University of Alberta

PRECEPTORSHIP AND NURSE PRACTITIONER EDUCATION: NAVIGATING THE LIMINAL SPACE

By

Diane B. Wilson Billay

A thesis submitted to the Faculty of Graduate Studies and Research
in partial fulfillment of the requirements for the degree of

Doctor of Philosophy

Faculty of Nursing

Fall 2010
Edmonton, Alberta

Examining Committee

Dr. Florence Myrick, Nursing, University of Alberta

Dr. Olive Yonge, Nursing, University of Alberta

Dr. Judith Lupart, Educational Psychology, University of Alberta

Dr. Marion Allen, Nursing, University of Alberta

Dr. Pauline Paul, Nursing, University of Alberta

Dr. Carroll Iwasiw, Nursing, University of Western Ontario

I dedicate the following thoughts to all the teachers who have come before me and who will surely come after me:

For those teachers who inspire in their students to ask *why not*, these words are for you.

ABSTRACT

Preceptorship is a teaching-learning approach in which learners are individually assigned to expert practitioners in the practice setting. The purpose is to provide them with daily experience on a one-to-one basis with a role model and resource person who is immediately available to them. Currently, the literature is replete with research on various aspects of preceptorship, including the preceptor role, the evaluation process, professional socialization, the promotion of clinical competence, and the fostering of critical thinking in undergraduate and graduate education, to name a few. To date, however, no studies have specifically explored the process involved in promoting the education of nurse practitioner students in preceptorship. The purpose of this grounded theory study was to explore the process used in preceptorship to prepare nurse practitioner students for their future role in professional practice. To that end, the process in which preceptors, nurse practitioner students, and faculty engage was explored. The sample comprised nurse practitioner students, preceptors and faculty from a large university in western Canada. Findings from this study revealed that as students proceeded through the preceptorship program they worked through or navigated what could be described as the liminal space or an in-between place.

As a result of the findings of this study, several crucial points have been recognized that have implications for the nurse practitioner student who engages in preceptorship. First, upon acceptance into an advanced practice nursing program it is important for students who are themselves experienced professionals in their own right, to understand the preceptorship process of transition, found in

this study to be the liminal space, intrinsic to which are adjustments from the role of nurse, to that of student and finally to that of the nurse practitioner. Second, to adequately prepare students for their transition, faculty need to develop curricula that address the challenges involved with this phenomenon, specifically knowledge related to threshold concepts and troublesome knowledge. Third, support for these students from faculty, preceptors and fellow students was found to directly affect the ability of these learners to successfully navigate their transitional process in preceptorship.

ACKNOWLEDGMENTS

I would like to acknowledge several people who guided and supported me throughout this study. First, I gratefully acknowledge and thank my thesis committee for their support and encouragement and for allowing me the privilege of working under their guidance. I extend my sincere gratitude and appreciation to Dr. Florence Myrick, my thesis supervisor and mentor, for several reasons: (a) her unwavering belief in my abilities as a budding researcher, (b) her encouragement to think outside the box, (c) her ability to ask of me the "who, what, where, when, why, and how" questions; and (d) her exceptional role modeling of what it means to be a "good teacher." I thank Dr. Olive Yonge for continuing to be a caring and supportive role model and for her words of encouragement. I also extend many thanks to Dr. Judith Lupart for her support and constructive comments and the thought-provoking questions she asked me. In addition, I thank the other members of my committee who provided much welcome support and for also stimulating my "little grey cells." These committee members include Drs. Marion Allen, Pauline Paul and Carroll Iwasiw.

I would also like to acknowledge the friendship and support of Drs. Kathleen Hunter, Florence Luhanga and Sheri Connor, who are inspirations to me as these women are remarkable human beings and scholars. To my peers Vicki Earle, Deirdre Jackman, Brian Parker, Zee Scully and Jayne Smitten, many thanks for your unconditional support. I also wish to thank the University of Alberta and the Faculty of Nursing for the teaching and research assistantships that I received throughout my studies. I also thank the nurse practitioner students, nurse

practitioner preceptors, and faculty members without whom this study would not have been possible for willingly sharing their time and knowledge.

Finally, a special thank you to my husband, brother and his family, and my parents. First, I wish to express my love and appreciation to my husband, Byron, for his unwavering support and understanding throughout my studies. His love and encouragement have played a major role in helping me to reach my goal. To my brother Andrew, sister-in-law Jeanine, and niece (Amanda) and nephews (Jacob and Lukas) many thanks for your encouragement and support. To my parents, Roger and Jessie Wilson I am proud to be your daughter.

In memory of an authentic human being, my father, Mr. Roger John Wilson. Whenever I see a dragonfly I shall remember your bright smile, your love of classical music and bicycle racing, your keen sense of humour, and your unfailing, loving support.

"I am because of you."

You are now learning how to live without breathing.

(September 9, 1928, to March 27, 2009)

TABLE OF CONTENTS

CHAPTER 1

INTRODUCTION

The Canadian health system is founded on the *Canada Health Act* (1984, 2003) and the principles of primary health care (College & Association of Registered Nurses of Alberta, 2005; World Health Organization [WHO], 1978). Health leaders in Canada advocate a primary health care focus on illness prevention and health promotion as key ingredients of a healthy society (Patterson, 2000). The principles of primary health care are: accessibility, public participation, health promotion, appropriate technology, and intersectoral cooperation (WHO, 1978). When these principles are merged with the regulations of the *Canada Health Act*, they provide a platform for health reform, which means that the role of the nurse practitioner is ideally situated within the current health care environment to provide cost effective, efficient and appropriate holistic health care to the population.

Almost three centuries ago, Jeanne Mance and the Grey Nuns established cottage hospitals and visited the sick in homes. They can be considered the first Canadian nurse practitioners because they espoused accessibility, public participation, and health promotion. Since those early years, outpost nurses, public health nurses, nurse practitioners in rural and isolated communities, and the Victorian Order of Nurses created a few of the advanced practice nursing roles that have evolved to deliver primary health care services (Patterson, 2000). As early as the 1970s, the Canadian Nurses Association (CNA) took a strong, yet controversial stand in support of the expanded role of the nurse. Even though the

CNA took this strong supportive stand, the term *nurse practitioner* is still often subject to interpretation ranging from an expanded, well-defined role of nurse to that of physician's assistant (Patterson, 2000).

Although formal support for the nurse practitioner role became obscure after the 1980s, a plethora of advanced roles for nurses continued to flourish, such as the clinical nurse specialist (CNS). Specifically, the qualifications for a CNS include a graduate degree in nursing with a clinical specialty focus (Capital Health Authority, 2001) and encompasses the following domains of practice: expert clinical practice, research, education, leadership, and professional development (the percentage spent in each domain varies depending on the role, Capital Health Authority, 2001). The roles of the nurse practitioner and the CNS are similar in scope of practice except for one major area; only the nurse practitioner can diagnose and clinically manage a patient using prescription drugs.

Since 2000 there has been a concerted effort to reform health care within health care regions, to improve the health of all Canadians. Along with several provincial and territorial governments, the Capital Health Authority (now Alberta Health Services) has reintroduced a health care role into areas traditionally under the purview of the medical profession (Patterson, 2000): the nurse practitioner in primary care. Because of renewed interest in this role, educational programs have been instituted to support this role.

Problem Statement

The nurse practitioner movement began in the 1960s, primarily in the United States of America. Since that time, this role has emerged as a major

provider of health care for Canadians. Preceptorship is the preferred approach to teaching nurse practitioners in the clinical setting. Considerable research has been conducted on how this model contributes to the education of undergraduate nursing students. However, to date no research has been conducted to ascertain how preceptorship contributes to the education of nurse practitioners from a process perspective. It is therefore timely to determine how preceptorship actually prepares nurse practitioners for their role in professional nursing practice.

Purpose of the Study

The purpose of this study, using the grounded theory method, was to explore the process used in preceptorship to prepare nurse practitioner students for their future role in professional practice. I examined the process in which preceptors, nurse practitioner preceptees, and faculty engage in preparing nurse practitioner students throughout the preceptorship experience.

Clarification of Terms

The following are key concepts deemed relevant to this study:

Faculty/Educator

A professor or educator at a university, college, or practice-focused agency who develops, monitors, maintains, and evaluates the quality of the preceptorship experience. This person is accountable for educating, supporting, and evaluating preceptors and students throughout the preceptorship experience (Schoener & Garrett, 1996).

Preceptor

An experienced (nursing/medical) professional who teaches, supervises, and serves as a role model for a student or graduate nurse for a prearranged period of time in a formalized program (Usher, Nolan, Reser, Owens, & Tollefson, 1999). A preceptor in this research was either a nurse practitioner or a physician.

Nurse Practitioner Student

A registered nurse who is a student pursuing graduate nursing education for the purpose of becoming a nurse practitioner.

Preceptorship

Kaviani and Stillwell (2000) describe preceptorship as:

an approach to clinical teaching that involves access to an experienced and competent role model and a means of building a supportive *one-to-one* teaching and learning relationship. This relationship tends to be short-term [and is aimed at] assisting the newly qualified practitioner or nursing student to adjust to the nursing role (p. 219).

Advanced Practice Registered Nurses

The nurse practitioner role is grounded in the nursing profession's values, knowledge, theories, and practice. It complements rather than replaces the role of other health care providers. Nurse practitioners diagnose and treat health problems, prescribe medications, and work autonomously in initiating patient care and collaborating with other health care professionals (Alberta Association of Registered Nurses, June, 2002). Two other categories of advanced practice registered nurses include the clinical nurse specialist and the nurse midwife

(CNA, 2000).

Advanced Nursing Practice

The deliberate, purposeful, and integrated use of expanded nursing knowledge, research, and clinical practice expertise, grounded in the profession's values of holistic, patient-centered care (Canadian Nurses Association, 2000).

CHAPTER 2

REVIEW OF RELATED LITERATURE

A review of the literature in nursing education revealed minimal information on precepting the nurse practitioner student. The themes found in the literature indicate that precepting a nurse practitioner student is a relatively new area of inquiry that warrants further exploration.

Preceptorship is a one-to-one learning experience in the clinical setting in which a student is paired with a clinical staff member who guides the student (Myrick & Billay, 2010; Peirce, 1991). Among the first researchers to explore preceptorship within the context of clinical education were Chickerella and Lutz (1981), who defined preceptorship as "an individualized teaching/learning method. Each student is assigned to a particular preceptor for the entire clinical rotation, so he or she can experience day-to-day practice with the model and resource person immediately available within the clinical setting" (p. 107). Germane to the use of the preceptorship approach to teaching and learning is the belief that the one-to-one situation is the most effective mechanism for learning (Myrick & Barrett, 1994). In addition, preceptorship affords nursing faculty and staff nurses the opportunity to collaborate in the process of enhancing the transition from the role of (nurse practitioner) student to (new nurse practitioner) staff nurse (Chickerella & Lutz, 1981; Ferguson, 1994). With this in mind, it is prudent to discuss the literature on specific topics related to preceptorship, such as the historical education of nurse practitioner students; the evolution of the

preceptorship model; and the roles and responsibilities of the faculty, preceptors, and nurse practitioner students.

Preceptorship

Historical Education of Nurse Practitioner Students

In Canada the first nurse practitioner program was initiated at Dalhousie University (Halifax, Nova Scotia) in 1967, specifically for nurses working in northern nursing stations. Since that time, other programs have emerged. In particular, in western Canada the University of Alberta has offered the Advanced Nursing Practice–Individual/Family Nursing Program since September 1997. As well, Athabasca University has offered the Master of Health Studies program since the fall of 1999 (Patterson, 2000).

As the nursing profession in Alberta progresses toward a more clearly defined role for nurse practitioners, there is still much debate on the level of education required of a nurse who takes on an advanced practice role. Currently, there appears to be agreement by faculties of nursing that this level of practice requires education beyond the basic level of registered nurse; some have suggested that it should be at a masters or doctoral level (Patterson, 2000). The nursing faculties at the University of Alberta, the University of Calgary, and Athabasca University concur that the nurse practitioner must be educated at the graduate level. Each of these educational institutions offers graduate-level nurse practitioner degrees specializing in various clinical areas such as gerontology, pediatrics, mental health, neonatal care, and oncology.

Given everything that nurse educators and practitioners know about the

history of the nurse practitioner movement in Canada, as well as the clinical and theoretical preparation required of nurses in advanced practice, it is interesting to note that there is little understanding about the process used to prepare nurse practitioner students for their role in professional practice, particularly with regard to the preceptorship experience. To acquire this understanding, therefore, it is important to explore this educational process through the eyes of the preceptor, nurse practitioner student, faculty member and the evolution of the preceptorship model, beginning with the positive impact that Florence Nightingale had in promoting the preceptorship experience.

Evolution of the Preceptorship Model

Florence Nightingale was the first nurse to promote a formal teaching and learning environment through a preceptorship experience. Specifically, Nightingale expected nurses to support the education of nursing students by guiding them in the care of their patients in the practice setting (Backenstose, 1983; Myrick & Yonge, 2003; Palmer, 1983). During the decades in which hospital diploma programs were the major approach to nursing education, the preceptorship model of student education faded into the background, and it was not until the 1960s that preceptorship reemerged as a relevant teaching and learning approach to clinical teaching (Myrick, 1988; Myrick & Yonge, 2005). By then, preceptorship had reemerged as a means to educate nurse practitioner students in the USA. During this time the preceptorship approach was formalized, and experienced nurses were used as preceptors to role model the art of nursing practice by meeting specific educational objectives in the practice setting (Myrick

& Yonge, 2005). The original preceptors in nurse practitioner programs were physicians, because primarily physicians at the time perceived that nurses had neither the experience nor the ability to teach this level of practitioner. Occurring simultaneously during this time was the transfer of nursing education from hospital schools of nursing to postsecondary institutions. However, it was not until the 1970s that the preceptorship approach to student education in the clinical setting began to gain momentum, to the point that this approach to teaching and learning is currently the preferred approach to the clinical teaching of senior nursing students (Myrick & Barrett, 1992; Myrick & Billay, 2010; Myrick & Yonge, 2005; Usher et al., 1999). In Canada, preceptorship is primarily used in the final practicum of undergraduate nursing students. Key to this approach is the interdependent roles and responsibilities of the preceptor, the faculty, and the nursing student.

Roles and Responsibilities of Faculty, Preceptor, and Student

The preceptorship model connects practice and education. Three key players within this learning environment, who facilitate the connection of practice with education, are the faculty, the preceptor, and the nursing student. This educational team is also known as the *triad*.

Faculty role. Faculty members bring a wealth of substantive knowledge, resources and insights into the teaching–learning environment (Myrick & Yonge, 2005). As such, faculty members assume many responsibilities throughout the preceptorship experience. These responsibilities include, but are not limited to, acting as a major support to the student and the preceptor, meeting directly with

the preceptor, making frequent visits to the clinical site, being visible and available at all times, ensuring congruency between the student's objectives and the preceptor's expectations, ensuring that the goals and objectives of the educational facility are achieved, maintaining open lines of communication between the practice and academic settings, assuming ultimate responsibility for the final evaluation and grading of the student's clinical performance, requiring a summative evaluation of the student from the preceptor, providing feedback to the preceptor regarding his or her teaching performance, responding to any immediate concerns that the preceptor or student raises, and being professional (Myrick & Yonge, 2005). Letizia and Jennrich (1998), Yonge, Ferguson, Myrick, and Haase (2003), and Seldomridge and Walsh (2006) all support Myrick and Yonge's (2005) identification of faculty responsibilities in the preceptorship experience.

Faculty who state that they are well prepared for their role attribute their preparedness to reading research, attending presentations, facilitating workshops, having previously precepted students, and interacting with other faculty (Yonge et al., 2003). Faculty attributes their lack of preparation for their role in preceptorship to a lack of information about preceptors, unawareness of students' expectations, a lack of the course orientation, and a lack of evaluative support (Yonge et al., 2003).

Preceptor role. The responsibility of the preceptor is to facilitate the professional growth of the student so that upon completion of the practicum the student is able to assume a full patient assignment, which, depending on the acuity of the practice setting, could mean assuming responsibility for up to as

many as 12 patients. During the preceptor–student relationship, the preceptor assumes various roles such as role model (Cohen & Musgrave, 1998; Kaviani & Stillwell, 2000; LeGris & Cote, 1997), facilitator (Kaviani & Stillwell, 2000), socializer of students into a new role (Bradshaw, Rule, & Hooper, 2002; Cohen & Musgrave, 1998; Kaviani & Stillwell, 2000), evaluator (Cohen & Musgrave, 1998; Schoener & Garrett, 1996), and nurturer. Although these descriptors are derived from the assumption that a preceptor should be adequately prepared for such roles, sometimes this is not the case (Billay & Yonge, 2004; Bryant & Williams, 2002; Coates & Gormley, 1997; Kaviani & Stillwell, 2000) and subsequently might result in a nurse practitioner student's experience of mental, physical, and/or emotional barriers to the teaching–learning experience. Adequate preceptor preparation includes (a) preceptor selection, which formally stipulates that a preceptor holds a baccalaureate degree in nursing, has expressed a desire to preceptor students, understands pedagogy and is an enthusiastic teacher, is able to appropriately evaluate others, and is regarded as an expert in his/her specific practice area; (b) support from colleagues, administration, and the faculty; (c) acknowledgement of the preceptor; and (d) the ability to effectively evaluate the student. These concepts pertaining to adequate preceptor preparation are significant considerations with regard not only to student learning, but also to the preceptorship relationship.

Preceptor selection. Often, preceptor selection is based solely upon availability, seniority, and/or experience in the profession (Bain, 1996: Letizia & Jennrich, 1998; Myrick & Barrett, 1994). Pragmatically, preceptors and students

are rarely, if ever, matched according to learning needs, teaching styles, personality, and/or educational background. Many research studies have outlined the need for more rigorous criteria and proposed identifiable characteristics for selecting a good clinical preceptor (Lockwood-Rayermann, 2003; Pardue, 2002). Some of these characteristics include a bachelor's degree or higher education (Ferguson & Calder, 1993; Oermann, 1996; Rosenlieb, 1993), greater than two years of full-time experience (Oermann, 1996), personal qualities such as strong leadership skills (Finger & Pape, 2002; Gray & Smith, 2000; Kaviani & Stillwell, 2000; Letizia & Jennrich, 1998), excellent communication skills (Byrd, Hood, & Youtsey, 1997; Letizia & Jennrich, 1998), commitment to the role of preceptor (Letizia & Jennrich, 1998; Myrick & Barrett, 1994), and the ability to stimulate critical thinking (Myrick, 2002; Myrick & Yonge, 2001; Phillips & Duke, 2001).

Acknowledgment in the form of incentives for preceptors is also recognized as a key consideration (Dibert & Goldenberg, 1995; Speers, Strzyzewski, & Ziolkowski, 2004; Stone & Rowles, 2002). Such incentives include the offering of preceptorship sessions to better prepare preceptors for their role, access to library facilities, credits for graduate school admission, to name a few.

Preparation and support. Support for preceptors in the form of preparation for the role has been identified as essential to the success of preceptorship programs (Dibert & Goldenberg, 1995; Speers et al., 2004; Stone & Rowles, 2002). To ensure that preceptors are adequately prepared to teach, they require knowledge of teaching and learning strategies and theories, principles of

adult education, communication skills, personality styles, values and role clarification, conflict resolution, assessment of individual learning needs, and evaluation of student performance. Typically, the formal structure in which preceptors prepare for their role involves basic and advanced preceptorship sessions facilitated by leaders in the field of preceptorship, faculty members, and graduate students (Freiburger, 2001; Pickens & Fargotstein, 2006; Speers et al., 2004). Basic session topics can include adult learning principles, process, styles, concepts, preceptors, teachers, healers, and guides; learning partnerships; preceptor characteristics; phases of preceptorship; roles of preceptors, students, nursing management/faculty (Pickens & Fargotstein, 2006); and questioning skills. Advanced session topics can include novice to expert theory, presence of horizontal violence, generational issues and solutions, how to deal with a failing student (evaluation), and other topics deemed relevant.

Another method used to educate preceptors while maintaining quality bedside care is an online preceptor education program (Phillips, 2006). However, there are advantages and disadvantages to both the preceptor and the educational program of using online programs. The main advantages of online learning for the preceptor are accessibility and convenience. Learners can access the course anytime and from anywhere that they can access the Internet. They can complete the courses at home or at the health-care institution. Consistency of education is another positive aspect of this type of educational program. Each preceptor is provided with the same content, regardless of the specialty in which he or she is employed. Online education is an efficient means for managers and educators to

educate preceptors regardless of staffing shortages, differing shift rotations, and employment in various areas. Adult learners, who tend to be mature, self-motivated, and independent, have shown improved learning in online courses (Phillips, 2006). The disadvantages of this method of preceptor preparation include lack of computer skills; computer and server availability; hospital release time; start-up costs for the institution/preceptor; home computer Internet connections; lack of support from administration, management, and staff; and the need to hire new technical personnel (Phillips, 2006).

Embedded within the role of the preceptor is the notion that this role can prove to be a challenge to this expert practitioner. Specifically, often described challenges associated with the preceptor role include limited time to spend with students, inflexibility in the orientation program to meet individual learning needs, lack of preceptor choice to assume his or her role, and the absence of support from non preceptor colleagues. These challenges can and should be acknowledged at the beginning of the preceptorship experience, and the triad (preceptor, student, faculty) should take steps to resolve them before serious issues arise. In other words, acknowledging potential issues before they arise will facilitate the preceptorship experience. The findings from one study, with a descriptive correlational design that included a sample of 59 preceptors (Dibert & Goldenberg, 1995), demonstrated that preceptors are likely to be committed to the preceptor role when there are worthwhile benefits, rewards, and supports. Dibert and Goldenberg also found that, despite increasing numbers of precepting experiences, the preceptors remained committed to the role, a surprising finding

given the concern expressed in the literature regarding the burnout associated with frequent precepting.

In a descriptive, exploratory study Yonge, Krahn, Trojan, Reid, and Haase (2002) asked two research questions about preceptor support: (a) did the preceptors feel adequately supported during the preceptorship, and what was the nature of their support? And (b) if they were not supported, what were the reasons for the lack of support? They conducted a pilot test with 25 preceptors prior to dissemination of the questionnaire, which they then distributed to the total population (N = 500) of nursing preceptors in Alberta, Canada. The final sample consisted of 295 respondents. The findings from the research study indicated that support for preceptors included ongoing dialogue with nursing instructors. When preceptors reported that support was available, they listed concrete strategies that the instructors used, such as being available and providing the preceptor with feedback, advice, and/or orientation. Spontaneous concern and involvement with the preceptorship experience also improved communication.

The recommendations from Yonge et al.'s (2002) study included facilitation of a partnership that supports the preceptor/instructor/student triad; hiring and evaluation of an onsite coordinator to act as a liaison between the preceptor and student and the educational agency; careful screening of students before their placement in preceptorship programs; and delayed placement of students with deficits related to knowledge, motivation, and/or language until such deficits have been corrected.

Rewards. The literature notes that rewarding preceptors involves some kind of concrete demonstration that they are effective and valued in their role. Rewards can take many forms; for example, preceptors can be paid more per hour, receive a certificate of accomplishment, be celebrated with a tea for their preceptorship experience, receive a much coveted textbook, be offered letters of commendation, be recognized on a plaque in the faculty of nursing/school of nursing, be given a contract with the agency to decrease their workload (Stone & Rowles, 2002), receive an appointment as adjunct faculty (with no salary or stipend; Stone & Rowles, 2002), or receive a student gift (such as an article of clothing or a mug with the logo of the faculty/school on the front; Speers et al., 2004; Yonge et al., 2002). However, Yonge et al. (2002a, 2002b) notes that preceptors prefer to be acknowledged rather than being rewarded. Preceptors state that from their perspective rewards are like prizes and that they are professionals and want to be treated as such. Preceptors want to feel appreciated knowing that they are providing an appropriate learning experience for their students (Yonge, et al., 2002a, 2002b).

Rewarding (aka acknowledging) a preceptor for a job well done will make him or her feel supported, respected, and validated. This recognition, in turn, provides the faculty with a loyal preceptor who will likely want to enter into a preceptorship relationship again. In other words, supporting the preceptor will motivate him or her to begin a preceptorship relationship at another time, and students will thus benefit from the preceptor's enthusiastic spirit, experience, and

passion to "do good" for them and the patients that they will serve. When preceptors are frequently called upon to precept students, however, there is also the potential for burnout (Dibert & Goldenberg, 1995).

Burnout can occur when the preceptor is not acknowledged or supported. According to the findings of Dibert and Goldenberg's (1995) study, which Usher et al. (1998) replicated, there are two types of acknowledgements: intrinsic and extrinsic. Intrinsic acknowledgement includes the opportunity to teach and influence practice, increase one's own knowledge base, and stimulate one's own thinking. Extrinsic acknowledgement might include pay differential, educational opportunities, journal subscriptions, or letters of commendation. To combat burnout, the preceptor, the faculty, and the institution must be vigilant in identifying it.

***Preceptor as evaluator*.** One of the most challenging aspects of the preceptor role is student evaluation (Hrobsky, & Kersbergen, 2002; Ihlenfeld, 2003; Rittman & Osburn, 1995; Seldomridge & Walsh, 2006; Speers et al., 2004; Yonge, Krahn, Trojan, & Reid, 1997; Yonge & Myrick, 2004; Yonge, Myrick, Ferguson, & Luhanga, 2005). The preceptor is a key player in evaluating students' clinical competencies, a challenging responsibility at best. It can be fraught with tension if the preceptor does not know how to effectively evaluate students. Not only do preceptors find student evaluations challenging, but so too do the students. Students might perceive this process as intimidating because the fate of their practice and professional socialization rests with the evaluative skill of the preceptor (Myrick & Yonge, 2005). According to Myrick and Yonge, the

preceptor as evaluator has five responsibilities to the student: being fair and equitable in conducting the student evaluation, using the students' learning objectives in evaluating, consulting regularly with students to discuss areas of strength and areas that require improvement, ensuring that students have input into their evaluation, and encouraging self-evaluation.

Preceptors might or might not be given specific criteria for evaluating the acceptability of students' overall performance. Faculty members must embrace the evaluator role. They must ensure that the preceptor can give students effective and fair summative evaluations, which the faculty member can accomplish by giving the preceptor an explicit evaluation guide and by both the faculty member and student meeting frequently with each other. Effective and timely communication is the key to evaluating students (Yonge et al., 1997).

Evaluation of students includes formative and summative components. Formative evaluation occurs throughout a clinical experience and provides students with ongoing feedback on what they have learned and what they still need to learn (Seldomridge & Walsh, 2006); it does not include grading per se. Formative evaluation ensures due process in that it affords students ample opportunities to continue to improve their performance. Conversely, summative evaluation involves the assignment of a quantitative rating based on evaluation data and judgments on performance. The designation of a clinical grade, such as a pass–fail or A through F, is the responsibility of the faculty member. The preceptor's responsibility is to provide data and information to the faculty member that will in turn contribute to the final grade. This responsibility can be

daunting if the preceptor is a novice, lacks confidence, has not been oriented appropriately to conducting a summative evaluation (Seldomridge & Walsh, 2006), and/or is precepting a student who engages in unsafe practice.

One major challenge associated with student evaluation is preceptor leniency. When preceptors use multiple data sources (e.g., preceptor, student, or ward staff) to gather evaluative information about a student, problems can occur. For example, the data-collection process is not without difficulty. To illustrate, faculty periodically observe a student in clinical practice, but must determine whether the behaviour is "typical". Both nursing students and preceptors' performance anxiety and stress during clinical experiences have been documented (Hrobsky & Kersbergen, 2002; Letizia & Jennrich, 1998; Mamchur & Myrick, 2003; Seldomridge & Walsh, 2006).

What happens when a student is failing in the clinical area regardless of the preceptor's supportive measures to improve the student's performance? Such a development can be particularly troubling to some preceptors. The reasons for student failure are many and include lack of skill development, poor preceptor–student match, or the student's lack of the necessary skills to work in the selected clinical environment (Luhanga, 2006; Yonge et al., 1997). Such students are a challenge to precept and evaluate, require additional time and energy, and might discourage preceptors from accepting future students (Yonge et al., 1997). In these kinds of situations student evaluation is particularly important. Yonge et al. recommended that students who experience such difficulty not engage in preceptorship experiences but, rather, that preceptorship should be available only

to students who have adequate nursing knowledge and will progress in the preceptorship.

Hrobsky and Kersbergen (2002) conducted a qualitative study in which they explored preceptor's perceptions of students' unsatisfactory clinical performance. They used a sample of four preceptors, and their data analysis resulted in three primary themes: hallmarks of poor clinical performance ("red flags"), preceptors' feelings, and the liaison faculty role. In terms of red flags, early in the clinical rotation the preceptor and faculty recognized a student whom they identified as struggling. These red flags included students who did not ask questions, displayed an unenthusiastic attitude towards nursing, and demonstrated unsatisfactory nursing skills. Students who did not ask questions raised red flags for the preceptor and faculty because they felt that it might indicate that the student was struggling as the learners were too anxious to think in the particular setting, or too stressed to ask pertinent questions**.**

The second theme focused on the preceptors' feelings of fear, anxiety, and self-doubt. Hrobsky and Kersbergen (2002) found that the preceptors' sense of fear and anxiety was related to their concern that the students would fail if they reported their observations, rather than a fear for patient safety. The preceptors expressed the concern that they themselves might be the cause of student failure, which thus raises issues related to their own self-esteem. Hrobsky and Kersbergen therefore found that, in the clinical situation, the faculty-liaison role is integral to the support of both the preceptor and the student. The preceptors identified three effective faculty liaison roles when they are confronted with unsuccessful

students: listening, being supportive, and following up after the experience (debriefing). The significance of this study lies in the potential to improve preceptor preparation and support the preceptor–faculty liaison relationship (Hrobsky & Kersbergen, 2002).

