able to think critically; engaged with patients; safe; competent; and diligent at all times in giving the best possible care.

The students associated their definitions of a good nurse with personal practice experiences, reflections on their own practice, and observations of their preceptor's practice. All students closely observed their preceptors' interactions with others, including patients, colleagues, interprofessional team members, and themselves. The students' choice to adopt their preceptors' attributes in their own practices depended largely on their personal values and ideal visions of nursing practice. If the students considered their preceptors' behaviours to be congruent

with their own values and actions, they expressed the intent to integrate these qualities into their practice.

Role modeling thus compelled the students to clarify their personal values in practice. In describing their preceptors' practices, the students evinced elements of Bandura's (1986) model of the learning process: a) attention, the exploration and interpretation of modeled activities; b) retention, the process of converting experiences into representative concepts; c) production, the organization of abilities into new response patterns; and d) motivation, the determination if learning will be applied to new situations.

The students' clarification of their personal values, upon observing their preceptors' practice, reflected authentic socialization in preceptorship. In other words, the students' remarks bore out the uniqueness of their learning and/or their practice values, in comparison to their preceptors. Some students did not therefore desire to adopt their preceptors' attributes or behaviours in their future practices. According to Bandura (1986), the influence of modeling depends on: a) the observer's judgment of his/her ability to model behaviour; b) the learner's perceptions of the modeled actions; and c) the consequences of engaging in similar behaviours. For students perceiving their values as different from those of their preceptors, engaging in similar actions meant the abandonment of personal values and authentic practice. Taylor (1991) suggests that self-definition arises in dialogue, and that authenticity is shaped by our interactions and relationships with others. For the students whose practice values differed from those of their

preceptors, reflection and self-awareness were vital in avoiding values inconsistent with their own:

> You also absorb some qualities of your preceptor, and you try to choose the best qualities that you want to emulate in your practice as well. But I am sure subconsciously I'm picking up on things that I'll have to address and reassess myself later just to make sure that I am practicing ethically as well. (Xeni, Interview #1, Lines 665-671, p. 15, 2013)

As with their nursing identities, it became evident that the students' moral identities were shaped through observations of practice and their relationships in preceptorship. As students discovered their distinctive identities, they became self-aware and integrated their personal values into practice; this was a fundamental process, facilitated by faculty members and preceptors.

c. Harmonizing personal values in practice: Students. Throughout the interviews, the students described who they were as individuals in the context of nursing education and, in particular, preceptorship. One student stated:

> It is just something that I am really passionate about. I have had past family experiences with [area], and I think that really opened my mind to wanting to learn more about [area]. Then I had a really good experience in [year] and that really made me want to have more experience with it. I don't think it is for everyone, just like anything, people have their own niches or passions and this just happens to be mine. (Meropi, Interview #1, Lines 107-118, p. 3, 2013)

Another student remarked:

> It's who I am. I can't identify myself just as a nurse, or just as a student or even just as a [religious denomination], because there is a lot more to my life. Throughout my nursing education, there have been a lot of points where I have conflicted with faculty, or conflicted with staff nurses, or conflicted with my own peers just on an ethical moral basis. I just found that incorporating my faith identity openly and honestly in my practice gave me more insights to patient care. (Xeni, Interview #2, Lines 113-142, p. 4, 2013)

The students also described how their attributes and values enhanced their practice. One student remarked: "Empathy and compassion, trying to understand that everybody is in their own place and they have gotten there and they are working through their own issues" (Agapi, Interview #2, Lines 52-55, p. 2, 2013). Another student emphasized her rationale for bringing personal values to the preceptorship area: "Being nonjudgmental . . . Especially in [area] . . .just realizing that people come from different walks of life and are dealing with it the best that they can" (Meropi, Interview #1, Lines 144-160, p. 4, 2013). Another student added:

> I try my very best to look at everybody objectively and not bring any judgments in with me. I often see patients get written off. When they come in, they are judged almost instantly. It's, "Oh well, this person is this, this person is that." I try really hard not to do that, especially in [area], because in that setting you see that person as they are before you put them in a hospital gown. I feel like they are almost a different person, if that makes sense. I just try to have that holistic approach in trying to leave your judgments out of it, and to just do the best nursing care that you can. (Fedra, Interview #2, Lines 52-65, pp. 1-2, 2013)

All students identified the personal values they brought to their preceptorships, explicitly recognizing the difficulty in separating practice from these values. They concurred that it is acceptable to bring one's personal values to practice, so long as those values do not negatively impact patient care. As one student remarked: "I think it is positive, as long as you are aware that those values are going to have an effect on patient care" (Desponia, Interview #2, p. 6, 2013). Another student commented:

> Certain people might have different values that aren't necessary positive to nursing, and they [person's values] could just cause more problems. So keeping in mind what is helpful, and what is not, and being realistic with

> your values is really important. (Meropi, Interview #2, Lines 302-309, p. 7, 2013)

The students described a variety of personal values they brought to practice: being nonjudgmental; treating people equally; living with integrity; being honest; valuing patient choice; treating others with respect and kindness; understanding the uniqueness of individuals; being optimistic; and being sensitive to others' perspectives. All students emphasized the importance of treating others as they would want to be treated. One student described it in the following way: "I think living with integrity, being honest, treating people the way you want to be treated" (Desponia, Interview #2, p. 3, 2013). Another remarked: "We sometimes get so into just our tasks and skills and forget about the actual person. We need to think why we are treating them a certain way and think how we would want to be treated" (Meropi, Interview #1, p.1, 2013).

The students agreed that personal values helped them relate to patients and build therapeutic relationships in practice. Lemonidou et al. (2004) found that empathy, caring, and emotion shape nursing students' ethical development, arising as students develop an awareness of their personal values when they empathize with patients.

> Empathetic service is a huge part of my nursing practice because I like to keep a very strong patient relation, patient connection when providing care . . . It's that empathetic service that really increases moral sensitivity for me . . . Just emphasizing portions and characteristics of yourself that can make you relatable to the patient while still remaining objective. Like, if you have ever been hospitalized, and you have ever been NPO for a surgery. You know how important it is for you when you are able to have food, to get that food, and just kind of make a human connection. (Xeni, Interview #2, Lines 66-93, pp. 2-3, 2013)

The students stressed the importance of personal values in assessing and reflecting on their practices, to ensure they were staying true to themselves. Such reflection derives from a virtue-based ethics approach, promoting the analysis of personal values, emotions, and perceptions in moral decision-making, all of which lead to action in practice (Begley, 2006; Doane et al., 2004; Scott, 1995; Sellman, 1997). These findings suggest that reflective practice helps to identify and differentiate between personal and professional values in practice (Martin, Yarbrough, & Alfred, 2003; Nolan & Smith, 1995; Pang & Wong, 1998; Pask, 1997; Weis & Schank, 1991). One student commented: "Even though you could compare yourself to everyone else and think you're okay in comparison to everyone, you have to compare your actions with your own moral standard and with idealistic principles rather than a relative comparison" (Xeni, Interview #2, p. 3, 2013). Another student remarked:

> Being self-aware, reflecting, all that stuff, it helps you to think congruently with your beliefs and actions, although there are times when it is difficult to stick to your values and beliefs, and there are always going to be situations like that that come up. (Meropi, Interview #2, Lines 291-295, p. 7, 2013)

Rognstad, Nortvedt, and Aasland (2004) claim that students acquire moral awareness when they identify the connections between their personal values and their cognitive, affective, and instrumental practices. This perspective is consistent with Habermas' (1973) belief that the unity between theoretical and practical reason helps to create moral insight. In their interactions with patients, preceptors, faculty, and others in the preceptorship, the students recognized their own authenticity, which in turn fostered moral consciousness.

All participants were asked what had shaped their personal values. The students identified their nursing education and their engagement in nursing practice as shaping their values for the latter. One student stated:

> I think that the nursing program and nursing in general has done that [shaped personal values], because I think nursing is that. Like, without the context and stuff, nursing sort of represents like human values in the basic sense. We are helping people. We see them at their weakest, typically. I think nursing has really helped shape my values at home . . . I think it is really sad when people don't have their family there. Sometimes we get frustrated with families in the hospital, but I think it is sad to be working with patients who don't have anybody there. So that, to me, has really enforced the importance of family and love and just caring. (Agapi, Interview #2, Lines 70-89, p. 2, 2013)

Another stated:

> Even in the nursing program itself, whether it be gaining more information or becoming more educated through philosophy, political science, or different various nursing courses that we took . . . Some of the talks we've had from various instructors over the years . . . Everyone is an expert in their own field and they can bring something interesting and new to each point of view. They bring something that you have never thought about before. (Fedra, Interview #2, Lines 60-76, p. 2, 2013)

Professional socialization in nursing education was found to influence the nursing students' development of value systems (du Toit, 1994; Seacrest, Norwood, & Keatley, 2003). The students described learning from role models in both the classroom and the clinical setting. One stated:

> Then in my psych rotation, I actually ended up in [area], and I ended up going and sitting in with one of the occupational therapy classes. She was maybe one of the most influential people in my experience there. She was very passionate about what she did. (Fedra, Interview #2, Lines 360-365, p. 8, 2013)

In both the classroom and the clinical setting, the students were encouraged to appreciate the perspectives of others, which in turn shaped their nursing practice.

This finding is consistent with Freire's (2000) view that self-awareness, acquired through reflection on and analysis of situations, fosters the ability to perceive reality from different perspectives.

None of the students cited ethical theories as influencing their personal values. This finding bears out the absence of a significant correlation between acquisition of theoretical knowledge in formal ethics courses, and undergraduate nursing students' ethical growth (Evans & Bendel, 2004; Kennedy, 1989; Wehrwein, 1990). Lectures in ethics do not impact nursing students' personal values (Cameron, Schaffer, & Park, 2001; Eddy et al., 1994). Although knowledge of ethical theories and codes can guide actions in practice, the findings from this study indicate that students' learning was embedded in relationships. As one student stated:

> Maintaining the two ethical standards that nursing has for me. Essentially with the professional standard with the religious standard, and how a conflict can arise between them but generally one enhances the other, and the other enhances it as well. So it's kind of going back to the duty based thinking. We have in the nursing profession, the perfect duty to uphold the Code of Ethics. But the Code of Ethics itself states, "This Code of Ethics is not enough to ensure ethical and safe and competent practice of all it's member's" that there is something of an internal quality that's required of nurses. (Xeni, Interview #2, Lines 41-53, p. 2, 2013)

While the students drew on ethical principles such as autonomy, respect, and dignity, their accounts of how their values were shaped were deeply relational. According to one student: "My upbringing, my family; religion, I guess, when I was younger . . . Mostly just family and upbringing." (Desponia, Interview #2, p. 3, 2013). Another described it this way: "I think part of it is, I guess, how I was raised: growing up in a poorer family and then being taught my

morals and judgments at a younger age; and going to church and those types of things" (Fedra, Interview #2, p. 2, 2013). Another remarked: "I would say a lot of those things that contribute to my personal identity would be my faith life, my personal home and family life, the way I engage with my immediate family" (Xeni, Interview #2, p. 24, 2013).

Students describing their values as shaped by family demonstrated recontextualization, wherein learners transfer the concepts, meanings, and symbols learned in one context to another (Bernstein, 1977). Through this process, they recontextualized their family values, and previous socialization processes, both in learning and in new experiences (Bernstein, 1977). According to Taylor (1991) family is a major source of individual authenticity. He suggests that the contributions of significant others to one's value system continue throughout one's life.

The students concurred that personal values played a role in how they responded to moral situations in practice. They described personal values that significantly affected their actions, reactions, and reflections. One student stated:

> I think we should respect [patient's] autonomy and I think we should make [hospitalization] more than a medical event. I think that we forget about the atmosphere and we forget about the [patient's] wishes and it is all about money. We want to speed things up and get people through and we don't really care about what the [patient] wants and what is necessarily good for the [patient] in the long run because we want to get people through quicker. (Desponia, Interview #1, Lines 77-85, p. 2, 2013)

Another stated:

> I think that if you are going to be providing care and trying to get somebody to achieve their best, you have to have a very caring philosophy about it. I think my preceptor did have a very caring philosophy about it.

> There was just an incident where it broke down a little bit. So, that kind of upset me, like the value of dignity, the value of autonomy. Just because in that interaction, it kind of took away my autonomy, in a way to, defend myself, to justify my practice, or to inquire about more information. (Xeni, Interview #2, Lines 563-576, p. 15, 2013)

As the students practiced alongside their preceptors, shared values in learning and practice emerged as a variable that shaped student learning and engagement. This is consistent with Myrick and Yonge's (2004) finding that role modeling, wherein individuals identify and assess the values and behaviours of others, is a fundamental process in preceptorship. Two students did not share their preceptors' values for learning in preceptorship. One stated: " I am pretty interested in studies . . . But my preceptor is not interested in that stuff. She's just, 'Whatever. There is my patient, and I don't really care about the studies'" (Agapi, Interview #1, Lines 175-180, p. 4, 2013).

The second student stated:

> She wants me to learn all the processes, the medical terminology, how to read the [monitor] and [intervention], but she doesn't seem to care about the why's as much as I do. Why are we doing this? She can give me reasoning, but very simple reasoning like because the doctor told her, because we need to push people through faster. She just doesn't go into deeper discussion with that kind of stuff. I have discussions with other nurses on the unit, but not with my preceptor. (Desponia, Interview #1, Lines 190-199, p. 5, 2013)

Both students valued integrating current research into practice, but felt that their preceptors were more focused on technical competencies and conventional ways of delivering care. Recognizing different values between oneself and others, and reasoning through these differences, are necessary for moral development (Taylor, 1991).

Students who shared their preceptors' learning and practice values described the latter as supportive of learning; active in seeking out new learning experiences; diligent in frequent debriefings; and committed in "pushing" them to learn. One student described it as follows:

> I didn't know what to expect going in there, and I didn't really know what my learning goals were going to be. She kind of helped direct me in areas of where other students have gone and wanted to learn about. (Meropi, Interview #1, Lines 235-239, p. 6, 2013)

Another explained:

> He took the time to ask me, "What experiences have you had prior to this? What kinds of things do you want to know a little about, but want to learn more about? What types of things are you hoping to see?" And when we see them, he walks me through them and says, "Look at this, this is what we normally do, this situation was an anomaly versus how we normally treat it." He just takes the time and makes sure that in everything I do I feel supported. (Fedra, Interview #1, Lines 463-472, p. 11, 2013)

These students who shared values with their preceptors also integrated those values for care into their practice. As one student remarked:

> Within that room of practicing safely, competently and ethically within all of our guidelines, there is that kind of room for style. And I see that little room with my preceptor in a good way, in the fact that she checks-in with patients more than she has to. And she'll make a point of doing that, and that's something that I would definitely want to incorporate into my practice. (Xeni, Interview #1, Lines 550-557, p. 13, 2013)

Another stated:

> How nice she is and how good she is at dealing with those really difficult patients that no one else wants to deal with. She's got a lot of those. But just her unending kindness and her love for people, no matter how inappropriate their behaviour. (Meropi, Interview #1, Lines 254-258, p. 6, 2013)

Yet another remarked:

> I asked him, "And I did notice, obviously you notice as well, that you end up in a lot of leadership roles. How do you get your co-workers to respect you? What are your attributes that you think make you a good leader? And what kinds of things work well for you?" And he's like, "The number one thing for me is respect" (Fedra, Interview #2, Lines 526-532, p. 12, 2013)

From their preceptors, these students adopted values such as a sound knowledge base; accountability for actions; flexibility and adaptability in facilitating cohesive teamwork; and the provision of safe and competent care. One student, who shared his preceptor's practice values, further stressed the importance of attentively observing his preceptor's actions, and analyzing the congruency between his own values and those actions. He also considered it important to be selective in the attributes and behaviours he integrated into his personal practice:

> I think a responsibility that we have as a student especially in preceptorship is to look at the aspects of their [preceptor's] practice that you really admire, and really respect, and try to emulate those as much as possible. Because, they'll teach you as much as you can by showing you technical skills, by testing your knowledge, but it is their interactions with patients and their reasoning behind things that you really have to pick-up. And if that is something that you want to emulate, that you want to build on in your own practice, you have to take that upon yourself to essentially take the effort to learn from your preceptor. (Xeni, Interview #1, Lines 842-854, p. 19, 2013)

All students felt their actions in practice were congruent with their values. As described by one: "Accountability, incorporating more of your own identity, your own ethical decisions while still remaining objective. That's kind of the main challenge, that piece, . . . was just remaining objective while still incorporating your core values" (Xeni, Interview #2, Lines 36-41, pp. 1-2, 2013). Others added:

> Being self-aware, reflecting, all that stuff. It helps you to think congruently with your beliefs and actions. Although, there are times when it is difficult to stick to your values and beliefs. There are always going to be situations that come up. But for the most part I feel like they [values and actions in practice] have aligned. (Meropi, Interview #2, Lines 291-296, p. 7, 2013)

> I remember last week there was an article in [magazine] . . . And one of the nurses was reading it out loud to everybody in the break room . . . And people were, just going, "Humph". Kind of scoffing at some of the stuff. And I just kept my mouth shut and didn't laugh along. I think people could tell that I wasn't impressed, but I really didn't say anything . . .They [nurses] just have so little respect for what [patients] want. (Desponia, Interview #1, Lines 305-321, pp. 7-8, 2013)

All students noted the importance of being self-aware, and of reflecting on practice, to assess whether their actions reflected their values. One student stated:

> With nursing, we've had to journal a lot on our experiences and reflections. So I started doing that a while ago and I tried to maintain that through my preceptorship. But because my thoughts go so quickly, sometimes I can't keep up with them. Journaling helps me slow them [thoughts] down a little bit and help me reflect on them, and I can just sit with them a little longer and ask myself more questions and go different places. (Agapi, Interview #1, Lines 596-605, pp. 13-14, 2013)

Another remarked:

> If you find yourself tempted to compromise in that way, or to take shortcuts that would negatively impede that, you have to really assess "Why am I taking that shortcut? What am I doing with that time? How is this impacting the patient?" Like breaks in sterile technique, breaks in clean technique and patient education as well . . . So it's just kind of constant assessment, constant reflection on a lot of those points where you want to be an idealistic nurse and improving upon them. (Xeni, Interview #2, Lines 229-240, pp. 6-7, 2013)

A third student reflected:

> Just taking a second to check yourself and then after through self-reflection saying, "How did I act towards patients today? What did I get from them? Were they all smiles around me, or did they want to rush out

> of the room maybe because I had a bad attitude?" (Meropi, Interview #1, Lines 489-494, p.1o, 2013)

Central concerns in the students' remarks lay in being heard to address moral issues in practice, and in having the courage to do what they believed to be correct. According to one student:

> I think I know in certain instances when something needs to happen, but sometimes you feel reluctant to do something. You don't feel that it is your place. But I think when you feel like you are doing the right thing and take that courage and that step to do something and to be that voice, then I think that's mobilizing power. So I think courage, to have courage to know that what you are doing is the right thing and do what you believe in. (Agapi, Interview #2, Lines 433-442, p. 10, 2013).

And another stated:

> I was too timid and too nervous and not confident enough to say anything on that first day. But it was my last day and I was finally like, "No, I have a voice, and I know this is wrong" and I felt that was something that had grown with me over time and throughout my experience there . . . I wasn't accepting it. I was acknowledging this is something that happens in the [unit] setting. And I wasn't accepting it, and that is exactly why I eventually said something on the last day. (Fedra, Interview #2, Lines 579-591, p. 13, 2013)

According to Bernstein (1996), voice is defined as the unity of a person with his/her individual consciousness. To bring one's voice to an issue is to demonstrate authenticity by expressing one's true self (Weyenberg, 1998). To evoke voice (Bernstein, 1996), however, power is required. In this study, the issue of power arose when the students were reluctant to bring their voices to moral issues in practice, for fear of creating adversarial relationships with their preceptors. One student expressed it in the following way: "I don't want to antagonize myself against her because I just want to graduate" (Desponia, Interview #1, p. 2, 2013). Another stated: "It was also my preceptor's first day

with me, and that person ultimately has control of me as their student over how I am going to proceed through my program and my course" (Fedra, Interview #1, p. 7, 2013).

The perceived power differential between preceptors and students presented a challenge to authentic practice. When the students felt powerless, they perceived that patients were not receiving holistic care, or that patient autonomy was not being upheld. These students resorted to strategies such as therapeutic communication, and additional assessments of the patients, when their preceptors were not present. One student remarked:

> When I had a chance, when it was just me one-on-one with the patient, I quickly did my own assessment . . .And then did my own, as best I could counseling . . .I felt that it was something that was important to me. So basically when he wasn't looking, I just did my own thing . . .I just wanted, for my own sake, I wanted her to make sure that she knew there was somebody who cared. . . Because I didn't feel like my preceptor did that for her. And nobody. The doctor hadn't, none of the other nurses had. (Fedra, Interview #1, Lines 840-848, p. 19, 2013)

Another stated:

> I really like to educate the patients about what things we are doing and why certain things might be happening. Sometimes when my preceptor, or other nurses or doctors in the room, I don't do it to the same extent because I think I am afraid that they are going to be "Oh, you are giving [the patient] too much information, they are not going to consent to whatever" (Desponia, Interview #1, Lines 850-857, p. 19, 2013)

One student participant, reticent to discuss moral issues with her preceptor, resorted to passive resistance:

> I thought they were being disrespectful and closed minded, but at the same time I didn't feel comfortable voicing my opinions because I was new and I didn't want to jeopardize my preceptorship. So I didn't want to be really up front in saying what I was thinking, but I didn't want to participate

> either. So just not saying anything was my way of dealing with it. (Desponia, Interview #2, Lines 198-204, p. 5, 2013)

Overall, students used various approaches to live out their personal values in practice. For their part, faculty members and preceptors reported listening to student accounts, and observing the harmonizing of personal values with practice encounters in preceptorship.