In terms of evaluation, a physician preceptor can also prove to be challenging for the nurse practitioner student. As a nurse practitioner, I have found that, unless the physician preceptor is provided with specific evaluation criteria, he or she might evaluate the nurse practitioner student similarly to the way that he or she would evaluate a medical intern or resident. Communication of expectations among the faculty, preceptor, and student is therefore critical to ensure effective and timely feedback and evaluation.

In the following section I will describe the role of the undergraduate nursing student and the intricacies of the nurse practitioner student role. I will discuss the role of the undergraduate nursing student to illustrate the close parallels between that role and the role of the nurse practitioner student.

Nurse Practitioner Student Role. Of note, the role of the undergraduate nursing student closely parallels the role of the nurse practitioner student. The major difference between these two roles is that the nurse practitioner student is already a registered nurse and is being educated at the graduate level. Kaviani and Stillwell (2000) and Myrick and Yonge (2005) concurred that the goal of the preceptorship experience is to pair student nurses with expert nurses who can act as their role model and who can be immediately available to the students on a one-to-one basis as they carry out their nursing care and proceed through the

learning process. The relationship between preceptors and nurse practitioner students is active and engaged, and all members of the triad work towards two common goals: patient safety and the success of the preceptorship experience. Just as preceptors and faculty members assume responsibilities in this relationship, so too do nurse practitioner students. These responsibilities include, but are not limited to, demonstrating a strong sense of commitment to their role; adhering to ethical and nursing standards of practice; engaging in respectful interactions with all persons involved in the preceptorship experience, including patients, families, and other staff; using careful judgment in clinical decision making; following through on the various roles and patient assignments for which they are responsible; demonstrating excellent time-management and organizational skills; ensuring that they are safe and competent in the nursing care of their patients; being well prepared for clinical; being aware of areas of strength as well as areas that need improvement; accepting constructive feedback into practice; and communicating openly with preceptors and faculty members (Myrick & Yonge, 2005).

Students who begin the preceptorship experience are expected to demonstrate technical and communication skills (Yonge & Myrick, 2004). Indeed, not only preceptors and faculty, but also nurse practitioner students, need to be prepared for this teaching and learning experience. LeGris and Cote (1997) found that the students in their study received the same orientation package that the preceptors did and questioned whether this was appropriate. In Nehls, Rather, and Guyette's (1997) phenomenological study in which the sample consisted of

10 senior-level undergraduate nursing students, 11 practicing nurse preceptors, and 10 faculty members, they discovered that the students valued spending time with practicing nurses. They repeatedly described the one-to-one relationship of student to preceptor in terms of time—the amount of time as well as how they spent the time. The students valued the preceptorship model of instruction because it gave them more time to learn "nursing thinking" alongside practicing nurses. Despite the lack of research on preparing nurse practitioner students in the practice setting, parallels can be drawn because they also value the time spent with preceptors.

I discuss student evaluation in the section above; however, the topic of student stress also deserves recognition. Researchers have acknowledged that the preceptorship experience is very stressful for undergraduate nursing students (Yonge, Myrick, & Haase, 2002). Yonge et al. identified sources of student stress as academic overload; multiple roles as students, caregivers, friends, and parents; limited family or social support; feelings of inadequacy; unrealistic self-perceptions; and the inability to achieve long-range goals. It is therefore important that the faculty member communicate regularly in person with the student and preceptor to determine how the experience is progressing; specifically, to identify problems, how the student and preceptor are coping, strategies to implement if problems are occurring, and a resolution to the conflict.

In contrast, the nurse practitioner student, unlike the undergraduate student, presents with a wealth of knowledge and experience. This student is already a registered nurse who has practiced professionally in another area and

now finds him or herself in the student role and again considered a novice. If this student is more academically prepared than his or her assigned preceptor, challenges can arise such as conflict and frustration on the part of both the student and the preceptor. With this in mind, the roles of the triad members within the preceptorship are important as are their preparation.

Preparation of Faculty, Preceptor, and Student

Faculty preparation. Donnelly (2003) recognized that faculty members who teach the clinical component in nurse practitioner programs require regular experience in direct clinical practice and/or in a practice that integrates clinical practice with teaching or research. Furthermore, faculty members who practice in clinical settings offer a different perspective on the classroom and clinical setting. In a recent study in which they evaluated the perceptions of staff nurses and the role of clinical practice in teaching undergraduate students, Langan (2003) demonstrated that there is less role strain and confusion for staff nurses who work with practicing faculty. In addition, Blair (2005) noted that faculty who practice in the clinical setting increase their credibility with nurse practitioner students, facilitate role modeling, enable faculty to supervise students directly by serving as preceptors, increase faculty visibility in the community, and support research. My findings concur with Blair's contention that faculty who teach in a nurse practitioner program should have nurse practitioner credentials, but I realize that having such credentials is often not possible simply because the nurse practitioner movement in Canada is relatively young compared to the nurse practitioner

movement in the USA. Thus there are an insufficient number of nurse practitioner–prepared faculty members who can assume this role.

Preceptor preparation. Some nurse practitioner students who require preceptors for their clinical practice often find that there are either none or too few available nurse practitioner preceptors. As an alternative, nurse practitioner students are permitted to access physician preceptors to augment their clinical practicum experiences (Stark, 2004). Fortunately, most physicians are receptive to precepting nurse practitioner students and are eager to contribute to the development of their skills. The disciplines of medicine and nursing, however, are uniquely different in their scope of practice and knowledge. Thus, when nurse practitioner students are precepted by physicians, various issues can arise regarding the professional development of the students. For example, their role and autonomy might not be fostered from a nursing perspective but, rather, within the context of the medical profession/discipline. The unique perspective of the nurse could therefore be obscured when they have physician preceptors. Ensuring, then, that the physicians are knowledgeable about nurse practitioner standards and scope of practice might address these concerns. Some physicians might have misconceptions about the overall practice of the nurse practitioner that reflect their lack of suitability to precept a nurse practitioner student. This challenge can be addressed, however, through educational sessions co-sponsored with the College of Physicians and Surgeons and the College and Association of Registered Nurses of Alberta (CARNA).

It is not advisable to precept a nurse practitioner student with a nurse who does not have advanced practice skills such as diagnosing; autonomous work experience; the authority to admit, discharge, or transfer patients; and the capacity to prescribe medications and read x-rays (Crumble, 2003). Rather, a nurse practitioner student should be precepted with someone who has, at the very least, advanced nursing/medical knowledge.

Nurse practitioner student preparation. The CNA (2000) recommended that nurse practitioner students be educated at the graduate level and stated that the cornerstone of advanced nursing practice is expertise characterized by an ability to assess and understand complex patient responses; demonstration of significant depth, knowledge, intervention skills, and strong intuitive skills in the practice area; and experience in specialized practice that concentrates on a particular aspect of nursing that might focus on age, medical diagnostic grouping, practice setting, or type of care. Advanced nursing practice requires graduate education that results in substantial theoretical, clinical, and research expertise (Kohr, 1998). Graduate degree programs in nursing are valued because they address a growing theoretical base in nursing, promote nursing research and the incorporation of new knowledge into nurses' practice, and ensure evaluation and documentation of nurses' achievements.

Historically, the development of advanced practice nursing courses has been uncoordinated and sporadic, with the effect that programs have been developed at differing academic levels, with an inconsistent balance between theory, practice, and varying duration (Donnelly, 2003; Wood, 1997). There

continues to be controversy over how best to prepare nurses for advanced practice roles. Offredy (2000) identified educational preparation for the role as critical regardless of the experience of the advanced practice nurse. A broader knowledge is crucial if advanced practice nurses are to develop the competencies required to effectively deliver health services. Lack of education limits the service and ultimately the decision-making capabilities of the nurse (Donnelly, 2003).

Development of clinical expertise requires that advanced practice nursing students be immersed in a clinical setting, where theory can be applied to develop their clinical reasoning skills. This process is best achieved in clinical settings in which the complexities of practice can provide the contextual background as part of the clinical picture (Donnelly, 2003).

Key to nurse practitioners' achieving and developing important clinical reasoning skills is the ability to think critically. Therefore, success depends on teaching and learning strategies designed to create learning environments that foster practice that promotes active rather than passive learning (Myrick & Yonge, 2002). The nursing literature identified many teaching strategies that involve active learner participation in the learning process and emphasize adult-learning and critical-thinking concepts. One of the strategies used to teach nurse practitioner students is patient simulation, which provides safe environments for students to practise the technical skills that they learned in the classroom and then apply theory to practice in the clinical setting (Scherer, Bruce, Graves, & Erdley, 2003).

The use of patient simulators is based on the theory that simulated learning advances the concept that declarative (knowing what) and procedural (knowing how) knowledge are learned at the same time (Scherer et al., 2003). A patient simulator demonstrates the following features: breath and heart sounds, pulses, other physiologic and pharmacologic features, and the ability to be intubated and intravenous access. Advantages of the simulation experience include the lack of a threat to patient safety, increased student self-esteem, enhanced critical-thinking and decision-making skills, exposure to serious and uncommon problems, the opportunity to learn from errors in a safe learning environment, consistency of experience, and active involvement of the learner. The disadvantages include financial cost, extensive faculty time commitment, tendency for a simulated environment to induce hypervigilance or exaggerated caution, and lack of documentation on the transfer of learning from a simulated environment to clinical practice (Scherer et al., 2003).

Another effective teaching and learning method involves the examination of and interaction with "real" patients in the laboratory setting. Faculties of nursing hire nursing students, graduate students, and/or actors to portray a patient scenario. The nurse practitioner student then examines this "patient" in a designated timeframe, using the technical skills and knowledge relevant to that particular assessment need. To illustrate, the nurse practitioner student might determine through eliciting the patient's history that the patient requires a cardiovascular and respiratory assessment and will then proceed to carry out these physical assessments. If, while conducting the physical exam, the student causes

the patient discomfort or anxiety, the patient can directly relay to the student his or her distress. As well, the student can, while conducting the assessments, monitor the patient's nonverbal language for any signs of distress, such as frowning, picking at the bed sheets, and/or tears in the eyes.

Discussion of not only teaching methods but also preceptors' teaching strategies is important in addressing nurse practitioner student education. Davis, Sawin, and Dunn (1993) identified the teaching strategies of 15 expert preceptors of nurse practitioner students. The panel of expert preceptors included both physicians and nurse practitioners. In interviews they identified a variety of strategies that they use in the clinical education of these students. Davis et al. categorized the strategies according to whether they oriented the students to the setting and practice, were used with all students, or were used depending on an individual student's strengths or needs. Among the preceptors, all of whom had been recommended as expert preceptors, they found two major preceptorship styles. One style included progressive preparation of students and increased responsibility based on their progress, and the other they described as a 'sink or swim' style in which the preceptor turned the students loose to succeed or flounder, but the preceptor was there to correct any judgment errors that the students made.

Supportive of the recognized importance of developing decision-making processes, Lipman and Deatrick (1997) designed an algorithm to prepare advanced practice nurses for clinical decision making. The algorithm emphasized the importance of taking an adequate history and maintaining an open mind

during situation assessment. They cited examples of the algorithm's application. Although a process for decision-making must be developed to realize clinical competence, investigations into the success of such guidelines have not been tested.

In summary, preceptors often describe precepting nurse practitioner students as a rewarding experience (Coates & Gormley, 1997; Dilbert, & Goldenberg, 1995). However, the processes involved in educating these students are not well documented in the literature. As a result, nurse educators might find it difficult to ensure that consistent and effective education occurs at the level of the advanced practitioner.

The primary goal of an advanced practice program is to ensure that nurse practitioner students are effectively prepared for their professional role as advanced practitioners. The main theme that was discovered from the literature review is that the process involved in preparing these nursing students for advanced practice has not been addressed. Stated differently, the question "What is actually going on in the preparation of the nurse practitioner student?" has not been explored. There is therefore a need for nurse educators and researchers to conduct studies to investigate this process in their respective educational organizations. Thus, the research question is "What is the process involved in educating nurse practitioner students in the preceptorship experience?"

Underlying Assumptions

The assumptions underlying this research study were as follows:

The preceptorship model is the preferred approach to: the clinical teaching of nurse practitioner students in the practice setting; preceptors play a major role in the educational experience of nurse practitioner students; faculty members contribute significantly to the education of nurse practitioners; an increased understanding of preceptorship is important to development, implementation and enhancement of the teaching/learning process in nurse practitioner programs; and, the data generated from this study will contribute to our further understanding of the role that preceptorship plays in the education of nurse practitioners.

Research Questions

The following questions guided this study:

What is the process involved in preceptorship to educate nurse practitioner students for their future role in professional nursing practice?

- What are the perceptions of the nurse practitioner students as to how they are being prepared throughout their preceptorship?
- What are the perceptions of the preceptors as to how they are preparing nurse practitioner students throughout the preceptorship?
- What are the perceptions of the faculty regarding the preparation of nurse practitioner students throughout the preceptorship?

CHAPTER 3

METHOD

Constant comparative analysis and theoretical sampling were central to this study. Ethical considerations, steps taken to ensure rigour and trustworthiness of this study will be addressed. First, symbolic interactionism will be discussed because of its relevance to grounded theory.

Symbolic Interactionism

The foundations for symbolic interactionism were established in the 1920s when two Americans, W. I. Thomas and Charles Cooley, discussed their ideas on *definitions of the situation* and *the looking glass*, respectively (Annells, 1996; Lomborg & Kirkevold, 2003). Approximately one decade later, the social psychologist George Herbert Mead (1962), an academic from the University of Chicago, further expanded on Thomas's and Cooley's ideas. To illustrate, Mead posited the social nature and origin of self:

> The individual enters as such into his own experience only as an object, not as a subject; and he can enter as an object only on the basis of social relations and interactions, only by means of his experiential transactions with other individuals in an organized social environment. (p. 225)

The main message that emerged from Mead's interactionist perspective was the essential defining of self through social roles, expectations, and societal perspectives of self. In the late 1960s, Herbert Blumer, once a student of Mead, further refined and expanded this notion of symbolic interactionism and he coined

the latter concept (Blumer, 1969a). During this time, Blumer centralized the concept of self, which he viewed similarly to Mead as a "uniquely human attribute that is constructed through social interaction" (Annells, 1996, p. 381). At a micro level, according to Blumer (1969b), when human beings interact with each other, they are involved in interpretive interaction, "Ordinarily, human beings respond to one another, as in carrying on a conversation, by interpreting one another's actions or remarks and then reacting on the basis of the interpretation" (p. 71).

The notion of symbols is intrinsic within Blumer's (1969b) premise, and, according to symbolic interactionism, the social life of the human is expressed through symbols, which usually take the form of language. Symbolic interactionism involves individuals' interpretations of a situation whereby these interactions with others and the sociocultural environment in which they exist is of the utmost importance (Benoliel, 1996). Indeed, behaviour and how it is communicated, as seen in our use of language, are important ingredients and focuses of symbolic interactionism. The link between symbolic interactionism and grounded theory provides the basis for the discussion of findings in chapter 4.

Study Design

I used grounded theory to explore the process involved in preceptorship to prepare nurse practitioner students in the clinical setting. Grounded theory is a qualitative method originating from the practice of generating theory from research, which is "grounded" in the data. The goal of this method is to develop theory. As Crooks (2001) explains, "Grounded theory gives us a picture of what

people do, what their prime concerns are, and how they deal with these concerns" (p. 25). My reason for using the grounded theory method is related to the lack of information in the literature regarding the process used by preceptors to teach nurse practitioner students. Many authors suggest that grounded theory is especially suited to studying areas in which there has been little research on a phenomenon or in which there is a need to gain a new perspective in familiar areas of research (Burns & Grove, 1995; Glaser & Strauss, 1967).

Providing the foundations for grounded theory is symbolic interactionism (Burns & Grove, 1995; Cutcliffe, 2000; McCann & Clark, 2003a), as previously noted, which involves exploring the processes of interaction between peoples' social roles and behaviour (McCann & Clark, 2003a). Interaction is symbolic because in these processes symbols, words, interpretations, gestures, and language are used to convey meaning. Symbolic interactionists contend that people construct their realities from the symbols around them through interaction; therefore, individuals are active participants in creating meaning from a situation (Cutcliffe, 2000; Morse, 1995).

Groups share meanings and communicate them to new members through socialization processes. Although these experiences are unique to each individual, researchers have recognized that individuals, who share common circumstances, such as nurse practitioner students, have common perceptions and thoughts and display common behaviour, which is the essence of grounded theory (Bogdan & Biklen, 1998; McCann & Clark, 2003a). As the underlying foundations for grounded theory, symbolic interactionism helped me to gain an understanding of

the meanings and shared definitions those nurse practitioner students, nurse practitioner preceptors, and faculty members created from their encounters while engaged in preceptorship. To date there is no knowledge in the literature on the process used to teach nurse practitioner students in the practice setting. In keeping with the grounded theory method, I conducted a preliminary review of the literature to enhance my knowledge and help to increase my theoretical sensitivity, to provide additional background to the study, and to identify gaps in the literature, which, in turn, justified the need for this study (Strauss & Corbin, 1998).

Setting and Population

This study was conducted in selected acute care practice settings, and I interviewed each participant at a mutually agreed upon place and time. The population for the study was comprised of nurse practitioner preceptors, nurse practitioner students engaged in their final practicum or who had completed their education within a six-month time frame, and faculty members from the advanced practice nurse practitioner stream at a large university in Western Canada. The purpose for interviewing the preceptor, the student, and the faculty was to include all members of the preceptorship triad, which would hopefully contribute to richer data and a more accurate perspective.

The Master of Nursing in Advanced Practice program. This program provides an intensive practicum based experience for students. Courses and practica experiences are intended to enhance knowledge and skills in clinical and community practice. Students also decide the population focus (i.e. neonate,

child, adult, or community/organization). Students choose either a thesis-based program or a course-based program. Thesis students are required to complete 10 courses together with a thesis. Course-based students are required to complete 11 courses (including one elective in their area of interest) together with a capping project.

In addition to the six core nursing courses, which include The Nature of Nursing Knowledge, Research Foundations, Statistics, Transforming Practice, Program Planning, and Pharmacotherapeutics, students in this advanced nurse practitioner program complete advanced nursing assessment and intervention courses, and an integrative practicum in a specialty area. The combined intersectoral practice component ranges between 400-600 hours. Students can focus on specialty areas such as adult health, child/family health, mental health or neonatal intensive care. Applicants normally are required to have a minimum of one year of recent full-time clinical nursing experience in the specialty area to which they are applying.

Recruitment of Participants

Recruitment procedures. Participants were recruited using several approaches. First, I contacted a key informant I knew who was a professional practice leader at a major hospital in western Canada and a previous colleague and asked her to distribute recruitment information to nurse practitioner/physician preceptors as well as to nurse practitioner students. The recruitment information that was given to this individual included the appropriate letter of information (Appendices A, B,) and consent form (Appendix D). In addition, I simultaneously

asked one faculty member to distribute the same information to nurse practitioner students engaged in the final practicum course at a Faculty of Nursing in western Canada. To recruit faculty members, I directly approached faculty who taught in the advanced practice stream at the above-mentioned Faculty of Nursing.

Initially, it was difficult to find volunteers for the study, especially for the nurse practitioner student group. About one month after I had received ethical approval from both the Ethics Review Committee and the regional health authority, I confirmed the first five participants, and within the next year I finished recruiting the remaining 10 participants through word of mouth referrals from previous participants.

With faculty permission, because I did not teach in the nurse practitioner program and therefore had no influence over the participants, I sent the letter of information (Appendix A) and consent form (Appendix D) for this study directly to the nurse practitioner students who were engaged in their final practicum experience. The letter of information included my office phone number and e-mail address so that students who wished to participate in the study could contact me directly. This process also helped to ensure the anonymity of potential participants. I made two follow-up requests: I took approximately five minutes at the beginning of two subsequent classes to reintroduce the research study to the nurse practitioner students. Once interested students signed a written consent, I made arrangements to meet with them at a time and location of mutual convenience. I also obtained demographic data from all participants at that time

(Appendices E, F, and G). The students retained one copy of the consent form for their own personal files.

I also recruited preceptors to participate in the study and gave them the letter of information (Appendix B), which contained my business phone number and e-mail address. Those who wished to participate in the study contacted me directly and arranged initial meetings, at which time they signed the consent form (Appendix D). I obtained their demographic data (Appendix F) at this time. The nurse preceptors retained one copy of the consent form for their own personal files. The preceptors whom I chose to participate in the study were new to the role and willing to precept a nurse practitioner student or had experience in precepting students.

I also approached faculty members who taught in the nurse practitioner program, and, once I had recruited them, I gave them the letter of information (Appendix C) with my business phone number and e-mail address. Those interested in participating in the study contacted me and arranged initial meetings, at which time I signed the consent form (Appendix D) and I obtained their demographic data (Appendix G). The faculty members retained one copy of the consent form for their own personal files.

Faculty members were chosen based upon their involvement with teaching in the nurse practitioner program, and nurse practitioner students were chosen who fulfilled the inclusion criteria. At the beginning of the study, I used purposive sampling, or sampling according to certain predetermined criteria (Patton, 1990).

Sample. A final sample of 15 participants was recruited for this study. This sample comprised four nurse practitioner students, four nurse practitioner preceptors and seven faculty members. All participants in this study were female. A total number of 33 interviews were conducted. The number of interviews per participant is detailed in Figure 1.

Figure 1 **Number of interviews per participant**

Student	Faculty	Preceptor
01 = two interviews	01 = two interviews	01 = three interviews
02 = two interviews	02 = three interviews	02 = one interview
03 = one interview	03 = three interviews	03 = three interviews
04 = two interviews	04 = three interviews	04 = one interview
	05 = two interviews	
	06 = three interviews	
	07 = two interviews	

With the exception of three participants who were interviewed once owing to their lack of availability for subsequent interviews, the remaining 12 participants were interviewed two to three times.

Students. All the students were prepared at the baccalaureate level, two were currently engaged in a Master of Nursing (MN) program, and two had completed MN degrees. The number of years of nursing education for these participants ranged from 6 to 14, with a mean of 8.75 years. The total number of years as a nurse practitioner student ranged from one to six, with a mean of three years.

Preceptors. I interviewed four preceptors but was unable to interview any physician preceptors. While the physician preceptors were approached several times to participate in this study, unfortunately none were forthcoming. Three out of the four participants were prepared at the MN level and one at the PhD level. The number of years as a preceptor ranged from one to nine, with a mean of 4.75 years. In terms of precepting other types of students, one had precepted only registered nurses, and three had precepted other students such as medical residents, undergraduate nursing students, and emergency medical services personnel.

Faculty. I interviewed seven faculty, one of whom held an MN degree; the remaining six held PhD degrees. The number of years of nursing education for each individual ranged from 10 to 14, with a mean of 12.4 years. It is clear that there is a breadth and depth of teaching experience in this advanced practice

program. To illustrate, the number of years that the participants were faculty members ranged from 0.5 to 32, with a mean of 13.9 years.

Ethical Considerations

Permission was sought in writing from the Associate Dean of the graduate program in the Faculty of Nursing at the university to conduct the study and received ethical approval from the Health Research Ethics Board. I used several measures to ensure the participants' confidentiality. I verbally and in writing explained to each participant the purpose and the potential benefits of the study and that their participation was voluntary. Their agreement to participate in an interview indicated their consent to participate in the study. In addition, the participants signed a written consent form (Appendix D) prior to being interviewed and audio recorded. To ensure confidentiality, I removed the names of the participants from the audio recordings, written transcripts, and field notes and replaced them with randomly assigned pseudonyms. Transcripts and other important data will be kept in a locked cabinet for seven years. As well, I have stored the consent forms separately from the interview data.

Data Collection

In this study, I collected data through one-to-one semistructured interviews with the participants and conducted a review of relevant documents such as the literature and course outlines to supplement the data whenever necessary. In addition, I kept a journal of my personal reflections on the fieldwork, because I assumed that a mixed approach to the data collection would result in richer data than a single approach would.

Interviews play a central role in data collection for a grounded theory study (Creswell, 1998; Schreiber, 2001). Interviews result in richer and more complex data, provide an opportunity to clarify questions if they are ambiguous or misunderstood, and allow me to directly observe nonverbal responses of the participants. Interviews in this study also gave participants an opportunity to discuss their thoughts and feelings about their preceptorship and allowed me to ask a broad range of in-depth questions.

As stated above, the interviews were semistructured and evolved in content based on the participants' responses. My decision to use interviews in this study was influenced by the nature of the research question, the aims of the study, and the chosen method (Glaser, 1978). For instance, because the study was inductive in nature and I sought to identify the process that preceptors use to prepare nurse practitioner students in the preceptorship experience, in depth semistructured interviews were the best approach to obtain rich data. Mayan (2001) explains that semistructured interviews are used "when the researcher knows something about the area of interest, for example, from the literature review, but not enough to know the answers to the questions that are asked" (p. 15). Because there is no literature on the process that preceptors use to prepare students for their role in the practice setting, the semistructured interviews afforded an opportunity to ask a range of in depth, open-ended questions and allowed the participants to describe their experiences and express their opinions, concerns, and feelings about the phenomenon under study in their own voices (Patton, 1990). The semistructured interviews allowed me to collect data from

individual participants by asking a set of open-ended questions in a specific order (Mayan, 2001), but I took care throughout the interview process to avoid imposing too much structure on the interviews, which might limit the amount and quality of data (McCann & Clark, 2003c; Schreiber, 2001).

Interviews were conducted at a mutually agreed upon time and place and were audio-recorded. Each interview lasted between 20 and 90 minutes. Before the interviews I obtained demographic data (Appendices E, F, and G) from all of the participants. An interview guide was used with open-ended questions (Appendices H, I, J) to assist the participants in narrating their encounters with nurse practitioner students (e.g.**,** "Please describe to me your role as a preceptor."). Sub questions were also asked to clarify statements, ideas, thoughts, and feelings to gain a fuller understanding of the phenomenon under study (Mayan, 2001). Initially, it was not possible to determine the specific sample size, as I did not know how many participants were required to achieve saturation. I also did not initially know the number of interviews that I would conduct; however, once the categories became saturated and no new data were obtained, the interviews stopped.

I compiled the interview guide questions from the literature. The dissertation supervisor, who is an expert in the area of preceptorship, checked the content validity of the questions. To assess my interviewing skills, my thesis supervisor reviewed the first few transcripts of interviews.

Data Management

I used the manual approach to manage the emerging data for two reasons. First, this strategy was the most cost effective as I used a common word processing program that is familiar to all—Microsoft Office Word. Finally, this strategy was more straightforward and simpler than using data management tools currently available to qualitative researchers.

As open coding progressed and categories began to emerge I assigned each category its own Word folder. For example, the category *Working Through Rites of Passage* encompassed many sub categories such as cognitive dissonance, challenged and being challenged. The data that emerged that fit and worked with either subcategory was copied from the transcript(s) and then pasted into the appropriate Word folder. As constant comparative analysis continued and the coding process progressed the number of folders (representing categories and subcategories) increased. Once theoretical coding began, I was then able to visually observe all the folders together and further collapse them so that all data fit and worked together. This process continued until saturation was reached. At the completion of the coding and analysis I identified four categories with each category containing anywhere from three to seven subcategories.

Data Organization and Analysis

Immediately following each interview, the audio recording, my field notes and subsequent memos were transcribed by a professional transcriptionist (Glaser, 1978; McCann & Clark, 2003c). I then read and reread the transcripts prior to coding, to become thoroughly familiar with and theoretically sensitive to the data

(Glaser, 1978; McCann & Clark, 2003c). The data were analyzed using constant comparison (Glaser, 1978; Glaser & Strauss, 1967). The main goal of this approach was to discover a core variable that would illuminate and explicate the main theme, which in this case was the process involved in preparing nurse practitioner students for professional practice (Glaser, 1978; Streubert & Carpenter, 1999). The core variable or the category that was central to the findings in this study, was related to as many other categories and their properties as possible, recurred frequently in the data, and accounted for most of the variation (Glaser, 1978; Streubert & Carpenter, 1999). Thus, in analyzing the data, I searched for a core variable that would serve as the central concept for data generation. The process involved going back and forth from one transcript to another and from one category to another to search for relationships among concepts.

Coding. Coding was used to analyze the data immediately after I commenced the data collection. Coding occurred at two levels: (1) substantive, which included open coding and selective coding, and (2) theoretical. Coding is the process of analyzing the data (Glaser, 1978) by asking questions about the data and comparing events, and then labeling those events and grouping them to form categories. The intent of coding was to conceptualize the data by analyzing them and identifying patterns or events in the data. The first steps in conceptualizing were to code patterns in the data, or give them conceptual labels (Glaser, 1978; McCann & Clark, 2003c). The first level of analysis guided my

decisions on the direction to take in the study; theoretical sampling provided the basis for selecting and focusing on a specific problem (Glaser, 1978).

Theoretical sampling. Theoretical sampling, central to the grounded theory method, refers to the process of selecting sites and/or participants based on their theoretical relevance rather than predetermination (Glaser, 1978). If deemed relevant to the study, I could select additional sites and participants as I created the codes and tried to saturate them. In other words, the data analysis guided me to the next sources of data collection (Strauss & Corbin, 1990) on the basis of the evolving relevant theoretical concepts. The basic question in theoretical sampling was "What groups or subgroups does one turn to next in data collection, and for what theoretical purpose?" (Glaser & Holton, 2004, p. 10). Once I had collected and analyzed the initial data, I then based further decisions about the participants, the sample size, and the type of data that needed to be collected on the emergent categories (Glaser, 1978).

As the data emerged, one student supplied the negative case, which is an experience that contrasts with those of other participants (Strauss & Corbin, 1990). Negative case analysis is one of the key components of theoretical sampling. As data were generated, I carefully examined the case of the participant who appeared to be the exception in the study. This negative case helped to elicit variations, and expand the developing grounded theory (Morse, 1991). In qualitative research, negative case analysis was also an important technique that enhanced the credibility of the study findings. To increase the credibility, I explored this case thoroughly to develop an understanding of the difference in this

particular case and incorporate it into the model, which resulted in flexibility and the variation required to strengthen the grounded theory (Strauss & Corbin, 1998). Thus, I was able to access key participants and sample relevant data that shed light on and confirmed or denied the emerging data and concepts (Schreiber, 2001).

To ensure confidentiality, participants were assigned a pseudonym to which only I had access. I retained their identifying information in a code book, which was locked in a cupboard when not in use. The theoretical sampling eventually directed the data collection, which continued until I achieved theoretical saturation. Saturation in grounded theory occurs "when no new data emerges relevant to particular categories and sub-categories, categories have conceptual density, and all variations in categories can be explained" (McCann & Clark, 2003a, p. 11). Saturation occurred in this study when I discovered no new data from which to develop the properties of the categories.

Substantive coding

Open coding. During the process of open coding, each piece of the data was carefully examined and compared with other data (Glaser, 1978). Open coding is the process of "fracturing" or breaking down the data into discrete parts to identify and name relevant categories (McCann & Clark, 2003a). The data were examined line by line to conceptualize them and identify patterns or events and then selected and labeled as codes the words or phrases that contained a single unit of meaning (Schreiber, 2001). Thus, substantive codes were established

based on the participants' descriptions of their experiences while they were engaged with nurse practitioner students in the preceptorship experience.

The codes at this level are referred to as *substantive* because they organize or codify the substances of the data and often use the participants' own words (Stern, 1980). Substantive codes are classified into two categories (Glaser, 1978): (1) those that are derived directly from the participants' own words (*in vivo* words); for example, *navigating*, *communicating*, *disappointment with lack of nurse practitioner student preparation*, *novice to expert*; and (2) those that are implied, which I constructed based on concepts obtained from the data; for example, *language use*, *collaborating with other faculty*, *foundational knowledge* (Glaser, 1978; Strauss & Corbin, 1990; Streubert & Carpenter, 1999). According to Glaser (1978), substantive codes "conceptualize the empirical substance of an area of research" (p. 55) and are different from theoretical codes, which "conceptualize how the substantive codes may relate to each other as hypotheses to be integrated into the theory" (p. 55). After I created them, the codes were compared with other categories to determine how they connected or clustered (Myrick, 1998). During this process, I searched for as many categories as possible and compared them with new indicators to uncover characteristics and relationships (Streubert & Carpenter, 1999). As the data collection progressed, codes were discarded that lacked foundation in the data and added more relevant codes (Glaser, 1978; Streubert & Carpenter, 1999).

A number of questions, including the following, guided the process of open coding: What is going on with regard to the process of precepting nurse

practitioner students? What do these data indicate with regard to this process? What category does this incident indicate? What are the basic psychological processes or social structural processes in which preceptors use while engaged in the preceptorship relationship with nurse practitioner students (Glaser, 1978, 1992)? These questions and many more that "arise as the theoretical codes emerge keep the substantive directions in tractable focus as they force the generation of a core category" (Glaser, 1978, p. 57).

Selective coding. Selective coding, the next level of analysis, is an integral phase in the discovery of the core category. During selective coding I moved from data analysis to concept and theory development through the process of data reduction by filtering information relevant to the topic, discarding extraneous information, and sampling selectively. During this stage I identified the core category that tied all other categories in the theory together and related it to other categories (Glaser, 1978). This category can be a process, a condition, or a consequence, and a storyline is often used to describe relationships between the core category and other concepts. Selective coding is often referred to as a process of reduction because it is designed specifically to facilitate the search for the core variable (Stern, 1980). Through this process I delimited the coding to only the categories related to the core variable(s), which in turn acted as a guide for further data collection and analysis (Glaser, 1978; Myrick, 1998). By doing so, I hoped to focus the research on one of the several basic social processes or conditions present in the data. During this analytic phase the following questions guided me (Glaser & Strauss, 1967) in describing the basic social psychological processes:

What is going on in the data? What is the focus of the study and the relationship of the data to the study? How do these nurse practitioner students navigate the preceptorship experience? How do faculty and preceptors impact the preceptorship experience? As well, the role of the extant literature became more important at this stage, and I turned to it to acquire sensitivity to and knowledge on grounded concepts. Thus, as further concepts emerged I began to read that relevant literature as a source of further data and compared it with the existing grounded data. Through the process of reduction and comparison, the core variable for the study emerged, and it was labeled "Navigating the liminal space." Once the core category was identified, I concentrated on modifying the categories and integrating the theory into the categories and subcategories (McCann & Clark, 2003c).

Theoretical coding. As the number of substantive codes accumulated, I turned to level two coding analysis, which involved theoretical coding, a process in which the data were ordered and the interrelation of the substantive categories was determined. The goal of second-level coding, according to Glaser (1978), is the generation of "an emergent set of categories and properties which fit, work and are relevant for integrating into a theory" (p. 56). During the theoretical coding, I constantly compared new data with the emerging clusters of data and assigned the data to clusters or categories according to obvious fit. This process enabled me to determine the particular category that was appropriate for the grouping of similar substantive codes. Each category was compared with every other category to ensure that the categories were mutually exclusive (Streubert &

Carpenter, 1999). During this second-level coding, the substantive codes, which I had developed during open coding, were collapsed into categories or higher-level concepts, including "positioning in preceptorship (teaching–learning)" and "repositioning on the threshold of becoming a new nurse practitioner."

Memoing. Another important step in the data analysis of this study was the writing of memos, which are the notes that I wrote throughout the research process to record and explain the theory as it was being developed (McCann & Clark, 2003a). As Glaser (1978) explains, memos are "the theorizing write-up of ideas about codes and their relationships as they strike the analyst while coding" (p. 83). In grounded theory, memos are used for three purposes: (1) to make explicit my preexisting assumptions, (2) to record methodological decisions on the conduct of the study, and (3) to speculate on and analyze the data (Glaser, 1978; Glaser & Strauss, 1967; Strauss & Corbin, 1990). Memoing raises data to a conceptual level, helps to develop the properties of each category, and presents hypotheses about connections between categories. During memo writing, I was guided by a number of questions that not only permitted the true emergence of the categories and their properties, but also prevented me from becoming lost in the re-experience of the data (Glaser, 1978; Myrick, 1998). These questions included the following: What relation did one code have to another? Were they separate codes, or was one code a property or a phase of another? Was one event the cause or the consequence of another, and what were the conditions that influenced the codes? For example, what was the relationship between navigating the journey

and the use of language? What was the relationship between natality (a metaphorical rebirth) and fostering relationships with others?

In summary, memoing was an essential tool for recording or capturing ideas and for abstraction and theory development, which continue throughout the study (Hutchinson, 1993). Glaser (1978) cautions, "If the analyst skips this stage by going directly from coding to sorting or writing, he is not doing grounded theory" (p. 83). Memoing is inductive during the process of conceptualizing the data or coding and deductive during the process of assessing how the conceptual labels, categories, and subcategories fit together (Hutchinson, 1993).

Rigour

According to Guba and Lincoln (1994), there are four criteria for the assessment of rigour or trustworthiness in qualitative research: (a) credibility for the assessment of truth-value, (b) fittingness for the assessment of applicability, (c) auditability for the assessment of consistency, and (d) confirmability for the assessment of neutrality.

Credibility

In a qualitative research study, *credibility* is demonstrated when the participants immediately recognize the reported research findings as their own experiences (Streubert & Carpenter, 1999). Feedback about the analysis was sought from the participants thus ensuring that the participants validated the findings of the study through member checks and member validation as Sandelowski (1986) advises. Once the audio-recorded interviews were transcribed, I gave the participants a chance to review them so they could fulfill

the expectation of member-checking and to ensure my interpretation of the data was correct. Credibility was also achieved by engaging with the participants over time and developing rapport, establishing trust, and working collaboratively with them.

The credibility of a qualitative study also depends on the credibility of the researcher (Patton, 1990). In qualitative research, the researcher is the instrument through which the data collection and analysis are conducted. Therefore, to ensure credibility, researchers should make explicit what they bring in terms of qualifications, experience, and perspective (Patton, 1990).

My professional and personal experiences and earlier studies had an impact on the selection of the research topic. For 10 years, I worked as a nurse practitioner in several clinical/practice settings. Currently I work as a nurse educator with Health Canada, First Nations and Inuit Health. Since 1995, I have also researched preceptorship, acted as a preceptor for nursing students, and directly experienced a personal transition as a skilled registered nurse to a new nurse practitioner.

My research plan for my PhD program was to conduct research in professional education. This specific project was related to exploring the process that preceptors use to impart their knowledge to nurse practitioner students throughout preceptorship, and determine how faculty and preceptors contribute to the preceptorship experience of nurse practitioner students. Preceptorship has been my area of interest for many years. The significance of exploring this particular area came about in the spring of 2005 when it was determined, after

completing an integrative review of the literature on preceptorship, that no research had been conducted to explore the process of precepting nurse practitioner students.

Fittingness

Fittingness refers to the probability that the research findings can have meaning or can be applied to contexts other than the one studied (Streubert & Carpenter, 1999). I ensured the fittingness, or transferability, of this study by collecting the data from different acute care settings. Two independent faculty members from two outside Faculties of Nursing were asked to read and comment on the credibility and transferability of the findings (Benton, 1996; Duffy, 2004). They concurred with my analysis of the data.

Auditability

Auditability refers to the ability of another researcher to follow the thinking, methods, and conclusion of the original researcher (Streubert & Carpenter, 1999). Beck (1993) asserts that a researcher demonstrates auditability when another researcher is able to follow the audit or decision trail of all of the decisions that the researcher made at every stage of the data analysis. Therefore, I ensured that a comprehensive audit trail was in place for future use by others. I also achieved dependability by asking my thesis supervisor to independently categorize the items as a check against bias.

Confirmability

If a study demonstrates credibility, auditability, and fittingness, it is also said to exhibit *confirmability* (Streubert & Carpenter, 1999). Confirmability was

achieved by keeping coded written material, memos, and field notes, as well as an audit trail. Therefore, throughout this study I took measures to ensure that these criteria were achieved and maintained to enhance the rigour of the study.

Limitations

The major limitations of the study included the following:

1. Only preceptors who had current experience in precepting a nurse practitioner student participated in the study (retrospectively), which thus excluded those who were not currently precepting a nurse practitioner student at the time of the data collection. I excluded this latter group because of the possibility of identifying the student.
2. The data that were collected through interviews might have increased bias because the participants might have revealed what they thought I wanted to hear, but not what they actually did or thought.

CHAPTER 4

FINDINGS AND DISCUSSION

> *For groups, as well as individuals, life itself means to separate and to be reunited, to change form and condition... It is to act and to cease, to wait and rest, and then to begin acting again, but in a different way.*
> (Van Gennep, [1909], 1960, p. 189)

Navigating The Liminal Space

Through an in-depth exploration and analysis of the interviews with students, preceptors and faculty, and the process of thinking and reflecting by me it became evident that the basic social psychological process known as *navigating the liminal space* reflected an active engagement in teaching–learning on the part of the student while engaged in preceptorship. Stated differently, the process of *navigating the liminal space* emerged from the data to explain what occurred throughout a student's preceptorship. Three key variables were subsumed in this process, which was also known as transitioning: (a) positioning in the teaching–learning experience, (b) repositioning on the threshold of becoming a nurse practitioner, and (c) embracing the new nurse practitioner role, which entailed a rebirth or "natality".

The diagram represented in Figure 1, on pages 71 and 224 outlines the complex processes of transition through this liminal space. Each figure in this chapter draws on components of this diagram to visually position these three variables within the broader context of this experience of transition from registered nurse to student to nurse practitioner. Each participant has been given a pseudonym to protect their identity.

Navigating the liminal space was the process of transition in which students engaged as they prepared for professional practice in the preceptorship context. Findings from this study revealed that as students proceeded through the preceptorship program they worked through or navigated what could be described as the liminal space or an in-between place. This navigation encompassed a process of transitioning from a place where they were deemed to be highly skilled registered nurses to one that included the role of nurse practitioner student and, finally, to the place where they emerged as nurse practitioners. As these students navigated their liminal space, they first positioned themselves or were positioned by others as learners/students and then repositioned themselves on the threshold of assuming the nurse practitioner role.

In the process of positioning themselves, students' worked through what could be described as rites of passage specific to preceptorship. They communicated or interacted with their preceptors, faculty and others through a language of navigating and used the knowledge they had acquired for the nurse practitioner role. The data also revealed that repositioning on the threshold of becoming a new type of nurse encompassed becoming affirmed again. This new professional space of affirmation, then, afforded novice nurse practitioners the opportunity to acknowledge and embrace their newly acquired professional identity. The process of becoming affirmed generated a sense of comfort and confidence, and an increased sense of recognition and respect from colleagues and fellow registered nurses. The process of positioning and repositioning resulted in what the literature described as a birth, or a professional rebirth, in which students

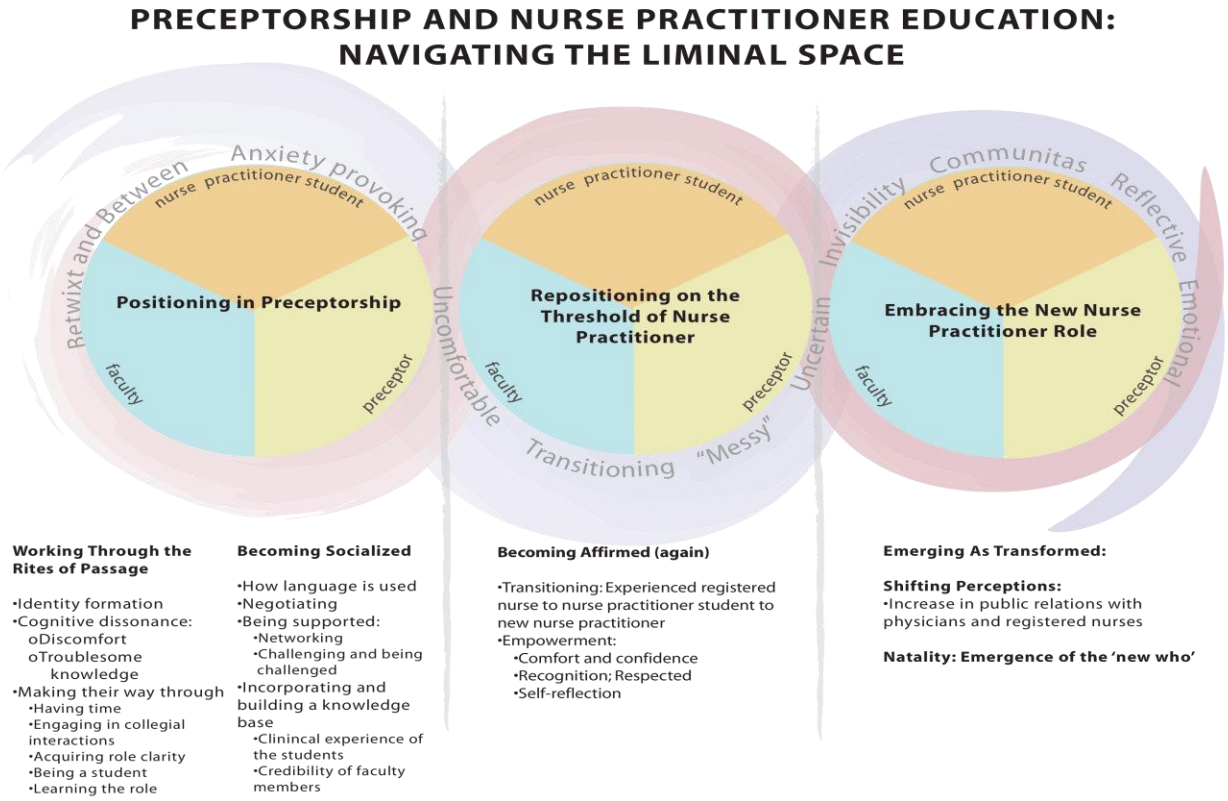
achieved greater comfort in their new-found role; more confident engagement with colleagues, in particular registered nurses and physicians; and transformation from the student role. It was during this phase of the process that students emerged from the uncertainty of the liminal space, the betwixt and between, and arrived at a place of accomplishment.

Significance of the circles and colors in the diagrams. The focus of any preceptorship is on the student. With this in mind, for this study, the faculty member as well as the preceptor provides support and nurtures the student as she/he transitions from the expert registered nurse to the new nurse practitioner. This complex and interconnected relationship is illustrated in the identical diagram found on pages 60 and 213. The circle represents the interdependence amongst the triad, but illustrates that the student is the focus of the educational encounter, hence she/he is located at the top of the diagram, while the nurse practitioner preceptor and the faculty member hold equal status and are located within the circle but just below the student but adjacent to each other. The colors of purple, yellow, blue are colors that are pleasing to observe but have no significant value otherwise.

The grounded theory method indicates a non-linear process that ebbs and flows as the coding progresses and the categories emerge. Constant comparative analysis is key to this inductive process, which further indicates a non-linear process. The descriptive words located on the perimeter of the diagram while flowing around each circle illustrate the characteristics of the liminal space that

are encountered by all members of the triad, with particular emphasis on how they are felt by the student.

Figure 1: Preceptorship and Nurse Practitioner Education



The Liminal Space

The liminal space was an interlude of transition through which students experientially and scholastically progressed through preceptorship (Figure 1). It is a space that students must navigate as they transposed from one sociopolitical state and status (the experienced registered nurse) to another (the nurse practitioner student). The liminal space is considered "sociopolitical" because it is bound by norms dictated by society, in this case professional norms and dictates; hence, it's inherent political nature. Turner (1979), for example, focuses on the changing status of the liminoid or one who is in a liminal space, which by its very nature indicates a sociopolitical context. This space is entered into briefly, "in a

passage toward something else; such persons are dipped into nonidentity and self-forgetfulness in order to change what they are" (Hirshfield, 1997, p. 208). According to Turner, liminality means "being on a threshold" and involves engaging in a state or process that is "betwixt-and-between" the normal, daily cultural and social states and processes of living one's life (1979, p. 465).

Liminality was evident throughout the findings of this study. For example, nurse practitioner students, nurse practitioner preceptors, and faculty members alike frequently acknowledged that students were in a state of limbo or flux. No longer were they in the role of experienced nurse nor were they yet bona fide nurse practitioners.

Further characteristics of this transitional state were reflected in participants' expressions of feeling like being in limbo or suddenly feeling as if they were in a state of being between past and present modes of daily existence, feelings of anxiety and discomfort, a sense of uncertainty, and the need to engage in self-reflection. One nurse practitioner student acknowledged the emotions involved in this transition from experienced registered nurse to novice student:

> One of the biggest things was making that transition from being the expert to the novice and not having a lot of support there to be the learner. It was a tough transition at first to realize what you don't know. And you thought you knew. And then increasing comfort, spending more time in the clinical area and realizing you actually know a lot more than you thought you did, and then getting comfortable with the nurse practitioner role in that setting (Sylvia, interview 1, Lines 41-64, pp. 1-2).

This observation corroborates the salient point described by Turner (1969, 1974, 1979), who refers to the short-term nature of the transitioning process as "the stairway". To illustrate, picture a typical stairway. You cross the threshold of the stairway and either walk up the stairs or down the stairs, knowing that you will leave the stairwell. Key is the knowledge that you will spend a short time walking (or transitioning) from one place to another. The students in this study described being in a process of transitioning from one state to another, from the role of experienced nurse to that of student. In other words, they felt they were in limbo, metaphorically positioned in the stairway for a short period of time, while they navigated their way from being an experienced nurse to being a student once more, and back again to being recognized as a professional nurse. During such a transition, nurse practitioner students may cross the threshold of the stairway many times, all the while anticipating that eventually they will exit as a transformed nurse (Clouder, 2005).

Echoed by one nurse practitioner student, feelings of anxiety were a common occurrence in this transition:

> When you have a specialized area and you are the student, you are very anxious—am I getting everything? Am I learning everything I need to [learn]? (Janet, interview 1, Lines 186-188, p. 3).

A faculty member described the anxiety experienced by these students as a necessary part of the transition:

> It is very difficult to go from being somebody who knows exactly what they are doing, they are on top of the game, they are seen as an expert in

> their area and then all of a sudden the rug gets pulled out from under them and they realize they know nothing, or feel like they know nothing, and that is just an awful experience, but it is part of the process of discovering what you do not know. It is pretty traumatic. (May, interview 1, Lines 86-96, p. 3).

In addition to feelings of anxiety, ambiguity also emerged as being intrinsic to navigating the liminal space (Cook-Sather, 2006; Hall, 1991; Turner, 1974, 1977), a theme also reported in a study by Chang, Mu and Tsay (2006). The term *ambiguity* originates from the Latin word *ambiguitas*, which means *doubtful*. To illustrate, inherent in this study was the perception the role of nurse practitioner was open to more than one interpretation, which in turn could be confusing to the nurse practitioner preceptor as well as to a student who was already anxious. A preceptor reflected this sentiment, as follows:

> The role [of nurse practitioner] can be kind of ambiguous. Even when you are a nurse practitioner there are days where you feel like you are kind of in that middle space of being a nurse but also really having to conform to a medical model and so trying to help that person muddle through. That can be a challenge (Sibi, interview 1, Lines 114-120, p. 3).

While navigating the liminal space, students and preceptors experienced not only conflicted feelings, but also significant changes in their dominant self-image. The student, according to Turner (1969), could be referred to as *liminoid*, questioning who he or she is, where he or she fits within the structure (in this case the preceptorship as a nurse practitioner student), and why he or she is there.

These conflicted feelings also involved the capability of the nurse practitioner student to access support and in turn whether or not support was made available.

Within the liminal space, or state of betwixt and between, there can develop what Turner (1969, 1974, 1975) and Cook-Sather (2006) refer to as a supportive social structure of *communitas.* This social structure served to initiate individuals, in these instance nurse practitioner students, to become a like-minded group who experienced similar if not the same feelings, challenges, and accomplishments, and which, at this period in their lives/careers, shared the same humanity. It is an equal and human relationship "between concrete, historical, idiosyncratic individuals" (Turner, 1969, p. 131). This group was not a typical social hierarchy but a communal group in which all were considered equal. For the initiates in this study, having a support group with whom to communicate was found to be integral to the successful navigation of the liminal space and thus to the completion of their transition. One student aptly illustrated the role of *communitas* as an important source of support:

> I think coping was a lot easier…. I found that actually having a class full of classmates to actually go back to and say do you feel this way as well because I feel like things are kind of out of control in my life…and so you look to your classmates to see how are you coping? What techniques are you using? (Sibi, interview 1, Lines 352-368, pp. 8-9).

In the literature on preceptorship, support for the student and preceptor is frequently identified as being crucial to the success of preceptorship (Coates & Gormley, 1997; Kaviani & Stillwell, 2000; Myrick & Yonge, 2002, 2005; Yonge

et al., 2002**).** Being embraced by a community of like-minded equals, then, was one means of receiving and giving that much-needed support.

Reflecting on the quotation at the beginning of this chapter, liminality can be described as a messy, yet necessary, process upon which someone's professional life was restructured. Once the flux resolved, then life was forevermore different for that person and for those around him or her. This liminal space represented a time during which students could also become emotional and uncertain about what they needed to learn, uncertain as to where their role fit within the larger context of health care, and confused as to whom and what they were becoming. It was a time for intense self-reflection and for asking themselves questions such as: Why am I doing this? What is the purpose of this advanced education? Who will benefit from my education? Once graduated, where do I go? One student expressed the following emotions and feelings of uncertainty:

> We tried to adapt by drawing on each other's experience. But I found by the end of the practicum I thought well do I really want to be doing this? Do I not want to be doing this? And I thought well this is the time where I need to decide. I am either in or I am out (Deb, interview #1, Lines 83-95, pp. 2-3).

Another student reinforced these perceptions:

> Of course there was this lack of knowledge that was reinforced when I started taking the clinical courses about how much there really is out there to know and how it was [difficult] to realize how little I knew and that put in a space of lacking confidence or of being unsure of myself…and I ask

> myself do I know enough to do this? You know, do I have enough knowledge to make the right decisions and to practice the way that I hope to practice? (Sheri, interview #2, Lines 717-736, p. 17).

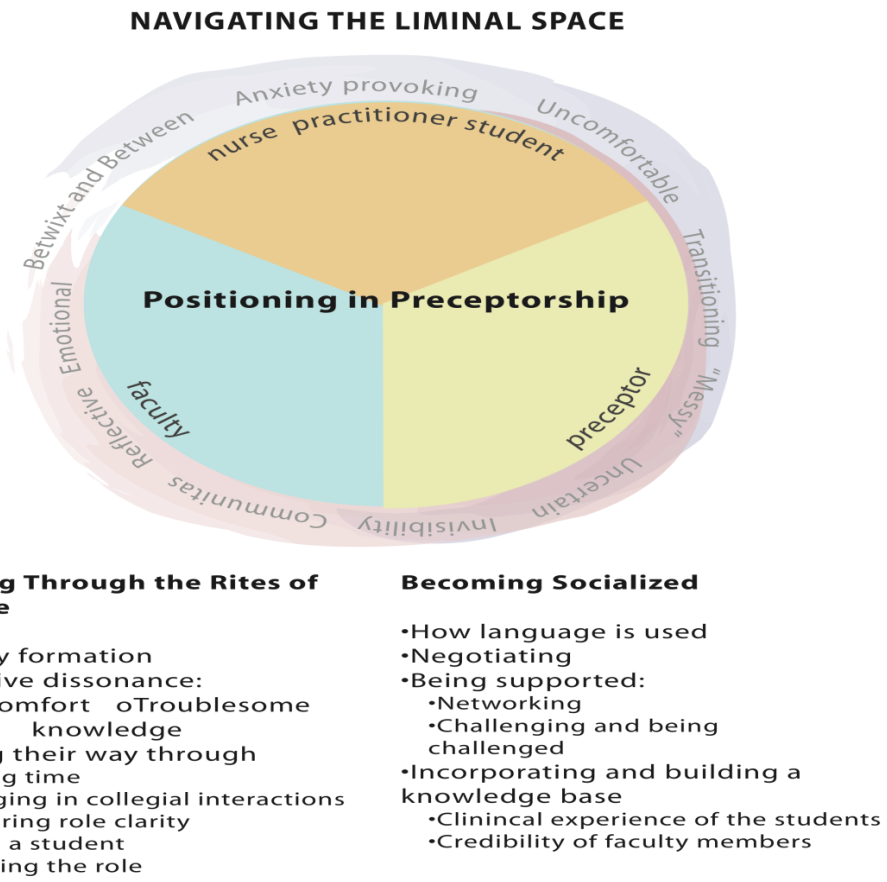
Positioning in Preceptorship

As previously noted, as nurse practitioner students embarked upon their transition from the role of experienced registered nurse to nurse practitioner student, the faculty first positioned them in the preceptorship experience. It was found in this study that students traversed two distinct phases in this transition: (a) working through the rites of passage, and (b) becoming socialized.

Working Through the Rites of Passage

Working through the rites of passage in this particular preceptorship and becoming socialized into its language were processes found to be important to navigating the liminal space, in particular positioning in this preceptorship experience (Figure 2). Initially, Van Gennep (1909, 1960), then Turner (1977), and more recently Hockey (2002) and Cook-Sather (2006), examined a three-part ritual-related structure: rites of separation (or the pre liminal state), threshold rites (or the liminal space), and rites of aggregation (or the post liminal space). Stated differently, the pre liminal space involved someone passing out of a previous phase or social status, whereas threshold rites reflected an ambiguous time and space during which someone was in a state of limbo; and, finally, rites of aggregation entail re-entry into a new social position or period (Hockey, 2002, p. 210).