Faculty members' perspectives on students. All faculty participants agreed that students bring personal values to preceptorship. They noted that students expressed both personal values and values expressing their vision of nursing. The faculty shared the view that the students' personal values influenced their practice; while skills and competencies could be taught, the students' values served to influence how they interpreted and executed those activities in practice. One faculty member stated:

> You are who you are because of what you believe. You can't get rid of history. I don't think it it's a negative . . . So one of the conversations I always have with the students is, "We all have our beliefs and our ideals, we all have our judgments, and we all have our own opinion, and there is nothing wrong with it. But if it impacts patient care, then it is a judgment" (Alethia, Interview #2, Lines 466-481, p. 11, 2013)

Another remarked:

> I think there are still many times where we teach our students that we need to leave our values elsewhere, 'that's not what shapes practice'. We've got all these codes and competencies, and I think somehow we teach them [students] that we do nursing independently of our values. So, we are not always owning that either. It is sort of, 'if you know these competencies you'll be a really great nurse'. And these skills, if you can perform them then, 'wow that's amazing' versus saying 'even that is shaped by what you value around how you both implement that, or whether you even execute it and really follow through on that knowledge.' (Hermione, Interview #2, Lines 149-159, p. 4, 2013)

Faculty members also brought their personal values to the preceptorship relationship. Although each faculty member possessed a unique perspective on how their personal values were shaped, family and previous nursing practice experiences emerged as common influences. Common values among faculty were the ability to recognize students as unique individuals, and the responsibility to support them in their learning. One faculty participant stated:

> I have to be out there, and ask them about their own personal life, so I get to know them a bit. I think they also have to know that they can say some things to me that might not be re— . . .I'm not saying it's not respectful, but that they have the liberty to say something that they may not normally say to a tutor. (Elpida, Interview #1, Lines 397-405, p. 9, 2013)

Faculty participants valued the creation of learning environments in which students could openly express their values, thoughts, and opinions to facilitate learning. One faculty member remarked: "I guess what I try to do is bring up situations where they can talk about them in a safe environment amongst the colleagues and with a mentor in the group" (Olympia, Interview #1, p. 3, 2013). Another explained:

> A lot of the conversations if we are together have been around creating spaces. In practice, we all know that we all get really busy. It is not all task oriented, but there aren't always spaces for contemplating what we do. So I think one of the pieces I've brought is this, "Let's think about what we do and what would you teach somebody, and what would you do" (Hermione, Interview #1, Lines 661-668, p. 15, 2013)

The faculty members also shared their teaching philosophies. One explained:

> Mine is 'teach a man to fish.' . . . You can teach anyone any skills, like a monkey can do a skill, but if we don't help students think about why . . . If you want to do a skill, what's the rationale for it? Is it the best practice? Is it the best thing for that person? If we don't start getting them to think

> about questioning and the reason why, if you don't get them to think about questioning, than they are going to do things by rote. (Alethia, Interview #2, Lines 19-29, p. 1, 2013)

Another remarked:

> My teaching philosophy got lost for a long time . . . My philosophy was that every person has the right to have one person believe in them at least one time in their life. And my hope was that when I taught, that's what it would be. And believe, give them some feeling that they can accomplish and do things, and give them feeling of "I'm not awful even though I failed, or am not doing well" (Elpida, Interview #2, Lines 22-32, p. 1, 2013)

Another stated:

> I am really interested in experience, very interested in relationships and really thinking about responsibilities and obligations that we all bring to that. So that's really some of my grounding around who I think that I am, and who I try to be as a teacher and imagine myself to be as a teacher. So that is really where some of my roots come from. (Hermione, Interview #1, Lines 755-766, p. 17, 2013)

A fourth faculty member stated:

> My values for them [students] are to have a safe learning environment, but to not ignore or pussy-foot around behaviours or perspectives that I think are going to cause them difficulty later on . . .So I try to encourage them to think about all of the perspectives. So a supportive, safe, respectful, and broad-minded perspective, because there is not only one way of doing anything. If they have principles behind what they are doing, they should feel good in the decisions that they make. (Olympia, Interview #1, Lines 525-549, p. 12, 2013)

A profoundly relational approach to teaching and learning was evident in the faculty members' teaching philosophies. They encouraged students to learn about themselves, as professionals transitioning from nursing students to graduate nurses. One faculty member explained:

> And that's the other piece we have to ask for is "who do you think you will be as a nurse?" because we all imagine that very differently. Then it

> is "how do we live that out in practice?" And that is where a lot of the bump-in places come from. Students come with "how do I fit into the culture?" So saying, "how can I sustain what I dream about, or imagine to be a nurse?" That is some of the very hard work. (Hermione, Interview #1, Lines 167-176, p. 4, 2013)

Another observed:

> They bring a lot of the preconceived ideas that they pick up in [fourth year clinical course] with them. One of the things that I have to work with them on is delegation and working as part of the team . . . You've determined in [fourth year clinical course] that you are an independent practitioner. Now you need to be an independent practitioner within a team setting and working with colleagues so you are helping them and they are helping you. (Olympia, Interview #1, Lines 190-211, p. 5, 2013)

The faculty encouraged students to gain an understanding of the practice context as well as the perspectives of patients, preceptors, and the interprofessional team. Through pedagogical approaches such as student-faculty member debriefing, reflective journaling, and group blogs on the course website, faculty members in this study facilitated students' awareness of their own values as well as the values of others. One faculty member stated:

> We do a lot of talking about situations that may arise and how might you think about this. So when I have students who are in an area where [patients] may die. We make sure that we have a discussion about, where they stand. Whether they've had an opportunity to think about it, what the experience might be for the [family], what are ways that you as a staff member might be supportive . . . So they can hash a few things out and think about things prior to going on the units, instead of all of a sudden going "I saw this and I didn't know what to do or think." So my role is to provide opportunities for them to talk about what they are going to be experiencing and then once they are out in preceptorship, supporting them. (Olympia, Interview #1, Lines 190-211, pp. 3-4, 2013)

Another commented:

> In some of our [website] discussions they'll identify: "This is what I have always believed and when I work in this area and I am challenged, can I

> just walk away and leave it?" And if students say: "Well, I am not comfortable doing this kind of thing, I'm not comfortable looking after a heart transplant patient because I believe the heart is the soul, and they have someone else's heart." And I say: "So if they arrest, are you not going to give CPR? Is this unit the best unit for you?" So, that is the kind of stuff we'll talk about. (Alethia, Interview #2, Lines 502-512, pp. 11-12, 2013)

In preceptorship, the faculty members' pedagogical approaches reflected a socialization process that was deeply relational. These approaches manifested caring and an ethic of care (Noddings, 2002a; 2002b), when they promoted supportive, safe, and respectful preceptorships based on reflection, dialogue, and practice. Preceptors likewise emphasized the importance of supportive relationships with students, to promote expression and exploration of the personal values they brought to preceptorship encounters.

Preceptors' perspectives on students. The preceptors shared the view that students bring their personal values to practice. Like faculty, the preceptors identified the need for students to be aware of their personal values, to be comfortable with experiences that challenged their belief systems, and to be able to set boundaries between their personal values and the patient's beliefs. In practice, the preceptors observed students demonstrating values such as kindness, honesty, non-judiciality and respect for patient autonomy. One preceptor stated:

> He was always very, very kind to patients. That was the one thing that really struck me about this preceptored student that I had . . . I think being a kind person is something that would help put the patients at ease, have them be less disruptive . . . I think that was the thing that really struck me, was how kind he always was to patients and their families. (Zisis, Interview #2, Lines 278-299, p. 7, 2013)

Another remarked:

> Another challenge that they had was trying to be nonjudgmental, because you get clients that have a hard life and you are trying to encourage them to be open with you . . .They tell you a lot of things. So it is trying to be nonjudgmental and open to them and letting them talk. Otherwise, they wouldn't come back if they thought you were thinking bad things about them . . .These students were both very good in that they did not judge people. (Kalliopi, Interview #1, Lines 147-166, p. 4, 2013)

Both faculty and preceptors cited students' previous experiences as a variable in shaping nursing identity and values. Owing to greater intimacy in the preceptor-student relationship, however, preceptors provided more insightful descriptions and greater understanding of their students' actions, behaviours and ways of being. One preceptor observed:

> He was such a quiet person, really into computers and gaming. So maybe that is where the patience comes from, I don't know. I noticed too, on his University ID, it appeared to me that he has lost a whole bunch of weight since he started University . . . Perhaps, that is where that has come from, that perseverance, kindness, that's just how he wanted to be treated, so he treats other people that way. (Zisis, Interview #2, Lines 313-326, pp. 7-8, 2013)

Preceptors reported bringing their own values to their practices and preceptorships, which they all agreed was necessary for competent practice. One stated:

> You have a patient's life in your hands. So if you don't have any set values for yourself, how are you supposed to properly take care of your patients? If we are adding in reliable, everyday they are depending on me to be at my top performance, right? So, I definitely have to bring it to my nursing practice. (Evangelia, Interview #2, 98-104, p. 3, 2013)

Another remarked:

> I think it is really important to ensure as much as possible, that the patient knows and understands what is going on . . . I find it very important to myself, to provide them with as truthful information as possible . . . It is a priority for me, that patients be as comfortable as they can be. Whether

> they need a bowel routine, or something for pain, or something for nausea, but just understanding what it is that they need and trying to work as much as I can to accomplish that. (Zisis, Interview #2, Lines 135-163, pp. 3-4, 2013)

One preceptor stated:

> If you are not honest, if you make up something or you tell a lie that they [clients] find out about, then they just won't trust you anymore, students and clients alike. If you're not open to them, they can tell right away, clients especially, then they consider you to be judgmental and they won't feel safe with you. (Kallopi, Interview #2, Lines 132-138, p. 3, 2013)

Another remarked:

> I would say ethical values in that respect would be the commitment of the nurse to the person who is receiving the care, and practicing within the domains of nursing. And try to overcome all of the challenges that may come, like any ethical concerns. Like if you do not believe in abortion and somebody wants to do it, it is still their right. Overcoming your thoughts and respecting the patient's or client's wishes, and then just being responsible. (Parthena, Interview #1, Lines 60-68, p. 2, 2013)

For the preceptors, important personal values in nursing practice were compassion; truthfulness; accountability; honesty; reliability; dependability; optimism; non-judiciality; respect for the individuality and dignity of others; and openness with patients. They agreed they could not separate their practices from their beliefs and values, emphasizing the importance of being able to voice them and to adhere to them when providing care. They believed that happiness in the profession requires a balance between the personal and professional, and indeed that many professional values are personal values, fundamental to nursing practice. One preceptor stated: "I don't know how you separate the two, how you can be compassionate out here and not at work. It should hopefully come hand in hand" (Evangelia, Interview #1, p. 6, 2013). Another preceptor

commented, "You have to maintain a balance, . . . respect your own profession and be happy with it, and maintain the dignity in practice. So . . . that is why you are practicing competently" (Parthena, Interview #1, p. 3, 2013). Others added:

> You have to be honest with your clients. Especially out here, if they figure that you are not being honest, they will never trust you and they will never come back . . . It is hard for them to trust . . .And for them to trust a lot of different people, because of different experiences throughout out their lives. So you have to try to be open and honest with them at all times. (Kallopi, Interview #1, Lines 106-115, p. 3, 2013)

The preceptors also believed that living out their values in practice helped to solidify their personal moral systems. One remarked:

> I am really open. As I am open to my culture, I am open to anybody else's culture. If that is your culture's practice, I totally respect it. And even if I am not agreeing to it on a personal note, that does not affect my practice. (Parthena, Interview #1, Lines 587-595, pp. 13-14, 2013)

Another stated:

> I think you are always born with some, not born, but raised with some different types of morals, like whatever your parents say and stuff. As I was going through nursing, I have learned different things, and I think I have grown in my definitions and what I have decided as right and wrong as it relates to my clients. (Kallopi, Interview #2, Lines 72-78, p. 2, 2013)

The preceptors concurred that they are judges of their own actions in practice, and that they must live with their consciences, in following their values. Habermas (1973) asserts that when ego and role identity consolidate, moral consciousness begins to form. As the preceptors established their roles as nurses, they progressed beyond forming identity and achieving technical competency in their areas of practice. They were thus able to draw from their interactive competence to consciously process moral issues and encounters in practice

(Habermas, 1973). The preceptors also observed that, in practice, living out one's values is sometimes easy, sometimes challenging. They offered unique accounts of influences on their personal values. Similar to the faculty participants, the preceptors cited family and nursing practice experiences as shaping their personal values. One preceptor remarked: "I'd probably say my mom. My mom is a nurse too. I kind of followed her footsteps" (Evangelia, Interview #1, p. 6, 2013). Another commented: "My mom, growing up, she's always been a funny individual . . . Sometimes you have one of those days where you are either going to laugh about it or you are going to cry. So, I'd rather laugh than cry" (Zisis, Interview #2, Lines 552-559, p. 13, 2013).

Another preceptor said:

> My parents, they both worked, they were always there throughout our whole lives . . .I think that all helps to shape me the way I am . . . Probably the caring because they were always there to help other people. They were constantly helping people, they were always foster parents and we always had lots of kids in our house. Sharing, caring, and open, I think that is what they taught me. (Kallopi, Interview #2, Lines 399-413, p. 9, 2013)

The preceptors also integrated their personal values into the student-preceptor relationship, creating supportive environments to facilitate honesty, openness, and trust. They felt a responsibility to offer diverse learning experiences to students, draw out their perspectives on practice, and support them in their learning. One preceptor stated:

> Giving them opportunities to learn new experiences . . . Every opportunity that I had I would try to teach any information or answer any of their questions, because there is always a lot of those. Also just help them guide their own practice, because everybody is going to do something differently than myself. So I had to recognize that they may do it slightly

> different, and that is okay too. (Evangelia, Interview #1, Lines 48-58, p. 2, 2013)

Another affirmed:

> It is definitely my role to listen to what the student's opinion is first, because everyone has their own beliefs and values regarding that type of situation . . .I think that it is important to iterate what our beliefs and values are so that we can be aware of them. I am always asking, "how do you feel about this situation?" . . . I ask what their beliefs are, and make sure that they understand what our responsibilities are within the context of the nursing role and then to integrate them, because it is important that the nurse feels comfortable on the unit. (Zisis, Interview #1, Lines 54-69, p. 2, 2013)

According to Yonge, Myrick, Ferguson, and Luhanga (2005), effective preceptorship is contingent on the preceptor's efforts to establish a trusting, supportive, and open relationship with the student. The preceptors in this study demonstrated respect for their students' individuality and expressed an empathetic understanding of their engagement in preceptorship. As with the faculty participants, it was evident that student learning was deeply embedded in the preceptor-student relationship, reflecting genuine socialization through relational knowing and role modeling. Myrick and Yonge (2004) found preceptorship to be a relational process, characterized by role modeling, respect, flexibility, openness, safety, and trust.

While some preceptors had not defined personal preceptorship philosophies, all stressed the importance of building student confidence to facilitate independence. The preceptors asserted it was vital for students to gain confidence in preceptorship, inasmuch as they would soon assume full responsibility for patient care. Lack of confidence in this transition could lead to

frustration, anxiety, and disengagement from practice, ultimately impacting quality of care. One preceptor remarked: "Their confidence—I think as you can build it. It is super important, because at the end of the day they are only a few months away from being on their own and having a patient's life in their hand" (Evangelia, Interview #1, Lines 495-499, p. 11, 2013). Other preceptors added:

> If you are not confident in what you are doing, you are scared, have anxiety, you are going to make more mistakes . . .It is not going to be a pleasant experience where you are working. And that is ultimately going to affect the quality of care that you give, and your work relationships. I feel that they have to be confident enough to know what they are doing, what is right, what is wrong. (Parthena, Interview #1, Lines 164-175, p. 4, 2013)

> I like to see them grow, and if they show me confidence by the end, then I know that they are going to be confident in practicing. If they are confident doing what they are doing now, I don't know, but I think that they would be confident in their practice as well. (Kallopi-2, p. 11, 2013)

Confidence is vital to moral development, insofar as the former encompasses how one knows and how one feels (Hauser, 2006). In students, confidence can foster a sense of control and assurance about their actions. To build confidence, the preceptors demonstrated honesty, trustworthiness, accountability, humility, respect, and acceptance to their students. One preceptor remarked:

> I've always been taught, it is better to ask a question and feel silly than to not ask it and not know, and contextually it can be a scary situation. I've tried really hard to tell my student that . . . We do that as co-workers on our unit all the time. "Can you just come and look at this for me to make sure that I am not seeing things, or I've got the right idea?" I think just the demonstration of that and the knowledge that they can feel comfortable enough to do that probably helps alleviate some anxiety. (Zisis, Interview #1, Lines 488-502, p. 11, 2013)

Another recounted:

> I am always honest with my students. I am a very open communicator. If I make a mistake, I tell them that I made the mistake and what I am going to do about it and how to correct it afterwards. If I don't know an answer to a question, I'll tell them that I don't know the answer, but that I will try to find the answer, hopefully. They seem to respond well to that. (Kallopi, Interview #1, Lines 95-101, p. 3, 2013)

In the preceptors' view, honesty, humility, and accountability fostered trust in the student-preceptor relationship. In this study, preceptors demonstrated accountability to their students by expressing self-awareness and seeking knowledge or assistance when in doubt. Preceptors also felt that humility, realistic expectations, openness, and trust with students served to decrease their anxiety, which in turn built their confidence and independence in practice.

The preceptors explained that unit culture could impact student confidence positively or negatively. One preceptor remarked:

> I think if you're knocked down a lot, I think that it [confidence] is hard to build, and I don't know how much that makes you really want to go into the workforce. I would hope to that if they do get through it, that they don't think that is what is supposed to happen to the next student . . . Hopefully they stick to thinking that at the end of the day we are all nurses. There is no nursing student and no nursing . . . We are all the same profession. (Evangelia, Interview #1 Lines 500-514, pp. 11-12, 2013)

Another commented:

> When we were training, if you had concerns, you were faced to go to a new person that you do not know . . .We had our instructor who used to visit us every day, but we were not really open to go and discuss it [concerns] with the staff. We might have said [concern], but then it was like, "you are disrupting our routine" or, "you are really irritating us". So we were not too open to do that. But having the one on one relationship and that knowing that you have to teach this new student, it kind of helps to develop the trust, the relationship, to be more confident and talk things out. (Parthena, Interview #1, Lines 389-404, p. 9, 2013)

The preceptors also suggested that a lack of confidence, owing to poor treatment, could lead to disillusionment and disengagement from nursing practice. The preceptors strove to ensure their students were positively integrated into the nursing team and accepted as valued team members. According to Myrick, Yonge & Billay (2010), preceptors play a vital role in creating a supportive learning environment, wherein students are accepted as valued members of the nursing team. The students' socialization process was also shaped by previous relationships and experiences.

d. Integrating previous experiences that shape individuality, practice, and personal knowing. The students' previous experiences, both in their nursing education and in their personal lives, were reflected in their perceptions of morals and ethics; their descriptions of values and the influences thereon; and their requests for preceptorship placements. Other studies have shown that previous experience and advanced years of study positively correlate with higher levels of moral reasoning in nursing students (Auvinen et al., 2004; Duckett et al., 1997; Duquette, 2004; Felton & Parsons, 1987; Haywood, 1989; Johnston, 1994; Kim, Park, & Han, 2007; Nolan & Market, 2002; Wehrwein, 1990).

Preceptorships ideally occur in areas chosen by the students, who typically choose areas in which they desire to pursue their future nursing careers, and/or areas congruent with their visions of nursing practice, personal values, and identities.

Individuals access memory every day. Ralston Saul (2002) suggests that memory gives context, shape and reason to our thoughts, questions, and actions.

Context is necessary for social life and relationships, while memory enables us to recognize our identities and invoke personal knowledge (Ralston Saul, 2002).

The students gave varied rationales for selecting or seeking particular areas of practice for their preceptorship placements: a positive experience in a previous clinical placement; an passion for a selected practice area; a motivation to learn more about an area related to personal family experiences; or a desire to acquire knowledge and skills for future practice in a selected area. Only one student was placed in an area not of her choosing. Three students, who had worked as undergraduate nursing employees, selected areas of practice different from those of their nursing employment. It was thus evident that previous, personal and practice experiences had shaped the students' choice of preceptorship placements.

Some educational philosophers regard the experience of thoughts, actions, events, and relationships as significant to learning. Dewey (1916) asserts that education is constructive; new experiences build on established beliefs and intellectual habits. In this study, nursing students' previous experiences shaped their individual identities and ways of personal knowing. All student participants' previous experiences shaped their practice perspectives and ways of knowing, thereby informing their actions in practice. One student stated: "I have vast life experiences, whether it be travelling, working with people, all of my volunteer work, my growing up . . . I've dealt with a lot of conflict. I think that that background has also played into how I deal with situations" (Fedra, Interview #2, Lines 204-208, p. 5, 2013). Another student remarked:

> Going to go back to first year, reflecting on when we were in the senior's homes. I still remember thinking, "that is not right" they [nurses, NAs] are being so rough with that older person or they are yelling at them. I remember thinking, "that is really wrong" but not having enough courage to do something about it. It was mostly taken back to post conference. So I had some morals, and I don't know how they have really changed. I think they have just solidified more and I've gotten more self-confidence to know how to deal with the issues. (Meropi, Interview #1, Lines 384-396, p. 9, 2013)

Socialization and role modeling impacted the novice nursing students' perspectives in practice as they progressed through their nursing programs.

Being a novice. Students were aware they were novices in their practice areas when they commenced their preceptorships. They questioned their knowledge, opinions, feelings of newness, and of "not knowing." They felt their inexperience bore on their ability to work through moral issues in practice, while perceiving that experience and understanding of practice could shape how they framed moral issues. They expressed insecurity about their knowledge base and feared that ignorance might lead to the incomplete assessment of issues in practice. Two students expected their perspectives on moral issues in practice to change as they gained experience and an understanding of the practice environment. One student commented:

> I guess I don't feel confident enough to bring up these issues with a big group at this point, and I'm afraid maybe it's something I don't know at this point that they do. Maybe I'm going to change my opinion in the future. (Desponia, Interview #1, Lines 349-353, p. 8, 2013)

Another stated:

> It is something that I am still thinking quite often about and I journal about it a lot and I'm actually going to try to write about it in my consolidation paper. Because I think it [consolidation paper] talks quite a lot about the big picture of nursing and I think it is a bit of an evolution and it will

> change all the time with the situation, and the unit that you are on because it is reflective of the culture of the unit. (Agapi, Interview #1, Lines 101-107, p. 3, 2013)

These findings are consistent with Habermas' (1973) theory of moral consciousness: as individuals progress from a generalized to an abstract role identity, moral consciousness begins to form. He defined moral consciousness as the ability to use interactive competence to consciously process moral issues and encounters. As the students in this study began to develop authentic role identities as nurses, competencies in their practices, and communication skills in their preceptorship areas, they began to deal with moral encounters in more meaningful ways.

The faculty participants described students as novices in their preceptorship areas. Three faculty members described students who encountered moral issues, whereby their inexperience was directly reflected in their actions or lack thereof. One faculty member recounted:

> She knew something was wrong, and only through debriefing did she realize she was still a student in her mind, and that's why she didn't do anything, because she had no power. "I don't know what's right or wrong here, but I don't think it's right. But I'm a student, and so—" (Elpida, Interview #1, Lines 335-341, p. 8, 2013)

Preceptors observed students progressing in their preceptorship placements and becoming more confident in their abilities to identify, analyze, understand, and address situations of concern. The preceptors agreed that the students' ability to identify and understand issues was related to their experience and immersion in practice. They also recognized that preceptorship could be

initially overwhelming for students, who would thus be anxious. One preceptor commented:

> He told me he was overwhelmed and very nervous and very aware that there was a lot of information that he had not dived into over the course of his nursing degree. But I think that a lot of what he didn't realize is that a lot of it builds on knowledge that you already have. (Zisis, Interview #1, Lines 330-335, p. 8, 2013)

Another observed:

> I think that, because it is going to be a whole new experience for them, and by the end they are going to be doing everything on their own, I think they are trying really hard to do everything perfectly. That is what they are nervous about, is to make sure they do everything perfectly. I try not to make them think that way, [but] you can't help it when you are a student. (Kallopi, Interview #2, Lines 465-472, p. 11, 2013)

Recognizing the impact of preceptorship on their students' psychological wellbeing, all preceptors drew from their own experiences as students. Three preceptor participants, who had undertaken preceptorship courses in their own nursing programs, understood the anxiety and uncertainty of being a novice, and their impact on a student's preceptorship experience. These preceptors emphasized the importance of supporting students and mitigating their anxiety to facilitate learning. One preceptor recounted:

> I had difficulty completing my final practicum when I was at the end of my nursing [program] . . . I think maybe that is what helped me a little more. I know there is frustration and challenge, and it can be really hard to deal with. At one point he told me in confidence that he might have to withdraw. And I thought, "I feel your frustration and your pain in that regard because you almost feel like you are defeated . . . It is exhausting. Learning and working twelve hour shifts, and working night twelve hour shifts that you never worked before in your life and this whole new unit, and [diagnosis], and [assessments]. It's overwhelming, but I think maybe my past experience and my own preceptorship challenges really helped that. (Zisis, Interview #2, Lines 451-477, pp. 10-11, 2013)

A second stated:

> I think it stems from my own preceptorship. I would often find my preceptor sitting on the computer planning her wedding. So you sort of gain your confidence by yourself, it shaped how I am. I think more involvement would be something that I would want to have. I would tell my student, "anytime you want me to back off, just tell me", because not everybody needs that constant hover, but just someone to be there. Even if they are just around the corner. I think that's important for a student to have, or at least potentially have. (Evangelia, Interview #1, Lines 557-569, p. 13, 2013)

A third stated:

> I ended up having two different preceptors because I was at [hospital] and half way through one of them left to go to a different job. But they encouraged me asking questions, they got me into all the experiences that they could, they were always watching out for me. If it was a really hard time, they would send me on a break, even thought they would not go on break. I just really enjoyed it, and I really liked them. They were very friendly too. So I'm that way too. (Kallopi, Interview #1, Lines 253-260, p. 6, 2013)

Yonge, Myrick, and Haase (2002) describe preceptorship as one of the most stressful nursing student experiences because it occurs in the context of a challenging practice environment, in which the preceptor and student endeavour to accommodate each other as professionals. Students' focus on transitioning and adjusting to the preceptorship area can initially impede their identification of and response to moral issues. In this study, the preceptors described the students as conscious of their newness to their practice areas, and of the amount they needed to learn. As the students progressed in their practices, so their preceptors observed, they increasingly identified and engaged readily with moral issues in practice.

e. Learning from others in preceptorship: Preceptor role-modeling.

The students compared their preceptors and other nurses' practices to their own, hypothetical ones. During initial interviews, students spoke primarily of nursing practice behaviours they found inconsistent with own their practice values or questionable for patient outcomes. This trend continued in the subsequent interviews, following the practice component of the preceptorships. However, the students also professed a better understanding of their previous observations, having taken time to explore and appreciate their preceptors' perspectives. The students' observations of their preceptors' and other nurses' practices thus shaped their moral identities.