Figure 2: Working Through the Rites of Passage



Working Through the Rites of Passage

Van Gennep's (1960) work can be summarized as seminal in describing the structural similarity of a variety of transitional rituals. These rituals signify the passage of society's individual members through the life course, such as birth, initiation, engagement, marriage, healing, and death (Hockey, 2002). In the findings of this study, the transitions identified by Van Gennep mirrored the process engaged in by nurse practitioner students throughout their preceptorship (Figure 2). Students' transitional rituals involved a professional yet often emotional change that began as soon as an experienced nurse became a student

once again, and continued as the student transformed into a newly graduated nurse practitioner. In other words, this process encompassed an ambiguous zone that was "betwixt and between fixed social positions" (Hockey, 2002, p. 213). Furthermore, as Van Gennep suggested, rites of passage act to pattern social experience through repetition.

This repetition of social experience was consistently noted in the data, in which I had ultimately identified and recorded further subcategories. These subcategories were identity formation, cognitive dissonance, discomfort, dealing with threshold concepts, making their way through the journey and challenges to the student and/or the preceptor. Central to a student's transition to the newly graduated nurse practitioner role were experiences of change that naturally occurred and were expected to occur (Hockey, 2002). Indeed, a nurse practitioner student could not experience rites of passages without change occurring.

Three rites of passage, as initially described by Van Gennep (1909, 1960), and later by Turner (1969), served to explain the context of advanced nurse practitioner practice. During the pre liminal or separation stage, experienced registered nurses separated from their professional status. In the intermediate state of liminality or transition, the student was positioned in a lower status, the student role. Finally, he or she transformed into the newly achieved role and status of graduated nurse practitioner. Hall (1991) further describes these three rites of passage as a process of moving from a space of a particular here-and-now into the in-between and then back to a space of a *new* here-and-now.

As previously mentioned, students frequently noted feelings of anxiety and of discomfort, as well as feelings of uncertainty about their transition from one state to another while in the student role. The unease experienced by these nurse practitioner students reflected an internal social dynamic of change, which was the schema that Turner (1969) uses to describe rites of passage experienced by members of a society. An example of one key internal social dynamic of change was the past professional identity of these students. Rather than focus on individual passage through fixed structure, Turner instead examines the fluidity of entire matrices of social relationships (Hockey, 2002). Turner's focus on the relationships of the whole social structure "fits, works and is relevant" regarding these research findings. As one reviews the data, it was evident that relationships between and amongst students and those with whom they interacted were key to their professional growth and ultimately to their professional relationships. Moreover, as students navigated their individual and co mingled liminal spaces, they did so in the company of others, all within the context of *communitas*. As Turner states, "whatever society we live in we are all related to one another; our own 'big moments' are 'big moments' for others as well" (1969, p. 7). A more detailed analysis and discussion of *communitas* occurs in the section on *Becoming Socialized, Being Supported* (p. 134). Key to working through the rites of passage, then, was the evolving professional identity of the nurse practitioner student and the process of identity formation.

> *"Self" is the meaning-maker—"an evolving yet coherent being, that consciously and unconsciously constructs and is constructed, reconstructs and is reconstructed, in interaction with the…institutions and people with which the self…learns—and "identity" is the meaning made by self.*
> (Cook-Sather, 2006, p. 116)

Identity formation. As student participants in this study transitioned from experienced nurse into the often uncertain role of the student, they were found to engage in a process of identity formation (Cook-Sather, 2006). Key to this transition was the engagement and facilitation of students by the preceptor(s) and faculty member(s). With this in mind, the definition of identity involved a multifaceted and dynamic individual, a collection of versions of self, created "as people position themselves and are positioned in relation to varied social practices" (Nasir & Saxe, 2003, p. 17). In the context of this study, then, the individual's concept of identity was associated with a specific professional group. The nurse practitioner students either positioned themselves or were actively positioned by another group (faculty, preceptors) in relation to an understanding of advanced practice nursing.

Nurse practitioner students who were assigned to an experienced nurse practitioner as their primary preceptor and role model, and who incorporated the institutional nursing philosophy into their practice, had been found to have strong nursing identities (Beale, Maguire & Carr, 1996). In keeping with this finding, one faculty member in this study commented upon the importance for the nurse practitioner student to be precepted by an experienced nurse practitioner:

> The whole preceptorship experience [will be better for the student if the preceptor is a nurse practitioner] because they [the nurse practitioner]

> know what they need to know and what the learning and experience was like for them. They have got a sense of making sense of that transition from nurse to nurse practitioner that a physician does not have (Jen, interview #2, Lines 489-495, p. 12).

One of the nurse practitioner preceptors in this study supported the viewpoint of this faculty member. She stated:

> Well I think experience is essential because nurse practitioners are nurses. They are not medical students. They are not from some other discipline. In terms of having nursing experience, I think the experience that you bring with you is what grounds you. I worried for students, this particular student I just talked about was someone who didn't have a lot of nursing experience and she was the first person in the group when discussing this… to identify I'm not the strongest nurse. I don't have as much experience. (Sheri, interview #1, Part A-Lines 588-601, pp. 14-15).

A faculty member further acknowledged that the nurse practitioner student learned more about the nurse practitioner role from an experienced nurse practitioner. She observed:

> Actually students who have had both a nurse practitioner and/or a physician as preceptor say they have learned much more from their nurse practitioner preceptor than from the physician, and they are functioning in the nurse practitioner role, so they receive socialization to the role, but they also receive what they need in relation to assessment and diagnosis and treatment decisions as well, because those individuals [the nurse

> practitioner as preceptor] are making those decisions. So, from my point of view that is usually a richer experience for students (Sue, interview #1, Lines 226-236, p. 5).

Stated differently, another faculty member espoused the importance of a preceptor who was a practicing nurse practitioner. She stated:

> A nurse practitioner has a nursing perspective on practice and is able to offer a deeper understanding of the role and role model how a nurse practitioner practice works, how they would approach things in a broader, more holistic perspective (May, interview #2, Lines 157-161, p. 4).

Taken all together, then, each of these study participants explicitly acknowledged that the professional identity of the nurse practitioner student was directly impacted by their preceptor's professional identity. Specifically, when an experienced nurse practitioner precepted a nurse practitioner student, the preceptorship experience proved to be a rich learning encounter and extremely beneficial to the student in preparation for their bona fide nurse practitioner role.

Role modeling was also found to be another important aspect specific to the role identity for nurse practitioner students. As May noted above, modeling the professional aspects of the nurse practitioner role by a preceptor who is an experienced nurse practitioner was fundamental to improving and augmenting the role identity for students. Indeed, as one nurse practitioner student noted, it was professionally beneficial to have a nurse practitioner as a preceptor. She noted:

> I think the benefit of having a nurse practitioner as a preceptor is when there is a lecture in an area that she or he [nurse practitioner] is working

> in, then she or he may be able to increase students awareness of the other aspects of the role or to see how to incorporate other aspects of the role in a daily or weekly basis in order to help the student learn what the role may be when he or she graduates. You will not have that if your preceptor is a physician (Janet, interview #1, Lines 436-444, p. 11).

Another key aspect of role identity found in this study, and one that was often described as being overlooked, was recognition of expertise by peers/colleagues. As Currie (2008) proposes, knowledge and expertise are not sufficient to ensure expert practice; recognition of expertise by others is also necessary. To practice as an expert, a nurse practitioner must first be recognized as an expert *by others*. With this in mind, it is acknowledged that respect from others supports the development of an expert self-identity (Currie, 2008). As one nurse practitioner student implied, part of acquiring role identity was being recognized by one's peers, which in turn helped to validate one self. She observed:

> You have got all that knowledge but it is the implementation of it and the people who are recognizing your level of knowledge, you then recognize it in yourself (Sylvia, interview #2, Lines 770-774, p. 18).

Fundamental to developing an identity as a nurse practitioner was having the confidence, support, and the respect (Currie, 2008) of the preceptor. One nurse practitioner stated:

> I had a fabulous preceptor who believed totally in me and said after the first day…"you can do this, just get in there and do it. If you have

> questions come to me…but you know that you know this stuff" (Gina, interview #1, Lines 126-133, pp. 3-4).

Another nurse practitioner student expressed how the use of the term "novice" adversely affected her sense of self, and in turn affected her role identity:

> You know, it is that novice term that really resonated the most because you are a novice nurse practitioner. In a way it is showing you are new to your role but at the same time when you think of the term novice, you think of inexperienced and I think it takes away however many years of experience you have when you have been an expert in a field…you do have a lot of experience, knowledge, confidence, respect…and you throw novice in there and it almost back pedals and you are left feeling [less confident] (Sylvia, interview #2, Lines 325-342, p. 8).

Linked to the importance of developing a sound role identity was establishing the trust of the preceptor (Currie, 2008). A preceptor noted:

> She [the nurse practitioner student] earned my trust I would say in her ability to be very astute, she was on top of things. She had a very good sense of the whole process of managing these patients and she earned my trust early on (Kim, interview #1, Lines 316-321, p. 8)

This recognition of prior expertise and the impact that recognition had on role identity was supported by a nurse practitioner student:

> I was told many times you know what you are doing, you have got a good strong knowledge base, figure it out what you need to do to take it to the next level from here but respecting the knowledge that I brought to the

> clinical area with me…I did not have to prove myself (Janet, interview #2, Part B, Lines 893-900, p. 22)

It was found that while several participants explicitly or implicitly noted the importance of colleagues' acknowledging prior professional expertise, others, specifically students, noted they felt uneasy regarding how many of the colleagues with whom they engaged during their practica, and even the students themselves, forgot or did not acknowledge the wealth of expertise and experience these students brought with them to the practice setting. This oversight, according to one preceptor (Deb), resulted in the potential for these students to feel a 'self-imposed invisibility.' This self-imposed invisibility was found to be due in part to students' initial lack of self-confidence that, while transitioning to the new nurse practitioner role, improved with experience and a positive preceptorship experience.

As one can appreciate the fundamental nature or essence of a nurse practitioner student's self-identity, or personal identity— henceforth known as *identity*—was critical with regard to how he or she viewed the world, managed and coped with stress, conducted her or himself professionally, and interacted with colleagues in a learning environment. With this in mind, when the student questioned her or his own fundamental reasons for being, thus questioning their identity, such as "Who am I?" and "What is my role here?" angst was found to occur. This threat to identity was found to lead to dissonance (Matz & Wood, 2005).

The ensuing uncertainty, discomfort, and anxiety that students experienced in situations where they were challenged by inconsistency requiring a life change, a change that occurred when entering a liminal space, was found to produce a state of discomfort and unease. This process emerged in the data as cognitive dissonance (Syx, 2008).

In this next section the findings and related discussion associated with cognitive dissonance in relation to working through the rites of passage will be discussed. Working through the rites of passage can often generate cognitive dissonance. The reason for this association between the rites of passage and cognitive dissonance was that the very nature of the rites of passage was emotional for the individual working through those rites. To illustrate, a student experiencing a change in professional status might possess preconceived ideas about what that rite of passage might entail, but such an expectation might not be found in the reality of their experience.

> *People find consistency comfortable and prefer to be consistent in their thoughts, beliefs, emotions, values, attitudes, and actions. When inconsistency exists, an individual feels an imbalance or dissonance.* (Gruber, 2003, p. 242)

Cognitive dissonance. Festinger (1957) describes cognitive dissonance as the state of possessing conflicting thoughts, beliefs, or attitudes, especially relating to behavioural decisions and attitudinal change. The liminal space navigated by nurse practitioner students while transitioning to the nurse practitioner role was a process that was found to contribute to their cognitive dissonance, which included feelings of anxiety, conflict, uncertainty, and discomfort. In the interviews, students as well as preceptors implicitly or

explicitly described episodes of cognitive dissonance. Typically, dissonance was due in part to a disconnection between what "should be" and what actually was. As a result, because of their prior nursing experience, these students often felt that what was actually happening either in the classroom or in the practice setting was unsettling because of a disconnect between their values, thoughts, beliefs, or attitudes and what actually occurred. In essence, the students and even the preceptors experienced a loss of what they perceived as being comfortable for them (Clouder, 2005); normal order was suspended, which proved to be unsettling for those involved (Clouder, 2005).

One student relayed how uncertain she was regarding her soon-to-be new role as a nurse practitioner: "What am I?" was a question she asked herself. She reflected:

> Going from being an expert back to being a novice [is uncertain] and one of my colleagues put it perfectly the other day. She said, "I am not sure. What am I doing here?" She [the colleague] was asked a question and could not answer it from a nurse practitioner point of view and she did not know the answer and then got asked if she could turn on the remote for somebody and she said, "I have to get your nurse" was her instant answer and she said, "well, I am not their registered nurse and I am not their nurse practitioner so I am nothing to them" (Janet, interview #2, Part B, Lines 65-82, p. 2).

This crisis in identity was found to lead to cognitive dissonance. This person felt she was 'betwixt and between' (Turner, 1977), no longer a bedside

registered nurse, but not yet a nurse practitioner. The stress a nurse practitioner student felt could become overwhelming if not properly addressed. Yet, based upon what this student said, the colleague was speaking about feelings of discomfort and role ambiguity, further lending support to the belief that *communitas*, previously discussed, was a hugely beneficial, symbiotic coping strategy that allowed each learner to garner emotional, mental, and even physical support from like-minded students who were also experiencing periods of cognitive dissonance. In other words, these two individuals had formed a relationship derived from their fundamental need to provide and be provided with support (Matz & Wood, 2005). In fact, according to McKimmie et al. (2003), knowing that others may have behaved in the same manner acts as a constant cognition, thereby reducing dissonance.

Another student stated how stressful the role was, particularly when nurse practitioner colleagues preferred to assume the role of physician replacement [assistant] and not the autonomous role of the nurse practitioner. As one student observed:

> Unfortunately there is a lot of pressure from the nurse practitioners that are already here and some of them who did want to be physician replacements [assistants] and that is what they want. So they come and they will deal with the pathology but really do not like to deal with the families. So in the workplace, there is this constant stressor between wanting to utilize my nursing background but feeling the pressure to just do the medical side of

> it and not be the physician replacement, and so it is hard (Deb, interview #1, Lines 433-452, pp. 10-11).

As Yonge, Myrick, and Haase (2002) found, being a student nurse is *stressful*. In fact, student nurses experienced more stress as students than they did during the first year of employment. This finding supported the data emerging from this particular study that nurse practitioner students also experienced significant stress during their educational preparation. It was the transitional process identified in this study as the liminal space in which they transformed from their self-assured nursing professional role to a new student role that was found to generate stress, anxiety, discomfort and a sense of disconnect. As witnessed in the preceding pages, this could be a time for great discomfort and messiness for them.

Viewed through a different lens, it was found that cognitive dissonance occurred when a nurse practitioner–preceptor identified ambiguity within the nurse practitioner role while trying to fit into and practice within a medical model. One preceptor described her dissonance this way:

> The role can be ambiguous. Even when you are a nurse practitioner there are days where you feel like you are kind of in that middle space of being a nurse but also really having to conform to a medical model and so trying to help that person muddle through. That can be a challenge (Sibi, interview #1, Lines 114-120, p. 2).

Another participant (student) acknowledged the ambiguity that occurred when physicians interpreted nursing roles:

> Whether we want to admit it or not, physicians are still driving the ship and physicians still very much impact who gets to do what and it changes on a daily basis. So the ambiguity comes from how someone interprets the role and how they let the role unfold even if they have a certain understanding of it because they will still have a huge impact on what I do on a daily basis (Deb, interview #2, Lines 442-450, p. 10).

A preceptor noted that once the student graduated and became a nurse practitioner, ambiguity still occurred. From this preceptors perspective students must be prepared for the continuing ambiguity:

> Nurse practitioners have gone into organizations but the infrastructure is not there to support them so I think that that is one of the key things that we need to do with the student is helping them to understand where they fit because there is not any clarity around that and I think that once they become nurse practitioners and that hits them, they become very disillusioned and confused and want to quit, so I think that if you can prepare them for that ahead of time for that ambiguity that some of this has to be figured out along the way (Sibi, interview #1, Lines 249-261, p. 6).

When a person experiences role ambiguity, and unless the associated stress is addressed in a meaningful manner, the individual also experiences discomfort and uncertainty (Festinger, 1957). With this in mind, associated with cognitive dissonance, therefore, is the concept of discomfort. The very nature of dissonance

involved feelings of intense discomfort. As a result, discomfort was identified as a recurring theme throughout the data.

Discomfort. Cognitive dissonance was also manifested by the expressions of discomfort expressed mainly by student participants. According to Meyer et al. (2006), cognitive dissonance and the resulting discomfort was not necessarily a negative experience in itself because it forced students to think critically, which could lead to a positive outcome. From a pedagogical standpoint, then, cognitive dissonance and the resultant discomfort could present learning opportunities to extend the students' "growing edge" (Meyer et al., 2006, p. 79). One student provided support for this perspective when she stated:

> I think it is very anxiety producing you know, anxiety is a sort of the underlying motivator because it is a whole new role and especially when for myself it was a whole new practice area and then the new role (Janet, interview #1, Lines 755-766, pp. 18-19).

Likewise, another student noted that she had to experience the discomfort associated with the liminal space in order to determine where she wanted to practice:

> So for me it was a better fit [in family practice] but I had to go through that process in order to find it [where I fit]. The preceptor/preceptee relationship I found was quite strained (Deb, interview #1, Lines 96-99, p. 3).

A student described her experience of discomfort in another way. She noted that while the preceptorship experience involved discomfort students could still learn from that uneasiness:

> Really all the way through there is a level of discomfort. I am not sure that is not a place though that you go to and not learn a lot from (Sheri, interview #1, Part A, Lines 630-633, p. 15).

If the student was experiencing discomfort, it was found that the best way for faculty to identify that discomfort was by ensuring good communication:

> Keeping the lines open and inviting them to call whenever there is an issue and then trying to touch base halfway through. Some students do not want to tell me and that is not wise, and I am not sure why that is, whether they take it as something lacking in themselves that they do not want to reveal but it is problematic if they do not tell me early that they are having trouble (Jen, interview #2, Lines 675-685, p. 16).

Recognizing student discomfort as an inevitable part of the transitioning process, one faculty member's approach was to challenge the students and to encourage the students to view such challenge positively:

> I have found that with students that if they are challenged they do learn more but to be challenged and to look at it positively as opposed to negatively and feeling threatened, which they do at the very beginning, that sort of goes along with their growth or transitioning (Gert, interview #3, Lines 176-195, p. 5).

Just as the occurrence of discomfort was found to be a reflection of the cognitive dissonance that students' encountered as they worked through the rites of passage, so, too, was the occurrence of troublesome knowledge which, according to Meyer and Land (2006), can be best explained from the perspective of threshold concepts, a phenomenon they identify as being intrinsic to the student as learner. On the one hand, there is knowledge that is easily understood and comprehended by students. On the other hand, there is knowledge that is difficult to comprehend. These threshold concepts or troublesome knowledge are experienced by students as being "conceptually difficult, counter intuitive or alien" (Meyer & Land, 2006, p. XV).

When troubles come, they come not single spies. (*Hamlet*, IV. V. 83-84)

There is no simple passage in learning from "easy" to "difficult"; mastery of a threshold concept often involves messy journeys back, forth and across conceptual terrain. (Cousin, 2006, p. 5)

Troublesome knowledge. Threshold concepts such as troublesome knowledge could provide a conceptual understanding of the process involved when nurse practitioner students were introduced to new knowledge when engaged in preceptorship. According to Meyer and Land (2006), threshold concepts could be viewed as separate from what many academics would describe as core concepts, or seminal knowledge a student must master in order to progress in a program of study.

For some students new knowledge may prove troublesome for many reasons. For example, new knowledge can involve a relinquishing of a sense of comfort in their own knowledge and experience as they engage in less familiar,

troubling or uncharted territory. The relinquishment of comfort had been found to generate a shift in these student's identities. As a result, for some students they could remain in that liminal space whereby they never (fully) embraced and appreciated a particular concept or progress in their professional growth (Meyer & Land, 2006). In the discipline of nursing there are concepts that, by their very nature, can open up the minds of students to new ways of thinking. A threshold concept, therefore, must be understood if the student is to progress successfully with his/her learning and professional growth otherwise it continues to generate cognitive dissonance.

To further explicate an understanding of threshold concepts Meyer and Land (2006) introduce five important characteristics that when identified, allow comprehension and recognition that a threshold concept is occurring:

1. Grasping a threshold concept is transformative because it involves ontological (understanding the nature of the professional role, e.g. nurse practitioner) as well as a conceptual shift. In essence we are what we know. New understandings are absorbed into our life story, becoming who we are, how we see and how we feel. This kind of "turn" in understanding a subject marks a pivotal initiation into any subject culture. To illustrate, the nurse practitioner student worked through a process (navigating the liminal space) of becoming a nurse practitioner.

2. A threshold concept is often irreversible. Once a person knows and understands such a concept it cannot be unlearned. For example, a nurse practitioner resuming the role of registered nurse.

3. A threshold concept is integrative in that it renders visible the hidden interrelatedness of phenomena, such that the learner has the ability to make connections that were hitherto hidden from view. For example, the advanced knowledge that was previously unknown to the student but with which the student is now connected.

4. A threshold concept is likely to be constrained in that "any conceptual space will have terminal frontiers, bordering with thresholds into new conceptual areas" (Meyer & Land, 2006, p. 6). For example, the new nurse practitioner in this study (student participants) will comprehend that her/his role is unique and *does not* mimic the role of the physician assistant or a resident.

5. According to Meyer and Land (2006), a threshold concept can be inhibited by an intuitive understanding of it. To expect students to relinquish their intuitive understandings can also prove troublesome because the reversal can also involve an uncomfortable and emotional repositioning. For example, registered nurses provide nursing diagnoses. However, the nurse practitioner role expects them to provide differential diagnoses, a skill that was once solely within the purview of the physician.

Troublesome knowledge can occur when a nurse is asked to perform a skill that is unfamiliar or to practice at a level that is beyond, in this case, the student's capability. For example, for a bedside nurse or a nurse prepared at the baccalaureate level, it is not the norm to perform a history and physical exam with

the depth and breadth expected of a nurse practitioner (student). Indeed, it is not the role of the baccalaureate nurse to be responsible for the knowledge, skills and abilities for which a nurse practitioner would be responsible. With this in mind, a preceptor described the difficulty a student, who was an inexperienced registered nurse, would face if she/he entered an advanced practice program lacking basic nursing knowledge:

> I think that you need to be at the level of an expert in basic nursing before you try to become a nurse practitioner because you use that knowledge and it is so hard when you go from being a nurse to a nurse practitioner. And if you do not have enough confidence in your abilities as a nurse, it can be very scary anyway but it can be very difficult to get through that initial [nurse practitioner] period (Betty, interview #1, Lines 91-105, p. 3).

In this study, several students had minimal nursing experience prior to entering this nurse practitioner program. The dissonance encountered by these students was evident when there was the expectation by faculty that these students be capable of building on previous experience as a nurse. For those students' troublesome knowledge emerged as a major challenge. A faculty member noted the process she followed to ascertain whether or not the student actually "got it;" whether the student could actually conduct an appropriate history and physical exam understanding all the nuances involved in that fundamental nurse practitioner process:

> I wanted to actually see the student present her patient and what her thought processes were, how she was making a differential diagnosis. Just

> watch her. Basically go on rounds for the morning, and as she went from patient to patient, she would present her patient, what she thought were the issues and what her plan was for care for that day. (Tracy, interview #1, Lines 1187-1192, p. 29).

This perspective helped to illustrate the importance of student understanding regarding the processes involved in learning particular knowledge, such as history and physical examination, for if a student was unable to comprehend that particular knowledge it would then be troublesome knowledge for them.

Understanding the fundamental differences between the nursing model and the medical model and how the role of the nurse practitioner must be situated within the advanced nursing model was also found to be ripe with troublesome knowledge. For example, a nurse practitioner–preceptor explained these fundamental differences in professional roles:

> I think there are differences in nursing and medicine at a very basic level in terms of how patients are approached. Based on personal experience I find that the medical model can be very disease oriented. So for example a nurse practitioner can learn very well from a physician about honing in on a diagnosis and how to treat that and how to intervene on that and depending on the physician, it can be quite limited to that. Whereas I see the nursing model as being more holistic and looking at not just the patient but the piece that comes with the patient, for example, the family (Sibi, interview #2, Lines 59-70, p. 2).

Troublesome knowledge was found to be limited not only to the lack of basic nursing knowledge, but also emerged regarding students' understanding of evidence based practice (EBP). When students, for example, were unable to grasp the importance of EBP to their new nurse practitioner role, dissonance was experienced, which in turn resulted in feelings of discomfort. As Sibi described, EBP provided the same kind of challenge for students as the grey areas with which they were confronted in their new roles. She stated:

> The other challenge is evidence-based practice, those kinds of things. Nurse practitioner students' kind of struggle with those grey areas sometimes where things are not always black and white; and, it is trying to support them through what might be those grey areas so I see that as being a challenge (Sibi, interview #1, Lines 123-125, p. 3).

Troublesome knowledge has also been associated with *disjunction* (Savin-Baden, 2006), which is described as becoming "stuck" in learning and not being able to move forward. In other words, disjunction can be conceived as being enabling or disabling in its impact on student learning and can, therefore, be perceived to be a place to which students might gravitate upon encountering a threshold concept when, for example, they are confronted with troublesome knowledge or knowledge that is alien to them. For example, interestingly, Savin-Badin argues that Context Based Learning (CBL) "is itself a threshold concept that results in disjunction in the lives of staff and students" (Savin-Baden, cited in Meyer & Land, 2006, p. xxi). This was an important assertion in light of the fact

that the participants (nurse practitioner students and faculty) in this study were taught through the CBL approach.

Metaphorically, disjunction has been described by students and faculty alike as running full-tilt into a brick wall (Savin-Baden, in Meyer & Land, 2006). Often these individuals try a myriad of ways to alleviate or mend that brick wall, but often to no avail. The strategies used to cope with disjunction can result in the individuals:

1. Retreating from the difficulty and opting out of any further learning.

2. Using avoidance tactics (Savin-Baden, in Meyer & Land, 2006).

   Illustrating strategies 1 and 2, one nurse practitioner student stated:
   I think by the time you finish your last practicum, you learn not to really expect too much. By that time you have learned that if you go to your instructor you are probably going to be told to go to the literature. So you learn to not even go that route (Deb, interview #1, Lines 872-882, p. 20).

3. Waiting for an event or stimulus that will help the individual (in this case the student) to move forward.

   For one student, her brick wall was represented by anxiety that was a result of her feeling like an imposter. The stimulus to help her move forward was to read an article on the imposter syndrome. This article helped her to realize that the anxiety she was feeling was what other students were experiencing and that it was normal. Reading the article helped her to cope:

There needs to be more that we can read about ourselves as nurse practitioners to try and figure out where we fit and I think this can very much help people just like the article, the imposter article that I read again yesterday because I needed that reinforcement of other people feeling this way. I think that is what my hope for this would be is that some nursing students are going to look at this and go this is what might happen to me or this is what my experience might reflect (Sheri, interview #2, Lines 1018-1027, p. 24).

4. Dealing directly with the metaphorical brick wall to help alleviate their discomfort. One nurse practitioner student encountered her brick wall when she had to educate her colleagues regarding her changing role from bedside nurse to the nurse practitioner role:

   [How I went about educating my colleagues was] I literally emailed them the nurse practitioner description … and then because of course we also started our working group months before we opened our clinic, so each time we met we also talked about how our clinic was going to work and how each of our roles were going to work in that clinic. So they knew what an RN would to. They did not know what a Nurse Practitioner would do but it was also what would a nurse practitioner do within this clinic? So it was this is how the nurse practitioner is different from a registered nurse (Janet, interview #2, Part B, Lines 1279-1290, p. 32).

In addition to these strategies, disjunction may also be managed through the enlisting of classmates, also known as the support system *communitas, as*

previously discussed. Indeed, relying on and seeking advice and help from other nurse practitioner students and preceptors, both past and current, may help nurse practitioner students to effectively work thorough disjunction and troublesome knowledge. Continuing along with the theme of disjunction, CBL was found to contribute to the disjunction. For example, CBL may encourage students to shift away from linear learning and instead move towards a more problem management style of learning. This approach can be an unfamiliar approach for most adult learners. This style of teaching and learning stipulates that students use procedural and personal knowledge that requires them to engage with strategy or moral dilemma problems (Savin-Baden, in Meyer & Land, 2006).

Faculty also reflected disjunction, especially if the student entered the program without prior experience. One faculty member noted:

> First of all this is advanced practice, so to me you are not coming to this setting and this clinical setting to relearn things that are from a basic program. I have this array of students, some who have been absolutely brilliant in many ways and also highly skilled and I have had some strugglers…sometimes people come into the NP program expecting to have a career change, so they have been outside the clinical arena for some time and want to get back into clinical practice so they bounce themselves into a NP program. If you are not practicing skills, they erode, and those are the students that I have seen struggle (Lila, interview #1, Lines 227-237, p. 6).

Similarly, a nurse practitioner student explained how difficult it was to make the transition from the role of registered nurse to nurse practitioner without prior nursing experience:

> If you are not confident in yourself as a registered nurse and do not have a lot of experience as a registered nurse it would potentially be a very difficult transition to a nurse practitioner (Sylvia, interview #1, Lines 649-650, p. 16).

As analysis of the data progressed, it was found that disjunction was often accompanied by or associated with feelings of frustration. One student expressed it this way:

> If you do not have a lot of expertise to draw on, people really struggled with what do I do with that [NP] role (Janet, interview #2, Lines 251-252, p. 7).

In addition to feelings of frustration, participants also experienced disappointment. One faculty member noted that she was disappointed when students were not prepared for their preceptorship experiences:

> My expectations for the student are that she or he is prepared for the preceptorship experience. In other words, that she or he will go out with the skills and abilities having practiced the skills and abilities that they need in order to actually interact with the patients. I have sometimes been disappointed with that piece (Sue, interview #1, Lines 59-68, p. 2).

Let us now revisit the notion that CBL can constitute troublesome knowledge. One nurse practitioner student described being instructed using a CBL focus that proved frustrating and ultimately troublesome. She observed:

> CBL did affect me because even though you had the textbooks, I know that what you read in a textbook does not always translate out into what you do in clinical practice. So when I had a question and the response from the instructor was well go look it up, well, I can look it up and I can find various opinions on it but I want to know what is done in practice within my region, and they [faculty] were unable to answer that (Deb, interview #1, Lines 140-150, p. 4).

For this student, CBL proved troublesome, especially when faculty could not answer her questions.

Participants who engaged in a CBL-focused program could experience disjunction and frustration, both of which lead to troublesome knowledge. Another student further explicated the phenomenon by observing when the CBL pedagogy was poorly understood by students, faculty members needed to provide students with guidelines addressing specific expectations. One student stated:

> I come from a more formal teaching setting and experience and I was used to that [manner of authoritative teaching]. I just think when you get to this level of knowledge that you need to be provided adequate guidelines to know what we were supposed to learn and to know what was going to be important for this group (Sheri, interview #1, Part A, Lines 679-692, p. 17).

This student noted that when engaged in learning at the more advanced level, they expected faculty guidance, for example, assigned required readings.

In this next section a discussion will occur addressing how the student traverses the various dimensions of preceptorship. Up to this point, I have analyzed and discussed the theme, Working Through the Rites of Passage. Within this theme there were found three sub concepts, two of which included prior professional identity and cognitive dissonance. What remains to be discussed and analyzed is the third sub theme: making their way through.

Making their way through. Subsumed in this aspect of the process were the following: (a) having time; (b) engaging in collegial interactions; (c) role confusion; (d) being a student; and, (e) learning the role.

***Having time*.** According to Yonge et al. (2005), 'time' plays a role in the effectiveness of preceptorship. In fact, these authors propose that time is the biggest hurdle for students, preceptors and faculty members to overcome in this professional relationship. The issue of time was found to be equally significant to this study. To illustrate, the data demonstrated that appropriate time was crucial to the preceptor, the student and the faculty member's each being able to make their way through the preceptorship experience. One student described this aspect of the process in the following way:

> I find the preceptors do not have time to really thoroughly read [preceptor preparation package] and kind of question what that might mean for implications for their own practice in taking on a student and so the first

> practicum I kind of felt like I was waffling through it and my preceptor was waffling through it (Deb, interview #1, Lines 43-54, p. 1).

Similarly, a nurse practitioner–preceptor noted how uncomfortable she was not having enough time to interact with the student and often this was due to her heavy workload. She stated:

> Unfortunately workload really impacts that quite significantly actually such that some days you just never really feel like you are giving enough to the student, that you are probably overlooking something… workload really greatly impacts [the time I can spend with a student] because it does not seem like you ever have enough time for them (Sibi, interview #1, Lines 64-80, p. 1).

Corlett (2000) provides further support that preceptors often have "difficulty in finding time to build an effective relationship with students because of their workload" (p. 500). Coates and Gormley (1997) also indicate that a lack of time spent with students has the potential to hinder preceptorship. According to this preceptor, the ideal situation would reflect having time built into her work day in order to accommodate the student:

> For me it is not the ideal [how the preceptorship experience is currently organized]. It is not the way I would like to do it but it is the means that we have right now. I would like to see things change. I would like to see nurse practitioner students precepted with nurse practitioners. I would like to see time built into the workday to accommodate the students' needs to

> very much recognize that they are in a student role and as a student you need constancy, reassurance (Sibi, interview #1, Lines 279-281, p. 7).

This notion of having time built into the preceptorship to accommodate the student is supported by Tanner et al. (2003) and Yonge et al. (2005).

Another aspect related to time, which was identified by a faculty member, involved what she regarded as being spread too thin. She stated:

> Student learning is affected when there are not enough faculty to teach and not enough preceptors to take the students. Student learning is certainly affected when we are spread too thin. We just do not have the time that we would want to devote to the students to be in all places at all times, and be able to do everything in a timely manner (May, interview #2, Lines 466-480, p. 12).

Corlett (2000) also notes that preceptors must have time to spend with students in order to facilitate their learning. A preceptor mirrored this premise and spoke of the importance of preceptors having time to provide educational support:

> It is important for the preceptor to have enough [time] for providing the educational support that the student may need within their program as well as what needs to occur within my own workday. Because in every workday you have meetings as well and multiple tasks. And making sure it's going to work for both because you hate to waste each other's time. (Gina, interview #1, Lines 32-40, p. 1).

While having time was found to be important to students making their way through, engaging in collegial interactions were also deemed important to

students as they worked their way through the preceptorship. Strategies to accomplish this could include the preceptor (A) introducing the student to colleagues while attending meetings, group rounds, or serendipitously; and, (B) ensuring the student is included in all teaching-learning opportunities found within the practice setting or larger health care community.

Engaging in collegial interactions. In the literature regarding preceptorship and the literature regarding nurse practitioners, the importance of students establishing collegial relationships with peers, colleagues and other members of the health care team is explicitly noted (Kaviani et al., 2000; Kleinpell et al., 2002; Myrick et al., 2010; Myrick et al., 2005; Robeson, 2009). As demonstrated in the data, it was the extent to which students engaged with others that in part affected how they made their way through the preceptorship. It was found that students, preceptors and faculty alike were actually aware of the importance of building and maintaining relationships with other health care professionals. It was the ability of students to build such relationships that would, to a large extent, help determine the success of the preceptorship (Cook-Sather, 2006). It was found that students not only engaged in collegial relationships/interactions with each other, but they built relationships with other health care professionals, as well.

Students in this study described a phenomenon that helped to illustrate the importance of collegiality whilst engaged in preceptorship. Turner (1969) describes this phenomenon as *communitas*. Essentially, for this study, communitas comprised a group of like-minded individuals-in this case students-

who fostered relationships with each other as a means of securing emotional and psychological support. This support was necessary for these students to navigate the liminal space. This collegial relationship afforded students a safe environment in which those involved could provide support each other. As one preceptor noted, communitas fostered collegiality. She stated:

> I think that students foster a lot of relationships amongst their colleagues as experts. They know that they can tie into them and some will develop friendships out of it. But students tend to foster relationships with their co-students that go lifelong and so it is almost like a little subculture but it follows along for them and then they have another network to share their growth and development (Preceptor 1, #3, Lines 938-947, p. 22).

A student provided further support as to the importance communitas played in the preceptorship. She stated:

> One of the most supporting things for me getting through the program were my classmates and working though the journey together and sharing our frustrations and our joys of when things went well, being able to share that with our colleagues so that we could all learn from it (Nurse practitioner student 02, #2, Part B, Lines 196-201, p. 5).

A faculty member acknowledged the importance of students supporting each other as colleagues. She stated:

> I think the students support each other quite a bit, because they come together every week for a three-hour period. At the beginning of class and at the end of class there are always dyads and triads and small groups

> chatting about their clinical practice…they certainly use each other as support a great deal and that is good (Faculty 3, #3, Lines 657-668, p. 15-16).

Students also built relationships with other health care colleagues, such as physicians. One faculty member started:

> Students need to be able to work with physicians. They need to understand that world so that is not a problem. Students need to be able to communicate in a way that their colleagues understand (May, interview #2, Lines 178-180, p. 5).

A preceptor addressed collegiality, but through a different lens. Rather, she noted the importance of faculty having more contact with preceptors, which in turn strengthened the relationship of this triad and made the faculty member more visible in the practice setting:

> I think that the faculty needs to have more contact with their preceptors on a face-to-face basis so that they actually know the people that they are sending their students to, because I think that could go a long way for dealing with some of the issues. If a preceptee is not happy with their preceptor or a preceptor is not happy with their student, I see the faculty member as being kind of that bridge between the two but you can not necessarily have the bridge if you do not know the players in the game, so I see that as being key, is the faculty knowing the people that are involved (Sibi, interview #2, Lines 282-293, p. 7).

A positive effect of building collegial relationships was its contribution to student confidence. With such confidence students were then better able to embrace the nurse practitioner role. A student illustrated the importance of being a confident student. She stated:

> The primary care experience was amazing. I had the most wonderful pediatrician and a GP that I was able to work with. They increased my confidence greatly, they started then bouncing ideas off me, we had lots of times where we would all shut the door and go, what do you think? I was very much respected in the clinical area by all of the people I worked with…The pediatrician learned from me just as much as I learned from her (Sylvia, interview #1, Lines 252-265, p. 6-7).

A faculty member illustrated the importance for students to actively engage in the preceptorship with colleagues, and to become engaged helped to ensure self-confidence. The faculty member noted:

> Part of your role as faculty is to help the students develop confidence in their own skills and abilities, and part of that is making sure they are out there practicing, they are not watching, they are practicing and while in the classroom they are actively engaged in the process, rather than just listening (Sue, interview #1, Lines 347-353, pp. 8-9).

Establishing collegial relationships was found to be a crucial component to students successfully making their way through the preceptorship. In fact, many of the established relationships continued long after the finish of the preceptorship. These longer-term relationships were identified as what Turner

(1969) described as communitas. These established relationships helped to provide those involved some semblance of role clarity.

Acquiring role clarity. According to Myrick and Yonge (2005), the successful formation of the student-preceptor relationship is one that is based upon respect and confidence. This connection allows each the freedom to interact, discuss and share knowledge. Essentially, then, the preceptorship relationship is a vehicle whereby the student is guided by the preceptor to make her/his way through the liminal space. Preceptorship can be, thus, an excellent and safe venue through which the student can gain confidence and competence in preparation for professional practice.

Prior to these registered nurses engaging in the student role, each would have described themselves as confident, professional and expert in their fields of nursing. They would have been described similarly by colleagues. Yet, upon assuming the student role, these participants soon found their levels of self-confidence beginning to wane. According to Turner (1969), while students navigate the liminal space they often experience a lack of self-confidence, at least initially. Compounding this was the potential for role confusion as a consequence of being precepted not only by nurse practitioners but also by physicians. In this study, self-confidence was often found to be influenced by whom precepted the student. Students were precepted by both nurse practitioners and by physicians. Regarding nurse practitioner as preceptor, participants acknowledged that students who were precepted by these professionals benefited the most in terms of

appropriate role modeling and being socialized to professional practice. One faculty member asserted:

> Actually students who have had both [nurse practitioner and physician] say they have learned much more from their nurse practitioner than from the physicians, and they are functioning in the nurse practitioner roles, so they get socialization, but they also get what they need in relation to assessment and diagnosis and treatment decisions as well, because those individuals are making those decisions. So, from my point of view that is usually a richer experience for the students (Sue, Interview #1, Lines 226-36, p. 6).

Further support was provided by another faculty member who advanced the opinion that students should be precepted by nurse practitioners, as these practitioners serve as role models. The faculty member stated:

> A nurse practitioner has a nursing perspective on practice and is able to offer a deeper understanding of the role and role model how a nurse practitioner works, how they would approach things in a broader, more holistic perspective (May, interview #2, Lines 157-161, p. 4).

Yet another faculty member noted that students ought to be precepted by nurse practitioners as this allowed students to become grounded in advanced practice rather than the practice of medicine. She stated:

> Physicians are being used [to precept nurse practitioner students] but [it is imperative to ensure that] these students have exposure to nurse practitioners because my worry is that the students get grounded in

> medicine versus grounded in nursing. (Tracy, interview #1, Lines 861–867, p. 21).

A preceptor mirrored the belief that students ought to be precepted by nurse practitioners, otherwise there is a concern the students might assume a physician assistant role. She stated:

> What I am seeing is that a nurse practitioner preceptor is a very important piece of a nurse practitioner student becoming a nurse practitioner in a nursing model. So in programs that do not have nurse practitioners as preceptors, I would be concerned that they [students] were going to fall into a physician assistant role (Sibi, interview 2, Lines 740–746. pp. 17-18).

Helping people to make a transition towards a sense of mastery involves the acquisition of knowledge and social support systems (Fraser, 1999; Hilton, 2002). For students to progress in the program they must master fundamental advanced knowledge that includes history taking, physical examinations of patients/clients, differential diagnoses, and treatment choices. The data are clear about the role the preceptor plays in the student's mastery of this knowledge, as it is clear that for those precepted by a nurse practitioner, it is that professional who provides significant nurturing and guidance during the preceptorship experience. However, for those students who availed upon the services of the physician preceptor, they, too, stated the physician provided valuable opportunities for learning skills but not the important role modeling that nurse practitioners offer. A faculty member commented upon the benefit of having a physician as a preceptor:

> The pulling together, the history and integrating it and applying it and coming up with a diagnosis. I think the confidence in terms of doing that and I am sure it helps them to apply the information they are reading about in the textbooks. Basically the physician preceptor gives them the opportunity in a supportive environment to actually apply it (Jen, interview #2, Lines 202-2113, p. 5).

Another faculty member noted that even though students were precepted with physicians, at some point in the experience students must be exposed to nurse practitioner preceptors:

> Physicians are being used to precept students but [it is important to ensure] that the students have exposure to nurse practitioners because my worry is that they [become] grounded in medicine versus grounded in nursing. And I have heard that on a few occasions from the nurse practitioners (Tracy, interview #1, Lines 861-866, p. 21).

The literature relating to nurse practitioner preparation acknowledges the importance of nurse practitioners precepting nurse practitioner students for professional practice (Amella, Brown, Resnick & Behler McArthur, 2001; Donnelly, 2003; Goolsby, 2000; Hart & Macnee, 2007; Stark, 2004; Tanner, Pohl, Ward, & Dontje, 2003). Furthermore, this literature notes that nurse practitioner preceptors structure ideas and interpret information in a different way from the strict biomedical model (Baumann, 1998). This proposition is supported by a preceptor. She observed:

> I see benefits to both, physician as preceptor and nurse practitioner, as preceptor. But what I am seeing is that a nurse practitioner preceptor is a very important piece of a nurse practitioner student becoming a nurse practitioner. Therefore, in programs that do not have nurse practitioner preceptors, I would be concerned that they were going to fall into a physician assistant role (Sibi, interview #2, Lines 740-746, pp. 17-18).

The belief that it is crucial for nurse practitioners to preceptor students resonates throughout the data; however, the current reality of the teaching and learning setting for these students is such that there often is a paucity of nurse practitioners to serve as preceptors so, instead, physicians are asked to fulfill that role. A nurse practitioner preceptor noted that students could benefit from being preceptored by a physician:

> A nurse practitioner student can learn very well from a physician about homing in on a diagnosis and how to treat that and how to intervene on that and depending on the physician, it can be quite limited to that (Sibi, interview #2, Lines 62-69, p. 2).

Yet, even though the literature makes a valid point that the optimal preceptorship experience involves the student being precepted by a nurse practitioner, there are scholars who propose that students can still receive valuable preceptorship experiences from physicians who are receptive to nurse practitioner students (Wallace Stark, 2004). A student supported this proposition:

> I certainly had a very knowledgeable preceptor but again not a nurse, so it was a different knowledge base. So more the medical model rather than a

> nursing model but certainly she helped guide the teaching and learning process (Janet, interview #2, Part B, Lines 871-875, p. 22).

Patterson and Hezekiah (2000) propose that advanced nursing practice calls for expertise in blending the knowledge of nursing with knowledge from medicine and other disciplines.

While it was found that the nurse practitioner-preceptor was preferable, others also acknowledged the contribution that physician-preceptors provided to preceptorship. One preceptor noted it was also beneficial for students to be precepted by physicians. She proposed that students benefited from this relationship because it enabled them to hone certain sets of technical skills such as history taking, physical examination and determining a differential diagnosis. In other words, being precepted by a physician afforded students opportunities to focus on different sets of skills, which in turn helped to increase the confidence levels of these students.

Lending further support for physicians serving as preceptors, one faculty member noted how a physician–preceptor provided excellent learning opportunities for the students. She stated:

> I am thinking of a couple of physician–preceptors that I think are absolutely wonderful and they love teaching and they invest a lot of themselves and their time and energy into looking for learning opportunities [for the students]…and they are actively looking for ways to impart knowledge…and you can just see they love teaching (May, interview #2, Lines 282-290, p. 7).

As these students made their way through the preceptorship experience, they engaged in establishing collegial relationships and role clarity. Equally important for students was to understand the importance of being a student as they navigated the liminal space.

Being a student. The findings from this study helped to determine that learning in the student role provided opportunities for questioning those involved with preceptorship, establishing the commitment of the preceptor, and understanding the process of guiding that preceptors provided for the students.

Myrick and Yonge (2005) note the importance of the preceptor's use of multiple types of questions to foster the critical thinking ability of students; however, equally important is the opportunity (being encouraged) to question the preceptor and others involved in the preceptorship. The opportunities to question those around them help these students to synthesize knowledge, skills and concepts that are important for their professional practice. One student noted the importance of being able to unconditionally question while engaged in the preceptorship experience. The preceptorship literature is replete with research noting that the 'job' of a student is to question and learn while engaged in the preceptorship relationship. It is the role, then, of the preceptor to model professionalism and to nurture the student through encouragement of the learner to ask questions. As noted by one student, it is important for students to:

> Learn and ask questions, so why not expose yourself to as much as you can and not be afraid of the exposure to everything because you are not expected to be the one with the whole responsibility. You are still the

> student and it is your opportunity to be involved and to question, but still know that at the end of the day you are still talking to your preceptor, reviewing everything (Janet, interview #1, Lines 202-13, p. 5).

Another student leant support to the assertion made above by stating:

> I think the benefit of the student is that you do not know everything. You can ask the questions (Sylvia, interview #1, Lines 159-161, p. 4).

It was found that not only was it an expectation that the student actively engaged in the learning environment through questioning those involved with the preceptorship, but there was also an expectation that the student be provided with appropriate opportunities to learn (Myrick et al., 2005). A student commented on this expectation of learning while involved in preceptorship, as follows:

> My expectations were that I would be allowed the opportunities to learn. To be responsible and to ask the questions, to be able to bounce off ideas regarding the differential diagnosis, to be allowed to make mistakes and to learn from those mistakes. Be allowed some independence yet have a backup there available for me. To receive feedback (Sylvia, interview #1, Lines 239-247, p. 5).

Another student noted that another role the preceptor assumed in the preceptorship was that of guide. She stated:

> The preceptor [acts as a] guide. So I never felt that I needed to know everything. I was, particularly with this preceptor, very lucky because if I did not know it, his philosophy was that is what I am here for is to try and

> help [you] figure that out and he is the first person to go and look up information (Sheri, interview #1, PART A, Lines 151-159, p. 4).

An equally important perception of students and their need to feel safe as they asked questions was the expectation that their preceptors allowed the students the freedom to make mistakes and learn from them. Mirroring another student's comments, one preceptor noted the importance of feeling safe in the preceptorship. She stated:

> I actually had a physician for my preceptor when I was doing my nurse practitioner studies and I thought he was very good in that he really allowed me the freedom and the autonomy to go and do my own thing and come back if I had questions. There was that trust that was established and that freedom to go out and make mistakes and …being able to ask any kind of question or being able to say I do not understand how this is important (Kim, interview #1, Lines 542-553, pp. 13-14).

Another student noted the importance of viewing the preceptorship as a safety net because she believed that this was the opportune time for students to question preceptors and colleagues; because, once the preceptorship was completed the safety net was gone. She observed:

> I do not know if everybody sees it that way [as a safety net], but I felt that same way as an undergraduate as well. Take your clinical placement and find as many learning opportunities as you can because you may as well do it while you are a student. See as much as you can because when you

> are finished there is a certain expectation t (Janet, interview #1, Lines 229-235, p. 6).

The multiple dimensions involved in being a student were deemed important to making their way through the preceptorship. It was found that learning the role of the student was equally important in order for students to successfully navigate the liminal space.

Learning the role. Each of the triad in the preceptorship experience—the student, the faculty member, and the preceptor—plays an essential role in the success of the preceptorship experience (Myrick et al., 2005). Think of the preceptorship experience as resembling an intricate ballet, perhaps *Swan Lake*. Each "cast member" (participant) plays a seminal role in the ebb and flow of the "performance" (the preceptorship experience). The nurse practitioner student represents the lead ballerina in this analogy, while the supporting roles belong to the preceptor and the faculty member. Each cast member plays a crucial role in the success of the "ballet." If one cast member falters, then they all falter; if one member performs a flawless ballet move, then the whole cast basks in the applause and adoration of the audience. However, if any cast member is ill-prepared for her or his role, then the success of the ballet is at stake, because for the ballet performance to be a success each member must learn the arabesque, chassé, sissonnes and plié expected of that role.

The same level of involvement and degree of preparation can be said for the students involved in the preceptorship experience as reflected in this study. Just as the role of the lead ballerina is crucial to the success of the ballet, so, too,

is the role of the student key to the success of the preceptorship. With this parallel in mind, a few questions became evident as the data analysis progressed. For example, what are the expectations of the student role? How is the student prepared for her or his role? These are important questions that became evident as a result of analyzing the data. To further explicate student responsibilities while engaged in this 'lead role', a discussion and analysis of student responsibilities emerged.

Key roles of students in this preceptorship experience, which also reflected what Myrick et al. (2005) proposed relating to the learning environment, was that students should be active participants in their teaching and learning endeavour, to arrive at the practice environment prepared to apply knowledge and skills they had learned in the lab and classroom, and to be proactive in pursuing individual learning opportunities (Myrick et al., 2005). As one faculty member noted, students must be 'self-starters' regarding seeking out learning opportunities. A faculty member stated:

> Well first of all I think I expect them to have a sense of what they want to get out of the experience. Have some idea, starting point, and I expect them to then be self-starters in terms of navigating how they are going to make the most of the clinical situation. I expect them to be assertive self-starters and navigate and negotiate with their preceptor somewhat how they are going to capitalize on what the clinical experience is (Jen, interview #1, Lines 51- 63, p. 2).

A faculty member explicitly described the active learning process in which students engaged in while in the preceptorship environment. The language this faculty member used to convey how student learning occurred was action orientated. Words used to describe student learning included *goes in*, *does*, and *reports to*. The use of these action words indicated that the faculty members acknowledged that the practicum was a time in which students actively engaged in and learned/synthesized the required substantive knowledge of their particular specialty area. Furthermore, actively participating with colleagues and the preceptor(s) in those learning environments afforded students opportunities to reflect on how to build their future nurse practitioner practice and what their future roles would be in those practice environments. One faculty stated:

> In the summer, the final practicum is much broader in terms of developing a broader range of skills. There is certainly some component of that; most of them are in the hospital, most of them are linked to a particular program and it is developing in-depth content—substantive knowledge with respect to that discipline, that content area, and thinking about how they would want to build a program from an NP perspective and thinking about what their role would be (May, interview #1, Lines 301-320, pp. 7-8).

Another faculty member described how important it was for students to first practise fundamental skills in a lab, skills such as performing a history and physical examination, and to develop the associated sequencing required to perform the procedure before having to perform the same skill in the preceptorship environment. As this faculty member stated, she wanted students to

be comfortable performing the skill before venturing out in the preceptorship experience, because, according to her, it was not the role of the preceptor to teach the student those basic skills. Rather, it was the role of the preceptor to socialize the student (Coates & Gormley, 1997; Dilbert, & Goldenberg, 1995) to the nurse practitioner role and to afford the student an opportunity to practise those skills on patients within the practice environment. The faculty member described the socialization process this way:

> I want them [the nurse practitioner students] to become comfortable conducting advanced physical assessment, histories and physical examinations. We review all that in class and then they go and practice the skills during the preceptorship. I give the preceptors a copy of the course outline and the expectations, and then what kinds of patients I would like them [the students] to see (Tracy, interview #1, Lines 337-344, p. 9).

Along this similar theme of preparation, Poncelet and O'Brien (2008) reported on the challenging aspects of transitioning from the status of medical student to the status of medical clerk(ship). For example, medical students reported frequently feeling unprepared for specific aspects of clinical practice/clerkship such as writing orders and progress notes. Clerkship directors likewise reported that third-year medical students were not sufficiently competent in important domains such as communication skills, interviewing/physical examinations, clinical epidemiology, and probabilistic thinking. To draw a parallel to the preparation of nurse practitioners, interpersonal and cognitive skills were found to be crucial to their success as well. It was important, therefore, for

nurse practitioner students to also master skills of communication, interviewing/performing physical examinations, and probabilistic thinking while engaged in preceptorship relationships.

In summary, this first phase of the process of navigating the liminal space, students positioned themselves in the preceptorship. Key to that positioning was: a) working through the rites of passage and b) becoming socialized.

There were many important layers through which a student had to navigate while working through the rites of passage. These layers included: a) forming an identity, b) overcoming cognitive dissonance, and c) making their way through. During this initial phase of navigating the liminal space, it was found that these students experienced periods of anxiety and discomfort, which for most, motivated them to engage with fellow students mainly as a coping mechanism, but also as a means of understanding program content. This was a time whereby each student engaged in a period of identity formation. Key to this transition was the engagement of facilitation of students by the preceptor(s) and faculty member(s).

It was found that students also encountered situations that resulted in the experience of cognitive dissonance. In essence, the students and even preceptors experienced a loss of what they perceived as being comfortable for them in their professional roles (Clouder, 2005). These students' experiences of discomfort were found to associate with troublesome knowledge, which essentially indicated that new knowledge could prove troublesome for students', a hurdle that must be

overcome otherwise a student could remain in the liminal space until such a time as he/she embraces a particular concept (Meyer & Land, 2006).

As students worked through the rites of passage, each one identified key aspects of the process that included having time, engaging in collegial interactions, acquiring role clarity, being a student, and learning the role. It was found that having time was crucial to preceptors, the students and faculty members making their way through the preceptorship. Yonge et al. (2005) note that time plays a role in the effectiveness of preceptorship. According to Corlett (2000) preceptors note the difficulty they have to find time to build an effective relationship with students because of workload.

It was found that engaging in collegial interactions was a crucial part of working through the rites of passage. I identified that students not only engaged in collegial relationships with each other, but they built relationships with other health care professionals, as well. Turners (1969) concept of communitas was found to be the appropriate concept to describe the phenomenon in this study whereby students relied on each other as a coping mechanism and as a means of securing emotional and psychological support. This support was essential for these students to navigate the liminal space.

Acquiring role clarity also was found to influence the process. Essentially, while students navigated the liminal space they often experienced an initial lack of self-confidence. Compounding this process was the potential for role confusion as a consequence of being precepted by physicians. I found that the majority of students favoured being precepted by nurse practitioners; however, the students

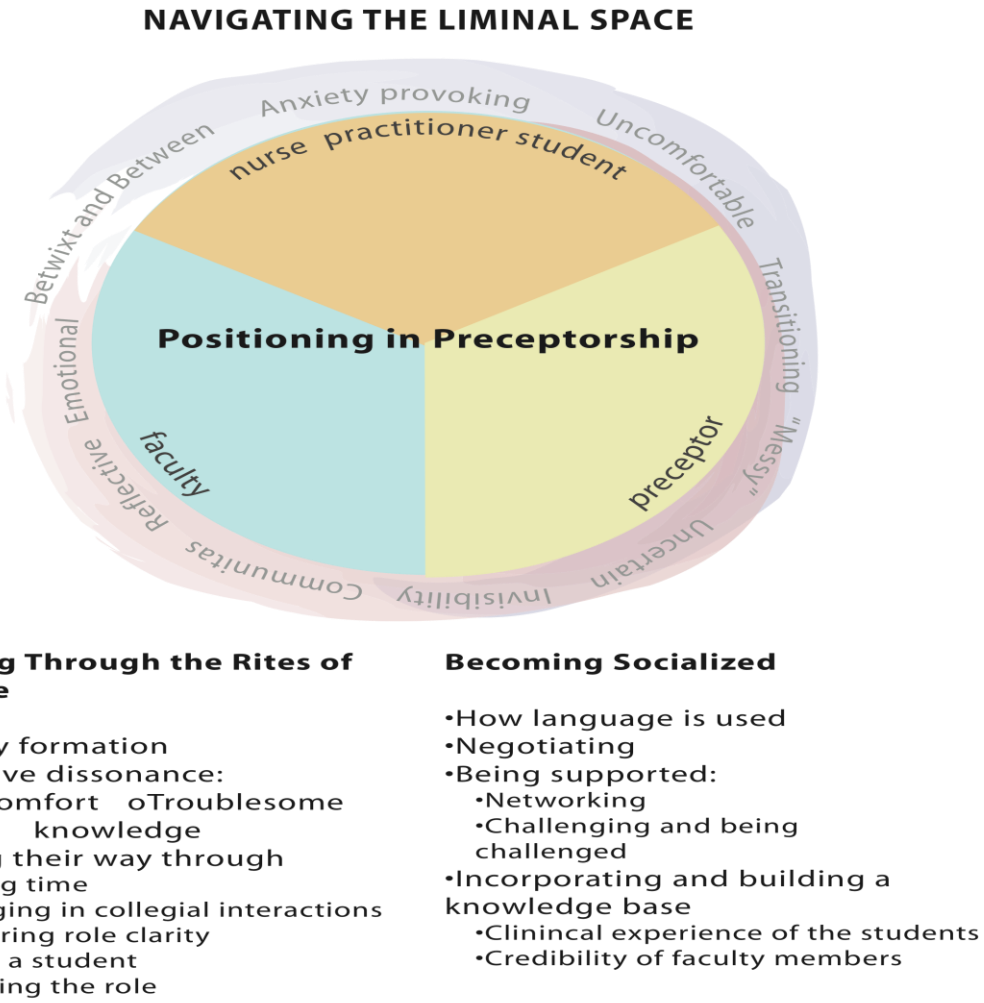
acknowledged there was benefit when precepted by physicians, as this scenario presented them with the opportunity to hone their technical skills such as history taking and advanced physical assessment.