In the initial interviews, four students expressed concern regarding a perceived lack of care on the part of their preceptors or other nurses, all practising in hospital settings. This perceived lack of care entailed an absence of compassion for and empathy with patients; unsafe practices; and disregard for patients' holistic health. These students felt such behaviour to be inconsistent with their personal values for nursing practice. One student remarked:

> I see some of the duties as a nurse to be truthful in all assessments and to the patient and the interdisciplinary team. I feel the way that it [epidural assessment] was charted . . .that it is just not being truthful . . .So I don't feel comfortable with that deception for convenience . . . So patient care and honesty really bug me about the initial assessment. (Xeni, Interview #1, Lines 283-287, p. 7, 2013)

When the students observed practices they considered unsafe and/or inconsistent with their values, they did recognize their moral obligation to ensure for the provision of competent care. Confronted with behaviours inconsistent with competent and caring practice, the students did not merely contemplate taking

action; they actually intervened to address their concerns. Despite their initial concerns about acting differently from their preceptors, for fear of creating adversarial relationships, three students intervened in covert ways to meet their perceived responsibilities to patients. One student recounted:

> When I had a chance, when it was just me one-on-one with the patient, I quickly did my own assessment . . . And then did my own, as best I could counseling . . .I felt that it was something that was important to me. So basically when he wasn't looking, I just did my own thing . . . I just wanted, for my own sake, I wanted her to make sure that she knew there was somebody who cared. (Fedra, Interview #1, Lines 840-846, p. 19, 2013)

While the students were troubled by this perceived lack of caring practice, they nonetheless believed their preceptors and other nurses cared for patients. The students concurred that each nurse's expression of caring and priorities for care were unique. One student remarked:

> I truly think that my preceptors do care . . . but I think that we all care in a different way. I think that we all have different things that we think are important for each patient and our priorities might be different. (Fedra, Interview #1, Lines 571-575, p. 13, 2013)

In reflecting on their preceptors' perspectives, the students grew to appreciate the dynamics bearing on their practices.

The students intended to integrate many of their preceptors' attributes into their future practices: helpfulness; extra effort; compassion; non-judiciality; respect and support of colleagues; and cohesive teamwork. Other attributes the students determined to avoid, such as unwillingness to question practice or further one's practice education; and minimizing a patients' ability to recover or improve. The students valued lifelong learning as well as patient advocacy. They

recognized their responsibility to question practice and to challenge the rationales for care practices as moral activities. Plato (as cited in Cahill, 2003) regarded questioning as a moral obligation.

All of the students reported that learning from their preceptors helped to shape their moral identities. Myrick, Yonge, Billay, and Luhanga (2011) suggest that practical wisdom is cultivated when nursing students practice under the guidance of their preceptors. Practical wisdom (phronesis) entails applying knowledge, derived from experience, in doing "good" for others through practical action (Myrick, Yonge, & Billay, 2010). In nursing, practical wisdom can be described as the virtue of knowing when to do the right thing, to the right person, at the right time, for the right reason (Sellman, 2009). In a grounded theory study on practical wisdom in preceptorship, Myrick, Yonge, and Billay (2010) discovered that preceptor role modeling and "doing good in the moment" (p. 84) influence student behaviour in similar situations. Students thus acquire practical wisdom by observing and engaging with educators and practitioners, who demonstrate professional phronesis in their actions (Sellman, 2009).

In this study, the students observed positive attributes and behaviours, demonstrated by their preceptors and other nurses, consistent with their own nursing practice values. The students expressed a desire to integrate these positive qualities into their own practices as graduate nurses. As they analyzed their preceptors' practices, the students authenticated their own identities and recognized their responsibilities to patients and to others.

In addition to observing their preceptors' practices, the students also learned about commitment in professional relationships, and the impact of effective relationship building on future practice. They valued their preceptors' perspectives on their behaviours in their practice relationships. Moreover, they emphasized the importance of self-awareness, and expression thereof, to these relationships. As one student recounted:

> It had happened a couple of times where we wouldn't talk to each other . . . And it happened more than once, fairly close together. So finally I was just like, well this relationship is almost finished and do I want to? I could either leave it and go forward, is the relationship that important to me that I want to talk to her about it? So I decided that maybe long term, it is not that important. But for the moment now, and to help me and my future, that it would probably be a good thing to bring it up with her. And so I brought it up with her. And it made a world of difference, and it was such an easy conversation to have. (Agapi, Interview #2, Lines 221-244, pp. 5-6, 2013)

Relationships with their preceptors taught the students to self-assess, to communicate honestly and openly, and to build cohesive relationships in practice. According to Noddings (2002a; 2002b), relationship building and maintenance illustrate the importance of relational learning to socialization and moral development. In addition to their relationships with preceptors and faculty members, the students' moral identities were shaped by the relationships they developed with patients during their preceptorships.

Learning from others in preceptorship: Learning in the student-patient relationship. Relationships with patients taught the students the importance of holistic care and of learning about patients as people, within the context of the health care environment. One student stated:

> I want to have a practice where I can look at my own practice, not just relative to everybody else, and say that I have made strong ethical/moral decisions when I'm with that patient. I believe to have those really strong moral/ethical decisions you have to be present in the dynamic and changing patient relationship. There won't be a prescribed right or wrong decision for every experience that you have when you are at the patient's bedside. So you really have to do a thorough assessment, engage and empathize as much as possible with the patient and where their strengths and weakness are, what kind of past experiences have shaped them while still maintaining the objectivity of a professional . . . So you can see a lot of patient progression if you are willing to take the step further and relate to your patient. (Xeni, Interview #1, Lines 597-621, p. 14, 2013)

The students came to understand and respect and their patients' individuality, life stories, contexts, and specific care needs. Moreover, they came to understand the importance of keeping patients informed, and of being accountable to them, in comprehensive care.

The students also recognized the importance of nonjudgmental care--namely differentiating the patients from the diseases or health deviations that had brought them into care. One student commented: "You have to focus on the care and not the circumstances surrounding why they [patient] are there . . . keeping that in mind is probably one of the biggest things to be able to go in and provide equitable care to everybody" (Agapi, Interview #1, Lines 137-146, p. 3-4, 2013). Another student stated:

> I want to stay true to who I am no matter how difficult a situation might be. And those values to remain impartial with patients, and not judge them, so that I can provide the same care to everyone no matter who it may be . . . I think just recognizing, especially in [area] that it's their illness . . . It's good to reflect on my values, like not judging people and trying to understand where they are coming from, so that I don't treat them differently. (Meropi, Interview #2, Lines 132-150, pp. 3-4, 2013)

The students emphasized holistic care over focusing on illness. Comprehensive assessment and collaboration were necessary to ensure all their patients' needs were met. One student stated: "I try to listen to 'What are your hopes for this experience in the beginning?' And then I try to facilitate that as much as I can" (Desponia, Interview #1, p. 4, 2013). Another commented:

> You have to dig a little deeper if you want to get to the concepts of health, if you want to get to how people find being well and the preservation of more abstract concepts like dignity, which can vary from person to person. So it's kind of engaging with your patient and understanding their critical thinking thought process. (Xeni, Interview #2, Lines 149-156, p. 4, 2013)

The necessities of recognizing responsibilities to others, and of fulfilling patients' wishes for care, clearly influenced the students' moral identities during their preceptorships. This finding is consistent with Nodding's (2002a; 2002b) ethic of care; the motivation to care—that is, attend and respond to others' needs—is fundamental to a moral life.

The students appreciated diversity in their relationships with patients. They also considered it important to acknowledge that diversity, and to appreciate the multiple, diverse perspectives of those practising. They learned the importance of accommodating, adapting, and evolving as practitioners, to meet patients' needs within a dynamic health environment. In other words, learning to appreciate diversity—and the unique experiences of others in practice—was fundamental to the students' moral development. The students thus learned to value their individuality, with regard to the reality of practice and the culture of the preceptorship setting.

f. Reconciling visions of nursing with reality and practice cultures.

All student participants entered preceptorship with preconceived ideas of nursing practice, and of ideal nursing practice. Prior to preceptorship, the students envisioned their selected practice areas as rewarding, eagerly anticipating new learning opportunities. Some students encountered a different reality. Incongruity between the students' visions of practice, and the realities they encountered, arose from: 1) the inability to live out their practice ideals and values in the preceptorship; and 2) disillusionment from the negative attitudes of nurses in the students' chosen areas of practice.

Four students, undertaking preceptorships in hospital settings, identified institutional practices incongruent with their vision of ideal nursing care. They were morally troubled by the lack of time given to holistic care, and by practice cultures that did not value patient autonomy. One student remarked:

> In some ways, I guess, morally, it would be nice to have more time with them, or less patients, so you could spend more time with everybody and help people out just a little bit more than what I feel that I can do now. (Agapi, Interview #1, Lines 41-45, p. 1, 2013)

Another recounted:

> [My values for patient care are] Making sure they are fully informed, making sure they are comfortable, and I've just been trying to provide the best care that I can within the constraints that I have in the institution and as a student. (Desponia, Interview #1, Lines 382-385, p. 9, 2013)

These students struggled morally, striving to reconcile their learning and care ideals with the realities they encountered. One student remarked: "I just thought nurses would be more supportive and more empowering, and a lot of times it just

seems like they don't really care, but I know that they do care" (Desponia, Interview #1, p. 6, 2013). Another student explained:

> I think that something that we got through my program, it was always engrained in us to look at the patient holistically . . . So I am not sure if it is a difference in education or that's worn off over time, or changed during time. (Fedra, Interview #1, Lines 617-625, p. 14, 2013)

New graduate nurses in acute care practice settings frequently face incongruity between their values of holistic care, acquired in nursing education, and the areas in which they practise (Philpin, 1999). In this study, students became frustrated when they were unable to provide the holistic, individualized care they had learned in their nursing programs. Self-assessment and reflection were important in assessing the care they provided, and in their commitment to the personal values and ideals that shaped their moral identities.

Faculty members also recognized the incompatibility between the students' visions of practice and the reality of preceptorship. One stated:

> We spend all our time and energy in this program teaching them "these are the appropriate ways to do things, this is best practice, this is how you should be doing communication". Then they go out and there is such a disconnect in some units, I think they do become very disillusioned. I wouldn't be surprised if this is why we lose 50% of them in 5 years, because the ideals we set up for them. (Olympia, Interview #2, Lines 428-435, p. 10, 2013)

Taylor (1991) attributes the moral tension arising from the inability to provide holistic care to emphasis on instrumental reason. Contemporary medical care systems emphasize interventions, treatments, and cures, while largely ignoring how treatments relate to patients' lived experience and holistic being. Overemphasis on intervention diminishes the value of the relationship between

the caregiver and patient (Taylor, 1991). As the students made sense of who they were in preceptorship, connecting past experiences to current practice, they learned that proper treatment of others entails respect for their holistic, dialogical, and historical nature (Taylor, 1991). The students experienced moral tension between their desire to treat patients holistically and the institutional expectation of expedient and efficient care.

Four student participants, who undertook preceptorships in hospital settings, observed that nurses' behaviours toward each other, and their perceived attitudes toward nursing practice as a whole, did not meet the students' ideals of nursing. The students were likewise disappointed by nurses' judgmental and non-supportive behaviours toward other members of the nursing team. These behaviours also amounted to frightening prospect for their future practices. One student recounted:

> You will often hear the senior staff, is what they call themselves, or what they call each other, talk about how the junior staff have no business being in the [area] or the [area]. That it is not their best team there and those types of things. And I'm like, "Oh, well, that is not a very positive thing to walk into hearing." It's like great, I'm going to be a junior staff and this is what the senior staff will be saying about me . . .When the junior staff are working in those areas, I'm not always sure if all of the senior staff are all that supportive. Or, if they are doing a good job, they would never ever say, "Oh you did a really good job today" or anything like that. That is not something that I have ever seen. (Fedra, Interview #1, Lines 791-807, p. 18, 2013)

Another student recalled:

> I actually found that the other day, because they [nurses in preceptorship area] were talking about the nurses in [area]. And I was like really? Because that was not really my perception of an [area] nurse at all . . . I don't understand the workings of that [area] and then when we left, my preceptor said something [negative comment about the nurse] to that effect. And I felt that somehow, I had to agree with her. And so I agreed

> with her. And I thought about it after, and I thought really? That's totally not fair. I don't know the circumstance of that [nurse] and I don't know that nurse. Yea, I didn't really like that. (Agapi, Interview #1, Lines 517 529, p. 12, 2013)

The students feared mistreatment among nurses could lead to uncaring behaviours toward patients. One student stated: "I've had some people tell me, some nurses who have been doing it for quite awhile say, that I was going to hate it. I don't really know why they said that" (Desponia-1, p. 11, 2013). Another student explained her disillusionment thus:

> My vision going into the nursing program in first year was very visionary, very excited, very wanting to help, be caring, compassionate . . . I spent a lot of time with nurses who have been working for a long time and I can see, I can feel the negativity. I can see how people get jaded quickly . . . I think that's one of the hardest things for me because I still am young and excited and new. Any ideas, or new exciting things that I have to say, or questions to ask, or things to offer, I feel like I get dismissed. "Oh, that is because you are new, don't worry, that will wear off." That is the attitude that is impressed upon me and that's frustrating. I went into this program all excited that I was going to help people. (Fedra, Interview #1, Lines 535-553, pp. 12-13, 2013)

These nursing students tended to become disillusioned by nurses' lack of caring—a core nursing practice value—which in turn influenced the students' moral development. Keen (1991) suggests that nurses unable to demonstrate care toward their colleagues are unlikely to provide optimal care to patients. Disappointed, discouraged, and confused by nurses who did not seem to care for each other or for their profession, the students nonetheless sought to understand why behaviours in practice did not meet their expectations of care. To this end, they open-mindedly analyzed the relationship between the context of their preceptorship placements and the nursing practices therein. The students discovered that practice context influences nursing care; burnout, fatigue, lack of

peer support, responsibilities to many individuals, and time constraints could all result in uncaring behaviours. One student remarked:

> When someone is burned out I see them as having little morals . . . I think [working] too long in really stressful units, not having peer support, not having the support you need. Not having the ability to talk about those issues and download with people . . . I find a lot of them [nurses] have a more like callous attitude and less morals than someone who has just come out [of a nursing program]. (Meropi, Interview #1, Lines 777-806, pp. 17-18, 2013)

As the students reconciled their visions of practice with the realities of their preceptorships, they began to understand that nurses also struggled to enact their visions of ideal nursing care. Practising alongside their preceptors, the students began to appreciate the factors compromising ideal care. Debriefing with preceptors afforded the students a greater understanding of some nurses' seemingly uncaring behaviours; their perspectives on the value of nursing care in institutions; and their frustration of being unable to deliver care consistent with their nursing values. The students also came to understand the importance of self-awareness in avoiding behaviours that might be perceived as uncaring; upholding personal values and caring behaviours; and promoting moral development. Endeavouring to understand other nurses' seemingly uncaring behaviours, together with their underlying perspectives, also shaped the students' moral development.

The students came to acknowledge contextual factors influencing nurses' ability to demonstrate care, and to identify their own responsibility to address caregiver fatigue and burnout. They came to recognize how nurses' behaviours can impact patients—how even small incidents of uncaring behaviour can have

detrimental outcomes. The students thus became aware of their own responsibility to address issues affecting nurses' abilities to enact caring behaviours in practice, and to advocate for policies that support nurses.

One student was able to live out her ideal vision of nursing in her preceptorship. In contrast to other students' placements, this student's preceptorship took place in a community practice, where she witnessed firsthand the daily lives of patients outside the hospital setting. This student lived out her personal values of nonjudiciality; respect; equality; and regard for "the patient as a person". The nurses in her preceptorship area strove to be proactive and visible advocates, thereby enhancing the lives of patients. Altogether, this student's preceptorship served to consolidate her moral identity and her values for practice. Just as a relationship existed between the culture of the preceptorship setting and student moral identity, it also became evident that assimilating into practice cultures was necessary for students to harmonize personal values in their preceptorship placements.

g. Assimilating into the practice cultures. In their preceptorship placements, the students found unit culture—whether positive or negative—integral to shaping their moral identities. While the students observed cohesive teamwork, they also deemed some behaviours maladaptive. Prominent among these was the acceptance of judgmental behaviours, either among staff or towards patients. For the students, nonjudiciality was an important value for practice; judgmental behaviours thus presented a moral issue. One student explained:

> I try my very best to look at everybody objectively and not bring any judgments in with me. I often see patients get written off. When they

> come in, they are judged almost instantly. It's, "Oh well, this person is this, this person is that." I try really hard not to do that, especially in [area], because in that setting you see that person as they are before you put them in a hospital gown. I feel like they are almost a different person, if that makes sense. I just try to have that holistic approach in trying to leave your judgments out of it, and to just do the best nursing care that you can. (Fedra, Interview #2, Lines 52-65, pp. 1-2, 2013)

The students expressed the importance in avoiding judgmental behaviours. Some student felt they had to behave in ways consistent with the dominant cultural norms of the unit, and/or their preceptors' beliefs, but not their own. Others resorted to passive resistance by "not saying anything" or behaving congruently with their personal values. In a grounded theory study on the socialization and values of new graduate nurses, Philpin (1999) found that nurses conformed with unit norms, rather than challenging them, to avoid being bullied or excluded from the nursing team.

The students were acutely aware of how they were being socialized into practice, and how group norms and values were influencing their own actions and behaviours. The desire to maintain cohesive, non-adversarial relationships with their preceptors took precedence, attributable both to the power differential in these relationships, and to gender differences regarding peer socialization and perceived conflict. As the majority of the student participants in this study were female, their avoidance of adversarial relationships might be attributable to their sensitivity and demonstration of moral concern for the perspectives of others (Gilligan, 1982). Individuals are socialized into peer groups; Lever (in Gilligan, 1982) and Gilligan (1982) identified gender differences that arise from perceived conflict amongst elementary school children. Using rule-bound games to

compare boys and girls' actions in a conflict, Lever observed that boys quarreled frequently, yet resolved their disputes effectively without terminating the game. When disputes arose among the girls, they tended to end the game; Lever concluded that they regarded maintenance and preservation of peer relationships as more important. The nursing students in this study likewise valued relationships with co-workers, avoiding challenges to their preceptors and other interpersonal conflicts. The students found it challenging to speak out or act counterculturally; they required courage to become social agents in practice.

Courage. Care theorists, drawing from pragmatism, nurture learners to become moral agents who hold true to their beliefs, thoughtfully analyse and evaluate encounters, and respond emotionally to the perspectives and needs of others (Noddings, 2002a; Noddings, 2002b). Noddings emphasizes that educators must attend to students' instincts, guiding them in the synthesis and analysis of information to develop sound decisions and actions. Faculty members and preceptors taking part in this study strove to guide the students to appreciate multiple practice perspectives in practice, in relation to their own perspectives and encounters. Sellman (2009) suggests that open-mindedness is vital for nurses; activities developing open-mindedness can guide nursing students toward practical wisdom, or professional phronesis. Moreover, behaviour according to one's own values and beliefs, in a given situation, requires initiative, persistence, and courage—qualities that must be nurtured throughout the educational process (Noddings, 2002a). Courage emerged as a theme in the interviews with the faculty and student participants. One faculty member remarked:

> I think that taking responsibility requires courage. Whether that's for your own learning, for your own life experiences, because the students had to live up to that and they wrote about this [upholding personal values in practice] . . . I think they need courage to live up to their own moral and ethical values. It's okay to have them, but we need to own them. And that does require a degree of courage, because you can't hide behind some competency if you do that. (Hermione, Interview #2, Lines 698-711, p. 16, 2013)

The faculty participants agreed that students need courage, yet their perceptions of courage varied. One faculty member felt courage was necessary for living up to one's values in practice, a view consistent with care theory. Two faculty members, working with students in hospital settings, felt courage enabled students to thrive in the nursing program and in preceptorship. One faculty participant stated:

> Courage. I am beginning to realize that students need courage to be in this program. I've been reading some of their papers recently, and oh my God, what they have gone through in this program! They need courage. So that is a value that I am starting to look at more. (Elpida, Interview #2, Lines 91-96, pp. 2-3, 2013)

The aim of fostering student courage is to develop moral practitioners who can advocate for their values and for the dignity of others. Possessing the courage to preserve one's dignity emerged as a prominent theme in this study. The students's need for courage perhaps correlated with the supportiveness of their preceptorship practice environments. A supportive preceptorship environment is essential for learning (Myrick, Yonge, & Billay, 2010); the absence of such an environment, in institutional care settings, could hinder the moral development of students.

The students themselves emphasized the importance of developing the courage to behave congruently with their personal values. One remarked:

> Courage in a sense, because I think I know in certain instances when something needs to happen. Sometimes you feel reluctant to do something, but you don't feel that it is your place. I think when you feel like you are doing the right thing and take that courage and that step to do something and just to be that voice, then I think that's mobilizing power. To have courage and just know that what you are doing is the right thing and do what you believe in. (Agapi, Interview #2, Lines 443-452, p. 10, 2013)

In keeping with the faculty perspectives, the students believed developing the courage to bring their voices forward was essential. They tended to voice concerns only later in their preceptorships, once they had become comfortable enough in their settings to advocate for their values. One student recounted:

> I got that heart racing feeling and my stomach felt heavy. It was like you were about to stand up in front of about 50,000 people and make a really important speech. As soon as she said it [nurse said derogatory comments about a patient], my stomach dropped. I was just like, this does not make me feel good, and I knew it was not right. I guess that would go back to my morals, or what I find ethical . . . I also felt like if I stood back and didn't say anything, I would be essentially encouraging the behaviour. So I didn't think that saying, "I don't really think that should be said" was crossing the line. I was just voicing I didn't think it was right. (Fedra, Interview #2, Lines 228-243, pp. 5-6, 2013)

Interestingly, toward the completion of their preceptorships, students felt they behaved more congruently with their values and developed the courage to stand up for their beliefs. This emergent courage could be attributed to the pedagogical fostering of reflexivity, self-awareness, and clarification of personal values. As they participated in debriefing sessions, the students began to move past their own perspectives, more readily recognizing their professional

responsibilities and obligations to others in nursing practice, particularly the patients.

2. Learning to Recognize the Patient's Experience

A second, core category emerging in this study was *learning to recognize the patient's experience.* By the second interview, all students had completed their preceptorship course. Free from the burden of acquiring competencies necessary to pass the course, they students were ready to reflect more deeply on the practice context and the patients' experiences.

Students. Central to students' moral development was the ability to identify and understand the context of the individuals for whom they were caring. According to Hauser, (2006), moral agents empathize and take others' perspectives. Nursing students demonstrate moral development in understanding others' experiences. One student stated:

> Especially as a student you have to really make sure you are having that one on one time with your patient, and that you are relating with your patient. And that you are engaging in that nurse patient relationship to make sure that their autonomy is being respected and their dignity and decision making process is still being respected. As I progress into becoming an RN and having an individual practice I wouldn't want to lose the lessons that I have learned as a student by being a very sensitive to the person and trading that in for all of the technical skills that you will need to acquire. (Xeni, Interview #1, Lines 813-825, pp. 18-19, 2013)

The students identified holistic care as a personal practice value. A perspective of patient context was essential therein, for consolidating personal values and providing comprehensive care, consistent with professional and ethical standards. The students conversed with patients, to learn about them as individuals and to demonstrate genuine caring, thereby coming to recognize the

importance of practicing holistically. In Taylor's (1991) view, authenticity involves respecting one's holistic, dialogical, and historical nature. The students required their preceptors and the nursing team to accept and respect them as individuals; in turn, they transferred this acceptance and respect to patients. The need to be treated holistically thus impelled the students to recognize the individuality of patients.

The students observed negative consequences from the lack of holistic assessment. Moreover, they recognized the importance of addressing their patients' psychological, financial, and social concerns. Students in acute care settings were particularly aware that the failure to assess and address aspects of a person's being could exacerbate physiological problems. The students came to understand the need to separate the patient from his/her health deviation or illness; the inability to do so, they observed, ultimately led to judgmentality and incomplete care.

The nursing students agreed the nursing program helped them to understand the importance of patients' perspectives and contexts. Two students affirmed the importance treating patients as though they were family members, to ensure the best possible care. One student stated: "If they were my family member, I would want them to be able to make an informed choice" (Desponia, Interview #2, p. 1, 2013). Another added:

> To treat them all equally, respect their beliefs, cultural, religion, like religious beliefs, traditions. And to treat them like you would treat your Grandma. Like with the care that they need, that's something that I try to keep in mind too, . . . because people are more inclined to take care of their own family and sometimes it is easy to cut corners. (Meropi, Interview #2, Lines 212-225, pp. 5-6, 2013)

All students emphasized collaboration with patients in care, recognizing patients' needs for choices and autonomy. As the students gained insight into their patients' perspectives, some students envisioned themselves in the patients' positions, thereby realizing the enormity of their situations. One student remarked:

> I listened to him and I recognized that he doesn't have much . . . I don't think I'd want to see anyone in that situation. He needs help and I know we have the ability to do that. I talked to him about the plan first to see that he was okay with it, and I went [to tell the preceptor and charge nurse], and I just think it was the right thing to do. (Agapi, Interview #1, Lines 295-304, p. 7, 2013)

Listening to the patients' stories, the students grew to recognize both the patients' experiences and their own duties and obligations in caring for them. Dialogue with patients helped the students to discover their abilities in assisting patients and making a difference in their care; to recognize their responsibility, as nurses, to listen to patients prior to making decisions or passing judgment; and to see that patients' vulnerability compelled them, as nurses, to protect and advocate. All the students valued questioning practice to ensure that patients were receiving safe, comprehensive care.