It was found, also, that when students were genuinely recognized as being in the student-learner role, they were found to be better able to question unconditionally those involved in preceptorship. In other words, this preceptorship provided students a safety net whereby they could feel safe and protected in their learner role.

The level of involvement of students and their degree of preparation for preceptorship were key factors in how well they worked through the rites of passage. Myrick et al. (2005) propose that students should be active participants in their teaching and learning endeavour, to arrive at the practice environment prepared to apply knowledge and skills they had learned in the lab and classroom, and to be proactive in pursuing individual learning opportunities. Stated differently, a key role for the student in this study was to be prepared to become actively engaged in the teaching-learning environment. As one faculty noted, students must be ‘self-starters’ regarding seeking out learning opportunities.

When events have communicable meaning, they have marks, notations, and are capable of con-notation and de-notation. They are more than mere occurrences; they have implications. (Dewey, 1925, p. 53)

Figure 3: Becoming socialized



Becoming Socialized

According to Meyer and Land (2003), language itself, as used within any academic discipline, can be a source of conceptual discomfort. They posit that within the academic environment certain ways of thinking occur, including the use of certain language to describe the academic/cognitive/technical skills of students. The data from this study supported this assertion, illustrating that the

language faculty and preceptors use to describe students (Figure 3) can impact the learning environment. This practice of using certain language when discussing students could be construed as labeling and could, therefore, be confusing for students and preceptors at best. Consequently, based upon what Dewey (1925) posited, communicable meaning is more than a mere occurrence. Language definitely has implications. To illustrate, some faculty members, while describing the academic/technical abilities of students, used the following expressive language: *self-starter*, *weak*, *strong*, *struggler*, *exceptional*, and *novice*. The use of this language by faculty has implications regarding the intentions of the message.

How language is used. An educational philosopher from the early 1900s, Dewey noted that language is not "mere agency for economizing energy in the interaction of humans. It is a release and amplification of energies that enter in to it, conferring upon them the added quality of meaning" (1925, p. 53). Key to the genius of what Dewey proposes are the words *intent* and *meaning*. Drawing a parallel with this study, what, then, are the *intentions* of faculty in using specific words to describe students, and what do those descriptors mean? For example, what does the words novice, *weak*, *self-starter*, or *struggler* actually mean to faculty within the context of preceptorship? How does one evaluate for weakness in this level of student? How does a faculty evaluate for the struggler? As one student expressed, she disliked the use of the word novice to describe students. She observed that in her opinion using the word novice to describe students was being compared to being a toddler. The student stated:

> When it is terms like novice, it makes me think of a toddler…It is that kind of connotation when you have got those terms and it is just words. In a way it should not impact how you are doing things but you have those terms that come up, and I think nursing wise, most of us going into the role have many years of experience on the wards or in different combinations…but it does have those connotations (Sylvia, interview #2, Lines 357-378, p. 9).

Along a similar theme, a preceptor brought to light an important point regarding language and meaning, which was that language, conveys meaning. A sentiment Dewey would support. To illustrate this point, the preceptor questioned the use of *self-starter*. She stated:

> Depending on how you use language, it can be very effective or it can also be detrimental. If you say somebody is a wonderful self-starter, what does that mean? They can get themselves going in the day or they are always looking for extra work and they have got a strong desire to learn? (Gina, interview #3, Lines 337-343, p. 8).

Whether intentional or not, use of such language by faculty and preceptors to describe students could affect the confidence of students who were already uncertain of their advanced practice role within the health care team. A faculty member provided an example of how meaning can adversely affect a student's progress in the preceptorship experience. She observed:

> Any of that negative language [*novice*, *weak*, *self-starter* and *struggler*] is bound to translate into decreased confidence and uncertainty in terms of

> competence, whereas positive language I think is much more likely to engender those feelings of confidence and competence. I think there is a definite correlation between them (Sue, interview #3, Lines 553-559, p. 13).

Another student stated that language was powerful, a notion that is supported by Dewey (1925). This student noted that language could affect the confidence levels of students and how students then perform in preceptored experiences. She stated:

> I think language is powerful and it can certainly have the potential to send students out the door more confident or less confident (Sheri, #3, Lines 411-415, p. 10).

From a pragmatic standpoint, then, *how* language was used to communicate amongst peers and colleagues was found to be important. Dewey (1925) notes that communication is an exchange that acquires something wanted. In the case of May, what was wanted was for students to understand the world of their peers (i.e., nursing, medicine) and all the nuances and language used to convey meaning within that discipline-specific context. She observed:

> The nurse practitioner student needs to be able to work with physicians. They need to understand that world so that it is not a problem. They need to be able to communicate in a way that their colleagues understand and appreciate and speak the language. So that is important (May, interview #2, Lines 178-183, p. 4).

A student nicely summed up the interplay between meaning, intent, and the need for clear communication, and the use of explicit language by the triad to convey exact connotation, as she noted:

> I would have used expert rather than highly functioning [to describe a student], but to me highly functioning means expert, and there is the problem, right? How on earth would you be a nurse if you were not highly functioning, so to me it is more the expert. To me, you need to be an expert to come into this role [of nurse practitioner]. You need to be an expert registered nurse and be comfortable in your role as a registered nurse to make that transition. We did not all speak the same language as you can tell by those words so try explaining to a preceptor what we are when we [are confused]. Even the language is confusing to those of us that are within [the role] so trying to explain it to those who are outside [the role] would create a huge problem (Janet, interview #2, Part B, Lines 464-479, p. 12).

Another aspect of functioning within a professional context that was found to be important included the ability of students to negotiate with colleagues, each other, and faculty/preceptors.

Negotiating. There is a paucity of literature addressing negotiation skills within the context of the preceptorship experience and the education of nurse practitioner students. The available literature is broad in nature and addresses communication in terms of the use of language within nurse practitioner education (Jones & Dupree Jones, 1998), communication styles of nurse

practitioners and the impact on patient outcomes (Charlton et al., 2008) and complex communication within the liminal space (Lugones, 2006).

Regardless of the context, when a person begins a negotiation, as a consumer negotiating with a street vendor, as someone who wishes to purchase a rug or as a nurse practitioner student negotiating a patient assignment with her/his preceptor, a successful negotiation requires the use of effective language and communication skills. Within the context of the practice setting, the data supports the notion that a student's ability to effectively communicate is important to a successful negotiation. To illustrate, a faculty member noted the importance of students' negotiation skills and even mentioned that faculty were beginning to talk about including negotiation skills in the advanced practice curriculum:

> [Learning negotiation skills] is a large part of the communication and the whole process is that negotiation to the point where we even talk about including it more in the core curriculum to develop negotiation skills …It is a large part when you are in more of an autonomous role that you are navigating for your salary, for your job description and role development but also in your day-to-day relationships in the interpersonal team that you are working with (Gert, interview #3, Lines 316-329, p. 8).

Another faculty member equated the student's ability to negotiate with political awareness, because from her perspective being politically aware was another means of communicating:

> The students need to negotiate the arrangement of the preceptorship. They need to have that kind of savvy and that kind of political awareness and I

> think that is a way of communicating. That is also just a strategy in terms of negotiating the system—do they figure out the lay of the land and do they figure out how the preceptor is going to prioritize the learners in the setting. I think there is a lot of negotiation that happens and I mean the faculty is hopefully involved in some of that negotiation as well on behalf of the student (Pru, interview #3, Lines 437-449, p. 10-11).

In essence, this faculty member was describing the skill of negotiation as a key communication strategy that students must learn in order to navigate the liminal space. As we know, the liminal space is extremely messy for students, a place that provoked anxiety and afforded these students much discomfort. So, when students were able to use negotiation to effectively navigate the liminal space, they were then able to cross the threshold and enter into the post liminal space.

Another important dimension to negotiation was found to include the need to view this skill with the bigger picture in mind. As a nurse practitioner noted, "you have to learn how to negotiate the bigger system, of how to get patients through the system, how to negotiate responsibilities, coverage, all that kind of stuff and it is within an advanced role" (Sylvia, interview #2, Lines 512-518, p. 12). When a student became a licensed nurse practitioner, if she or he did not know how to effectively negotiate either for her or his needs or the needs of the patient, then problems could occur. Even students who were unprepared to negotiate might not be placed in appropriate preceptorship experiences, as one preceptor observed:

> So there might be a competition for experiences, for patient care experiences so it does require a certain level of negotiation so that everybody gets a fair shot at those experiences. I guess I would say that that is something that we see on a daily basis and the preceptee will have to lean to do that when they are a full-fledged nurse practitioner. It is something else to see the nurse practitioner preceptor doing on behalf of the preceptee in terms of navigating some of those experiences so that everybody gets a fair share (Sibi, interview #2, Lines 135-144, p. 4).

A key point in this quote is that the preceptor negotiated on behalf of the student. This activity was deemed to be crucial for the student to witness because by witnessing the negotiation, the student observed the preceptor role-modeling one aspect of the nurse practitioner role, which was of course the skill of negotiation. This aspect of negotiation was also found to include another important dimension of professional practice, which was the necessity of students being supported by preceptors and faculty members alike.

Being supported. The preceptorship literature is very clear in terms of how important a supportive environment is for the students within the preceptorship experience (Myrick & Yonge, 2005; Yonge, et al., 2005). If the environment was not supportive, however, the preceptorship experience could potentially fail. Stark (2004) also asserts that faculty ought to provide support for physician preceptors if the preceptorship is to work. Allen (2002) conducts a research study where the findings indicate preceptors require faculty support, even if the support is in the form of a phone call. Ferguson (1994) supports this

assertion. Linked with this notion of support, then, were found to be the following attributes or concepts: the ability to teach, to role model, and to network; and, the idea of communitas, and challenging the student/preceptor. One faculty member noted the importance of support in the context of student transition, as follows:

> It is such a key element and you listed off a few areas of what that support might be and look like but as you are maybe finding out, I think it is probably another ripe area really to get at how can we support the student in this transition? We talk globally about wanting, needing support but what is it really and how do we build that into the program I think is a key issue (Gert, interview #3, Lines 350-358, p. 9)?

This faculty member noted an important point, which was how do we build support into the program. In other words, what this faculty member asked was how can we prepare faculty for the preceptorship experience, but more importantly, how can we prepare faculty to provide support for students? Again, this faculty member questioned what *support* really means, at least from the viewpoint of this Faculty of Nursing, and then how that support can be communicated to all involved parties. Yet, it was not only the support for the student population that was important. Support for the preceptors was of equal importance, as illustrated by Myrick (1988) who proposes that preceptors require just as much support as students, and that preceptors ought to be precepted. This outlook was demonstrated by the following faculty member:

> I suspect some of that might be amenable if we had some kind of coaching or mentoring for the preceptors themselves so that they actually did not

> have to sort of go through the dark and learn these things, to have some kind of workshop for them so that they get that familiarity or some kind of formatting whether it is written you know here is what students should be capable of doing. I think they need that kind of background on the students but I mean experience always helps too. I have always thought you can always tell a teacher. There are just some people who are wonderful teachers and you can see that they have a gift (Lila, interview #1, Lines 200-216, pp. 5-6).

This faculty member appropriately noted that preceptors must also be provided support from faculty (Hetzel Campbell & Hawkins, 2007). Faculty can provide this support to the preceptors by communicating the role in such a manner that preceptors not only assimilate the knowledge quickly (Yonge et al., 2005), but also practice applying it in a safe environment. These preceptors can have the opportunity to practise their role through established preceptorship conferences offered at a Faculty of Nursing at the undergraduate level.

Not only do preceptors and students require support, but so, too, do faculty members. A faculty member has an obligation to facilitate the learning of students to the best of her or his ability, but this task can prove insurmountable if the faculty member lacks the ability to teach. What is important for the faculty to realize is that there are avenues that can be accessed within the academic setting that will provide guidance and knowledge regarding pedagogical theory and philosophy. Tracy noted the importance of adequate teacher preparation:

> I think it would be important to prepare clinicians if they are going to be involved in teaching or prepare faculty to make sure that they know how to teach (Tracy, interview #1, Lines 896-899, p. 21).

Another key dimension involved in the support of students also involved the preceptor actively communicating with the student even before the practicum had begun. As Preceptor 01 noted, communicating with the student even before the practicum began helped to avoid a lot of miscommunication and misunderstanding. This approach also demonstrated to the student that the preceptor was willing to provide active support. In essence, this 'pre-communication,' if you will, demonstrated a willingness by the preceptor to begin establishing a collegial relationship with the student, as demonstrated by the following observation:

> Everybody learns differently. So that is why I like to meet with the student ahead of time now and get to know who they are, how they communicate, they can understand how I communicate, so we can overcome barriers as quickly as we can in the beginning of the experience. And then if somebody does have limitations in their clinical skills where they need more support, knowing that up front you can change your timing or expectations. So that you are supporting them more (Gina, interview #1, Lines 82-91, pp. 2-3).

Another dimension noted in the data relating to support and communication revolved around the preceptor's ability to accurately determine the progress of the student. For example, a supportive preceptor could determine

if a student was asking for help at the appropriate times and/or stages of evolution; if a student was experiencing challenges, then a preceptor who communicated with students could solve problems in a timely manner and determine why a student is not communicating at all. As Glaser asks, "What is actually going on?" A student remarked on the preceptor's need to be aware and her or his ability to then effectively communicate with students:

> I think it is the preceptor's ability to gage where you are at as well. It comes back to the communication and navigating but their recognition of your progression as a learner for the most part you would think we would be seeking to increase our experience and expand as early as we can but the preceptor being able to recognize if you are not asking for help…and being able to guide so that you are not left pushing yourself too far where you maybe do not need to be at and getting into trouble (Sylvia, interview #2, Lines 177-189, pp. 4-5).

As previously mentioned, the ability to teach was an important skill for the preceptor to master or, at the very least, to grasp. There are, however, two common misconceptions that any nurse can be a preceptor and that any nurse can teach (Coates, & Gormley, 1997; Finger & Pape, 2002; Kaviani & Stillwell, 2000; Usher, Noland, Reser, Owens, & Tollefson, 1999). These statements can be challenged, as noted by faculty member 07:

> Many disciplines I think go by the notion if you have expert knowledge, willingness to share and advanced skills that these attributes automatically make you a good teacher, but there is a whole discipline that focuses just

> on developing educators, so we are in some ways straddling a couple of disciplines, are we not? But I think it would be great if every discipline, such as nursing, has in it some elements of teaching and learning. So knowledge of those and it would require maybe a workshop (Jen, interview #2, Lines 290-300, p. 7).

Linked with the perspective that being supported is an important dimension involved in communication, the ability for students to network was also deemed by the data to be equally important if the student was to successfully navigate the liminal space.

Networking. In this study, networking was found to be a valuable skill because with it students could grow as professionals, prosper in their practice settings, and effectively translate knowledge to those settings, including translating for colleagues the roles and responsibilities of the nurse practitioner. According to Robeson (2009), who discusses networking within the context of public health, networking involves interconnection of individuals, groups or organizations within a specific domain of knowledge and practice that interact socially and share knowledge with others to achieve a common goal, which in the context of this study involved students achieving the status of new nurse practitioner. Furthermore, Robeson (2009) proposes that networking is particularly valuable for sharing tacit knowledge and enabling its adaptation and implementation in a local context, an outcome these students hoped to achieve.

Networking enables knowledge sharing across organizational, sectoral and geographic boundaries. In addition, networking can legitimate that knowledge,

promoting adaptation and local understanding/implementation (Robeson, 2009). This point was crucial because it was found that all students/new nurse practitioners endeavoured to effectively educate their colleagues about the nurse practitioner role, and through such networking, this collective understanding was possible.

According to Robeson (2009), the opportunities for learning and development offered by networking could help individuals perform their professional roles and develop a sense of belonging, which in this study also afforded students a sense of appreciation for the networks/relationships that were made. One student observed:

> One of my preceptors who was only a preceptor in my final practicum, one of the things she said to me when I was done was you can call me anytime and I think that is the highest regards as a colleague, when you are new at something. They also recognize that being new at anything, you always seek resources. So I think it really resonates. I think that I am very thankful for the relationships I made both with preceptors and with my fellow students (Sheri, interview #2, Lines 907-919, p. 21).

This quote helps to illustrate the significance of networking and support within preceptorship. Her words make explicit how thankful she is for the support and relationships she has fostered with preceptors and her fellow students.

A faculty member commented upon the importance of students establishing collegial networks amongst themselves. This faculty noted she observed students who established those networks and how comfortable those

students were with each other. She also identified the need for the Faculty to foster collegiality amongst students. She stated:

> Developing collegial networks is important. The more they can [interact with each other in class], the more comfortable I think they are knowing each other's strengths, and developing some collegial networks so that when they actually get out into practice, they have people that they can access if they need help. So I think the more we can foster that in the program, I am sure the better (Sue, interview #3, Lines 164-172, p. 4).

As noted above, the benefits of networking are many for individuals and organizations. For example, becoming socialized through networking can facilitate the development of and access to expertise, mechanisms to share knowledge, and to enable reuse and reapplication of knowledge (Robeson, 2009). While networking tended to prove beneficial, there could be a potential downside regarding the sharing of power, for example, the prominence and power of some members could become distorted by such variables as the roles they assume, the network structure or the network leadership (Robeson, 2009). This distortion of power could enable certain members to use power abusively to manipulate other members, create closed networks or silos, and enhance their own or another's status (Robeson, 2009). Interestingly, it was found in this study that students, preceptors and faculty members alike described the concepts of 'power' and 'empowerment' within a positive framework. A detailed discussion of power and empowerment will occur in the section entitled *Becoming Affirmed*.

With this information in hand, let us now explore at the micro level the concept of networking through the lens of the nurse practitioner students, but even before this occurs let us determine, for curiosity's sake, how many results pertaining to *networking* occurred in a library search conducted using the following parameters: access the NEOS data base at the university involved in this study, then typed the term *networking*, highlighting the term *title*. The result of the search yielded an astounding 1,004 titles**.** The disciplines represented in the results of the literature search included the following: nursing and public health, education, computing technology, business management, (software and artificial intelligence) engineering, as well as communication sites, such as social networking sites *Twitter*© and *Face Book*©, to name a few. This literature search served to illustrate that networking is prominent within all disciplines and within all levels of society.

Given the composition of these students' demographics, networking is typically a part of their everyday lives, and in this age of technology, networking can be as easy as picking up their mobile phone. This student demographic typically represented a population that was used to communicating on handheld devices such as smart phones and personal digital assistants and Internet cafés. In essence, these students were hard-wired into the global community and could access any kind of information at any time, and communicate with anyone at any time. It was found to be important for these students to establish networks, whether with colleagues, preceptors, friends and other students. Equally important for students to become socialized to professional practice was their need to learn

how to collaborate and network with colleagues, other students, and preceptors. According to Myrick and Yonge (2005) it is important for preceptors to role model for students the skills of collaboration and networking, because doing so affords the student the feeling that he/she belongs and is welcome by colleagues. In addition, Kleinpell et al., (2002) note that networking has the potential for fostering and expanding professional practice, which is the ultimate goal for the successful student and nurse practitioner.

A faculty member noted that students who acknowledged the importance of actively engaging in networking and establishing networks were typically the students who succeeded as nurse practitioners and continued to grow:

> Those that acknowledge [the importance of networking] and acknowledge and realize that it is a continuous process start developing those networks for continued learning and can navigate, etc, all those previous things. Those are the ones that if you want to label it success, will continue to grow and develop and sort of empower themselves (Gert, interview #3, Lines 547-555, p. 13)

As Robeson (2009) points out, it is important to establish networks for many reasons. For nurse practitioner students, effectively networking with colleagues was important for them to feel accepted within the practice setting and respected by those colleagues. Networking was also an effective use of time because not only were these students using the skill of networking to learn from experts the roles and responsibilities of the nurse practitioner, they were also educating and acting as ambassadors to those colleagues about the nurse practitioner role.

A student noted the importance of establishing networks with colleagues and fellow students that often continued long after graduation:

> We have learned I think by the time you finish your last practicum to not really expect too much. By that time you have learned that if you go to your instructor [faculty member] you are probably going to be told to go to the literature. So you learn to not even go that route [and ask the faculty member]. If I were telling a student who was coming up behind me I would say you are probably going to be able to expect that you have built networks that you can count on and that will probably continue long after you finish your program (Deb, interview #1 , Lines 872-882, p. 20).

A major form of networking that occurred in this study was found to be communitas, or the intentional coming together of students for the purpose of informal professional/social support. From the perspective of one preceptor, such networks were an important aspect of student life because each student within the community benefited from the support of the group and benefited by engaging in discussions about the nurse practitioner role. One student observed:

> I think that the students foster a lot of relationships amongst their colleagues as well, like their classmates…They tend to foster relationships with their co-students that go lifelong and so it is almost like a little subculture but it follows along for them and then they have another network to share their growth and development with (Gina, interview #3, Lines 938-947, p. 22).

Another student supported this observation about the importance of having a network of classmates who supported each other and who also shared experiences that ultimately helped each other learn and grow professionally. She stated:

> One of the most supportive things for me getting through the program was my classmates and working through the journey together and sharing our frustrations and our joys of when things went well, being able to share that with our colleagues so that we could all learn from it (Janet, interview #2, Part B, Lines196-201, p. 5).

A faculty member also noted:

> I think the students support each other quite a bit, because they come together every week for a three-hour period. At the beginning of class and at the end of class there are always dyads and triads and small groups chatting about their clinical practice…they certainly use each other as support a great deal and that is good because I am not going to be there when they graduate but they will be there for each other (Sue, interview #3, Lines 657-671, P. 15-16).

Equally important to becoming socialized was the need for students to challenge and be challenged by colleagues, preceptors and faculty.

Challenging and being challenged. Education and learning are not the same. Education is an activity undertaken by one or more people to effect change in the knowledge, skills, attitudes, and abilities of those who engage in the pedagogical activity (Knowles et al., 2005). The term emphasizes the educator rather than the learner. Conversely, the term *learning* emphasizes the person in

whom the change is expected to occur (Knowles, et al., 2005). With these perspectives in mind, this section of the study will focus on learning and the learner, or the student.

As one preceptor noted, while it was important to challenge students pedagogically, perhaps raising the bar too high placed students at a distinct disadvantage. So she proposed why not instead raise the bar slowly, thereby ensuring the confidence of the student. She observed:

> It can be a challenge for the students and you would hate to raise the bar so high. We have expectations that students must meet all these goals, but if the students are not able to jump that high, why can we not start lower and then slowly increase the bar as their confidence builds versus ruining their self-esteem (Gina, interview #1, Lines 91 to 93, p. 3).

It was found that challenging students in the practice setting fostered their growth and development as nurse practitioners. However, when challenging a learner, it was important to remember that this person was a learner who needed support to learn. A student noted:

> It was get in there and do it, come back out if you have any questions and then my preceptor would challenge me to go well what else do you think it could be? In a way that was tough because I was making that transition to going okay you are asking me to do a skill that I am not all that well prepared for, yet it was learning to trust myself to be able to do that and yet knowing that I had backup if I needed it (Janet, interview #2, Part B, Lines 314-322, p. 8).

Challenging the student could also mean challenging their previously held beliefs, values, and behaviours with the knowledge that they would be confronted with ones they may not want to consider. This experience produced anxiety, but such anxiety should be accepted as a normal component of learning and not something to be avoided at all costs (Knowles et al., 2005). In keeping with the concept of liminality, Knowles acknowledges that the inevitable feelings of anxiety experienced by students, while uncomfortable, are necessary for a successful navigation of the liminal space. It was also found that in light of such anxiety, it was important for the preceptor to nurture the student. One student observed:

> Nurturing with challenging. I think in this role you need to be challenged so sometimes I was uncomfortable based on that but it was a place in which people wanted you to succeed (Sheri, interview #2, Lines 253-256, p. 6).

A faculty member also noted the importance of the preceptor's ability to challenge the student but to also know when to stand back and give the student much needed space. In essence knowing when to foster student autonomy. She stated:

> A good preceptor then will know when the student needs to be pushed to be a little bit more independent or hang back that I need to be a little bit more observant to see what you are doing and then certainly do that teaching and feedback, to question them (Gert, interview #1, Lines 627-633, p. 15).

In the data it was deemed that a strong *knowledge base* for students and faculty was crucial for a successful preceptorship. As well, it was found to be important that the preceptor be a practicing nurse practitioner.

Incorporating and building a knowledge base. The data further distinguished just what knowledge was important for these two groups to possess. For the students, it was important for them to enter the program with already well-established clinical knowledge in the area in which they intended to practise upon graduation. For the faculty, it was important that they possess current nurse practitioner knowledge.

Clinical experience of the students. According to Lindeman (1926), a pioneering educational theorist, adult education is a process:

> …through which learners become aware of significant experience. Recognition of significance leads to evaluation. Meanings accompany experience when we know what is happening and what importance the event includes for our personalities (p. 169).

Gessner (1956) essentially agreed with Lindeman regarding the importance of experience in the teaching–learning environment. In fact, Gessner noted that in an adult class the student's experience counts for as much as the teacher's knowledge. He went on to explain that in his opinion in some of the best classes it is sometimes difficult to discover who is learning most, the teacher or the students. It was found in this study that it was important for students to have had prior clinical experience before engaging in the advanced practice program. To

illustrate, a preceptor noted the importance of coming into the program as an established, experienced expert in basic nursing. She observed:

> I think you need to be at the level of an expert in basic nursing before you try to become a nurse practitioner because you use that knowledge and it is so hard when you go from being a nurse to a nurse practitioner, you probably know that if you did the same thing that you are right back to being a novice again, right? And if you do not have enough confidence in your abilities as a nurse, it can be very scary anyways but it can be very difficult to get through that initial period. So, I think you have to be an expert in the clinical area where you want to practice (Betty, interview #1, Lines 91-107, P. 3).

A faculty member viewed experience through a somewhat different lens. Specifically, she noted an assumption by faculty that students ought to be admitted to the program with an experience of basic history taking; however, based upon the charting she reviewed, she observed that perhaps this was a misplaced assumption:

> A nurse should know how to take a history but I tell you, I read histories in the charts and it does not look like we are doing a very good job of teaching students how to chart. We have so many tick boxes to fill in, so this is a very different skill to do physical examinations and histories at this level and so we assume that they have got some knowledge that they are building on but it is a very new way of thinking (Pru, interview #3, Lines 549-559, p. 13).

Faculty member 04 noted that conducting physical examinations and histories at this level was a difficult skill to master, yet mastery of those skills was an expectation of the program. While learning advanced skills was deemed by this faculty member to be difficult for some students to learn, involving 'new ways of thinking', the language used by this faculty to communicate this difficulty implied a liminal space, a discomfort that students and even this faculty experienced. As previously noted, Knowles (1995) said that this "experience" may produce anxiety, but such anxiety should be accepted as a normal component of learning and not something to be avoided at all costs. Similarly, Dewey (1938) stated that the central concept of education of students is experience. In his system, "experience is always the starting point of an educational process; it is never the result. All genuine education comes about through experience" (Dewey, 1938, p. 13). With this thinking in mind, I believe that even though students were involved in what had been previously described as troublesome knowledge, it was important for them to experience the difficulty, because, according to Dewey (1938), experience is the starting point of an educational process, a process that is often messy.

Another aspect relating to experience was the need for preceptors to be practicing nurse practitioners. This aspect has already been discussed in this document, but it also fits here. Faculty and students agreed that it was imperative for preceptors to be nurse practitioners. While it was acknowledged that in certain practice settings this could not always be the case, this relationship was acknowledged by faculty and students to represent the ideal teaching–learning

situation. A strong theme identified in the data was that being precepted by an experienced nurse practitioner was the optimal means by which to learn the role of nurse practitioner. The following three participants—representing faculty and students--strongly supported the need for preceptors to be nurse practitioners. One faculty stated:

> The whole preceptorship [will be easier for the student if the preceptor is a nurse practitioner] because they know what they need to know and what the learning and experience was like for them. They have got a sense of making that transition from nurse to nurse practitioner that a physician does not. Some physicians are very naïve in terms of what nurses basically can do in terms of skills and the background training (Jen, interview #2, Lines 489-495, p. 12).

Another faculty observed:

> A nurse practitioner has a nursing perspective on practice and is able to offer a deeper understanding of the role and role model how a nurse practitioner practices, how they would approach things in a broader, more holistic perspective (May, interview #2, Lines 157-161, p. 4).

A student continues in support:

> I think experience is essential because nurse practitioners are nurses. They are not medical students. They are not from some other discipline…I think the experience that you bring with you is what grounds you (Sheri, interview #1, Part A, Lines 588-594, p. 14).

Credibility of faculty. It was found that faculty members were the greatest advocates for educators possessing current nurse practitioner licensure and maintaining a clinical practice. The reason for this assertion is the belief that faculty who practised as nurse practitioners knew what it was like for students to experience the liminal space. Faculty prepared as nurse practitioners also had the unique opportunity to converse with students as professionals who had lived and do live the life of the nurse practitioner. In other words, the faculty would have direct and current experience of what it meant to practice as a nurse practitioner.

Donnelly (2003) provides another voice for the clinical expertise of faculty members in order to prepare nurse practitioner students for professional practice. Even though there is the inherent belief in the value of faculty members practicing nurse practitioners, Patton (2000) notes there is a dilemma regarding the shortage of qualified nurse practitioners serving as full-time faculty members in Faculties of Nursing, a dilemma that many Canadian Faculties of Nursing are currently addressing. To illustrate the importance of faculty being practicing nurse practitioners, a faculty member stated that it was the experience of being the nurse practitioner that helped illustrate the role to the student. She observed:

> Growing the faculty that also have the experience and the background of working as nurse practitioners because it is different than being the Registered Nurse, and we would expect it to be different because it is advanced practice. It is a career pathway so it is a developmental thing. I think that if you have the background and the experience that helps illustrate things to the student (Lila, interview #1, Lines 374-383, p. 9).

Another faculty member noted the importance of the nurse practitioner credential. She stated:

> The clinical expertise or clinical background I think is essential. By that I mean because the nurse practitioner role is such a hands on clinical management role, I think it is essential for the faculty member to have a background in that area. If you teach in a nurse practitioner program you need to have someone, whether it is the instructor or the faculty lead that is an actual nurse practitioner…it gives you credibility (Tracy, interview #1, Lines 801-828, p. 20).

Tracy proposed a clinical teaching model wherein a PhD-prepared nursing faculty was paired with a practising nurse practitioner. This arrangement would potentially address credential issues as well as issues relating to faculty knowledge and experience of faculty. She observed:

> I believe you need to have faculty that are nurse practitioner prepared, practicing nurse practitioners. If they are not, then pairing them up with an NP in that area and I keep hearing it from students because you are coming at it from a clinical perspective. On the other hand, so if you had a PhD prepared faculty of nursing professor paired with a nurse practitioner who may not be PhD prepared but actually is a practicing NP. It makes a world of difference (Tracy, interview #2, Lines 1029-1039, p. 25).

In summary, the process in which students engage to become socialized in the nurse practitioner role was an active one. It was also found that the time spent involved with preceptorship afforded the students the necessary experience

needed with which to navigate the liminal space. The means by which these students were able to become socialized by way of preceptorship included the following: a) identifying how language was used, b) negotiating, c) being supported, and d) incorporating and building a knowledge base.

According to Meyer and Land (2006), language can be a source of conceptual discomfort. They propose that within academic settings certain ways of thinking occur, including the use of certain language. What Meyer and Land proposed was found to be true for this study. The practice of using certain language when discussing students could be construed as labeling and could be confusing for students and preceptors alike. Dewey (1925) proposes that language has implications, a notion that was supported by the findings from this study. To illustrate, language such as *self-starter*, *weak, strong, struggler, exceptional* and *novice* all had implications regarding the intention of the message. As one student noted, the use of language such as novice made her feel like a toddler.

It was found that the skill of negotiation was crucial for students to master while engaged in preceptorship. More importantly, a successful negotiation was also found to require the effective use of language and communication skills. A key aspect of negotiation was identified to include being politically aware. The identified reason for this need for students to be politically aware revolved around the faculty's belief that being politically aware positively affected communication between and amongst students and colleagues.

Crucial to these students becoming socialized to the nurse practitioner role was their expectation they would be supported while in preceptorship. Myrick and

Yonge (2005) propose that it is important for students to be surrounded by a supportive environment within the teaching-learning environment. Other studies support the findings of this study with regard to the importance of support. For example, Allen (2002) and Stark (2004) each note that while it is important for students to be supported, it is equally important for preceptors and faculty to be supported as well.

It was found that linked with the need for appropriate and adequate support for students, faculty and preceptors was the importance of networking and challenging and being challenged within preceptorship, for without engagement in those activities the student might not successfully navigate the liminal space. An important aspect of networking is the value of sharing tacit knowledge and enabling its adaptation and implementation in a local context (Robeson, 2009). To illustrate, networking enabled knowledge sharing across all boundaries, which, in the case of these students, allowed them to effectively educate their colleagues about the nurse practitioner role.

Equally important to becoming socialized was the need for students to challenge and to be challenged by colleagues, preceptors and faculty. It was found that challenging students in the practice setting fostered their growth and development as nurse practitioners. However, when challenging a learner, it was important to remember that this person was a learner who needed support to learn. It was found that challenging the learner also meant challenging their previously held beliefs, values, and behaviours with the knowledge that they would be confronted with ones they may not want to consider. According to Knowles et al.

(2005), when students are confronted with knowledge that could prove anxiety provoking, the resultant anxiety often proves to be a catalyst for change. In other words, the anxiety should be accepted as a normal consequence of learning and should not be avoided, but rather embraced.

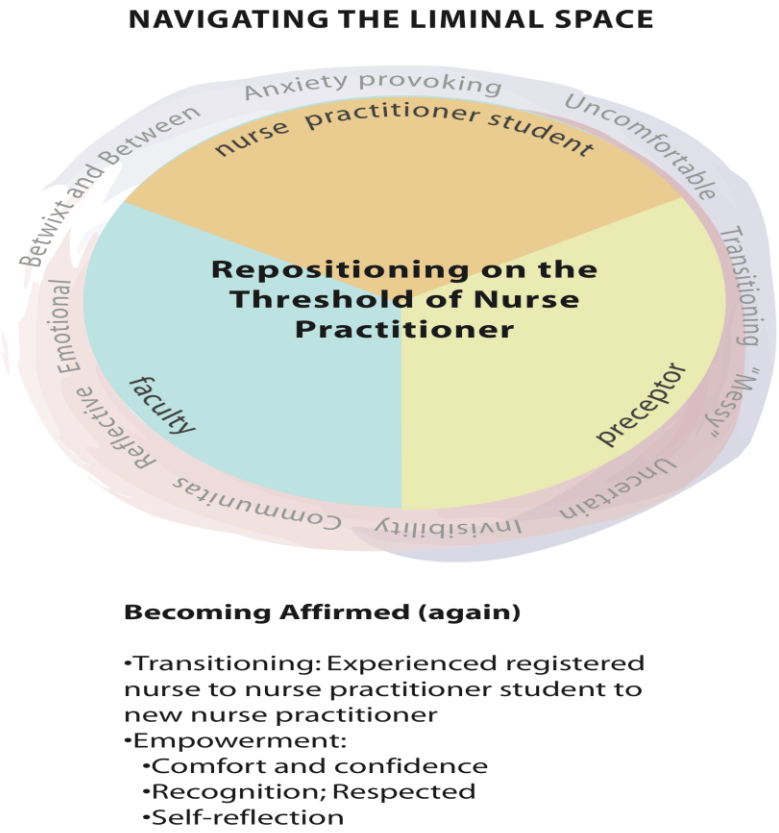
The data further distinguished just what knowledge was important for students and faculty to possess. The participants were explicit when noting that students must be admitted with already well-established clinical knowledge in their area of focus. Dewey (1938), Gessner (1956) and Lindeman (1926) each note the importance of experience in the teaching and learning environment. In addition, it was found that preceptors should be practicing nurse practitioners.

Another identified element that was crucial for student socialization included the need for the faculty teaching in this program to be licensed nurse practitioners. Donnelly (2003) provides support for the need for clinical expertise of faculty members in order to prepare students for professional practice.

Repositioning on the Threshold of Nurse Practitioner

Transitions can be…defined as starting with an ending, followed by a period of confusion and distress, and leading to a new beginning. (Williams, 1999)

Figure 4: Repositioning on the threshold of nurse practitioner



It was found that for these students the journey they embarked upon to become a new nurse practitioner was at times messy, emotional, ambiguous, yet affirming. As they navigated the liminal space and engaged in the process of becoming socialized to the nurse practitioner role, many noted that with an increase in their confidence levels came a sense of becoming affirmed again (Figure 4). In other words, the students were now found to be entering into the second phase of navigating the liminal space in that they were repositioning on

the threshold of nurse practitioner. This phase of the process included transitioning from the role of experienced registered nurse to the new nurse practitioner and resulting feelings of empowerment. Before an in-depth discussion occurs regarding becoming affirmed, clarification is required regarding the concept of *transition*.

Transition

Widespread use of the word transition suggests that it is an important concept. The data in this study support this supposition. Transitional definitions alter according to the disciplinary focus, but most agree that transition involves people's responses during a passage of change. According to Marineau (2005), definitions of transition in the nursing literature date from 1957, when Tyhurst was the first to introduce the dictionary definition of transition into the mental health literature. It was defined as "a passage or change from one place or state or act or set of circumstances to another" (Tyhurst, 1957, p. 150). At that time, Tyhurst identified the attributes of transition to include the following: a phase of turmoil; disturbances in bodily functions, mood, and cognition; symptoms of psychological distress; and altered time perspective. That definition is reminiscent of the characteristics of the liminal space and its attributes as identified and discussed previously by Turner (1967, 1969) and were experienced by study participants. Similarly, Golan (1981) defines it as "moving from one stage or event in life to another with varying degrees of instability in the adaptive process" (p. 21). Chick and Meleis (1986) define transition as the "passage or movement from one life phase, condition, status, or place to another" (p. 239). The

definitions of transition, as posited by these authors, are congruent with those of Van Gennep and Turner's, who as previously discussed, describe it as uncomfortable, anxiety provoking and messy. As one student stated:

> You are trying to gain your confidence but as you go along and people are expecting something more of you and your own confidence and self-assurance level are not there yet so that is where the angst, the anxiety comes from (Sylvia, interview #2, Lines 81-83, p. 2).

Another student commented on how anxiety was good and a motivator. She observed:

> I think it is a very anxiety producing [experience] you know, anxiety is good—it is a sort of underlying motivator (Janet, interview #1, Lines 755-756, p. 18).

Janet noted the importance of anxiety as a motivator to learn, especially, as I posits, when the content that must be learned involves threshold concepts and troublesome knowledge. In essence, the anxiety drives the student to learn the troublesome knowledge in order to escape the self-imposed anxiety state. In other words, while the anxiety is uncomfortable, it provides the necessary stimulus or impetus for the student to learn.

Yet another student expressed the anxiety she felt as she transitioned from the experienced nurse to the student role. She also emphasized the importance of receiving the support of her fellow students (communitas). She observed:

> Did you think about being the new nurse practitioner? I am not sure you think about it as much as you just do it and it comes with all of those

> anxieties and fears of I do not know enough, how I am ever going to know enough to do this. Although as I said, we did have conversations about it with each other. What it was like to be an expert in your area or at least have some experience. And to go back to something even if you are still in the same area, you are still looking at it in a very different way (Sheri, interview #1, Part B, Lines 238-250, p. 6).

Transition occurs over time and entails change and adaptation, for example personal, relational, situational, societal, developmental or environmental. Reconstruction of a valued self-identity is essential to transition (Kralik et al., 2006). The data support this notion of a restructured self-identity. However, before students can begin to engage in restructuring their self-identity, they must feel that they are becoming affirmed again.

A key aspect of becoming affirmed again identified in the data involved the transition students undergo as they move from the role of experienced registered nurse, back to the role of the student, and then culminating in assuming the new nurse practitioner role. In addition, another important milestone in becoming affirmed again was the eventual empowerment student's felt as they transitioned to their new role. This feeling of empowerment in turn lead to the students increased sense of competence and confidence, respect and recognition by peers, and facilitated engagement in self-reflection.

Becoming Affirmed (again)

Transitioning: Experienced registered nurse to student to new nurse practitioner. A central assumption of transition theory is that change involves

reorganization and reintegration of meaning, identity, and role taking, which are all significant factors in determining nursing actions with client's response to health change (Meleis, 1993; Tomlinson, 1996). Even though Meleis and Tomlinson address transition through a health change lens, the notion of reorganization and reintegration suggests that a parallel can be drawn with regard to the transformative process through which nurse practitioner students progressed while learning from their respective preceptors. The transitions in which these students engage involved long-term processes that resulted in reorganization of both their psychological and behavioural perspectives (Tomlinson, 1996) and included an eventual reintegration into a new role perceived to be at a higher level of status. Turner (1977) concurs that a person experiencing the liminal space will re-emerge with a higher status than that which she or he began. In other words, students were found to experience daily a shift in their prior identity, beliefs, knowledge, attitudes and skills, from what they once knew to be relevant, given their practice context, to a new way of perceiving identity and knowledge at the level of the advanced practitioner. To illustrate these concepts, a faculty member noted that students often asked the following: "Am I a nurse? Am I a doctor? Where do I fit? What am I?" (Gert, interview #3, Lines 424-425, p. 11).

Transition is the way we come to terms with change. (Bridges, 2001, p. 3)

Transitions may be easy to identify, or may occur so slowly that they remain elusive and difficult to document; they may be overt and easy to describe, or so deeply meaningful that the person has difficulty articulating the significance of the changes (Morse, 2009). The change that occurred was derived from changing states or status within the individuals or groups. To illustrate, students and faculty spoke about the student transition as they moved from the expert nurse role to the student role. In particular, they noted the transition students witnessed as they journeyed from the expert role back to the student role and then completing the program as newly graduated nurse practitioners, albeit novices once again. A student provided the following observation:

> It is back to that student part. So it is back to that novice role. The expert part, and you are back in the novice place where you are trying to find your footing again, trying to incorporate the skills that you have learned and be able to use them in a functional way and for me some of it is still trying to remember some of the new things that I have learned because it can be awhile between the time that you have practiced them…It was the adjustment to go back to the student role. It was very strange and it still is (Sheri, interview #3, Lines 71-81, p. 2).

Successful transition also included maintaining or developing strong connections with others (Arman & Rehnsfeldt, 2003) and learning ways to adapt to change through a heightened awareness of self (Fraser, 1999; Hilton, 2002;

Kralik, 2002; Martin-McDonald & Biernoff, 2002; Shaul, 1997). The students from this study described at length their need to establish networks and collegial relationships with each other. Turner (1969; 1979) described this collegial relationship as *communitas*, a relationship that is fully embraced by these students, as follows:

> I think they foster many relationships amongst their classmates. The students know their preceptors. They look at them as experts. They know that they can seek guidance from them and some will develop friendships out of it. But the students tend to foster relationships with their co-students that go life-long and so they share their growth and development with them (Gina, interview #3, Lines 938-947, p. 22).

A student shared this sentiment of collegiality, as follows:

> One of the most supporting things for me getting through the program was my classmates and working through the journey together and sharing our frustrations and our joys when things went well, being able to share that with our colleagues so that we could all learn from it (Janet, interview #2, Part B, Lines 196-201, p. 5).

A most striking finding noted in the data was the challenge to a student's self-identity that occurred during the transition process. This challenge manifested itself in the form of anxiety and discomfort as students transitioned from one status (experienced nurse) to another (the new nurse practitioner). Kralik et al. (2006) notes that self-identity is threatened during the disruption that occurs while transitioning and there is a need, therefore, for reconstruction of identity based on

new roles and responsibilities**.** A faculty member concurred and noted that tension arises when colleagues perceive you to be at a higher status than they are:

> So for this faculty member how the student deals with that tension and how she or he (re)navigates her or his role is crucial for her/his success during that transition period (Sue, interview #3, Lines 820-832, p. 19).

It is evident, therefore, that transition is not simply change, but rather the process that people go through to incorporate the change or disruption into their lives (Kralik et al., 2006). In other words, these students must be able to acknowledge the change that is occurring to their self-identity, embrace the change, and then incorporate the new self-identity so that they can move on. Many students noted that they constantly struggled as they transitioned from the expert nurse to the student role, and then for some students, as they transitioned from the role of learner to that of new nurse practitioner. To illustrate the tension and anxiety that students experience as they transition from one status to another, a student discussed the fears associated with not knowing enough, as follows:

> I am not sure you think about being the new nurse practitioner as much as you just do it and it comes with all of those anxieties and fears of I do not know enough, how am I ever going to know enough to do this (Sheri, interview #1, Lines 240-243, p. 6).

As these students progressed in their journey, it was noted in the data that the students encountered a decrease in their sense of professional competence, paired with an increase in role ambiguity. Later, however, as the students navigated the

liminal space, they regained a sense of professional identity and comfort with their new roles. In other words, the students felt a sense of empowerment.

Empowerment. Empowerment has been defined many ways, but typically by what it is not (Corbally et al., 2007; Rappaport 1984, 1987), but there tends to be a consensus that it is a process (Myrick et al., 2010; Kuokkanen & Leino-Kilpi, 2001; Zimmerman, 1995). Zimmerman (1995) describes the empowerment process as one in which people seek out or are given opportunities to manage their own destiny and influence the decisions that affect their lives. Similarly, Sprietzer and Quinn (2001) propose that empowered individuals see themselves as having the ability to choose how to do their work (self-determination), as having a connection with their work (meaning), as being technically competent to perform a task (competent), and having the ability to influence their surroundings and see that they make a difference (impact). Nurse participants in a study by Corbally et al. (2007) believe that empowerment is conceptualized as "freedom and authority to make decisions in practice" (Corbally, et al., 2007, p. 171). I believe that empowerment is an evolutionary process that students experienced over time, and was supported by the data. To illustrate, the empowerment of students were dependent upon whether or not each achieved the following: (a) an increase in comfort and confidence, (b) an increase in recognition and respect, and (c) an increase in self-reflection.

As the students transitioned from experienced nurse to student, they noted how empowered they felt. To illustrate, a faculty member noted this sense of

empowerment; however, for those students who did not leave the liminal space, the student did not feel that sense of empowerment. She observed:

> Those that have made more of a "successful transition" from graduate to new nurse practitioner have made it through the student role, they are beginning to feel more and more a sense of empowerment up to the end but then boom, they start out again. And again those that I think are stuck in the liminal space, they do not feel that sense of empowerment because they are just not sure what they are doing, what they want (Gert, interview #3, Lines 478-488, pp. 11-12).

Gert continued by noting that these students were lifelong learners and that learning was a continuous process, and that students who continued to grow and develop would empower themselves. She observed:

> Those that acknowledge that they are life long learners and realize that it is a continuous process, start developing those networks for continued learning and can navigate, etc., all those previous things. Those are the ones that if you want to label it success will continue to grow and develop and know how to empower themselves, otherwise, no, it is those that do not that become frustrated and leave (Gert, interview #3, Lines 547-555, p. 13).

Comfort and confidence. Embedded within the belief that empowerment of the student was important for the preceptorship to be a success, was the notion that an increase in professional comfort and confidence was fundamental to that sense of empowerment. To illustrate, a student noted how a positive preceptorship

experience helped to increase her confidence, which was her stated goal at the beginning of her preceptorship. She observed:

> I think an expectation of myself if you are looking at the 3 ½ to 4 months of the experience, was to increase confidence and as the preceptorship experience progressed, to feel an increase in my knowledge base. I guess with the confidence and the knowledge base, to be functioning more independently…feeling confident at the end of the experience to know that okay, I am bouncing this off you. But if I was not bouncing this off you I would still be correct in what I was planning for my patient (Janet, interview #1, Lines 262-276, p. 6).

Another student commented upon how essential it was to have confidence, because with confidence you could question yourself as to whether you could have done something more or differently for a patient. She stated:

> Once you have the confidence in your abilities and when you feel more confident, you can go back and question yourself more. You are more comfortable questioning yourself; not because you are cutting yourself down but you are trying to look at what more you could do for the patient. Was there something more I could have offered there? It is self-improvement I guess because you are more confident in yourself so you are not worried about what you have missed. It is what more can I do (Sylvia, interview #2, Lines 788-802, p. 19).

To lend further support to the assertion that a confident student will provide acceptable, advanced care for patients, a preceptor noted that her or his unit had hired a couple of the students that were precepted because they shone as students:

> We have hired a couple of the students we had because, when you have worked with them and you can see what their potential is and how bright they are and how eager they are to learn, and you have the opportunity as a preceptor to get to know them and to see where they shine and to work with them on what they are not so great at, but they have such potential. That is a very rewarding experience for a preceptor. So having the ability to then work with those students as they become nurse practitioner interns and nurse practitioners, it is a very positive experience (Betty, interview #1, Lines 934-946, p. 23).

Sibi noted that not only is the preceptorship experience valuable as a tool with which to apply the knowledge learned in the classroom, but it is also a valuable tool for gaining confidence, as she noted:

> The preceptorship experience is where you get to apply what you learn, so you get to apply the knowledge. But what I see is something a little bit maybe not as direct as that and that is gaining confidence and I am seeing that in a lot of the students right now is that they were in different roles before. Some of them in pretty high intense roles and they were confident and comfortable in those roles and they come into a new role and they all of a sudden they are no longer confident. So I see that that clinical

> experience as being a way to build confidence, as being very important, the 'I can really do this role' (Sibi, interview #2, Lines 839-850, p. 20).

Recognition: Being respected. Just as confidence and comfort are important to becoming an empowered nurse practitioner, so, too, is an increase in recognition and respect important. Another dimension to empowerment that is key to student growth and development is an increase in recognition and respect. There are many definitions of respect found in the literature, but the one proposed by Browne (1993) is most fitting:

> Respect is a basic moral principle and human right that is accountable to the values of human dignity, worthiness, and self-determination (p. 213).

A worthy example illustrating the value of human dignity is found within the next quotation:

> The primary care experience was amazing. I had the most wonderful pediatrician as a preceptor. She increased my confidence greatly, she started bouncing ideas off me, we had many times where we would shut the door and go, what do you think? I was very much respected in the clinical area by all the people I worked with. Anything that was unusual that came in they would come and grab me, come here and see this rash, what do you think this is? Tell me your differential diagnosis, go off and do that research and bring it back to me. Any time that I brought in research, she would thank me. The pediatrician learned from me just as much as I learned from her. The support that I received there was fabulous (Sylvia, interview #1, Lines 252-271, pp.6-7).

As Disch, Beilman and Ingbar (2001) suggest, when nurses feel respected by their leaders they feel good about what they are doing and are able to meet the challenges of their work.

Also important to an empowered clinician within the teaching–learning environment is the need to be trusted by those with whom the student works, but most particularly by the preceptor (DeCicco et al., 2006). A preceptor noted that while she was a nurse practitioner student she was precepted by a physician who trusted her enough to "go out and make mistakes," meaning that part of the benefit of engaging in a preceptorship experience was the freedom to make mistakes as a learner:

> I actually had a physician for my preceptor when I was doing my nurse practitioner studies and I thought he was very good in that he really allowed me the freedom and the autonomy to go and do my own thing and come back if you have questions. There was that trust that was established or that freedom to go out and make mistakes and, or not make mistakes hopefully, and clarify the not question is a dumb question, being able to ask any kind of question or being able to say I do not understand how this is important (Kim, interview #1, Lines 542-553, pp. 13-14).

When a preceptor acknowledges it is acceptable to make mistakes as a learner, it is, therefore, a testament to the trust that has developed between the teacher and the learner. The researcher supports this assertion that respect is fundamental to an employee's trust of others within the organization (Mishra & Spreitzer, 1998; DeCicco, et al., 2006). While the aforementioned literature focused on

employee's trust, there is a parallel to be drawn with respect to student and preceptor trust.

Another student noted that her preceptor's acknowledging and respecting her prior expertise and strong knowledge base meant that she did not have to prove herself to anyone. She stated:

> I was told many times you know what you are doing, you have got a good strong knowledge base, figure out what you need to do to take it to the next level from here, but respecting the knowledge that I brought to the clinical area with me…I did not have to prove myself (Janet, interview #2, Part B, Lines 893-900, p. 22).

This comment by the student was important in helping to understand empowerment within the context of the learning environment, because it highlighted the reality of how often experts in their field had to prove themselves to colleagues when taking on a different role, or moving to a different practice setting.

Self-reflection. Just as an increase in comfort and confidence and an increase in recognition and respect are important dimensions to an empowered person, so, too, is an increase in self-reflection. As one student noted, self-reflection is when someone "figures out where they are at and how they are measuring up and what is the fit in their new setting" (Sheri, interview #3, Lines 736-740, p.p. 17). Another student continued discussing the topic of *fit* but jokingly asking herself why she had wanted to become a nurse practitioner:

> You know it is scary. There is a lot of self-doubt associated with it and thinking why did I go back to school. It is that looking back and thinking okay, I knew what I was doing there. There was a comfort level and now, because you get to a point where you think okay there is more that I can be doing but then in retrospect you are looking back and think what the heck did I do? [chuckle] I wanted to put myself through all this? (Sylvia, interview #2, Lines 99-107, p. 3).

Even though this student jokingly questioned why she went back to school, she was astute enough to address the question through self-reflection. This implies an empowered individual who has the capacity to question even when the question is one that might lead to an uncomfortable answer. Another nurse practitioner student acknowledged the importance of discussion and self-reflection but within the context of a group dynamic. To illustrate, this student described how her classmates reflected and then discussed how you go from being an expert back to a novice:

> Some of the discussions that we had both in class and out were about how you go from being an expert back to a novice. So you go from being an expert in your clinical field to being a novice as a nurse practitioner again in whatever area that is. Just about what it is like and how you go into this role knowing that in some ways you really are back to that novice place again (Kim, interview #1, Part B, Lines 219-232, p. 5).

By reflecting on the question, "how do you go from being an expert back to a novice", the students (begin to) come to an understanding of what that process

meant to each of them and to their individual practice environments. The act of reflecting essentially helped each student in his or her actualization of individual empowerment, which in turn helped each person to transform into the new nurse practitioner. As Zimmerman (1995) notes, empowerment is observed when people seek out or are given opportunities to manage their own destiny and influence the decisions that affect their lives.

According to Le Cornu (2009), the study of reflection is something that underpins many conversations about learning and its outcomes and effects. In recent years, it has been a major focus in the work of scholars such as Mezirow (1978, 1981, 1991), Brookfield (2001, 2005) and Schön (1991). Mezirow and Brookfield both concentrate specifically on critical reflection, analyzing its properties and arguing for its necessity as a means of transforming both individuals and society (LeCormu, 2009). Mezirow's (1978, 1991) perspective of transformation is integrally tied to the role of reflection within human development and to a progressively staged growth. What Mezirow proposes fits and is relevant, in that the students who are self-reflective are those who are growing in a professional sense. As Mezirow (1981) suggests, reflection is integrally tied to meaning-making:

> Meaning-making refers to a lifelong process of understanding the world and our relationship with it. In adult education, meaning-making is often associated with critical reflection and transformative learning (p. 394).

Meaning-making is a hallmark of the lifelong learner.

Up to this point, the students have been seen as transitioning from their previous status of experienced registered nurse to the new status of student. This next section will explore and analyze the data as it relates to the transformation of these students to their new role of the new nurse practitioner.

In summary, it was found that for these students they often described their journey through the liminal space as being messy, emotional, and ambiguous, yet affirming. The transition experienced by these students was viewed by the triad as a necessary process in which to engage for successful navigation of the liminal space to occur. Chick and Meleis (1986) define transition as "a passage or movement from one life phase, condition, status, or place to another" (p. 239). This definition of transition is congruent with those of Van Gennep and Turner. As these students transitioned to the new role of nurse practitioner I discovered that they became affirmed again, a milestone that eventually resulted in these students feeling empowered. It was also found that this sense of empowerment resulted in these students feeling increased levels of confidence and comfort.

It was found that an equally important aspect to a successful transition involved the challenge to a student's self-identity. Kralik et al. (2006) note that self-identity is threatened during the disruption that occurs while transitioning. As the students moved from positioning to repositioning in the liminal space they experienced a sense of empowerment. Intertwined with this sense of empowerment was an increase in student comfort, confidence, recognition, respect, and self-reflection.

Embracing the New Nurse Practitioner Role

Most authors describe transition as not only a passage or movement but also a time of inner re-orientation and/or transformation. (Kralik et al., 2006, p. 324)

Figure 5: Embracing the New Nurse Practitioner Role

Emerging as Transformed

- **Shifting Perception**
    - Increase in public relations with physicians and registered nurses
- **Natality: Emergence of the "New Who"**

The emergence of the 'new who' marks the final phase in the process of navigating the liminal space. This phase of the process was entitled, *embracing the new nurse practitioner role* and was deemed such because this final phase represents the time whereby the students are now prepared to assume and embrace their new role of nurse practitioner. It was found that the process in which the students engaged was a transformative one, which involved (a) shifting perceptions and an increase in public relations with physicians and registered nurses, and (b) an increased comfort level with the new nurse practitioner role, leading to a rebirth or a "new who."