As they advanced in their preceptorships, the students grew to recognize the bilateral processes involved in the nurse-patient relationship. One student observed:

> Just consciously being aware of your body language and how you are feeling . . . Like patient's behaviours can put some people off, and be really frustrating at times and you can't let that show because that's going to interact with your ability to help that patient . . . And that can be done while you are with a patient, just taking a second to check yourself and then after through self-reflection saying, "How did I act towards patients

> today? What did I get from them? Were they all smiles around me, or did they want to rush out of the room maybe because I had a bad attitude?" (Meropi, Interview #1, Lines 471-494, p. 11, 2013)

The students agreed that positive encounters with nurses encouraged patients to disclose information and improved their regard for nursing and health care. Conversely, negative experiences caused patients to avoid accessing health care or disclosing important information.

The students stressed the importance of placing personal issues and struggles aside to focus on patient care. Acquiring technical competency, while investing time in learning about patients as individuals, was particularly challenging:

> I need to continue to expand my knowledge base to become comfortable with skills and the technical aspects of care, and then hopefully to anticipate those needs before they come up so I can be competent when any patient walks on the unit. But in compensation to that, especially as a student you have to really make sure you are having that one on one time with your patient, and that you are relating with your patient. And that you are engaging in that nurse patient relationship to make sure that their autonomy is being respected. (Xeni, Interview #1, Lines 806-817, p. 18, 2013)

In addition to the technical proficiency and the skills necessary for practice, the students needed to acquire a vast amount of biophysical and psychological information about the patient populations in their preceptorship placements. They felt themselves novices, unsure of the practices in these placements. Students in hospital settings learned to be diligent with their time and care priority management, to spend time with patients. One student explained:

> Because sometimes, especially with some of the patients you can feel like a glorified medication dispenser in a way, right? Some of them are on so many medications. So if you are just spending more time doing

> something like that than actually talking to them like looking at the holistic picture, that can be a little bit troublesome in a way. (Agapi, Interview #1, Lines 54-60, p. 2, 2013)

Engaging patients—and exploring their experiences in the hospital setting—could be difficult owing to the brevity of their stays; the severity of their illnesses; and the inadequate staffing levels on the units.

In contrast to the four students in the hospital setting, the student in community practice did not report the same challenges. She described community work as more focused on holistic care, emphasizing patients' biophysical, psychological, and social issues equally. Observing and working actively with patients in their own environment, she found it easy to observe and appreciate their actual experiences.

Faculty members' and preceptors' perceptions of students' learning. The faculty participants—particularly those who supervised students in acute care areas—were aware that students struggled to balance technical aspects of care with understanding of their patients as individuals. One faculty member remarked:

> I think they started seeing the patient. Whereas they didn't see the patient before, they saw the skills and all the work that they had to do. And now they started bringing, they had all the knowledge, they had all the skills now they could start looking at the patient and evaluating everything that is going on. (Elpida, Interview #2, Lines 235-249, p. 6, 2013)

Another commented:

> My expectation at midterm is that they are probably going to focus on the patient's diagnosis and skills. At midterm I say, "If you are still focusing on that, we've got to push it, because you've got to get to that transition." So it is all a process, 170 hours isn't a long time. So I say, "We need the big picture, not just you are doing this skill. Why are we doing this skill?

> Is it appropriate at this time for this person?" (Alethia, Interview #2, Lines 247-256, p. 6, 2013)

In the students' moral development, individual learning and consolidation of identity were prerequisites for recognizing the individuality of patients. Compared to the students and preceptors, the faculty members did not describe student engagement with patients in detail, insofar as these members were not present to observe directly the students' daily practices. The preceptors provided more thoughtful descriptions of their students' engagement with patients. One preceptor remarked:

> When he went in at the bedside, he put all that to the side and just be really kind and thoughtful and, as empathetic as he can. (Zisis, Interview #2, p. 7, 2013)

Another stated:

> Anything that came up in the community . . . she would want to attend it or see what it was all about and everyone [community members] was pretty good about it too. And they'll let you come visit and see what was happening. So she talked a lot to people, and they really appreciated that, they liked her telling stories. (Kallopi, Interview #1, Lines 465-471, p. 11, 2013)

Overall, the preceptors agreed that preceptorship enhanced the students' capacity to understand patients' values and ideals for care. They also knew the inability to perceive patients as individuals, in the context of care, could have negative consequences. One preceptor recounted:

> We're kind of the liaison between the families and the other members of the care team. We're the ones who are always there, so I think it is up to us in some ways to really communicate that to whoever is appropriate, or to go after the people who can provide the answers because I don't think it's [patients not being informed] fair. Especially when someone's waiting on something like a [diagnosis] result or something, it's just not fair to be

> able to wait longer then they have to. (Zisis, Interview #2, Lines 198-207, p. 5, 2013)

Preceptors routinely observed students as they dialogued with patients; listened to their stories; recognized their uniqueness; cared for them as individuals; made mutual decisions with them; kept them informed; built cohesive relationships with them; and attended community events to better understand them. In these student-patient relationships, the preceptors also witnessed the patients' receptivity toward the students.

The preceptors spoke of role modeling through the exploration of their patients' contexts in dialogue. All preceptors impressed on their students the importance of exploring patients' experiences in an honest, nonjudgmental manner—particularly when patients' health behaviours differed from normative health practices. One preceptor, distinguishing between patients' health-seeking behaviours and care providers' values for health, stressed the need for students to respect and value the former:

> I think, in order to protect people, sometimes you have to do things that might not be considered proper by other people. Like you have to consider the pros and cons of the different situations to see what actually works. For instance, it might not be ethical for a mom to smoke during pregnancy, but what if she went from smoking marijuana to just smoking cigarettes? Then we would think that was a good thing, a positive change. So it might not be ethical, but we are still commending her for what she was trying to do. (Kalliopi, Interview #2, Lines 43-53, pp. 1-2, 2013)

The preceptors wanted students to be aware of their own values, and to avoid imposing them on their patients. For their part, the students learned to suspend their own needs and emotions while embracing humanity in care. One preceptor observed:

> Even when he got frustrated he wouldn't show it . . . When he went in at the bedside, he put all that to the side and just was really kind and thoughtful and, as empathetic as he can . . . I think that was the thing that really struck me, was how kind he always was to patients and their families. (Zisis, Interview #2, Lines 290-299, p. 7, 2013)

In their preceptors' view, the students developed morally through exploring patients' experiences; recognizing and respecting patients' personal values and values for care; and temporarily putting patients' needs and emotions ahead of their own. Engaging with patients in the preceptorship areas gave the students professional fulfillment and an appreciation for the connections made. The preceptors were moral role models, genuinely caring and attentive with their patients. Observing this, the students were socialized into authentic caring for others, gaining awareness of moral issues in practice, and of the importance of communication to create meaning in practice encounters.

3. Identifying Moral Issues in Practice and Creating Meaning of Practice Encounters

A third, core category related to students' moral development was the identification of moral encounters in practice and the creation of meaning therefrom. This category comprised: a) identifying moral encounters or issues, both in practice and in the preceptorship relationship; b) creating meaning through dialogue with preceptors, faculty members, peers and others; and c) creating meaning through personal ways of knowing. Safe spaces and support systems were vital to dialogue, out of which meaning in practice encounters arose.

Socrates defines morality as an individual's search for meaning in life and existence (Sommerville, 2006). When students face complex situations in

preceptorship, they create meaning from these encounters. In their preceptorships, the students learned strategies to create meaning and to address complexities in practice. To understand complex issues, individuals work through tensions between subjective and objective; individual and collective; knowable and unknowable; and obligations to act and to exercise restraint (Sommerville, 2006). The students described three phases of finding meaning in their encounters: identifying a moral encounter or issue in practice; dialoguing with others to create meaning therefrom; and integrating personal ways of knowing into that meaning.

Students' moral issues in practice. I asked the students to describe moral issues or encounters in practice. In contrast to nonmoral social issues, moral issues encompass expected patterns of behaviour, duties, and consequences associated with transgressions (Hauser, 2006). Emotions often illuminate moral issues and moral transgressions, such as guilt arising from the consequences of actions (Hauser, 2006). In this study, moral issues in preceptorship fell into two key themes: clinical practice situations and relationships within the preceptorship triad.

For the students, moral issues arose from encounters and aspects of the practice environment that limited their nursing practice. Moral issues in practice situations were underlain by perceived moral tensions between the students' personal, moral values for practice and the realities thereof. These situational moral issues comprised: lack of time for engagement with patients, owing to task workload; the inability to provide holistic care; nurses' judgmental attitudes, lack

of patient advocacy, and unsafe practices not addressed by others; prioritization of institutional and medical values over nursing values; and the lack of acknowledgement of nursing contributions to health care.

The students were morally troubled by nursing behaviours that seemed to conflict with nursing values. This incongruity made the students all the more aware of the direct relationship between professional identity and practice behaviours. The students were particularly concerned that the nurses' unprofessional behaviours negatively impacted patient care.

One student was particularly concerned by her peers' competitiveness, which led them to suppress their personal values and beliefs in classroom situations and in clinical experiences:

> Ambition to get the highest grades; I think they are scared of the tutor getting the wrong opinion of them, being weak. Nobody wants to appear weak in this program, especially in clinical where you are all together and it is really competitive. (Desponia, Interview #1, Lines 738-743, p. 17, 2013)

Of the moral issues the students encountered in practice, patient suffering was the most prevalent; the theme of individual suffering was common to all interviews. *Suffering* (2014) is defined as the pain caused by injury, illness, loss, and so on; it encompasses physical, mental, or emotional pain. In a broad sense, actual or potential loss by patients, or others in the preceptorship, resonated the majority of the participants on a personal level. They were empathetic to others' suffering, identifying their obligation as nurses to alleviate others' distress. For the students, patient suffering included psychological suffering and social

rejection. While the students did not mention moral issues related to patients' physical suffering, their faculty members and the preceptors observed them:

> I don't think this student was able to pull it all together; it's just come together as she can think about the pieces, because all she could think about initially was the suffering of the patient and was this right. And all the pieces started coming together afterward. (Elpida, Interview #1, Lines 72-76, p. 2, 2013)

Another preceptor stated:

> Just because the child was so upset, I think. It had nothing to do with the [actual intervention] itself; it was just that the child was so terrified, so upset that she was fighting so much. And then the way that they were holding her down really I don't think she personally agreed with. So I think it just made her even more upset. (Kallopi, Interview #2, Lines 334-340, p. 8, 2013)

Rather than referring to ethical theory or principles, the students considered action essential to alleviate the suffering of their patients. One student observed:

> I just did my own thing . . . I just wanted, for my own sake, I wanted her to make sure that she knew there was somebody who cared whether she was dead or alive. Because I didn't feel like my preceptor did that for her. And nobody. The doctor hadn't, none of the other nurses had. (Fedra, Interview #1, Lines 849-858, p. 19, 2013)

Another recounted:

> I don't think I'd want to see anyone in that situation. So I . . . just [thought], He needs help, and I know we have the ability to do that. Yes, I talked to him about the plan first to see that he was okay with it, and I just think it was the right thing to do. (Agapi, Interview #1, Lines 300-304, p. 7, 2013)

This belief in the obligation to respond to suffering through action, without regard to specific guidelines, illustrates that descriptive principles of human behaviour do not necessarily have a causal relationship with prescriptive

principles (Hauser, 2006). The students responded to patient suffering not out of principle-based ethics, but out of a need to attend and respond to the experiences of others (Noddings, 2002a; Noddings, 2002b). For the faculty members, observing students working to create meaning from these encounters, the significance of recognizing the patient's experience was a central theme.

Confronting another's suffering, and recognizing the experience as complex, presents an opportunity to find meaning in life (Sommerville, 2006). The uniqueness of each patient encounter, and the context of care, led to varied lessons for the students, which they viewed as shaping their future practices. When one student encountered the physical suffering of a patient, as observed by a faculty member, the student learned about advocating for those unable to advocate for themselves:

> I think I can see already for this student it is already going upward, because all of the pieces are starting to fit together, and she can start talking about all the pieces. She knows what is standard practice and what isn't standard practice, and she is learning to have a voice. (Elpida, Interview #1, Lines 158-164, p. 4, 2013)

In another faculty participant's recollection, a student listened to stories from patients' family members, identifying the historical context and significance thereof for her patients; thereby, she better understood their perspectives, health behaviours, and conditions bringing them to care. The students were thus socialized into authentic caring practices as they explored the experiences of their patients, and of others. In addition to encountering moral issues in practice, students also cited moral issues arising from their relationships with their preceptors.

Moral encounters in the student-preceptor relationship. Moral issues within the preceptorship triad related primarily to the student-preceptor relationships. While all the students had cohesive relationships with their preceptors, they also experienced conflicts therein. While conflict is a natural element of any relationship, three students identified key moments of tension with their preceptors. Two of the three described this tension as persistent.

One student experienced a moral issue, arising from her perception that her values for learning and practice were incongruent with those of her preceptor. This student was reluctant to discuss her concerns and moral issues with her preceptor, for fear of creating an adversarial relationship and inviting possible reprisals. As a result, she was unable to engage with her preceptor to create meaning from moral issues in practice; this absence of candid dialogue significantly shaped her learning process.

Another student, identifying moral issues within his student-preceptor relationship, recalled a direct conflict with his preceptor in the presence of a patient. In this encounter, the preceptor made derogatory comments about the student's practice and progress, in the presence of a patient who had just experienced a life-changing event. The student was nonetheless able to put aside his immediate reaction and personal distress:

> So kind of not taking it just as the comment, but taking that comment and really assessing it. Not taking it as an insult, but professionally taking it first and dissecting it and then trying to get the implications as clearly as I can. So just kind of realizing that she was stressed, that it was a stressful environment. And that what was said had had a strong emotional component to it. (Xeni, Interview #2, Lines 671-679, p. 18, 2013)

While this student was able to contextualize the behaviour of his preceptor, he considered his preceptor's actions and comments morally troubling because they did not reflect the nursing values for humanistic care and professionalism in relationships. The student directly addressed the preceptor's comments in a private setting. Together, they worked towards a resolution to facilitate the student's learning and completion of the preceptorship course. They were able to amend their relationship because they addressed the situation immediately after it occurred, demonstrating self-awareness of their actions in their discussion.

Situational and relational moral issues evoked the students' awareness of actions or behaviours contrasting with their personal value systems. Consequently, they engaged in deep introspection about their personal values and beliefs regarding nursing practice. The students moreover spoke with faculty members, preceptors, peers, friends and family members about morally troubling issues they encountered in their preceptorships.

a. Dialoguing with others to create meaning in practice. Consistent with care theory, dialogue is central to moral education because it always indicates interest and concern for the other's perspective (Noddings, 2002a). The aim of dialogue is to understand the "other" (Noddings, 2002a). Dialogue imparts information about the participants, supports the relationship, motivates further thought and reflection, and increases the participants' communicative competence. It is the means through which we learn what the other wants and needs, and through which we monitor the side effects of our actions (Noddings, 2002a). Support systems for nursing students emerged as an important construct.

To explore practice encounters and create meaning therefrom, students dialogued with preceptors, faculty members, peers, other nurses, family and friends.

Dialoguing with preceptors to create meaning: Students. In preceptorship, the preceptors played a vital role in assisting the students to create meaning from moral issues in practice. Four students reported that their preceptors helped them to understand encounters and moral issues. One student did not address her moral issues with her preceptor, whose values she viewed as opposite to her own.

To create meaning from moral issues in practice, the students dialogued with their preceptors. For their part, the preceptors employed various approaches to help the students create this meaning, such as asking the students to share their perspectives on encounters or moral issues. This approach helped the students create meaning and facilitated the preceptors' understanding of their students' thoughts and actions. One student recounted:

> First of all she checked to see if I had the same opinion on it, on the situation, and I did. And just helped me understand and see how these people need to be advocated for, and it was her a lot, just telling stories how she had helped patients, where they had been in a bad situation because they weren't being advocated for. (Meropi, Interview #1, Lines 79-86, p. 2, 2013)

Another stated:

> I just brought that up to my preceptor, who was also not assigned to that room, and we discussed what that meant for ethical practice, what that meant for routines on the floor, and how we have to make sure we are getting in those checks at the appropriate times. (Xeni, Interview #1, Lines 76-81, p. 2, 2013)

The students reported that, in discussions on moral issues, their preceptors encouraged them to analyze the ethical implications for practice and consider other nurses' assumptions and perspectives guiding their actions. All preceptors encouraged their students to think about how to address similar encounters in future practice.

As they dialogued to create meaning from moral issues, the students also observed their preceptors' self-awareness, out of which they created their own meanings. One student recalled:

> Two weeks later when I passed that program, she said that I was doing very well and that I was going to be a good registered nurse, and that some things that came up with time management were things that she had trouble herself dealing with . . . She also disclosed to me "you do a lot of work, it is a lot of work that you do, I worked a shift without you and I realized how much work it was" (Xeni, Interview #2, Lines 485-501, p. 13, 2013)

Two students, who experienced moral issues with their preceptors, cited the importance of dialogue to appreciate the latter's perspectives, and to express their feelings, thereby resolving relational issues. Both students came to appreciate the need to address relational tensions in a forthright manner, mindful of their own thoughts, behaviours, and actions. One remarked:

> Because everything was subtle, there was nothing obviously glaring at me in the face that was wrong with our relationship, it just felt like there was tension at different points . . . I think she appreciated, or saw that I was actually reflecting on my own behaviour in that situation . . . it was just a matter of communicating that to her. (Agapi, Interview #2, Lines 146-160, p. 4, 2013)

Working through relational, moral issues with their preceptors, the students learned the value of relating; understanding others in practice; and working as a cohesive team in delivering safe, competent nursing care to patients.

Notwithstanding routine, end-of-shift dialogues with their preceptors, the students waited to personally address moral issues or sort through encounters. Three students waited until the end of their preceptorship placements to speak with their preceptors about significant moral issues troubling them. The students needed time to reflect on these issues—whether they pertained to their preceptors' practices or the preceptor-student relationships—and to feel assured their preceptors would be receptive to their concerns. Inasmuch as the students believed voicing these concerns could potentially create conflict with the preceptors and compromise their completion of the course, they delayed discussing them. When the three students at last discussed these issues with their preceptors, upon completion of their preceptorship placements, the preceptors addressed their concerns respectfully and attentively, showing self-awareness and reflexivity. One student remarked:

> He asked me, "Is there anything that I could have done differently? Anything that could have been more beneficial to you?" And I was like, "Did you remember that [patient]?" And I reiterated the situation to him. He sees patients all the time. For me it was a big experience, but for him it was more every day . . . And he's like, "You are right, that one particular situation, I feel we did a crappy job at treating that patient holistically. I think that happens here in [area] and it shouldn't." (Fedra, Interview #2, Lines 93-112, pp. 2-3, 2013)

The students were thus able to appreciate their preceptors' perspective and to learn from their responses.

Preceptors' observations of students. Throughout the preceptorship, the preceptors debriefed with their students. The preceptors agreed it was their role to "be there" to listen to students; to acknowledge their perspectives; to be open and respectful; and to ensure that the students were comfortable discussing practice concerns. They felt it was their responsibility to help students explore their perspectives and feelings in practice. One preceptor remarked: "I just basically let her tell me what her concerns were. So I let her do a lot of the talking at first and why she was upset by it [incident]" (Kallopi, Interview #2, Lines 297-299, p. 7, 2013). Another recounted: "I always at the end of shifts, we talk. They say how their day was, what did you find difficult, any topics you want to go over . . . things you didn't find easy on the shift" (Parthena, Interview #1, Lines 247-250, p. 6, 2013). Other preceptors added:

> Asking him, "What do you think about this situation?' And getting him to tell me what he thinks . . . Just trying to see exactly where his general ideas about a certain situation might lie and trying to discern what parts he might be overlooking or just too busy to think about, or inexperienced to think about. Just sort of getting him to think "outside the box". (Zisis, Interview #2, Lines 227-239, pp. 5-6, 2013)

> She talks to me about it. I think talking about it is a big thing. I think keeping it inside could be harder for her to deal with it. I think as long as they verbalize it, that is a good thing . . . So she obviously is trying to work it out somehow, so that is good. (Evangelia, Interview #2, Lines 400-406, p. 9, 2013)

To further assist the students to create meaning from the moral issues they encountered in practice, the preceptors helped the students:

- to understand the perspectives of patients, families, and nurses;
- to reflect and identify their professional responsibilities;
- to clarify their values;
- to integrate their learning into their value systems;

- to explore ways to balance their personal values with patients' wishes;
- to identify the contextual factors involved;
- to research topics of concern, thereby enhancing their knowledge of issues and informing their thought processes.

By engaging students in this interpretive process, whereby they evaluated the means and outcomes of their practices, the preceptors cultivated their practical wisdom (Myrick, Yonge, & Billay, 2010).

The preceptors guided their students to discover of the dynamics of the practice area and the moral encounters shaped thereby, such as the patients' circumstances and rationales for care protocols; the context of work and how it influenced the nurses' well-being; the significance of teamwork; and the contributions of each team member to provide care. The preceptors cited the busy nature of acute care practice, in hospital settings, as a barrier to debriefing with students about practice issues.

The preceptors agreed that individual perspectives influence moral issues and situations. When debriefing with the students, the preceptors encouraged them to rationalize moral issues, and to understand the emotional reactions, perspectives and experiences of patients and others. As the preceptors offered the students their perspectives on troubling practice encounters and moral issues, they too became more aware of themselves and their perspectives on care. As much as the students, the preceptors valued debriefing in helping them to appreciate the former's perspectives. One preceptor recounted:

> We did a lot of reflection after each day. And I think that was good, because they could tell you what they saw and how it could be a totally different experience. I would see one thing, and they would be looking at something else. So, it was really neat to see how the same situation is

> viewed by two different people and what she took from it based on what I did was neat to see. (Evangelia, Interview #2, Lines 505-512, p. 12, 2013)

When preceptors debriefed with their students, they helped them to analyze their professional responsibilities by encouraging them to share their thoughts and feelings about encounters and moral issues. The preceptors assessed their students' thoughts and actions, evaluated them for congruency with professional responsibilities, and appraised the students' abilities to identify their professional obligations in a given situation. If the students felt confused, the preceptors prompted them to further explore and clarify their professional responsibilities, in the context of a given situation. The preceptors also prompted the students to explore how their emotional reactions shaped their perceptions of the situation. One preceptor explained:

> We stayed a little longer after the shift just to talk and see if everything was okay with him after what had happened . . . It is important to understand and be comfortable with handling those kinds of situations, and that it is definitely my job as a preceptor to ensure that the student is not traumatized by that situation. That they have an opportunity to express how they feel about it, and are made aware that there are supports if they are feeling overwhelmed. (Zisis, Interview #1, Lines 87-107, pp. 2-3, 2013)

The preceptors noted that a significant purpose of debriefing was to ensure the students' well-being, mindful of the stress brought on by unfamiliar areas of practice, and the struggle to transition from the student role to that of an independent, graduate nurse. As individual practitioners, the preceptors demonstrated genuine concern for their students' learning and well-being, thereby actively engaging them in authentic caring practices. This genuine concern in attending and responding to student needs reflected the preceptors' ethic of care.

The preceptors also agreed that encountering the same moral issues with different patients, over time, helped to create meaning in practice. One preceptor commented:

> I think that once you've had 15 patients in that same scenario, then you are like, "okay, I am just going to do my, what I need to do to make sure this patient is comfortable". So I think the first couple [of patients], it will take a while. I am sure that I was like that when I started too. I'm sure my attitude isn't quite how it was eight years ago. I think that just over time it would change. (Evangelia, Interview #1, Lines 383-390, p. 9, 2013)

They acknowledged that the students, as novices in their preceptorship areas, were just beginning to identify and address moral issues in practice. The preceptors moreover believed that sufficient exposure to a given practice area was instrumental in shaping the students' perspectives on moral issues in practice.

Like the faculty participants, the preceptors stressed the importance of student preparation in addressing moral encounters, circumventing additional anxiety, and coping with new, overwhelming learning environments. One preceptor explained:

> Preparing a student is important because if they are not prepared to see what they see when they walk into a room, not everyone is comfortable working with a patient with a [assessment status] . . . So that presentation in itself can be a little shocking. So I think it is important to prepare a student for what that may look like. When they walk into a room and they have that emotional preparedness. And sometimes it is not as shocking to some people as others, because it is each individual. (Zisis, Interview #1, Lines 131-143, pp. 3-4, 2013)

The preceptors prepared the students by explaining how patients would appear, and what kind of care the students would need to provide in each situation. They urged students to contemplate how they would react to these situations, prior to being placed therein. The preceptors agreed with the faculty

members that preparation was necessitated by the students' potential inability, in practice situations, to identify what to do immediately. They nevertheless concurred that such preparation, while helpful, was no substitute for engaging in the actual process. One preceptor elaborated:

> Well, even your first patient that codes. When you are doing your CPR recert [recertification], you do your rates of 30 and 2 and just go ahead and do it on this dummy, but the instant it's a patient it is totally different. You have done exactly the same thing in the CPR class, but it is 100% different when it is someone that is there in that situation . . .So I think just more exposure to the real thing, not just the scenario is what will help them. (Evangelia, Interview #2, Lines 474-494, p. 11, 2013)

Whereas the faculty members engaged the students in hypothetical situations, to prepare them cognitively for practice, the preceptors prepared them by directly assessing their ability to cope emotionally with anticipated situations. When the students reported moral issues in practice situations, faculty generally dialogued with them for several days or weeks following the encounters. The students thus had more time to rationalize and reflect on the moral issues when they debriefed with faculty members. As the preceptors and students practiced closely together daily, the preceptors were in the position to observe and address the students' immediate reactions. For the most part, these reactions were emotional. As one preceptor stated:

> Just because the child was so upset I think, it had nothing to do with the actual immunization itself, it was just that the child was so terrified, so upset that she was fighting so much. And then the way that they were holding her down, I don't think she personally agreed with. So I think it just made her [the student] even more upset. (Kallopi, Interview #2, Lines 334-340, p. 8, 2013)

The preceptors genuinely came to understand the significance of individuality when they debriefed with their students about practice encounters and moral issues. They attributed the difference between their students' and their own perspectives to emotions and emotional responses. Whereas the preceptors often appraised encounters based on previous experience and professional knowledge, they viewed the students' initial appraisals of encounters as emotional. The preceptors often described the students as upset, especially by patient suffering. They attributed such responses to the students' lack of exposure to clinical situations.

The preceptors demonstrated thoughtful self-awareness when debriefing with the students. They also described themselves as somewhat desensitized to nursing interventions that evoked emotional reactions from their students. Reflecting on their own experiences as nursing students and novice nurses, the preceptors recalled being more sensitive to patient reactions arising from nursing interventions and care. They attributed their desensitization to consistent exposure to given situations, and to awareness of patients' actions and reactions to issues. One preceptor remarked:

> I think the physical restraining thing was the biggest issue for him . . . I remember first thinking, it is cruel because this person doesn't really know who they are, where they are, what is going on at all . . .But sometimes it is a matter of their safety, and it's hard. I think it is really a hard thing to watch . . .I guess I've sort of become desensitized in a way. But I try not to let it undermine thinking about their safety and trying to discern whether it is actually appropriate or not. (Zisis, Interview #2, Lines 638-698, pp. 14-15, 2013)

Another stated:

> It didn't really upset me; it was just because the child was moving so much, I thought that it was a safety issue for me. Because kids scream all the time with me, it doesn't bother me any more. But for her, I think it was just because the child was so upset that she felt so bad for the child that she didn't want to do it. (Kallopi, Interview #1, Lines 356-361, p. 8, 2013)

The preceptors also agreed that desensitization could be positive or negative, depending on the encounter or moral issue. One commented:

> I think it depends what you are being desensitized to. With the immunizations, it would be a positive thing because you are not being upset or worked up about it because the child is crying [then] the parents don't get upset, because you are nice and calm, they become calm as well. Being calm helps calm down the child, it is a circle. So in that situation, it is a positive thing. Becoming desensitized to, say something else like [issue] because there is so much of it [in practice area], and then just not necessarily thinking, but not getting upset about it might be different, that would be a bad thing, I think. (Kallopi, Interview #2, Lines 362-374, pp. 8-9, 2013)

The preceptors believed that desensitization to certain issues could negatively impact their practice by limiting their motivation to help patients. Preceptors expressed the need to be self-aware, regarding desensitization to certain issues, in order to continue providing safe, competent patient care.

The preceptors noted that their students sought to understand moral encounters by discussing them with others, searching for information about the issues, and journaling reflexively. In debriefing their students, the preceptors observed them identifying encounters or moral issues; acknowledging their personal beliefs in these situations; distinguishing the patients' beliefs from their own; and identifying boundaries and professional responsibilities. The students also identified contextual factors influencing encounters or situations. This recognition occurred over time, rather than immediately afterward in the

debriefings. Immediately following encounters, and shortly thereafter, the students were more likely to focus on their personal, emotional reactions and the rationales thereof. The students justified their reactions by explaining they "did not want to do what they did not feel was right". The preceptors agreed it was important to encourage students to create meaning from these situations—meaning which they could adapt to future practice.

Throughout the interviews, I invited the preceptors to share their personal perspectives regarding moral issues in practice. Without exception, they reported that their perspectives evolved over time, given their repeated exposure to such issues. The preceptors also agreed that every encounter was unique, yielding different insights with regard to addressing future encounters. One preceptor stated:

> I think repeated exposure is huge. Like I mean if you look at your first patient that passes away, that one is huge. I'll never forget mine. And then, you know, I don't remember my 8th or my 10th. Or you remember the really sad ones, like the younger patients. So I think repeated exposure makes your experience different. You take away different things from each experience. And I think it helps how to deal with each issue if it comes up. (Evangelia, Interview #2, Lines 415-422, p. 10, 2013)

Observing their students' emotional reactions to encounters in practice, some preceptors became more mindful of their own moral issues, and how their views thereon had evolved. Dialogues with students, to explore their perspectives as novice nurses, inspired the preceptors to reflect more readily on the moral issues in their own practices.

Moral issues for preceptors in practice. Two of the four preceptors, both practising in hospital settings, indicated moral concerns in practice. Prominent

among these were patients' dignity and suffering, in situations where they could not choose for themselves. These moral issues had an emotional impact on the preceptors. One preceptor remarked:

> I have issues with it too [restraining patients] . . . It's got to be terrifying [for the patient], but not everyone is aware that it is for their own safety. And it is hard to remind patients who have [diagnosis] of that because they can't always comprehend the reasons why. That is probably the hardest, when someone is pleading with you not to [apply restraints] as you are doing it. (Zisis, Interview #2. Lines 733-741, pp. 16-17, 2013)

Another stated:

> I think it is just, where is the compassion for the patient? In your head, you are like "this patient is suffering". It is so easy to; not easy to, I'm not saying easy to take their life, that is not what I mean, but easy to end their suffering. Especially when you see five days later, there is nothing more and they stop treatment. Then they put them in total compassionate care or whatever. Then it is like, why did we go through this for five days, why was it not done before? (Evangelia, Interview #1, Lines 324-333, p. 8, 2013)

Compassionate responses are moral emotions arising when individuals face others' suffering (Hauser, 2006). The preceptors described their moral issues as contrary to their personal and professional values. One preceptor daily encountered a moral issue related to patient suffering, as a consequence of life-sustaining medical interventions. Her colleagues also shared the same moral concern, leading to frequent, negative conversations. She remarked:

> There are always ethical issues on our unit. Sometimes, you have one patient and you are like "why are they doing this to them?" and that makes it hard on you. You don't necessarily need to reflect it on to all your patients, but you tend to. You know, there is always staff lounge talk, right? It is sometimes negative, unfortunately. So that makes it hard I think. (Evangelia, Interview #1, Lines 294-301, p. 7, 2013)

This preceptor attributed her colleagues' negative conversations to their belief that holistic patient care—a nursing value—was secondary to medical interventions. While she acknowledged the need to express frustration when values for care are inconsistent with practices in the clinical area, she was also mindful of the challenges arising from such expression. Negativity in nurses' conversations could transfer both to patients and to students, adversely affecting learning. This participant regretted her negativity, especially in the presence of new staff members and students. She stated:

> I don't want them to start off on that foot, because there is like such a potential for it [preceptorship] to be a positive thing that I wouldn't want to ruin it for a student. I don't know what changes it. I guess it should be like that all the time, I shouldn't engage in negative conversation. But sometimes it is helpful just to vent. But I think when there is a student around, it is more like "well, maybe we should not vent right now," because they don't necessarily know that that is a negative thing until they are exposed to it. (Evangelia, Interview #2, Lines 171-182, p. 4, 2013)

The preceptors agreed that students should be allowed to create their own meanings from encounters and issues in practice, rather than adopting their preceptors' beliefs. This view accorded with the professional nursing responsibility to respect autonomous decision-making.

Two preceptors expressed no moral issues in practice. The preceptor in the community setting felt the institution supported her, notwithstanding institutional practices and policies that limited her ability to offer patients the best possible care. Daily engagement with patients, in their own contexts, perhaps accounted for her freedom from moral issues. Comparing her previous, hospital practice with her current community practice, she contended that the former's time constraints, resource deficits, and the biophysical emphasis on care

prevented her from engaging with patients and understanding their individual contexts. In her view, community settings facilitated holistic care, insofar as nurses therein could observe their patients' lived contexts and better meet their needs thereby.

The other preceptor expressing no moral issues practised in a hospital setting, wherein she felt able to live out her personal and professional values:

> I am really open. As I am open to my culture, I am open to anybody else's culture. If that is your culture's practice, I totally respect it. And even if I am not agreeing to it on a personal note, that does not affect my practice. (Parthena, Interview #1, Lines 587-595, pp. 13-14, 2013)

The preceptors' unique perspectives on moral issues in nursing practice contributed to their students' moral development, through harmonization of personal values; integration of previous experiences; reconciliation of practice realities; recognition of patients' individual contexts; and engagement with others to create meaning from practice.

Dialoguing with faculty members to create meaning: Students. In addition to engaging with their preceptors to create meaning in practice, the students also conversed with faculty members to gain understanding therein. One student indicated:

> I have briefly talked to her about it, and she's really good and letting me voice everything, and she agrees with me about a lot of this stuff. She has a similar background in [area], and I think that's why she went into [area], is a lot of the same issues. (Desponia, Interview #1, Lines 255-259, p. 6, 2013)

The students regarded faculty as a resource to which they could turn for support and guidance with practice concerns. Student discussions with faculty, on

moral issues, were contingent on the dynamics within the student–faculty member–preceptor triad. Three students engaged with faculty to understand general encounters and moral issues in preceptorship. A fourth student engaged daily with her preceptor to make sense of these situations, and hence did not engage with her faculty member. Another student had minimal contact with her faculty member, approaching her only for emotional support after witnessing a patient's death.

Faculty members helped students in various ways, recounted by the latter, to create meaning from the moral issues encountered in practice. One faculty member helped a student clarify her practice values, when she perceived those of her preceptor to differ and thus felt unable to discuss moral issues with her. This student engaged with her faculty member and other nurses in the preceptorship area to create meaning. Engaging these individuals, who shared her practice values, helped the student to clarify them and to reinforce their meaning. Given the difference between her nursing care practice values in the preceptorship area, and those of her preceptor and the institution, she was aware that her socialization into this environment could potentially change her values for practice.

> I guess I don't feel confident enough to bring up these issues with a big group all at once at this point, and I'm afraid maybe its something I don't know at this point that they do. Maybe I'm going to change my opinion in the future. (Desponia, Interview #1, Lines 349-353, 2013)

Another student discussed, with his faculty member, moral issues arising from an encounter with his preceptor. The faculty member was accessible and supportive, helping him to work through these issues. Thus able to openly discuss the incident and his feelings, the student was able to further reflect on the

encounter to gain meaning thereon. The faculty member helped the student to reflect on and to clarify the moral issue, and to work towards resolving it.

> So, by the end of the shift I had confronted my preceptor about it. We had gone through a plan of action. Once we had got that officially laid out I sent it to my preceptor, and then also to my faculty member. And she [faculty member] just approved it, and asked if I had any concerns about the situation and asked if I was still feeling okay in my preceptorship experience. We had done a phone call update regarding that, and any of the residue that was left over from the situation was handled, more so, with me and my tutor. (Xeni, Interview #1, Lines 447-457, 2013)

In student-faculty member relationships, creating meaning was a pedagogical endeavour shaping the moral development of the nursing students. The faculty members' pedagogy reflected elements of care theory and a relation-centered focus. Consistent with care theory, the faculty members encouraged the students to engage with and appreciate the context of their preceptorship practices, thereby gaining insight into their personal values; their relationships in practice; the perspectives of others; and virtues such as respect, honesty, courage and compassion. Faculty members encouraged the students to engage in relational encounters, to understand how they felt treated by others and to foresee themselves as nurses treating patients. According to Noddings (2002a), pedagogical approaches reflecting an ethic of care result in individuals' acquisition of virtues and/or behaviours evincing their moral motivation to demonstrate "goodness."

Faculty members' observations of students. The faculty participants described themselves as facilitators, helping the students to make sense of the preceptorship process. As one faculty participant remarked:

> I think talking with them, about how did they feel about the situation. What do they think their role could have been? Do they think this was normal? Even sometimes you have to push the boundaries, if you make the decision this was not normal, what should you have done? Can you think about that? (Elpida, Interview #1, Lines 320-326, pp. 7-8, 2013)

Another recounted:

> I had a student e-mail me last week and said: "My journal must get really boring, because I think I am repeating myself." And I said: "No, lets read this really carefully, because what I see is something very different. What I see is you are growing as a practitioner. You are able to more clearly recognize some of your pieces that trouble you, that aren't so clear." (Hermione, Interview #1, Lines 271-277, pp. 6-7, 2013)

Through strategies such as dialogue, reflective journals and blogs on the course website, faculty members engaged with their students to create meaning in practice. All faculty participants emphasized that the search for understanding and meaning in practice is a significant learning outcome of preceptorship. One faculty member stated: "One has . . . learned to search, not just for material, but for more understanding of things . . .Are those moral things to be taking away? They are strong things to be taken away, and supportive things" (Elpida, Interview #2, p. 10, 2013).

All faculty members debriefed with their students to explore issues in practice, and to help them understand why these issues were significant to them. Debriefing enhanced the students' moral awareness and development by allowing them to share, to learn more about their thought processes, and to recognize the factors that enhanced or impeded those processes (Noddings, 2002a). The faculty members agreed that dialogue with students, about their encounters, helped them develop self-awareness, clarify their practice values, and identify desirable

behaviours for future practice: "And I often say to my students, 'Go back to the patient. If it is distressing to you, what caused that? Let's engage with that'" (Hermione, Interview #1, p. 2, 2013).

Faculty members spoke of encouraging of the students in debriefings to "look at the big picture," by prompting them to consider the interplay of personal, contextual, interpersonal, and institutional factors that affect an encounter or issue. One faculty remarked:

> And role model it through discussion, if they are part of the discussions. So on our blogs we'll have a discussion going and two students will make one comment, but I might bring in a different perspective just to help them keep thinking about other views on the situation. (Olympia, Interview #1, Lines 498-502, p. 11, 2013)

Another stated:

> The idea of [course website] is that you are all in different areas . . . This one place where you can all come together, and you knew each other in [course], you can actually chat. And if there is something that comes to mind you might want to say, "have you guys ever come up with this? What do you think?" . . . I find what they'll do then is say, "remember when we did this course, we looked at such and such," and, "when I was studying or wewere doing this course, I actually did some research on that and this is the information I had, this was a great article." So, I find I use it more as a debrief. (Alethia, Interview #2, Lines 147-162, p. 4, 2013)

The faculty members encouraged the students to consider their own and others' perspectives and values to make sense of encounters and issues. They also urged the students to reflect on their thoughts, behaviours, actions, and reactions to create meaning from practice encounters. In the faculty members' view, self-awareness prompted students to clarify their values and analyze their practices, in relation to nursing responsibilities and obligations to others, such as patients. The

faculty members moreover encouraged the students to consider different actions and outcomes with regard to issues and situations.

The faculty members were open-minded in debriefings, thereby acting as role models and encouraging the student to consider others' perspectives. Faculty behaviours demonstrated professional phronesis, namely the ability to recognize and respond to moral issues in practice in a caring and respectful manner (Sellman, 2009). In their view, open-mindedness helped the students feel comfortable enough to express their own feelings and perspectives. The faculty members thus endeavoured to create trusting, caring, and accepting professional relationships, wherein students could appreciate open-mindedness and adopt in their future practices.

All faculty members emphasized that students needed time to process their encounters: "I think part of it is that they have spaces they have made where they can process, but they need that silent time with who they are" (Hermione, Interview #1, p. 11, 2013). Another added:

> I didn't get the whole piece at the beginning, and so the whole bits and pieces, different things just kept coming out. I don't know if it is because, especially if you have just started on a [unit], you are overwhelmed with everything that you are doing and they are overwhelmed with tasks. Am I doing this right? And trying to get organized. So, I don't think this student was able to pull it all together, it's just come together as she can think about the pieces. (Elpida, Interview #1, Lines 66-74, p. 2, 2013)

The faculty members learned of significant issues or distressing situations after they occurred, often one to two weeks later, speculating that students perhaps desired to work through these issues first with their preceptors or other supports, such as peers. The faculty members thus struggled in assisting students

to resolve practice issues and to create meaning, having not observed for themselves the practice contexts, the actions of others, and the students' actions and reactions to their situations.

Faculty members also came to understand the students' thought processes from their reflective journals, together with their comments on the course website. Observing student encounters and issues from a third-person perspective, faculty members were able to direct them to explore these issues from an alternative point of view. As their perspectives differed from other sources of support, such as preceptors and peers, faculty members felt that sharing these perspectives with students gave breadth and depth to the meanings arising from moral issues.

The faculty members observed that, as the students became immersed in preceptorship, they created their own meanings over time, processing their thoughts, feelings, and encounters in practice. The students learned to seek out sources of support, such as their preceptors and peers, with whom to discuss their concerns. The students' evolution reflected their relational approach to creating meaning in practice, integral to their socialization into nursing practice and to their own identities.

Faculty members also noted that students engaged both in rational processes to understand situations, and in emotional processes to reflect on the feelings arising therefrom. Rationality entailed identifying a moral issue in a practice encounter, reflecting thereon, and analyzing to create meaning. As the students reflected, they integrated their theoretical knowledge and previous practices, analyzing influences such as the context of practice and the relationship

to theory. Reflection entailed identifying professional responsibilities in practice and obligations to others; acknowledging the need to be accountable for one's actions; and recognizing the importance of learning from experience. The faculty members also explained that the students learned to identify the consequences of inadequate nursing care and their implications both for nursing practice and for patient outcomes. Frequently, the students compared their actions with what they believed their preceptors would do.

When the students associated their practices with those of their preceptors, they were engaging in a socialization process—learning the normative behaviours of nurses in the preceptorship setting. The students could decide thereby whether or not to adopt selected behaviours, an attribute of moral development. One faculty member remarked:

> I think they really took them [preceptor's attributes] on, and that was partially because their preceptors just displayed some of that. So I do think they have taken on some of those kinds of things, but they also came with some of them. So some of them were probably more reinforced than necessarily completely developed. (Hermione, Interview #2, Lines 486-492, p. 11, 2013)

Another recounted:

> I talk to them about that and what they want to be and to look at attributes that your preceptor has. Or look at attributes that your buddy nurses had or a tutor has had, and what do you want to take with you, and what don't you want? And all of it is learning. (Alethia, Interview #2, Lines 102-106, p. 3, 2013)

Yet another commented:

> One of the discussion things I have with them is: "Okay, what is something that you will take away from this preceptorship that you will build into your own practice?" . . . So when you graduate, what are the pieces that you are going to keep with you? What are the pieces that you

> are going to say: "I'm not going to be doing that in my practice"? (Olympia, Interview #1, Lines 286-294, p. 7, 2013)

Faculty members thus observed the students' searches for personal meaning in practice, believing their preceptorship encounters would shape their future practices.

Creating meaning was not a finite journey, according to the faculty members; it was a construct that constantly evolved within the individual. Dialogue and reflection, to create meaning from practice encounters, contributed to the students' identities as nurses. Care theorists have emphasized the importance of conversation and reflection in moral education, encouraging these practices in pedagogy. Noddings (2002a) asserts that conversations are essential to moral life insofar as they demonstrate care, promote trust among individuals, and invite recollection and reflection on experiences. As the students debriefed with preceptors, faculty members, nurses, and peers, they were also learning to be attentive, responsive, respectful and caring.

Dialoguing with peers in the nursing program and nurses in the preceptorship practice area to create meaning. Faculty and student participants both observed that students engaged with peers to create meaning from practice encounters. The students regarded their peers as sources of support, able to understand and to empathize with their perspectives:

> Because they are the only ones going through the exact same thing you are going through. They are the only ones who really understand it and who've been in those situations and can understand what you are going through. So it's the most therapeutic to talk to them rather than anybody I find. (Desponia, Interview #2, Lines 322-326, p. 8, 2013)

Three students concurred that peer support sustained emotional well-being and promoted learning to enhance nursing practice. Talking with others about encounters and moral issues enabled them to reflect, to analyze their own values, and to discover others' values and perspectives. As a result, the students learned about themselves; they moreover learned ways to approach complex situations in future practice. One student stated:

> Because you can always learn things from other people, like they can provide you with new ways that you can approach a situation, or a new technique, or something they've had experience with in the past. You are never going to not benefit from talking to someone else you can get a different perspective on things, different view. I feel that peer support is essential in nursing . . . I am constantly getting tips from other nurses, and sharing of those tips is so important, things you can't learn from a textbook necessarily. (Meropi, Interview #2, Lines 79-90, p. 2, 2013)

Additionally, these participants found it therapeutic to express their feelings and to vent their emotions when they debriefed with their peers. They also shared their diverse experiences in different preceptorship practice settings:

> My roommate is also in nursing and she is in her [preceptorship] as well, and she is in [area] which is very different from [area]. So we talk about different [experiences], she talks about what her things and her fiascos and her big deals were. And I'm like: "That is kind of cool, but I could never do your job, that sounds awfully boring to me." And then I'll talk about the things that I did at work and she's like: "Uggh, I would never want to do your job, that sounds awful to me." But we both are able to make sense of it. (Fedra, Interview #1, Lines 446-454, p. 10, 2013)

These conversations were instrumental in helping students to understand why they had selected one area of practice over another. In other words, debriefing helped them to affirm their personal identities in practice, a core process in nursing student moral development.

Preceptorship differs from traditional clinical courses, wherein students practice in a peer group under the direct supervision of a tutor; in preceptorship, the students were no longer directly connected to their peers on the learning unit. Faculty had the option of using blogs on the course website, to facilitate student connection with peers and discussion about the preceptorship course. Faculty members perceived the website blog to be a safe place for students to dialogue and to support each other in creating meaning from moral encounters.

The preceptors had no knowledge of their students' engagement with peers to create meaning from encounters and moral issues in practice. However, the preceptors themselves engaged with other members of the nursing team to do likewise. One preceptor stated:

> We talk to each other all the time. Sometimes it is good, sometimes it is bad . . . I think at the end of the day, we are still pretty good at leaving that challenge and leaving those thoughts back there and going and taking care of the patient. Definitely peers are huge, because they can see the same thing as you they are probably going to have the same thoughts. So, it is good to know that you are not the only one thinking them. (Evangelia, Interview #1, Lines 627-636, p. 14, 2013)

From their preceptors role-modeling, the students learned the nursing socialization process of creating meaning from situations and moral issues in practice. The preceptors demonstrated moral development as they sought out peers for support, meaning, dialogue, and reflection.

Two of the five students engaged with other nurses in their preceptorship areas to create meaning from encounters and moral issues, having perceived that their learning and practice values differed from those of their preceptors. They sought out nurses whom they identified as having similar practice values, with

whom they could converse deeply about encounters and moral issues in practice. One student recounted:

> Why are we doing this? She can give me reasoning, but very simple reasoning, if that makes sense—because the doctor told her, because we need to push people through faster. She just doesn't go into deeper discussion with that kind of stuff. I have discussions with other nurses on the unit, but not with my preceptor. (Desponia, Interview #1, Lines 193-199, p. 5, 2013)

Another remarked:

> I don't feel that I have those kinds of deep conversations with my preceptor. I think that a lot of times I might have them with other RNs on the unit, and those RNs are typically degree nurses or master's-level nurses. (Agapi, Interview #1, Lines 448-452, p. 10, 2013)

The RNs whom these students sought out shared their characteristics, being baccalaureate-prepared, recently graduated, closer in age, and likeminded about practice in the preceptorship area. One student remarked: "Most of them are a bit younger. They've graduated in the last five years, and they have university education—BScN. They are just open people, and they seem to have had the same questions as me" (Desponia, Interview #1, p. 5, 2013). The students also dialogued with other sources of support, such as close friends and family members, to create meaning of both moral encounters and issues in their preceptorship practice.

Dialoguing with family and close friends to create meaning. The students approached family and close friends both for emotional support and for reaffirmation of their identities. One student, whose practice values contrasted with those of her preceptor and those of the institution, sought encouragement and validation of her values from family members. Faculty members also reported

that students sought family support in their preceptorship practices, and three preceptors stressed the importance thereof. It can be hypothesized that family members offer emotional support, safe spaces to express feelings, and affirmation of personhood and personal values. According to care theory, we commonly engage in care for the first time in family units. Family members reflect an ethic of care in attending and responding to individuals (Noddings, 2002b). Consequently, family relationships are a starting point in the development of personal ways of knowing.

b. Creating meaning through personal ways of knowing.

> Emotion is central to moral life, but moral life can't be reduced to emotion; neither can it be reduced to rational thinking (Noddings, 2002a p. 42).

As the students engaged with their preceptors and faculty members to create meaning from practice encounters and moral issues, they drew on internal cognitive and affective processes to consolidate this meaning. These internal processes were foundational to their moral development, encompassing both rational and emotional orientations. Creating meaning entailed integrating personal values to guide one's actions in nursing practice. Analysis and interpretation of encounters and moral issues provided a foundation for basic presumptions, guiding moral decision making in future encounters. Sommerville (2006) identifies four basic presumptions in moral decision-making:

- Yes: There are no restrictions or conditions on what we want to do;
- No: We must not do this;
- No, unless: We must not do it unless we can justify it and express the requirements for justification;
- Yes, but: We might do it, but not if certain circumstances prevail.

Carper (2006) concludes that nurses engage in four fundamental patterns of knowing: empirical, aesthetic, personal, and ethical. In this study, students engaged in forms of personal knowing—cognitive, emotional, and relational—to create meaning from practice encounters and moral issues. Nursing educators pay considerable attention to developing cognitive ways of knowing and the ability to rationally address encounters and moral issues. The data in this study, however, indicated that emotions are equally meritorious in creating meaning from encounters and moral issues in practice. Despite their awareness of deontological, utilitarian, principle-based ethics, and their knowledge of applying theories to practice encounters, only one of the five student participants used a duty-based ethics approach to guide his practice.

Hauser (2006) regards emotions as integral to life; emotions influence actions, being deeply rooted in the sense of self and other. When individuals face moral dilemmas or encounters, emotion commonly generates an automatic reaction, followed by a critical, rational evaluation of what should be done. Social psychologist Jonathan Haidt (as cited in Hauser, 2006) proposed that humans demonstrate four types of moral emotions:

- other-condemning: contempt, anger, and disgust;
- self-conscious: shame, embarrassment, and guilt;
- other-suffering: compassion;
- other-praising: gratitude and elevation.

These moral emotions provide individuals with instincts of right or wrong, and what they should or should not do (Hauser, 2006). The students exhibited moral emotions as they created meaning from practice. From preceptors' and other

nurses' practices, they displayed other-condemning and other-praising. From practice encounters with patients, they demonstrated other-suffering and compassion. From moral issues that arose in the preceptorship triad, they expressed other-condemning and self-consciousness.

Upon its introduction into nursing curriculum in the 1980s, ethics theory was predominantly delivered to nursing students through lectures (Cassidy & Oddi, 1988, 1991; Duckett et al., 1997; Felton & Parsons, 1987; Frisch, 1987; Gaul, 1987; Haywood, 1989; Hembree, 1988; Johnson, 1994; Krawczyk, 1997). Over the past two decades, nurse educators have increasingly recognized the importance of personal and relational ways of knowing as they relate to teaching ethics (Cameron, Schaffer, & Park, 2001; Doane et al., 2004; Han & Ahn, 2000; Kelly, 1992, 1993, 1996; Lemonidou et al., 2004; Myrick. Yonge, & Billay, 2010; Oberle, 1995; Pang & Wong, 1998; Park et al., 2003; Roberts, 1996; Rognstad, Nortvedt, & Aasland, 2004; Sellman, 2007). Multidisciplinary research is revealing how individuals engage in personal ways of knowing in moral situations. Neuroscience researchers have found the significance of emotions in moral decision-making. To demonstrate the relationship between brain activation and moral dilemmas, Greene (as cited in Hauser, 2006) used brain imaging to study his subjects as they read a series of moral dilemmas, thereby exploring the contributions of emotion and reasoning to moral judgment. Greene discovered that the subjects spent more time working out answers in moral-personal scenarios than they did working through moral-impersonal scenarios. In the moral-personal scenarios, the brain scans displayed significant activation in

areas involved in emotional processing. When the subjects judged moral-personal cases, in which utilitarian consequences to maximize good directly conflicted with the deontological rule of "do no harm," the conflict directly engaged the anterior cingulate, the region of the brain that regulates emotion. When people confront certain types of moral dilemmas, they thus activate a cast network of brain regions, including areas involved in emotion, decision-making, conflict, social relations, and memory (Hauser, 2006). This research lends support to the finding that emotional responses are significant to personal ways of knowing and how nursing students respond to, and create meaning of moral encounters in practice.

The students dialogued and reflected with their preceptors, faculty members, peers and others, to create personal meaning from their practice encounters in preceptorship. Reflective journaling is a common nursing pedagogical strategy to promote reflection on practice and awareness of one's thoughts, behaviours, emotional responses and values; however, this study demonstrated that personal meaning in practice emerged through dialogue, in the context of relationships. Faculty members and preceptors strove to create safe, candid, non-judgmental environments for students to reflect on practice encounters and express their perspectives and emotions. This finding is consistent with Noddings (2002a: 2002b) view that engaging in dialogue within the context of caring, attentive, responsive relationships is central to moral education.

c. Creating safe spaces for students to explore moral encounters and issues in practice. The faculty members and preceptors regarded safe spaces as

essential for students to debrief, to explore encounters and moral issues, to determine if they were providing appropriate care for patients, and to weigh their nursing responsibilities.

Preceptors. Working alongside the students, preceptors witnessed firsthand their encounters in practice, and offered insight into their emotional responses. The preceptors also strove to engage students in discussion following encounters, enabling them to ask questions, express concerns and explore personal responses. One preceptor remarked:

> By just talking to them and saying: "Look, it's okay that you are not comfortable, it's a totally foreign thing, it is not something that the general public ever has to deal with." . . . I think that it is important to express that discomfort. I think that is the only way you are ever going to deal with it or find out that you can't handle it. Either way, it is important to know who you are so you can be there for the patient if that is possible. (Zisis, Interview #1, Lines 165-176, p. 4, 2013)

Another stated:

> She talks to me about it. I think talking about it is a big thing. I think keeping it inside could be harder for her to deal with it. I think as long as they verbalize it, that is a good thing . . . So she obviously is trying to work it out somehow, so that is good. (Evangelia, Interview #2, Lines 400-406, p. 9, 2013)

The preceptors reported engaging students in dialogue, after encountering significant events in practice, and upon completion of their shifts. They also identified barriers to debriefing such as lack of time after a busy shift and multiple responsibilities. Preceptors in charge of shifts, for example, were unable to afford sufficient time to explore issues with their students, as their charge responsibilities assumed priority. The preceptors strove to direct students to sources of support—primarily the nursing and interprofessional teams in their practice areas—if they

felt overwhelmed by practice encounters. The preceptors valued peers with similar perspectives to create meaning in practice, reassured that these individuals shared their thoughts and feelings about moral issues therein. The preceptors' openness and understanding of their students' perspectives helped them to create safe spaces for the latter to explore moral issues and practice encounters. When debriefing with students, the preceptors were also cognizant of their own demeanours, endeavouring to convey attentive, respectful, and nonjudgmental attitudes.

The preceptors recalled their own nursing education experiences, wherein faculty members or nurses permitted them to talk candidly about practice encounters and moral issues. They also recalled times when they were unable to engage others in open and accepting discussions. The preceptors' own experiences thus influenced their creation of opportunities for their students to explore thoughts and feelings related to encounters and moral issues in practice. The preceptors also recalled that past experiences had shaped their values for openness, acceptance, fairness and diligence in practice. One remarked:

> I've always considered myself to be a bit of a nerd, a geek, I've kind of embraced that more as I have gotten older. Because, you know, kids tease when you are young, no one likes that. But it's important to know who you are and be proud of who you are. Because otherwise, you are in for a lot of hard times going where you want to go. (Zisis, Interview #2, Lines 541-547, p. 12, 2013)

The preceptors endeavoured to ensure their students knew they were supported, safe to ask questions and to be honest in their practices, knowing that lack of support could impact their confidence and lead to errors in practice.

The preceptors also described the influence of the practice culture on creating safe spaces. Ensuring that their students felt safe to ask questions and to address concerns in practice was important to the preceptors, who viewed an open and accepting environment as essential for safe patient care. They speculated that the students and new graduates were afraid to ask questions because they were afraid that other nurses would perceive them as incompetent. In one preceptor's words:

> I think that they expect that they are supposed to know everything. They have just finished four years of nursing school and then, I don't know. There is always the [student] role. They wonder if their question is going to be perceived as a stupid question, or 'how come you don't know that?' You get those answers. So I think that is probably why they are a bit shy about it. (Evangelia, Interview #2, Lines 156-161, p. 4, 2013)

Another stated:

> [Role modeling humility is important] because then they can understand that it is okay, because they are not going to know every single thing when they graduate and they won't feel so overwhelmed. And it's also about the trust thing. That they know that you are not going to make up an answer that will not be right, and [you will] come back with a right answer, hopefully. (Kallopi, Interview #2, Lines 147-153, p. 3-4)

The preceptors wanted the students to know *they* were aware the students were learning, and that learning was an ongoing process. As preceptors, they strove to treat their students equally, thereby ensuring that the students' future relationships with patients and the nursing team would be respectful and fair. They made their students visible and included them in the team. Faculty members shared this view; students needed to be aware that they were learners, and supportive relationships were necessary for them to learn from their practice encounters.

Faculty members. The faculty participants agreed with the preceptors that safe spaces were essential for students to create meaning of encounters in practice. One stated:

> I think in order to do that piece of recognizing our own values and our own kinds of ways of being and knowing requires a safe space. And if there isn't a safe space or we've not earned it in some ways, to make sure that we have created that. And not individually, but I think as a collective, then I don't think, I am not sure students are able to do that. (Hermione, Interview #2, Lines 175-181, p. 4, 2013)

Another remarked:

> We do an awful lot of talking about situations that may arise and how might you think about this . . .I guess what I try to do is bring up situations where they can talk about them in a safe environment amongst the colleagues and with a mentor in the group. (Olympia, Interview #1, Lines 122-133, p. 3, 2013)

Faculty members categorized safe spaces as private moments for reflection, physical spaces within the classroom; online settings; and dialogue within the student-preceptor relationship.

Faculty members had a role in creating safe spaces for students to discuss their thoughts and feelings related to encounters and moral issues in practice, and in guiding students to create meaning therefrom. In the faculty members' view, a goal of preceptorship was to nurture the development of nurses who advocate and question practice critically. Safe spaces were necessary to allow students to question and challenge practice. Three faculty participants offered the blog discussions on the course website as safe spaces for students to explore encounters and moral issues with their peers. As the students were no longer practicing alongside their peers in their clinical learning structures, website blogs

proved effective in keeping them connected. The faculty members viewed peer relationships as instrumental in creating meaning from encounters and moral issues in practice.

In the faculty members' view, cohesive student-preceptor relationships helped preceptors to construct safe spaces for students to create meaning from practice encounters and moral issues. One faculty participant stressed that preceptors needed safe spaces as well, to reflect on their teaching approaches, relationships with the students, and the overall preceptorship process. All faculty members agreed that students needed to understand the importance of safe spaces in practice for dialogue, and of creating these spaces as members of a nursing team.

Recognizing safe spaces: Students. The students acknowledged that their preceptorships included safe spaces to discuss their thoughts and feelings related to encounters and moral issues in practice. They also concurred that it was essential to discuss values, morals, and ethics in the practice area. Their accounts varied as to how safe spaces were created, but cohesive relationships were inevitably the foundation thereof. While the students reflected privately and created personal meanings thereby, they nonetheless required supportive relationships within their practice areas to clarify their thoughts, to express their feelings, and to feel reassured. Recognizing the importance of safe spaces reflected a socialization process wherein the students learned to value openness, diversity, and respect, in their discussions of personal values and perspectives in practice.

All the students reported that their faculty members created safe spaces throughout the preceptorship, enabling them to dialogue and explore moral issues in practice. Four students reported that their preceptors created such spaces, albeit near the completion of their preceptorships, perhaps owing to the need for trust prior to conversations about values, beliefs, perceptions, and concerns. More so than the students, the preceptors and the faculty members elaborated on the idea of safe spaces in practice, possibly because it was they who created these spaces. Their role was to facilitate learning, to role model the importance of community within practice, and to enable students to share and create meaning from moral issues.

d. Support systems. The need for support systems is analogous to the need for safe spaces, wherein students identify, explore, and create meaning from encounters and moral issues in practice. One faculty member commented:

> What I try and do with my students is to bring it back to them. To just keep introducing these notions and also to introduce the some of it you can't reconcile. You are going to make decisions, but what you need is a community in which you come back to in which you can talk about this. (Hermione, Interview #1, Lines 449-454, p. 10, 2013)

The faculty participants emphasized that students need to be aware of their support systems. For the students, these comprised family, friends, and peers in the nursing program. Some faculty members actively maintained peer support systems through the use of discussion blogs on the course website, enabling the students to share their thoughts and feelings about their clinical experiences in preceptorship.

All faculty participants strongly identified their role in supporting students throughout the preceptorship. One commented: "I think my role is in a lot of cases providing opportunities for them to talk about what they are going to be experiencing, and then once they are out in the preceptorship, supporting them" (Olympia, Interview #1, p. 3, 2013). Another stated: "The values that you bring are the support that you have for the student, trying to balance everything with them and still make them feel good about themselves. I don't know if those are values, but they're needed" (Elpida, Interview #2, p. 7, 2013). Another remarked: "I have tried to reinforce that in a way: 'I am really pleased that you have stayed and continued and have invested time and energy and thought in your practice'" (Hermione, Interview #1, p. 18, 2013). The preceptorship was the beginning of a transition from nursing studies to nursing practice, and the faculty viewed their supporting role as vital in affirming and encouraging students. The faculty participants strove to be there for students, to support them through challenging practice experiences, and to assist them in completing the preceptorship course if they were struggling or disengaged. In the transition, the students worried about their identity and fit with practice settings; limited employment opportunities that would not allow them to remain in their desired practice areas; and the level of support they would encounter in new clinical areas. These issues presented significant implications for and challenges to the students' personhood, therefore the faculty members considered their supporting role to be critical.

The preceptors agreed with the faculty participants that the students needed to be aware of their support systems, if they were overwhelmed or

confronted by moral situations and issues in practice. One preceptor remarked: "As long as they talk about it with whomever they need to, I think that is a big thing to do" (Evangelia-1, p. 13, 2013). Another preceptor commented:

> My job as a preceptor is to ensure that the students are not traumatized in some way by that situation, that they have an opportunity to express how they feel about it, and [make them] aware that there are supports if they are feeling overwhelmed. (Zisis, Interview #1, Lines 97-101, p. 3, 2013)

The preceptors identified themselves as primary supports for students, ensuring the students knew that they were available to them. They attended to students' well-being by actively assessing them and ensuring they were not distressed, uncomfortable, or anxious about practice. They intervened to respond to their students' emotions and to put them at ease. Such genuine caring for their students' welfare might have led to transference, insofar as the students were cared for within their professional practice. From their own student experiences, the preceptors recalled having attentive, caring preceptors. Consequently, they transferred this genuine concern for their students' well-being to their practice as preceptors.

Learning to identify support systems. In their preceptorships, the students learned to value support systems, recognizing the universal need for support and the impossibility of carrying out nursing care independently. Each student's support system was a unique, comprising faculty members, preceptors, family, friends, and peers. Students identified support persons or groups based on their relationships therewith, and their shared values. If the students had open relationships and shared values with their preceptors, they identified the preceptors as sources of support. One student, whose values in practice differed

from her preceptor's, identified her faculty member, other nurses on the unit, and her family as support systems instead. The students learned in their preceptorships that peer support among the nurses in the team is essential. As one student remarked:

> Peer support is a huge thing to prevent burnout, as well as self-awareness and reflection. And to feel when you are getting stressed, just to be able to talk to your peers about it and say: "Okay, I need to take a five minute break, can someone watch the desk?" (Meropi, Interview #2, Lines 61-66, p. 2, 2013)

In preceptorship, the students gained independence and transitioned from the student role to the graduate nurse role. Accordingly, they worked to understand the significance of support systems in practice. Within the team, they experienced support in various ways, such as working to assist one another; equitably distributing patient-care responsibilities; and collaborating on issues related to immediate patient care. In their conversations with members of the nursing team, the students came to understand that nurses also struggle to work through moral issues in practice. To the students, support systems needed to be nonjudgmental, caring, and respectful of their individual values. They learned that support systems serve to promote authentic engagement in practice by enabling nurses to express their values, feelings, and beliefs.

4. Becoming an Advocate and Reconciling Moral Issues in Practice

A fourth, core category in this study entailed becoming an advocate and reconciling moral issues in practice. This part of the overall process comprised rational and emotional processes leading to action in practice; learning to be

proactive; and developing relational insight to socially negotiate practice environments, before vocally addressing moral issues in practice.

a. Becoming an advocate: Rational and emotional processes that lead to action in practice. In describing morally significant encounters in preceptorship, the student participants detailed the rational thought processes in which they engaged before they acted as advocates for their patients. Four of the five students had the opportunity to act as patient advocates in their preceptorships. The fifth student was not able to advocate because she perceived that her practice values differed from those of her preceptor and the nursing team. As a result, she feared that if she advocated for a patient, the nursing team would not accept her.

When faced with moral issues, the students engaged in rational thought processes, variously considering patients' struggles and needs; the environment; appropriate times to advocate for patients; the impact of the students' actions for patients on their care; others' perceptions of the students' actions; their obligations and responsibilities in the nursing role; and the consequences of inaction. They contemplated dialoguing with patients to explore their concerns and involving them in mutual decision-making. One student remarked:

> I just wanted him to feel better and feel that he was getting the best care. That's why I asked, I went up there with that in mind, thinking that this guy is struggling and I think he needs help . . . So that is why I went back to my preceptor and the manager with: "I think he needs other help that we are not giving him." So it got more people involved that way. (Agapi, Interview #2, Lines 404-414, pp. 9-10, 2013)

Another recounted:

> It felt really good, for sure, for me. I was finally able to put my two cents in and do something good for a patient, that I hope made a difference. And the patient really expressed that this was helping after the second case conference and so, [I was] just relieved knowing that it actually did something. (Meropi, Interview #1, Lines 309-314, p. 7, 2013)

The students also engaged in emotional processes that shaped their actions. They empathized with their patients, wanting them to feel better and to receive the best care possible. The moral emotion of other-suffering (Hauser, 2006) emerged as the predominant process of emotional knowing for the student participants. As they engaged in emotional knowing, they demonstrated compassion and responded to others. When they advocated for their patients, they felt they helped them and upheld their values for practice.

When the students encountered moral issues arising from conflicts with their preceptors, they engaged in rational thought processes such as exercising self-awareness to understand their own, personal factors affecting the situation; endeavouring to understand the contextual factors shaping the encounter, and communication with their preceptors; seeking meaning behind their preceptors' comments and actions; seeking to understand their preceptors as individuals, and the personal circumstances that shaped their communication; and acknowledging the emotional components of communication. One student stated:

> It kind of started from the start of the shift where she was quite stressed, we had dealt with a couple changes to our patient schedule that morning, which was kind of tough, and she had taken two personal days the week before . . . So kind of not taking it just as the comment, but taking that comment and really assessing it. Not taking it as an insult, but professionally taking it first and dissecting it and then trying to get the implications as clearly as I can. So, realizing that she was stressed, that it was a stressful environment. And that what was said had had a strong emotional component to it. (Xeni, Interview #2, 664-679, p. 18, 2013)

Another described:

> I took that [relationship concern] to her [preceptor] and I just explained how that was stressful and how we were [interacting]. Because everything was subtle, there was nothing obviously glaring in me in the face that was wrong with our relationship, it just felt like there was tension at different points . . . I think she appreciated, or saw that I was actually reflecting on my own behaviour in that situation . . . it was just a matter of communicating that to her. (Agapi, Interview #2, Lines 145-160, p. 4, 2013)

The students demonstrated moral behaviour, moral development, and an ethic of care (Noddings, 2002a; 2002b), in establish, valuing, maintaining, and/or improving their relationships with their preceptors. As they worked to resolve issues therein, the students recognized the importance of self-awareness and initiative, and of addressing interpersonal conflict immediately. Disregarding relational issues, they recognized, could further jeopardize the preceptor-student relationship.

The students deliberated on how best to address moral issues in their relationships with their preceptors, mindful of the emotions therein and the others' feelings and experiences. Working through their relational issues, the students recognized the significance of moral interdependence, entailed by their own contributions, and those of the preceptors, to these relationships. Within their relationships with their preceptors, students came to realize that their ability to be good to others depended on how others treated them (Noddings, 2002b).

Confronting moral issues within the student-preceptor relationship, the students feared how their preceptors would receive their concerns. One student stated, "Part of it was, . . . I'm scared. That was my emotional component. If I am going to say that she had an emotional component to her comment, I can't

deny that I had an emotional component. So I'm scared" (Xeni, Interview #2, p. 20, 2013).

Two students experienced moral issues with their preceptors related to professionalism and collegiality. They felt their preceptors' behaviours towards them contrasted with their personal values for care, evoking the moral emotions of other-condemning and self-consciousness, and leading them to question their own nursing identities and practices. One student's preceptor made negative comments about his practice in front of a patient. The student responded emotionally, perceiving a threat to his identity. He moreover expressed concern about patients' perceptions of nurses, as caregivers, behaving disrespectfully:

> Just the timing of it was very inappropriate. I think that could have negatively impacted the patient and also the person providing care to the patient, which was me. So it's just like working as a good member of the team, and encouraging people to do better, which encourages good patient care. And breaking down your staff, and breaking down your colleagues is not a way you are going to motivate them to provide good patient care. But the breakdown of professionalism was the big thing for me and it was kind of an emotionally charged disclosure as well. (Xeni, Interview ##2, Lines 471-483, p. 13, 2013)

Before working through their moral issues with their preceptors, both students took care to assess these issues first. They thoughtfully evaluated the potential impact of their emotional responses on their relationships with their preceptors, concluding that self-assessment and understanding of context would be more constructive than self-centeredness. One student recounted:

> My own emotional component of being afraid of failing was not as strong as it would have been, had I addressed it right at that moment in the patient room. So just approaching it more as somebody willing to learn, rather than somebody hurt by a comment. Because I think that was what she had wanted to see from that interaction. She wanted to see me have a

> desire for succeeding and improving, rather than see me hurt and see me questioning my practice . . . So trying to approach her as a learner, as the comment she made warranted. (Xeni, Interview #2, Lines 794-803, p. 21, 2013)

Both students took into account their preceptors' experience, and what the preceptors would want to hear in a discussion of relational issues. The students strove to address their issues as self-aware learners and avoid emotional responses. Both demonstrated self-awareness, feeling it was the most constructive way to address moral issues within the preceptor-student relationship. After discussing their issues with their preceptors, the students felt satisfied that they had improved their relationships. One student stated:

> I think that is something that we had been talking about throughout the term, and that is maybe why our relationship was okay. And then at the end she really let go of me in the last week. So it actually worked out really well, I thought, in the end. We got each other gifts and stuff. (Agapi, Interview #2, Lines 131-137, p. 3, 2013)

The students also emphasized the importance of resolving relational issues, knowing that cohesive, professional relationships were fundamental to quality nursing practice, and that valuing these relationships was moral. One student remarked:

> Having those issues with my preceptor and then deciding to talk to her about that, and recognizing maybe even though this relationship is not the most important, it is sort of a gateway to making every relationship on some level important. (Agapi, Interview #2, Lines 556-560, p. 13, 2013)

Another commented:

> Optimism . . . So that's very harmonious with my identity as a [religion], because I want to be optimistic and be positive. So continually thinking in a positive regard for people. Because if I would have taken the disclosure negatively I would have been thinking that the whole interaction on her

> side was that she wanted to negatively impact me . . .It's just kind of refusing to think poorly of people. (Xeni, Interview #2, Lines 849-874, p. 22-23, 2013)

b. Learning to be proactive. As the students worked through their thought processes to present their moral issues, they learned to be proactive. Working through situational and relational moral issues, they perceived an obligation both to advocate for their patients and to address concerning situations in practice. One student remarked:

> I also felt like if I stood back and didn't say anything, I would be essentially encouraging the behaviour, in my opinion. So I didn't think that saying "I don't really think that should be said" was crossing the line. (Fedra, Interview #2, Lines 238-241, p. 6, 2013)

Another stated:

> Now that he is getting better, he is starting to recognize what happened and how sick he was and he was reflecting about his decisions . . .I was concerned about that and took that back to my preceptor and some of the other nurses. . . So we did end up writing it on the charge board so maybe social work and spiritual care could just to talk with him and see where he is at. So, I just felt obligated. (Agapi, Interview #1, Lines 15-32, p. 1, 2013)

A third student remarked:

> What really bothered me is the severity of the consequence of not doing those [restraint] checks and the fact that the patient at that point couldn't advocate for their own safety because they were confused. So it really falls solely on the nurse to make sure that those checks are done. That duty was 100% the nurse and it was violated, or neglected or not charted appropriately, and that made me very concerned. (Xeni, Interview #1, Lines 198-220, p. 5, 2013)

The students thus contemplated the negative implications of complacency and failure to respect patient care, professional relationships, and personal identity. In so doing, they continued to identify their professional responsibilities,

both to their patients and to the nursing team, to ensure the delivery of safe and competent care.

As the students worked through moral situations arising in practice encounters, they realized that patients are often vulnerable, relying on nurses to intervene when they cannot advocate for themselves. The students thus perceived the obligation to maintain patient safety and dignity. Those students facing moral issues within the preceptor triad also understood their responsibility to maintain cohesive, collegial relationships with nurses to ensure effective patient care. Living and observing the consequences of inaction and, its impact on others in practice, the students felt compelled to act.

The student participants all identified the need for courage and confidence in bringing their voices to issues and acting as advocates. They struggled to address issues at the outset, mindful of the unfamiliarity of their practice areas, their role ambiguity, and the risk of antagonizing their preceptors. As they advanced in their preceptorship courses, the students felt more comfortable voicing their concerns. Four students felt supported by their preceptors in bringing their voices to issues of concern; the preceptors moreover supported these students within the nursing team, if they had vocalized issues. Overall, the students believed the nursing program had encouraged them to voice their concerns in practice. Four students felt preceptorship had nurtured their voices.

The fifth student, unable to use her voice to advocate in practice, resisted passively and did not engage with the nursing team members expressing practice values contrary to her own. She felt her practice values conflicted with those of

both her preceptor and most nurses in the preceptorship area; thus she refrained from advocacy behaviours, fearing ostracization by the nursing team. Her cognitive and emotional processes thus evinced socialization by assimilation into group norms, out of fear of rejection. She remarked:

> I thought they were being disrespectful and closed minded, but at the same time, I didn't feel comfortable voicing my opinions because I was new, and I didn't want to jeopardize my preceptorship. So I didn't want to be really up front in saying what I was thinking; but I didn't want to participate either. So just not saying anything was my way of dealing with it. (Desponia, Interview #2, Lines 198-204, p. 5, 2013)

In this student's view, she developed morally by upholding her practice values and resisting socialization into the prevailing attitudes of the nurses in the preceptorship area. She understood the importance of self-awareness in staying true to her practice values and in abstaining from behaviours inconsistent therewith. Notably, this student felt the nurses in the preceptorship area had lost a valuable part of their role as patient advocates, borne out in the patients' practice of hiring other individuals to act as advocates throughout their stay on the unit. She stated:

> The hospital can be a chaotic environment . . . patients especially in [area] can feel that they are out of their control. But if they have that one person that is on their side to empower them and say to them what is going on, it's valuable to them. And that is why a lot of [patients] are having a [hired attendant], I think, because they don't feel they are really getting that from the hospital staff . . . But nurses, I think we can have a role in doing that even better than [attendant] because we know exactly what is going on. (Desponia, Interview #2, Lines 353-362, pp. 8-9, 2013)

Although most students were able to develop and use their voices, they identified barriers to action in the preceptorship experience. One stated:

> As a student you often feel a sense of powerlessness. Especially when it comes down to ethical or moral dilemmas that are not always cut and dry, black and white. It is not that they [preceptors] are governing with an iron fist or that they are a tyrant, or anything like that. But at the end of the day, they are your boss, or who you should look up to, or the person that you are watching to see how they deal with certain situations in a certain way and how you should in the future consider treating them. (Fedra, Interview #1, Lines 298-308, p. 7, 2013)

Another commented:

> At this point I haven't really voiced any of this stuff to her, because I have been having a lot of these feelings during this preceptorship about the [interventions] and I don't want to antagonize myself against her because I just want to graduate and finish this. (Desponia, Interview #1, Lines 57-64, p. 2, 2013)

One student remarked:

> I think I know in certain instances when something needs to happen, but sometimes you feel reluctant to do something. You don't feel that it is your place or whatever. But I think when you just feel like you are doing the right thing and take that courage and that step to do something and just to be that voice. (Agapi, Interview #2, Lines 433-442, p. 10, 2013)

And another stated:

> Being intimidated. Kind of worried that they would just listen [to me], or half listen and just continue to have their negative view of the patient. Worried that I would be almost annoying to them . . . Worried about how that would impact their attitudes. Would it make it worse if I did this? Would it make them hate the patient even more? (Meropi, Interview #1, Lines 294-303, p. 7, 2013)

For the students, barriers to advocacy comprised:

- powerlessness in their student roles;
- role ambiguity related to their scope of practice;
- fear of antagonizing their preceptors through their actions, thereby jeopardizing the preceptorship;
- fear of antagonizing the nursing team and the staff, thereby failing to gain their acceptance;
- fear of poor references or lack of acceptance by team members when applying to the preceptorship area after graduation;

- ignorance in assessing complex situations in practice, as novices;
- failure to be mindful the preceptors' experience in the practice areas.

Students in hospital settings also identified institutional constraints, fast pace of practice, and nurses' lack of time to address their concerns, as barriers to advocating and acting in practice. These barriers all reflected the socialization process.

The students experienced these barriers most acutely at the outset of their preceptorships, much less so upon completion. In between, they built and consolidated relationships with their preceptors, establishing trust and safety in discussing issues of concern. The students also endeavoured to assess the context of moral encounters arising in the practice environment, prior to actively addressing their concerns thereon.

c. Developing relational insight and learning to socially navigate practice environments: Students. In preceptorship, the students developed vital relational insights and the ability to socially navigate their practice environments. Before bringing their voices to practice or advocating for patients, the students assessed the environment to determine if it was appropriate to do so. In their view, the nursing program helped them navigate the practice environment and use their voices. They learned communication skills such as assertiveness, acknowledgement of their own perspectives, and judgment regarding appropriate lines of communication, thereby transforming how they brought their voices to practice. One student stated:

> I think I am quite an outspoken person and I use my voice wherever necessary. In the first few weeks it was a lot harder, but now I feel like I usually propose things in the form of a question. So then it is not like:

> "Well, I think we need to do this!" It is more like: "Well, do you think this might be a good idea for this particular patient?" And then if it gets dismissed, I say: "Oh, well in the past I have seen this, and I noticed it seemed to help or it worked, I'm just wondering if we can try it" . . . So I don't sound like, because they often talk about students or new grads thinking they are "know it alls". (Fedra, Interview #1, Lines 676-692, p. 15, 2013)

Developing their critical thinking abilities, and learning to ask *why*, were also central to the students' voicing of issues and concerns in practice. The role modeling of their mentors in education and in practice shaped the students' interactions and communications therein, as did their life experiences and upbringings. The students strove to assess their environments and choose appropriate times to address issues, thereby ensuring that others would receive their words and actions constructively. One student remarked:

> We learn how to, like they tell us in the program, if you want to file a complaint this is how, or if you have a problem with a staff member . . . but socially, I guess I've just grown up . . . It was so difficult for me in the beginning [of the nursing program] to ask why, it was just this is what I've been told. And then developing my critical thinking I think has been huge. And learning about different personalities, and learning more about people. (Meropi, Interview #1, Lines 662-678, pp. 16-17, 2013)

Another student stated:

> I think absolutely it [demonstrating self-awareness] does versus approaching the situation saying: "Well, I think you did this wrong" and making "you" statements where they come across as accusatory and almost borderline abrasive. Rather than approaching it with: "I think it might have, I'm not sure, but I think it might have went a little differently had we approached it this way". And I think that something I have definitely learned in my nursing program was all of our communication skills, and not addressing things in an abrasive way. (Fedra, Interview #2, Lines 145-155, p. 4, 2013)

Another commented:

> Prior to being in the nursing program, I didn't really have that interaction with a professional stance . . . If you have to address something that they [peers] say in class to the group because it is wrong, you have to be very professional in the way you do that, . . . and accurately assessing yourself lets you dissect what is going on, how you are feeling and what are all the components that are interacting in the statement that you made. In [receiving] a statement that another person has made, you can first identify what is going on with yourself and then identify what is going on with them. (Xeni, Interview #2, Lines 840-847, p. 22, 2013)

Prior to advocating, the students contemplated how their words and actions might impact their patients. They felt their actions could either help patients or compromise their care, by influencing the views of the team members. As novice practitioners in the preceptorship area, the students feared the latter. As they grew to appreciate their professional responsibilities to patients, however, they felt obliged to advocate. Faculty members observed the students identifying their obligations to patients and learning how to communicate concerns strategically, both to preceptors and to the nursing team, to mobilize action.

Faculty members' observations of students. The faculty participants agreed that the students learned how to be assertive yet respectful, at the correct times, in their preceptorships. In their view, the students learned to assess the practice environment, and to read social cues, prior to bringing their voices to practice issues. One faculty participant stated:

> There is also this unit environment and can you have the ability to, I don't want to say lay-low, because that is not really true. Do you have the ability to step back and just observe your environment and figure out how it works and then start to step into conversations? Do you go into it open enough that you watch and you listen and take your cues from your preceptor? Or do you go into it with a sense of, this is who I am, you should accept me. I guess it is the sense of openness that the student comes to the unit with. (Olympia, Interview #1, Lines 735-745, p. 17, 2013)

To the faculty participants, preceptorship taught the students to understand their own communication styles, and to be aware how their preceptors and the nursing teams perceived them. The students thereby learned to maintain their sense of self when they communicated with others. This view corroborated that of the students, on effectively communicating their perspectives or concerns about their practice encounters.

For the faculty members, it was important for the students to realize that their voices mattered in practice; learning how to use them was a vital preceptorship outcome. One faulty member stated:

> We talk to them about being advocates and having a voice for your clients, but I don't think it comes together. In reading all my students' journals this time around, I realize it doesn't come together until the end. Because almost all of them speak of, even in [4th-year clinical course], they could not center on anything but their skills. And they did that for their first half of clinical in [preceptorship course] also. And then all of a sudden, there was a difference, they felt secure, and then they could see the world and start having a voice. (Elpida, Interview #2, Lines 160-169, p. 4, 2013)

The faculty members corroborated the students' view that their advocacy behaviours emerged upon the completion their preceptorships, when they felt more secure in their preceptorship settings and more confident in their nursing practices. Faculty members also identified social, institutional, and political barriers to advocacy in practice, noting that care settings can intimidate new graduates and thus suppress such actions. One faculty member remarked:

> It will be interesting to see what they will be able to take into a different care context . . . I am hopeful that they can hang on to those memories and say, 'No, that does work in places,' and have a voice to create that space. But I can't be certain, because I do know what happens in some of the other care environments as well. That can be really daunting as a new

> graduate . . . So I am hopeful that they will find their place and continue that advocacy. (Hermione, Interview #2, Lines 506-521, p. 12, 2013)

In the faculty members' view, preceptors role-modeled assessment of social cues in practice, encouraged the students to advocate in practice, and supported such advocacy. One faculty member stated:

> I find that the preceptors now are very, very strong advocates. They're very solid in their ethics, the ones that I have seen lately . . . And one preceptor told me, the student, I wrote in his evaluation that he had to tell his preceptor to back off. And instead of her taking it negatively, she took it as this is a great thing that you have learned. Because you are going to have to do that with other people. (Elpida, Interview #2, Lines 136-144, pp. 3-4, 2013)

For their part, preceptors observed and promoted their students' abilities to ask questions and voice concerns in preceptorship.

Preceptors' observations of students. Insofar as preceptorship begins a student's transition to independent practice and the role of registered nurse, the preceptors agreed it was important to nurture the students' voices. They encouraged the acknowledgement and use of these voices in practice by advocating for their students, by creating opportunities for them to speak up—both in the nursing teams and in the multidisciplinary ones—and by role-modeling appropriate behaviours. One preceptor stated: "I think they do have a voice if they want to have it, if you encourage it as a preceptor" (Evangelia, Interview #1, p. 16, 2013). Another preceptor explained:

> The other day I went in and the patient load had been distributed so that I had more patients than anyone else did on the unit because my preceptored student can take three. Well, in discussion with the charge nurse that day I said: "I don't think that is fair because I'm still technically responsible for these patients and from a teaching point of view, I'm not able to give my student the time I need to answer questions" . . . So I think in that way it is

> advocating for the student. (Zisis, Interview #1, Lines 525-542, p. 12, 2013)

The preceptors observed the students' nervousness about using their voices at the outset of their preceptorships. Like the faculty members, the preceptors speculated that the students required acceptance and confidence in their environment before giving voice to their perspectives in practice. In the students' own view, and that of their faculty members, they were also assessing and analyzing their preceptorship environments to determine when and how to bring issues forward.

The preceptors described themselves as advocates for their students throughout the preceptorship process. In addition to supporting students when they brought their practice concerns forward, some preceptors advocated for their students to ensure their health and welfare, mindful of their exhaustion. To the students, these actions demonstrated care and a readiness to advocate when needed, thereby fostering their own advocacy behaviours. Two preceptors, recalling their own preceptors' advocacy, knew the importance thereof during this stressful, transitional period. These preceptors advocated in their practices, both as nurses and as preceptors. Care theory posits that individuals cared for by others, who demonstrate genuine social and ethical virtues, are likely to adopt these virtues themselves (Noddings, 2002b). Preceptorship thus socialized the students by demonstrating the significance of care, a vital insight for authentic, caring nursing practice.

The preceptors also created opportunities for their students to use their voices in practice. As one remarked:

> I try to encourage it. With my student this time, I think the 3rd day I was like: "You get to give rounds [with the doctor]". That was huge for her, she was so nervous. And she brought up things that sometimes I don't necessarily think about because I have been doing it for so long . . . Sometimes I forget the little things and to a student sometimes those aren't little things, they are big things. The fact that she brings them up I think is good, because I don't know if she would have had she been on her own . . . I think they do have a voice, it they want to have it. (Evangelia, Lines 707-719, p. 16, 2013)

As the preceptors encouraged their students to use their voices, they began to appreciate the students' perspectives in practice, which in turn facilitated their own self-awareness and learning.

To their students, the preceptors strove to impart patient advocacy and critical thinking in nursing practice, knowing the absence thereof could lead to detrimental patient outcomes. They encouraged their students to assess, analyze, and question best interventions and care in practice. One commented:

> I think that is one of the nursing qualities that we need. We have to be advocates for our patients . . .Their patient, they should be able to identify them with respect to their culture, their uniqueness, treat them with dignity and make sure that you advocate for their well-being when they are under your care. (Parthena, Interview #1, Lines 561-569, p. 13, 2013)

All the preceptors understood the importance of advocating for patients as persons in care. They strove to teach students that patients were individuals with unique values and contexts, vulnerable when they accessed health care services; and that nurses were obliged to protect their dignity and personhood by advocating for them. The preceptors worked with their students to impart the uniqueness of patients and the importance of advocacy in practice. When they debriefed with their students, the preceptors encouraged them to challenge their assumptions; to appreciate others' perspectives; to analyze practices according to

professional standards; to recognize the patients' contexts; to acknowledge their professional obligations to patients; and to know themselves. This process helped the students to understand the significance of their actions in shaping the experiences of patients as health care recipients.

d. Reconciling moral issues in practice. Reconciliation (1991) is the process of making one entity consistent with another and allowing two entities to be true at the same time. Reconciliation is needed in nursing practice when equally creditable values come into conflict, such as the need to preserve a patient's safety using means that might compromise that patient's dignity. The resulting uncertainty, wherein nurses must decide on practice actions favouring one value over another, obliges them to justify and understand different courses of action based on these competing, professional values. In preceptorship, the nursing students learned to address these conflicts and work through the uncertainty arising therefrom, thereby contributing to their moral development.

Students. When the students faced moral issues in preceptorship, they worked to reconcile their beliefs about these encounters, variously remarking that they could not "know everything" by the end of their preceptorships; that their personal values were incongruent with institutional values for care; that personal values and the perceived behaviours of others in practice needed to be reconciled; and that they would not always be able to meet their standards of nursing all the time owing to contextual factors.

The students came to recognize that not everything can be reconciled, and that reconciliation entails ongoing learning, as perspectives change with time and

experience. Sommerville (2006) notes that we must be comfortable with uncertainty to gain moral insight; we are more likely to make moral mistakes when we try to reconcile the irreconcilable, rather than accepting it and reflecting on our thoughts and actions. Living with uncertainty and complexity requires more than rationality; nurses must also acknowledge emotional ways of knowing in response to complex realities (Sommerville, 2006). For all of the participants in this study, moral emotions such as self-consciousness and other-suffering were central to reconciliation. For the students, reconciliation entailed being self-aware, upholding their moral values in their thoughts and actions; and learning to influence their future practices.

In the process of reconciling, the students examined other perspectives, evaluated issues fairly and open-mindedly, and assessed themselves to ensure that they were not being judgmental. Reconciliation was complicated and prolonged by the competing values therein; the students therefore strove to identify and adhere to their established personal value systems to maintain moral practice. One student remarked:

> We have the, in a sense with the nursing profession, the perfect duty to uphold the Code of Ethics. But the Code of Ethics itself states that "this Code of Ethics is not enough to ensure ethical and safe and competent practice of all its members" that there is something of an internal quality that's required of nurses. (Xeni, Interview #2, Lines 47-53, p. 2, 2013)

As students created meaning to reconcile moral encounters in practice, faculty members facilitated these reconciliations and observed the students' engagement therein.

Faculty members' observations of students. As the students worked to reconcile issues in practice, the faculty members observed them clarifying their values. One faculty participant stated:

> I think there are still many times where we teach our students that we need to leave our values elsewhere, "that's not what shapes practice". We've got all these codes and competencies, and I think somehow we teach them [students] that we do nursing independently of our values. So, we are not always owning that either. It is sort of, 'if you know these competencies you'll be a really great nurse'. And these skills, if you can perform them then, 'wow that's amazing' versus saying 'even that is shaped by what you value around how you both implement that, or whether you even execute it and really follow through on that knowledge.' (Hermione, Interview #2, Lines 149-159, p. 4, 2013)

Another stated:

> The same with reconciling who you are. In nursing school for the most part you are learning what would be the ideal care to give a patient; and what they are learning out there is- I am going to work as best I can to give them the best care, but, sometimes that is not going to be [the best care]. I am not going to be able to do it because of manpower, timing, whatever else. (Olympia, Interview #1, Lines 258-267, p. 6, 2013)

Creating conditions to encourage goodness in and among individuals, rather than directly teaching virtues, reflects care theory, namely the belief that moral motivation arises within the individual or within interactions (Sellman, 2011; Noddings, 2002a; 2002b). In this study, nursing student moral development occured in the context of the preceptorship relationship. In dialoguing with students to help them create meaning from practice encounters, preceptors and faculty members imparted attention, responsiveness, respect, and care. The resulting, safe spaces enabled the virtues of respect, honesty, compassion, fairness, courage, cooperation, and responsibility to flourish.

In the faculty members' view, the students reconciled moral practice issues pertaining to: their personal values for care versus patients' choices and actions; their personal values for care versus the institutional values, policies and procedures; and their perceived ideals for nursing versus the reality thereof. Overall, the faculty members considered the students more likely to analyze their own values rather than prescriptive, ethical principles for nursing practice. Beyond imparting ethics theory, the faculty members used the pedagogical strategies of reflection and dialogue to foster meaning and wisdom.

Like the students, the faculty participants believed that not every moral issue could or should be reconciled. In their view, reconciliation was unique to each individual, but impossible in isolation; support systems were always necessary. This view evinces an ethic of care, which depends on a strong community (Noddings, 2002a; Noddings, 2002b). The preceptors, for their part, regarded themselves as sources of support for their students, helping them to reconcile practice issues.

Preceptors' observations of students. Sharing the view that reconciliation is unique to each individual, the preceptors observed that the students reconciled issues in varying ways, such as recognizing professional responsibilities and acknowledging patients' choices and desires for care.

The preceptors agreed that repeated exposure to moral issues and situations in practice helped students reconcile and respond to them. Enjoyment was vital to coping with and reconciling everyday practice issues arising in morally challenging areas. One preceptor remarked: "Especially on our unit,

because there are things that happen that are terrible all the time. So I think you have to enjoy your job as well, so you can get over those times" (Evangelia-2, p. 6, 2013). Additional preceptors' comments included the following:

> I think it is important to have fun and enjoy yourself, not necessarily at the expense of your responsibilities, but in spite of them . . . It's important to know who you are and be proud of who you are, because otherwise there are a lot of hard times going where you want to go. (Zisis, Interview #2, Lines 532-547, p. 12, 2013)

> Work should be a fun place. And they should learn that during the preceptorship so when they come into the graduate role, when they are going into a new experience at work they should be able to gel into that atmosphere, make friends, or be a good team player to work with them. Help others out if they are in trouble. (Parthena, Interview #1, Lines 307-312, p. 7, 2013)

Assisting students to work through moral issues in practice, the preceptors were mindful of their own issues and processes of reconciliation. Accepting that moral issues were part of their practices, and sharing the view that reconciliation was unique to each individual, the preceptors described a variety of reconciliation processes. One preceptor recounted:

> Well, sometimes it's hard, but sometimes you think that they [patients] are in a better place. I think that is a thing that I try to focus on vs. that instant moment that the patient has past away that's, 'oh my gosh, that's too much to deal with.' You know what I mean. Their suffering has ended, I try and think there has got to be a silver lining somewhere, so that is what I try to focus on. (Evangelia, Interview #2, Lines 438-444, p. 10, 2013)

> I am really open. As I am open to my culture, I am open to anybody else's culture. If that is your culture's practice, I totally respect it. And even if I am not agreeing to it on a personal note that does not affect my practice . . . I would respect the client, and I would go along, I wound not refuse to work with them, or I would have no issues working with a client. (Parthena, Interview #1, Lines 587-599, pp. 13-14, 2013)

The preceptors' reconciliation processes included acknowledgement of conflicts between professional responsibilities; delivery of appropriate practices or interventions; awareness of desensitization to moral issues in practice; enquiry into practice; self-awareness and self-analysis to ensure consistency of practice with care values; acknowledgment and respect for the views of others; thoroughness in care delivery; and integration of religious and personal values in practice. One student reacted emotionally to a moral encounter in practice. When her preceptor debriefed her immediately thereafter, the student tried to rationalize the situation by reasoning through conflicting responsibilities and understanding the family's wishes, yet her emotional reaction to the patient's emotional distress was too significant. Over time, the student worked through her moral reaction of other-suffering, created meaning from the encounter, and thereby decided never again to engage in interventions or practices that did not "feel right." This student's reconciliation and creation of meaning illustrated the power of empathy and emotion to shape moral judgments (Hauser, 2006). Moral emotions thus served to shape the moral development of nursing students in this study.

Synopsis

The purpose of grounded theory research is to explicate how individuals actually conduct their actions (Glaser & Strauss, 1967; Milliken & Schreiber, 2001). Individuals form and direct their actions through relationships with others, which in turn create both shared and unique meanings (Milliken & Schreiber, 2001). In this study, I explored the basic, psychosocial process of moral development in preceptorship to satisfy personal curiosity, to support nursing

student achievement and satisfaction in practice, and to engender a greater understanding of:

- faculty and preceptor roles in engaging nursing students in the practice setting;
- preceptor and faculty engagement with nursing students in moral issues;
- nursing students' perceptions of their preceptorships and their relationships with preceptors and faculty;
- nursing students' engagement with moral issues, and their thought processes leading to decision-making and action;
- issues of concern for nursing students in preceptorship;
- the perspective of nursing students in preceptorship as they transition from the role of student to that of registered nurse;
- factors peripheral to the nursing student–preceptor–faculty triad that shape the students' preceptorships;
- effective preceptor/faculty pedagogical strategies in shaping nursing moral student development in preceptorship.

As data emerged, a deeply relational socialization process was found to shape nursing student moral development within the nursing student–preceptor–faculty relationship. With the guidance of my supervisor, I identified this process as *socializing for authentic caring engagement in nursing practice.*

Consistent with human science approaches to inquiry, I regarded nursing students as holistic beings within their preceptorships, illustrating how they actually engaged with encounters and moral issues to shape their moral development as they transitioned into professional nursing practice. Nursing student participants created meanings unique to each of them. *Authenticity*—being true to one's self, character, or spirit—was found to be significant to the basic psychosocial process of moral development, as nursing students held unique personal values which informed their learning. As psychosocial processes entail relationships with others, and the creation of meaning thereby, *socialization* was found to characterize the nursing student–preceptor–faculty relationship shaping

nursing student moral development. Within this socialization process, relational and pedagogical approaches evinced *care* theory; individuals engaged in attentive and responsive interactions that reflected genuine care for each other. Ultimately, these elements contributed to the moral development of nursing students transitioning into professional *nursing practice*.

In this study, the core process of *socializing for authentic caring engagement in nursing practice* was found to reflect nursing student moral development in preceptorship. This process consisted of four key categories: 1) distinguishing nursing and moral identity; 2) learning to recognize the patient's experience; 3) identifying moral encounters and creating meaning of those encounters; and 4) becoming a social agent and reconciling moral issues in practice. Each of these categories included ambient conditions. *Distinguishing nursing and moral identity* comprised finding one's "fit" with a practice area; defining the "good" nurse; harmonizing personal values in practice; integrating previous experiences; learning from others in the preceptorship; reconciling visions of nursing with the reality of practice; and assimilating into practice cultures. This category accounted for the reciprocal process whereby nursing students integrated their values into practice to develop nursing identity and moral identity, and appreciate the uniqueness of the patient's individual contexts as recipients of care. Central to this process was the ability of nursing students to establish nursing and moral identities, in order to see beyond themselves, thereby recognizing the individual contexts of patients for whom they cared. As nursing students built and refined their nursing and moral identities, and *recognized the*

patients' experiences, they created meanings within the context of caring relationships in practice.

Identifying moral issues in practice and creating meaning of practice encounters comprised identifying moral encounters, both in practice and in the preceptorship relationship; dialoguing with others to create meaning in practice; and engaging in personal ways of knowing. This category accounted for nursing student relationships with preceptors, faculty members, peers, other nurses and support systems, which gave rise to safe spaces for nursing students to engage with encounters and moral issues in practice, thereby creating personal meanings. In so doing, nursing students individually clarified their values and determined their future courses as nurses socialized into professional practice. They also identified how they were creating meaning from encounters, through their rational and emotional responses thereto, and through their personal ways of knowing. As students derived meaning from practice encounters, they proceeded to reconcile and take action to address practice encounters. *Becoming an advocate and reconciling moral issues in practice* entailed acting based on rational and emotional processes, learning to be proactive, developing relational insight to socially navigate practice environments, and reconciling moral encounters in practice.

Collectively, these four key categories reflected a process informing and guiding nursing students' behaviours and actions in practice. These behaviours and actions were shaped by development of identity; integration of personal values into practice; recognition of the uniqueness of patients; participation with

preceptors, faculty members, peers and others to create meaning from encounters in practice; and recognition of the significance of personal, rational and emotional responses. The psychosocial process of socializing for authentic, caring, nursing practice thus led to the advocacy of nursing student behaviour in practice.

CHAPTER 5: SUMMARY AND CONCLUSIONS, IMPLICATIONS, RECOMMENDATIONS, AND LIMITATIONS

Summary and Conclusions

The purpose of this study was to explore the basic, psychosocial process of nursing student moral development in preceptorship. *Socializing for authentic caring engagement in nursing practice* was the substantive theory of nursing student moral development emerging from this study. The process of moral development in nursing student preceptorship has never been studied before. As this is the first study of moral development in preceptorship using a grounded theory method, only a substantive theory can be generated from the data. Glaser and Strauss (1967) suggest that multiple theories are needed to generate inclusive, formal theories. To that end, further investigation of nursing student moral development is required.

Theories emerging from grounded theory studies reflect a process, rather than a perfected entity (Glaser and Strauss, 1967). The substantive theory, *socializing for authentic caring engagement in nursing practice*, uncovered the nature of nursing student moral development in the contexts of preceptorship relationships and clinical practice settings. Glaser and Strauss (1967) suggest that "the discussional form of formulating theory gives a feeling of 'ever developing' to the theory, allows it to become quite rich, complex, dense, and makes its fit and relevance easy to comprehend" (p.32). *Socializing for authentic caring engagement in nursing practice*, and the four key categories comprised therein, constitute a substantive theory for further investigations of nursing student moral

development. Nurse educators can use the results of this study to develop pedagogical strategies to strengthen preceptorship practice, such as: a) fulfilling nursing student requests for areas of preceptorship practice that "fit" with their personhood; b) exploiting the potential of attentive, responsive and caring relationships between students, preceptors and faculty to facilitate student moral development; c) establishing safe spaces for students to dialogue and create meaning from practice encounters, both within the preceptorship triad and within the peer network, and; d) providing students opportunities to act as patient advocates.

As theory can inform nursing practice, developing a theory for a practice discipline can guide the daily practices of professionals. The three research questions guiding this study were: 1) What are the basic psychosocial processes of moral development occuring in the preceptorship relationship? 2) What are nursing students' perceptions of morals? 3) What are nursing student's conceptions of how their moral development is shaped by the preceptorship experience?

In this study, the basic, psychosocial process of *socializing for authentic caring engagement in nursing practice* comprised four key categories: a) distinguishing nursing and moral identity; b) learning to recognize the patient's experience; c) identifying moral encounters and creating meaning of those encounters; and d) becoming a social agent and reconciling moral issues in practice. Each category contained ambient conditions, described and summarized in Chapter 4.

In this study, nursing student participants perceived morals as a set of values—personally constructed and developed during one's upbringing—governing conduct. They particularly felt their moral development was shaped throughout their nursing programs and preceptorships, describing this process as a dynamic search for understanding and knowledge leading to independent practice. In their preceptorships, the students dialogued with many individuals—including preceptors, faculty members, and peers—to reflect on their experiences and gain insight into their emotional reactions, actions, and obligations to others. These conversations taught the students to be mindful of other perspectives, such as those of patients, colleagues, and the members of the preceptorship triad.

In the students' view, moral development was unique for each person. It entailed the abilities to identify moral issues in practice; to be aware of one's values and analyze practice encounters in accordance therewith; to compare and assess one's own practice, and the practices of others, with one's values; to be open to others' perspectives; to reflect on practice; to voice concerns; and to understand the uniqueness of patients and other practitioners. These descriptions of moral development were reflected in the four key categories emerging from this study.

Implications for Nursing Education

The findings of this study have several implications for nursing education:

1. Within the preceptorship relationship, the roles of faculty members and preceptors are fundamental to student growth and moral development.

2. Faculty members and preceptors are instrumental in creating safe spaces for nursing students to clarify personal values, to explore encounters and moral issues in practice, and to create meaning therefrom.
3. In preceptorship, pedagogical strategies such as debriefing, promoting reflection, and role modeling enable students: a) to develop an understanding of their personal identities and values; b) to recognize multiple perspectives in practice; c) to learn the uniqueness of patients' contexts; d) to create meaning in practice, and; e) to explore more readily their emotional and rational responses to encounters in practice.
4. Insofar as peers help students to create meaning in practice, clinical course measures—such as allocating time in pre and/or post conference sessions, and implementing website technology to allow students to blog and connect with peers to discuss practice encounters and moral issues—can contribute to nursing student moral development.
4. Students' emotional responses to practice encounters significantly impact their moral development.
5. Faced with moral encounters in practice, nursing students rarely consult formal ethics theory; while principle-based ethics may guide responses to moral issues in practice, in preceptorship it is equally

valuable to enable students to explore their personal values and emotions arising from such issues and encounters.

6. The preceptorship relationship is foundational to the creation of meaning from moral issues and practice encounters—a key component of nursing student moral development.
7. When preceptors debriefed nursing students on their encounters and moral issues, it became apparent that the preceptors faced similar situations, and that dialogue thereon could impact all members of the preceptorship triad; it is therefore important to attend to these members' perspectives, and to create safe spaces for them to debrief their practice encounters as well.
8. The exploration of personal, nursing, and moral identity is foundational to the moral development of nursing students; enabling them to recognize, refine and engage with these identities—and assigning them to clinical preceptorship practice areas that fit their personhood—facilitates authentic engagement in nursing practice.

Critical Considerations

1. This study contains evidence that ethics is a construct that is internal to individuals. In addition to imparting knowledge of formal ethics theory to nursing students, using a variety of pedagogical strategies including lectures on ethics theory, reflective journaling, and debriefing about learning and practice can be significant to facilitating knowledge of ethics and awareness of moral in nursing education programs.

2. This study contains evidence that moral development and knowledge of ethics is enhanced within the context of relationships in nursing education. These relationships include; student-preceptor, student-faculty member and student-student. Engaging in dialogue within the context of these relationships can facilitate the identification of moral issues in practice and evoke moral awareness in students as they engage in values clarification to create meaning of practice issues.
3. Emerging from this study was a substantive theory of nursing student moral development that uncovers the basic psychosocial processes that students experience as they are transitioning into professional practice. The substantive theory, *Socializing for Authentic Caring Engagement in Nursing Practice,* is a new theory that derives from an investigation of nursing students learning in a variety of clinical practice settings. Nursing educators can use data from this study to enhance awareness of the basic psychosocial processes shaping nursing student moral development.
4. This study was located in the context of relational ethics. Nodding's (2002a; 2002b) ethic of care was identified and selected as the care theory that supported the emerging substantive theory of nursing student moral development in preceptorship. Nodding's work derives from education and her specific focus is on pedagogical strategies to evoke awareness of moral behaviour in learners. Noddings was selected due to her emphasis the importance of relationships and

dialogue in the moral development of learners. However, it is acknowledged that there are equally meritorious care theories originating in nursing and nursing education such as the works of Bevis and Watson (1989).

Recommendations for Future Research

This research introduces a new area of study, acknowledging that socialization for authentic caring engagement in nursing practice occurs during the transition to professional nursing practice. With respect to the findings of this study, I recommend further nursing research on undergraduate nursing education and preceptorship courses, with foci such as:

- the relationship between formal nursing education and the nurturing of personal identity in nursing students;
- nursing educators' perceptions of care theory and care ethics, as reflected in the nursing curricula;
- sources of support for preceptors as they engage students with moral issues and encounters in practice;
- nursing students' emotional responses to moral encounters or issues in practice;
- processes facilitating the moral development of nursing students placed in preceptorship areas not of their choosing, or those lacking cohesive relationships with their preceptors;
- the moral development of nursing students practicing in acute care placements as compared to those in community practice.

The substantive theory, *socializing for authentic caring engagement in nursing practice,* provides a potential approach to clinical teaching and learning, conceptualizing nursing student moral development in preceptorship. In taking this process into account, nursing curriculum developers should consider the creation of caring climates and safe, ethical spaces; the respect and nurture of nursing students' identities; the recognition of others' diversity and humanity in

practice; and the potential of moral emotion and diverse ways of knowing to engender advocacy, virtue in nursing practice, and meaning from encounters and moral issues.

Recommendations

Based on the findings of this study, I recommend implementing or maintaining the following nursing curricular practices:

1. Pedagogies facilitating peer support and safe spaces to explore encounters and moral issues in practice;
2. Program and preceptorship strategies to facilitate the recognition of personal identity and others' perspectives, such as reflective journaling, debriefing, and critical dialogue;
3. Where feasible, placement of students in their preferred areas for preceptorships and clinical courses;
4. Measures supporting faculty members and preceptors in their roles as educators and professionals, such as orientations, debriefing groups, workshops and seminars;
5. Safe spaces, such as blog spaces on course websites and pre/post conference sessions, for nursing students to engage with peers and faculty mentors for the purpose of exploring practice encounters and moral issues;
6. Integration or increased emphasis on care ethics and patterns of intrinsic engagement with encounters and moral issues, such as

personal values clarification and moral emotions, in formal ethics courses;

7. Critical analysis of curricular philosophy by program administrators, to assess its congruence with pedagogical approaches in classroom, laboratory and clinical settings;
8. Pedagogical approaches—such as debriefing—reflecting an ethic of care on the part of faculty members and preceptors, thereby imparting the values of attentiveness and responsiveness to students, and making them feel cared for;
9. Reassessment of evaluation and grading policies in preceptorship, accounting for the influence of perceived power differentials on student identity, socialization into practice, and moral development;
10. Mitigation of these perceived power differentials by faculty and preceptors.

Limitations

An intrinsic limitation to this study was researcher technique and bias. As the researcher is the instrument in qualitative research, misrepresentation or errors in data collection, analysis and interpretation can result from strongly held values or feelings on the researcher's part (Holloway & Wheeler, 2010). To control for my bias and to gain theoretical insight into the emerging data, I maintained an audit trail consisting of operational memos, analytical memos, and a reflexive researcher diary. During interviews, I asked general, open-ended questions to ensure they followed the participants' responses, rather than forcing the data

based on my presuppositions. Furthermore, I endeavoured to establish diversity in the data by comparing incidents with other incidents, or with properties of a category, to identify as many similarities or differences as possible, thereby reducing bias.

The homogeneity of student sample may have been a limitation. A sample of participants from a diverse range of backgrounds may have served to enrich the findings. A sample size of 13 participants, while small by some measures, was sufficient to achieve saturation of themes inasmuch as: a) I did not identify new themes emerging in subsequent participant interviews; b) I determined the data was comprehensive; and c) I concluded that the variability and relationships between categories could be explained sufficiently to develop a supporting theory (Morse, 1995; O'Reilly & Parker, 2012). The themes emerging from ongoing analysis of transcribed interviews served to corroborate the initial data (Richards & Morse, 2007). Moreover, three different population groups yielded diverse data; Glaser and Strauss (1967) suggest that studying similar groups, as opposed to one group, enhances saturation as more categories are yielded.

As the main source of data collection, semi-structured interviews may have limited the study inasmuch as researcher questioning techniques and participant responses can lead to biased results; participants may be selective in their disclosure, and researchers may force data when posing questions. The breadth of the phenomena of interest may have limited the study. Morals, moral identity, and moral character have been explored for centuries, by countless

philosophers; locating moral development in one moral/ethical model may thus have been a limitation.

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APPENDIX A: KOHLBERG'S STAGES OF MORAL DEVELOPMENT

Level	Stage	Factors guiding moral behavior
Preconventional	1. Heteronymous morality	Punishment and obedience
Preconventional	2. Instrument morality	Individual instrument purpose and exchange
Conventional	3. Mutual morality	Mutual interpersonal expectations, relationships and conformity
Conventional	4. Social system morality	Social system and conscience maintenance
Postconventional	5. Social contract morality	Prior rights and social contracts acknowledged
Postconventional	6. Universal ethical morality	Universal ethical principles

APPENDIX B: STUDENT INFORMATION SHEET

Research Project: **Nursing Student Moral Development in Preceptorship: A Grounded Theory Study**

Investigator:	Supervisor:
Jill Vihos, RN, BScN, MN PhD student Faculty of Nursing University of Alberta Edmonton, AB E-mail: jem3@ualberta.ca Phone: (780) 850-6459 (cell)	Florence Myrick, RN, BN, MScN, PhD Professor Faculty of Nursing 4-238 Edmonton Clinic Health Academy 11405-87 Ave University of Alberta Edmonton, AB T6G 1C9 E-mail : flo.myrick@ualberta.ca Phone: (780) 492-0251

Invitation to Participate and Study Purpose

As an undergraduate nursing student, you are invited to participate in a qualitative research study that aims to investigate the processes of moral growth during a clinical preceptorship course. The main goal is to explore how nurse preceptors and faculty members facilitate nursing student's ability to translate what they think is a "good" intervention or decision into action

Voluntary Participation

If you choose, your participation is completely voluntary and you can withdraw you consent to participate at any time during the study. If you ever chose to withdraw your consent, any information you have passed onto the researchers will be deleted and no longer be part of the study. Also you will be free to refuse to answer any questions or discuss any topics you do not wish to.

Participating in the Study

If you decide to participate, we will ask you to take part in two separate 1-hour individual interviews with one of the researchers listed above. This will be done shortly after you commence participation in NURS 495, and prior to the end of the NURS 495 course. The interview(s) will take place at a time and location that is convenient for both you and the researcher. All interviews will be tape-recorded and the discussion transcribed for analysis by the researcher. To protect your identity only the researcher will know your name and the tape-recorded interviews will be coded with a number.

After the initial interview the researcher might need to contact you briefly to clarify or expound on a topic already discussed. This may also serve to ensure that we are correctly capturing your feedback. This part of the study, if needed, would also be completely voluntary and you would not have to do this follow-up to be able to participate in the initial interview.

Confidentiality

Your participation is completely voluntary and confidential. No other faculty member from your program will know you are participating in this study unless you chose to share that information. All information that you provide will be kept confidential, only to be shared between the two principal investigators and the research team for the purpose of analyzing the findings. All tape recordings, transcriptions of your comments, and written notes we collect from you will be locked in a safe that is only accessible by the investigators of this study.

Upon completion of the study, all tape recordings and documents of your specific comments will be destroyed. Also it is our intention to publish and distribute the findings, therefore it is possible that some specific comments you make will be incorporated into study reports but your name and identifying information will not appear in any way.

Benefits and Risks

There will likely be no direct or immediate benefit to you for participating in this study but your participation will be beneficial in helping nurse educators develop and improve learning experiences for other nursing students.

Based on the literature there is no foreseeable risks for you in participating in this study. Participating in this study will not influence your grades in this course. This study is for the purpose of improving knowledge and understanding of how nursing students generally demonstrate moral growth and will in no way impact your academic progress in the nursing program.

It is our intention that there will be no expenses incurred by you as a result of participating in this study. A parking voucher can be made available to you on the day of your interview(s) and there will be snacks and beverages available.

Please contact either of the two investigators listed above for any questions or concerns you may have about participating in this study. Thank you for your time in reading this information and considering participation in our study.

Sincerely,

Jill Vihos, RN, BScN, MN, PhD Student

APPENDIX C: REGISTERED NURSE PRECEPTOR AND FACULTY MEMBER INFORMATION SHEET

Research Project: **Nursing Student Moral Development in Preceptorship: A Grounded Theory Study**

Investigator:	Supervisor:
Jill Vihos, RN, BScN, MN PhD student	Florence Myrick, RN, BN, MScN, PhD
Faculty of Nursing University of Alberta Edmonton, AB E-mail: jem3@ualberta.ca Phone: (780) 850-6459 (cell)	Professor Faculty of Nursing 4-238 Edmonton Clinic Health Academy 11405-87 Ave University of Alberta Edmonton, AB T6G 1C9 E-mail: flo.myrick@ualberta.ca Phone: (780) 492-0251

Invitation to Participate and Study Purpose

As a registered nurse preceptor or faculty member, you are invited to participate in a qualitative research study that aims to investigate the processes of moral growth during a clinical preceptorship course. The main goal is to explore how nurse preceptors and faculty members facilitate nursing student's ability to translate what they think is a "good" intervention or decision into action

Voluntary Participation

If you choose, your participation is completely voluntary and you can withdraw you consent to participate at any time during the study. If you ever chose to withdraw your consent, any information you have passed onto the researchers will be deleted and no longer be part of the study. Also you will be free to refuse to answer any questions or discuss any topics you do not wish to.

Participating in the Study

If you decide to participate, we will ask you to take part in two separate 1-hour individual interviews with one of the researchers listed above. This will be done shortly after you commence participation in NURS 495, and prior to the end of the NURS 495 course. The interview(s) will take place at a time and location that is convenient for both you and the researcher. All interviews will be tape-recorded and the discussion transcribed for analysis by the researcher. To protect your identity only the researcher will know your name and the tape-recorded interviews will be coded with a number.

After the initial interview the researcher might need to contact you briefly to clarify or expound on a topic already discussed. This may also serve to ensure that we are correctly capturing your feedback. This part of the study, if needed, would also be completely voluntary and you would not have to do this follow-up to be able to participate in the initial interview.

Confidentiality

Your participation is completely voluntary and confidential. No other faculty member from your program will know you are participating in this study unless you chose to share that information. All information that you provide will be kept confidential, only to be shared between the two principal investigators and the research team for the purpose of analyzing the findings. All tape recordings, transcriptions of your comments, and written notes we collect from you will be locked in a safe that is only accessible by the investigators of this study.

Upon completion of the study, all tape recordings and documents of your specific comments will be destroyed. Also it is our intention to publish and distribute the findings, therefore it is possible that some specific comments you make will be incorporated into study reports but your name and identifying information will not appear in any way.

Benefits and Risks

There will likely be no direct or immediate benefit to you for participating in this study but your participation will be beneficial in helping nurse educators develop and improve learning experiences for other nursing students.

Based on the literature there is no foreseeable risks for you in participating in this study. This study is for the purpose of improving knowledge and understanding of how nursing students generally demonstrate moral growth and will in no way impact your academic progress in the nursing program.

It is our intention that there will be no expenses incurred by you as a result of participating in this study. A parking voucher can be made available to you on the day of your interview(s) and there will be snacks and beverages available.

Please contact either of the two investigators listed above for any questions or concerns you may have about participating in this study. Thank you for your time in reading this information and considering participation in our study.

Sincerely,

Jill Vihos, RN, BScN, MN, PhD Student

APPENDIX D: CONSENT FORM

Title of Project: Nursing Student Moral Development in Preceptorship: A Grounded Theory Study

Investigator:

Jill Vihos, RN, BScN, MN, PhD student
Phone: (780) 850-6459
E-mail: jem3@ualberta.ca

Supervisor:

Florence Myrick, RN, BN MScN PhD
Phone: (780) 492-0251
E-mail: flo.myrick@ualberta.ca

The following is to be completed by the study participants:

Do you understand that you have been asked to be in a research study?	Yes	No
Have you received a copy of the attached information sheet?	Yes	No
Have you had an opportunity to ask questions and discuss the study?	Yes	No
Do you understand that you are free to refuse to participate or withdraw from the study at any time without giving a reason?	Yes	No
Has the issue of confidentiality been explained to you?	Yes	No
Do you consent to being interviewed?	Yes	No
Do you consent to being audio-taped when interviewed?	Yes	No
Do you agree to have your data reviewed at a later date?	Yes	No
Do you understand who will have access to your information and comments made during your interview(s)	Yes	No
This study was explained to me by:_____ Date:_____		

I agree to participate in this study.

_____ _____ _____

Signature of participant Printed Name Date

I believe the person signing this consent form understands what is involved in this study and voluntarily agrees to participate.

_____	_____	_____
Signature of investigator	Printed Name	Date

***A copy of this consent form must be given to the subjects.**

APPENDIX E: DEMOGRAPHIC DATA: NURSING STUDENTS

1. Code: _____
2. Age range in years (please circle): 20-29 30-39 40-49 50-59 60-69
3. Gender: Male Female
4. Other University Education:
   _____
5. Brief description of previous experience with moral issues in an nursing program:

   _____

   _____

Demographic Data – Preceptor

1. Code: _____
2. Age range in years (please circle): 20-29 30-39 40-49 50-59 60-69
3. Gender: Male Female
4. Other University Education:
   _____
5. Brief description of previous experience with moral issues in an nursing program:

   _____

   _____

Demographic Data – Faculty Member

1. Code: _____
2. Age in years (please circle): 20-29 30-39 40-49 50-59 60-69
3. Gender: Male Female
4. Other University Education:
   _____

5. Brief description of previous experience with moral issues in an nursing program:

   _____

   _____

APPENDIX F: GUIDING AREAS OF DISCUSSION AND GUIDING QUESTIONS

These questions will be utilized as a guide in the first interview to provide systematic data collection for all participants. Because it is not possible to determine a priori what successive interviews will include, subsequent interviews will be used to obtain explanations concerning areas that lack clarity. They will further direct questioning, which will provide a more complete description for the theory development.

Students

Incident analysis

i.e. Describe a clinical incident from your preceptorship experience in which you believed moral reasoning to be involved.

Moral perception

i.e. What does the term moral mean to you?

Preceptors

Incident analysis

i.e. Describe an incident from your preceptorship experience in which you believed moral reasoning to be involved

Moral perception

i.e. What does the term moral mean to you?

Faculty

Incident analysis

i.e. Describe an incident from your facilitation experience in the preceptorship experience in which you believe moral reasoning to be involved

Moral perception

i.e. What does the term moral mean to you?

APPENDIX G: QUESTIONS TO ASSESS THE THEORY GENERATED

1. Is the researcher's main emphasis on verifying or generating theory?
2. Is the researcher more interested in substantive or formal theory?
3. What is the scope of the theory used in the publication?
4. To what degree is the theory grounded?
5. How dense in conceptual detail is the theory?
6. What kinds of data are used, and in what capacity, in relation to the theory?
7. To what degree is the theory integrated?
8. How much clarity does the researcher reveal about the type of theory that he/she uses?