Transformative Learning and Preceptorship

Brookfield (2003) observed that the word *transformative* implies that an "apocalyptic event" (p. 141) has been provoked. He believes that the choice of this word is completely justified, and I would agree. He stated:

> I believe that an act of learning can be called transformative if it involves a fundamental recognition, questioning, and reordering of how one's thoughts or actions are formed (p. 142).

Transformative learning and transformation can be life-altering for the person involved in the process, as well as for those associated with the event; in this case it is the student undergoing the transformation from registered nurse to nurse practitioner. In keeping with transformative learning, for example, questioning underlying beliefs, values and assumptions was a process in this study as they moved along the trajectory of registered nurse to student to this final place in the study called nurse practitioner. A big part of shifting perceptions involved collaborative practice.

Emerging as Transformed

Shifting perceptions. Collaborative practice is the way by which nurses and physicians work together to share and solve patient problems and initiate decision-making responsibilities to care for patients (Chang, Mu, & Tsay, 2006; Cummings, Fraser & Tarlier, 2003; Marfell, 2002). Furthermore, collaborative practice is a dynamic, interpersonal process in which two or more individuals make a commitment to each other to interact authentically and constructively to solve problems and to learn from each other in order to accomplish identified

goals, purposes or outcomes (Marfell, 2002). This kind of practice is based upon cooperation, mutual respect, and acceptance of the validity of different approaches to patient care. This kind of collaboration also affords the physician a chance to understand the roles and viewpoints of advanced practice nurses (Marfell, 2002) as in the case of the nurse practitioner. Essentially, collaborative practice involves all stakeholders to shift perspectives. In some instances these perspectives have been held firm for a long time, and so for some individuals relinquishing or changing those perspectives could prove counter intuitive and difficult. This thinking is very much supported by the data, as students commented on having to spend much time educating physicians about the role of the nurse practitioner ergo shifting their perceptions.

To achieve an effective collaborative practice, in addition to strengthening education, training, active participation and learning, nurses and physicians need to trust and respect each other in their professions (Kleinpell et al., 2002). However, trust and respect do not occur immediately. Rather, trust and respect occur over time and require mutual open communication (Kleinpell et al., 2002). These themes have been discussed previously in this study. One preceptor noted that she insisted that the student participate in all meetings that she was expected to attend. The preceptor believed this activity was an excellent way for the student to witness and ultimately understand team building and appropriate communication amongst colleagues as she stated:

> We participate with the medical team as well. Whenever there are meetings and presentation with the medical students or residents, we

> participate in those as well. So that we have a good understanding of team building. When I have students come with me, they participate in everything that I participate in, so if I go to a nurse practitioner meeting they come along with me. If there are case reviews, they are in there participating as well, so that they get a good idea of the different complexities (Gina, interview #1, Lines 42-53, pp. 1-2).

While in the practice setting, a student noted her need to educate those around her about the role of nurse practitioner and how, over time, and as she gained experience, she became comfortable with transitioning to the new role of nurse practitioner. She observed:

> The first preceptorship experience was working with a pediatrician in his office, but not working with any nurses, so working with physicians. So the impact on that was trying to learn what a nurse practitioner would do without having a nurse practitioner there to help guide you. So very involved in educating the physicians that I worked with what a nurse practitioner could and could not do. How the role could be developed, how the role could be utilized, and how I was there to learn but also to teach them what the role was. So it was a big impact…it was a tough transition at first to realize what you do not know. And you thought you knew. And then increasing comfort, spending more time in clinical area, realizing you actually know, and then getting comfortable with the nurse practitioner role in that setting (Sylvia, interview #1, Lines 41-64, pp. 1-2).

One faculty member succinctly noted how important it was for students to foster collegial relationships with colleagues if they were to shift perceptions or they would not survive, emphasizing how crucial it was for students to foster collegial relationships early on in the transitioning process:

> Well the students have to foster relationships with physicians and registered nurses or they will not survive (Sue, interview #3, Lines 1039-1041, p. 24).

Another student concurs:

> My summer preceptorships were very different and I had four or five different areas that I ended up working with various different physicians and the biggest problem I had with them was that they had absolutely no idea what my role would be as a nurse practitioner. I spent a great deal of time educating THEM what a nurse practitioner role was because they do not work with them either so they did not know what I was there to learn, how I was supposed to **not** be a resident (Sylvia, #1, Lines 134-144, p. 4).

Another student provides support for the importance of building networks and relationships with physicians to assist them to understand the role amongst present/future colleagues. She stated:

> It resonates that students spend time fostering relationships with physicians because the physicians really do not understand what the role can be, should be, and is. Some are extremely supportive and walk up and say I want one of those, while others ask well how are you different [than a

> resident]. I have actually been called [by a physician] a never-graduated resident (Janet, interview #2, Part B, Lines 1198-1202, p. 30).

Another preceptor noted:

> I have recently changed positions in the last two years and found that moving to an institution that did not have many nurse practitioners, it was a struggle for the nurses to understand that yes, I can write orders and yes, these do have to be followed. They are not suggestions. And yes, these are why we made those decisions. So when I run into that from somewhere I take the time to say this is why we made this decision. This is why we are doing this. So that they understand what the theory is behind it, the rationale, and they go, "Oh. I had not thought of it that way," so it is taking that time. It is not just educating nurse practitioners. It is also educating everybody who works with the population at large (Gina, interview #1, Lines 316-329, p. 8).

Another example that related to shifting perceptions and the link with collegiality was provided by a student who noted an example of a budding mentoring-collegial relationship between herself and her physician–preceptor:

> They also recognize that being new at anything you always seek resources. So I think it really resonates. I think I am very thankful for the relationships I made and thankful for the relationships I made with both preceptors but also with my fellow students (Sheri, interview #2, Lines 907-919, p. 21).

Likewise, within the milieu of shifting perceptions and collaborative practice, the data indicated that as they navigated the liminal space and eventually transformed to the new nurse practitioner role, each, to some degree, demonstrated a comfort with the new nurse practitioner role. In other words, each student eventually felt competent to assume the role of new nurse practitioner in her or his respective practice setting surrounded by colleagues who together build respectful and trusting relationships (Kleinpell et al., 2002). To illustrate, a student noted that many of her student colleagues have many years of nursing experience and those educational and life experiences are important for a successful transition and transformation:

> We are older for the most part. We bring that world of experience with us. Most of us in the program have been working for at least 10 years as nurses before going into this program, so bringing that life experience with us. Bringing those educational experiences with us. It is all on the continuum of nursing and it is taking the nursing knowledge to that next level of how do I enhance what it is that I do. What more do I need to learn to go beyond just diagnosis? It is a tough transition learning how to decide, for example, which prescriptions would be appropriate. How would I then write the prescription? So those are just skills that are not something that we as registered nurses necessarily have the experience to do…and then getting a comfort level with doing those procedures. But doing them with that nursing focus that residents do not have (Sylvia, interview #1, Lines 420-441, pp. 10-11).

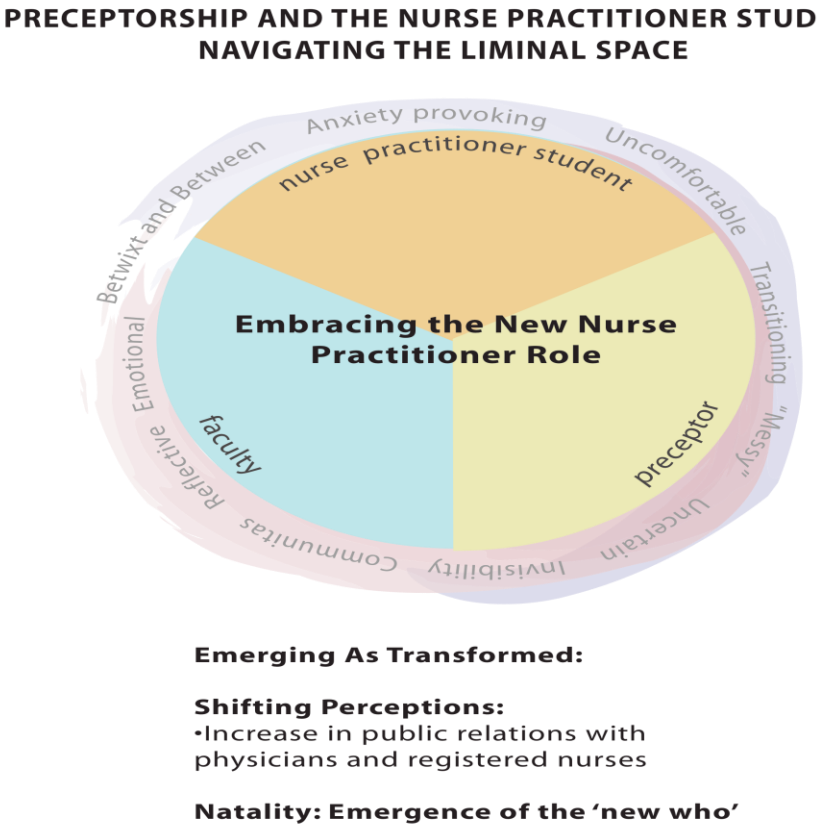
A preceptor noted that over time colleagues who worked with these students began to shift their perceptions regarding just how knowledgeable and skillful the students were. This recognition of ability by colleagues helped these students to become more comfortable in their new role. A preceptor observed:

> They do foster new relationships because as the students are developing their skills, as they get comfortable presenting to the larger team, which is mostly other nurse practitioners and other physicians and they are developing their credibility. For those that get more comfortable and as they share their knowledge and they show what their skill levels are, the physicians take notice and the all recall oh, that is so and so, that is the person that we had as a student and boy they were great! And then it creates another basis of expertise that is acknowledged at other levels as well (Gina, interview #3, Lines 908-919, p. 20-21).

In summary, as students continued their transformation from experienced nurse to student they continued to educate colleagues about the role of the nurse practitioner, which in turn forced a change in how these colleagues viewed this advanced nursing practice role. It was also found that an important factor involved in educating other health care colleagues about this new role was the need for all involved to embrace the necessity for mutual respect and trust. The culmination of a student's transformation was a rebirth, or as Arendt (1958) might propose, the emergence of a "new who," which will be discussed in the next section.

Natality: Emergence of the "New Who"

Natality is not the beginning of something but of somebody, who is a beginner himself. (Arendt, 1958)



As the above quotation reflects, according to Arendt (1958), natality involves (re)birth, or a "new who." Natality is conceived here as a fundamental capacity to bring new phenomena into existence (Arendt, 1958). In the context of this study, then, natality refers to the emergence of the new nurse practitioner. To provide clarity, natality is not being referred to here in the context of religion, but rather, in the context of a new who (Arendt, 1958), which is at times referring to a political who. It is important, therefore, to note that woven throughout this study

were the threads of emerging political awareness on the part of these students who through their preceptorship and interaction with colleagues developed a budding awareness of the political nature of who they were becoming, which included the new role they would eventually assume. Natality, therefore, was action personified; it signified a new process in which these students engaged at the beginning, at the middle and at the culmination of their preceptorship, and even extending into their new nurse practitioner position. According to Arendt (1958), people forgot that natality was the most general human condition of existence, in which a capacity for action was rooted.

To help illustrate Arendt's (1958) point about political action, a preceptor described how important it was for students to learn to be political in order for the students to first navigate their role via language in order to grow into their new nurse practitioner role. She stated:

> We need to be more involved and that's what I mean by that. We need to be more political. We cannot just sit back and let it happen to us and then complain about it. We have to be more proactive. But I think that the difficulty is that we don't necessarily have powerful bodies navigating on our behalf and I don't want to get too much into the politics cause I don't want to stray from what your topic is, but we haven't necessarily learned these skills either and so I don't necessarily have the language to go to that table and say in the language that the politicians and the American Medical Association or Canadian Medical Association, Alberta Medical Association is going to use. So there's something about the language, is

> what language catches people's attention in order to be able to navigate (Sibi, interview #2, Lines 383-397, pp. 9-10).

This preceptor noted that students must be politically aware, but the preceptor too must be politically aware. A faculty member lent support for the notion that the natality of students involved the preceptors being politically well informed:

> The preceptor needs to navigate the arrangements of the preceptorship. They need to know that kind of political awareness. That's also just a strategy in terms of navigating the system, is do they figure out the lay of the land and do they figure out how the preceptor is going to prioritize the learners in the setting and I think there's a lot of negotiation that happens and I mean the faculty is hopefully involved in some of that negotiation as well on behalf of the student (Pru, interview #3, Lines 437-449, pp. 10-11).

Natality, thus, was a fundamental capacity to give birth to the new: a new who of the student and the change in the 'who's' of all other students (Arendt, 1958). Action, "an infinite improbability that occurs regularly," intercepts the inexorable procession from life to death, and almost seems like a miracle to those who are bound by the sight of this inevitability. "The miracle that saves the world, the realm of human affairs, from its normal, 'natural' ruin is ultimately the fact of natality, in which the faculty of action is ontologically rooted" (Arendt, 1958, 184, 246–7). People forget that natality is the most general human condition of existence, in which a capacity for action is rooted, a fact that was previously noted. A student provided an example of how her preceptors helped to grow the

new who, as follows:

> It was get in there and do it, come out if you have any questions and then would challenge me to go well what else do you think it could be? It was, in ways that was kind of tough because I was making that transition to going okay you're asking me to do a skill that I'm not all that well prepared for yet and it was learning to trust myself to be able to do that and yet knowing that I had a backup if I needed it but certainly I found that my preceptors were absolutely amazing in terms of allowing me to be a learner and yet pushing me to my levels that they expected me to be at (Janet, interview #2, Part B, Lines 314-325, p. 8)

Not only was it important within the preceptorship experience to grow students as the new who, but it was equally important to grow faculty as the new who, for it was the nurse practitioner-prepared faculty member who would have credibility with the students, and who would also have personal knowledge of what it meant to transition through the liminal space, experience that the non-nurse practitioner-prepared faculty member does not have. To illustrate, one faculty member proposed that those faculty preparing students for advanced practice are themselves practicing nurse practitioners, as follows:

> It is important to grow the faculty that have the experience and the background of working as nurse practitioners because it's different than being the RN– and we would expect it to be different because it's as I said it is advanced practice. It is a career pathway so it is a developmental thing

> so I think if you have the background and the experience that helps illustrate things to the students (Lila, interview #1, Lines 374-383, p. 9).

To further illustrate Arendt's (1958) point about natality involving an active process of learning and exploration, I would also add the necessity of being creative and curious as being components of the active learner. Lila, a faculty member, further proposed that students must be active learners who are leaders and role models for colleagues:

> The students need to be very self-motivated in terms of looking for information, being aware of research, being aware of practice guidelines, being a life long learner with lots of curiosity because again we function in a clinical environment where things are changing all the time and rapidly and so we can't have this model of learning once and never learning again. They need to be always on the move and working, growing, and changing so that is an important component. I think they need to be leaders and role models for the nurses that they work with – they should not be functioning as a physician assistant. They are a nurse (Lila, interview #1, Lines 300-321, p. 8).

In summary, a logical outcome of natality, or a "new who", is the ability of students to authentically engage in collaborative practice. When students have gained an acceptable level of comfort, confidence and respect from colleagues, it was a logical progression, then, to assume they were ready to begin anew, or as the literature states, face a natality or a "new birth" (Turner, 1969, 1974, 1977), or as Arendt (1958) posited a "new who."

In summary, the liminal space is characterized by attributes such as feelings of anxiety, discomfort, and messiness. In this space, students also tended to become self-reflective about the very process in which they found themselves engaged. During the navigating process they were found to rely heavily on their established social support systems otherwise known as communitas.

Findings also revealed that for students to successfully navigate the liminal space they engaged in three phases, which included: 1) positioning in the preceptorship (teaching-learning) experience, 2) repositioning on the threshold of nurse practitioner, and 3) embracing the new nurse practitioner role. During the *first phase*, these students entered the liminal space not really knowing what to expect in terms of how they would process the discipline-related knowledge, how they would become the nurse practitioner or how difficult the process actually would be. It was also found, however, that they did realize early on in the preceptorship that this process involved entering into many collaborations with colleagues and other health care providers. This first phase, in other words, involved the students *working through the rites of passage* so that they eventually socialized into the role of nurse practitioner. In other words, the role they were about to assume was not an isolated role, but rather, a role that involved working collaboratively with a community of health care professionals for the betterment of the patient.

During this phase students learned the importance of negotiation with colleagues and of being supported, while at the same time they also began to realize the importance of *prior experience*. It was found that when students first

entered into preceptorship they questioned whether or not their prior experience meant anything to their colleagues. Over time they came to understand that their prior identity or their experience played a very important part in how they coped while in the preceptorship and their eventual success.

The first phase also elicited in the students feelings of *cognitive dissonance,* particularly during times when they were confronted with what I identified as troublesome knowledge or knowledge that was either alien to them, was difficult to grasp, or was counter intuitive. As one student observed, the resulting discomfort proved to be a motivating factor to learning. It was also found that *making their way through* was a necessary component to navigating the liminal space. As the concept indicates, this was an active phase for students because they became actively involved in navigating the preceptorship. These students were beginning to ask the question 'who am I' and 'why am I here.'

During this initial phase of the preceptorship, these students were afforded the opportunity to *become socialized* into the role of nurse practitioner. This part of the navigation process involved aspects of communication, in particular *how language was used* by faculty and preceptors in relation to characterization of the students when in the practice setting. Language typically used by some faculty and some preceptors to describe students included 'self-starter', novice', 'weak', and 'strong'. As one student reflected, the use of what they considered a derogatory term gave the impression that those using the term thought of the student like one would a toddler. Such findings emphasized or revealed that crucial to navigating the liminal space was the tangible need for students to feel

that they were *supported* by the faculty member and the preceptor and the use of such language tended at time to circumvent such feelings of support. There is a plethora of literature supporting the need for student support while engaged in preceptorship.

Students, faculty and nurse practitioner preceptors alike acknowledged the need for preceptors to be practicing *nurse practitioners.* A member of the triad noted, however, that there was still value to a preceptorship when the preceptor was a physician. In this instance the value of physician as preceptor was in the ability to afford the students the opportunity to hone their technical skills, in particular history taking and the performance of the physical examination. The downside was that the physician could not serve as a bona fide role model for the nurse practitioner student. Students also noted that the optimal learning situation involved faculty who were prepared as nurse practitioners. As they identified when faculty were nurse practitioners this leant credibility to the teaching and learning environment because the faculty themselves had experienced what it was like to be a nurse practitioner student. In other words they could walk in the students' shoes.

The *second phase* in navigating the liminal space involved *repositioning on the threshold of the nurse practitioner*. Students *became affirmed again*. At this phase of the process students had typically progressed to the point in their learning where they felt a marked increase in comfort and confidence with their new role. Essentially, up to this point in the preceptorship these students were experiencing great levels of anxiety, discomfort and messiness, but now with their

increased levels of comfort and confidence they transitioned to the point where they felt affirmed again. This was the phase during which these students experienced empowerment. They explicitly began to express that they were feeling more settled within the new role of nurse practitioner. They began to feel respected and recognized as a new nurse practitioner. During this phase in the process it was found that they also spent much time involved in self-reflection. And, while the students felt empowered they still experienced periods of uncertainty. This occasional uncertainty was due in part because they were still learning the role.

The *final phase* involved in navigating the liminal space was the students' embracing of the new nurse practitioner role. This was the time during which they described themselves as being more confident and comfortable in assuming the new role. It was also noted in this phase that these students began to further engage more readily with colleagues for the express purpose of educating these colleagues about the nurse practitioner role. In other words, this phase saw these students engaging with registered nurses and physicians to shift their preconceived perceptions about the nurse practitioner role. Essentially, then, the students assumed a public relations role with colleagues thus confirming their growing confidence.

This phase represented the culmination of the process of navigating the liminal space. This final phase represented natality or a rebirth for these students. They had navigated the liminal space and were now ready to embrace the nurse practitioner role. These student experienced what would be described by Arendt

(1958, p.8) as a ‘new who’. Metaphorically they emerged from their pupae and assumed the form of the newly emerged butterfly. Moreover, they became a visually, emotionally, and psychologically transformed person. Having successfully navigated the liminal space, these students were now ready to assume their new role of nurse practitioner.

CHAPTER 5

SUMMARY AND CONCLUSIONS, IMPLICATIONS, RECOMMENDATIONS AND LIMITATIONS

Summary and Conclusions

Grounded theory is a method that was developed for the documentation of change, of actions inherent in the change, or the processes involved in the transition (Morse, 2009). It is intended to be used for the explication of conditions, strategies, causes, and consequences, with its purpose being that of helping us understand human responses (Morse, 2009). This study, therefore, explored the process used to educate nurse practitioner students within the preceptorship experience for professional practice. My incentive for embarking on this study was motivated by a sense of inquiry and a need to positively impact the education of nurse practitioner students, as follows: a) to ascertain how students were actually being prepared for the nurse practitioner role within the teaching–learning environment, b) to determine how nurse practitioner students transitioned to the new nurse practitioner role, and c) to identify educational strategies that would progress the education and practice of nurse practitioners. As the data emerged, I uncovered a multidimensional process that was occurring in preceptorship to educate nurse practitioner students via preceptorship. I identified this process as *Navigating the Liminal Space.*

According to Turner (1969), liminality is a space that is described as the ‘betwixt and between’. In this study, liminality represented a state in which

students were no longer considered ‘expert nurses’, yet they were not deemed graduate nurse practitioners either. As one student observed she felt as if she did not fit anywhere. Navigating the liminal space by nurse practitioner students while engaged in preceptorship was found to be an active and interactive process in which students navigated their transition from experienced registered nurse to new nurse practitioner. This process was found to comprise multiple phases: (a) positioning in preceptorship (teaching/learning), (b) repositioning on the threshold of new nurse practitioner, and, (c) embracing the new nurse practitioner role.

The first component, *positioning in the preceptorship experience*, may be described as the context in which students *work through rites of passage* and *became socialized.* In discussing their working through rites of passage, students identified the aspects of prior professional identity, cognitive dissonance and making their way through. Likewise, preceptors and faculty provided insights into these categories as well. *Becoming socialized* addressed the many dimensions of communicating within the preceptorship relationship/experience. Specifically, the members of the triad discussed communicating within the following contexts: how language was used; negotiating; being supported, which also included aspects of communitas and challenging the student and preceptor; as well as, the knowledge base of students, faculty, and preceptors.

The second major component involved in the process of navigating the liminal space was *repositioning on the threshold of nurse practitioner*. This component may be described as that facet of the process in which students *become affirmed again*. Students, faculty, and preceptors alike addressed the

process of transitioning by the student from the experienced registered nurse as they moved on a trajectory from the experienced registered nurse to nursing student to their new role as a nurse practitioner. When these students felt they were affirmed again, they spoke of feeling empowered, which indicated they felt more comfortable and confident in assuming the new status and role.

The final phase involved in the process of navigating the liminal space was identified as embracing the new nurse practitioner role. This was a time of shifting perspectives and the acquisition of a new who. Students described an increase in public relations with colleagues and an increased comfort level with their new nurse practitioner role. These students were no longer deemed 'betwixt and between.' Rather they had experienced a *natality*, or a new "who" (Arendt, 1958), and had emerged in their new status of nurse practitioner.

Implications for Nursing Education

In light of the findings of this study, there are several major implications for nursing education:

1. Intrinsic to the process of navigating the liminal space, students position themselves in preceptorship (teaching-learning). While positioned in that space, students find themselves working through rites of passage. From a pedagogical perspective, then, it is important for faculty members to acknowledge this space in which students find themselves. This finding has potential to impact curriculum development for a variety of reasons: (a) how faculty members ensure prior professional identities of students are valued within the educational environment and how is the notion of "identity" incorporated into curriculum development; (b) how faculty members address and facilitate the learning of troublesome knowledge within the teaching and learning environment; and (c) how the curriculum facilitates students who are navigating their journey and transitioning to a new "who."
2. A second aspect to positioning in preceptorship (teaching–learning) is the phase of becoming socialized. Key to this phase is how communication occurs amongst the triad and within what specific contexts communication takes place. This matter of communication has implications from a pedagogical perspective. Implications include the following: (a) how faculty ensure for effective and efficient communication amongst and with students and preceptors; (b) how faculty members facilitate the formation of environments of communitas within the academic setting; and (c) what it means for the

teaching–learning environment when faculty are not prepared as practicing nurse practitioners.

3. Another dimension of navigating the liminal space that is directly related to that space involves the part that transitioning plays. From a pedagogical perspective, it would be important to address: (a) how students are prepared for the emotional, active, messy, anxiety-provoking aspects of the liminal space, (b) explore the reliance on communitas to fulfill what appears to be the major support for students, and (c) identify how the curriculum can support and foster the transitioning process students undergo as they navigate the liminal space.
4. Intrinsic to the process of navigating the liminal space, students reposition themselves on the threshold of becoming a new nurse practitioner. From a teaching–learning perspective faculty and preceptors need to identify specific ways with which to facilitate the new professional identity of the students. Another implication may address the empowerment of students. Specifically, mechanisms need to be identified in the curriculum that can promote and foster the empowerment of students.
5. The transformative process essentially represents the culmination of students transitioning from experienced registered nurses to new nurse practitioner. While engaged in this active process, students are role modeled the value of collaborative practice. The implications for nursing education are, therefore, infinite.

6. From a teaching–learning perspective, the act of transformation for most students can prove challenging. It is therefore imperative to identify the implications for curriculum development, given the difficulties these students can encounter. In other words, the onus is on the faculty to accommodate for transitioning students within curriculum development.

Implications for Future Research

In light of the findings of this study, there are several major implications for nursing research:

1. This research opens up a new area for study that addresses the liminal space of nurse practitioner students engaged in the transition process.
2. These findings suggest that nursing research should continue to engage in research projects that focus on professional education and advanced nursing practice, with topics that could include the following:

    a. What is the process involved in the transformation of newly graduated nurse practitioners to their new professional role?

    b. How are newly graduated nurse practitioners supported in their new role?

    c. How does the culture of nursing acknowledge (support) the role of the nurse practitioner?

    d. What is the process involved in registered nurses deciding to engage in graduate education at the level of the nurse practitioner?

e. How does preceptorship influence the professional practice of the new nurse practitioner?

f. What is the process involved in teaching nurse practitioner students threshold concepts and troublesome knowledge?

    i. (What is the process involved in) (How do) nurse practitioner students learn threshold concepts and troublesome knowledge?

g. Why do some students successfully navigate the liminal space of understanding and others do not?

h. How can teachers/faculty design a curriculum that invites students to enter liminal spaces?

i. Time is an essential element in transition and therefore longitudinal studies are required to explore experiences during the pre liminal phase, the liminal period and the post-liminal period (or re-incorporating period) that results in new ways of living and being as the outcome of the transition experience.

In conclusion, data generation is essential for the development of a much-needed theoretical base for clinical teaching at the graduate level. This research provides empirical findings that reflect the richness of preceptorship for nurse practitioner students. It has generated data that can be used to

understand the contextual reality of the preceptorship relationship and the transitioning process in which students engaged while navigating the liminal space.

The process of navigating the liminal space of students while engaged in preceptorship provides a framework with which to view the often messy, emotional, anxiety provoking space of these students. As a result of the findings from this study, it is evident to me that faculties of nursing must address the importance the liminal space plays in the education of nurse practitioner students. Indeed, the transitioning process that these students experience during the journey to new nurse practitioner is essential to these students reaching the status of a new “who”.

Recommendations

Based on the findings of this study, the following recommendations are offered:

1. Adhere to specific admission guidelines of nurse practitioner students
   1.1. Require that those admitted to the program have a baseline understanding of nursing knowledge, specifically history taking and physical assessment

2. Provide ongoing crucial support for students and preceptors
   2.1. Faculty conduct site visits to ascertain how a preceptorship is progressing

   2.2. Faculty and preceptors ensure that time is built into the workday to accommodate the students' needs to very much recognize that they are in a student role and as a student they need constancy and reassurance

3. Introduce nurse practitioner students to the CBL method of teaching-learning. At the beginning of each academic year conduct a week end session addressing the following important areas of CBL: (a) historical context of the method, (b) teaching and learning strategies inherent in the process, and (c) expected outcomes, to name a few.

4. Some physicians might have misconceptions about the overall practice of the nurse practitioner that reflect their lack of suitability to precept a nurse practitioner student. This challenge can be addressed, however, through educational sessions co-sponsored with the College of Physicians and Surgeons and the College and Association of Registered Nurses of Alberta (CARNA).

5. Preceptors to provide ongoing opportunities for students to build relationships with other health care professionals

6. Develop a nurse practitioner-focused *preceptorship booklet* targeting preceptors and students that could include the following information:

    6.1.1. Roles and responsibilities of the triad

    6.1.2. Role expectations

    6.1.3. Evaluation expectations and process

    6.1.4. Prior to the commencement of the practicum, discuss and review with students and preceptors the preceptorship booklet

    6.2. Link with the established preceptorship conferences to focus on nurse practitioner related content

    6.2.1. Incorporate case studies, discussion

7. Develop a *transition course* (Poncelet et al., 2008) for nurse practitioner students. Content could include the following:

    7.1. Incorporate theory from Brookfield, Dewey, Knowles, Foucault, Meyer & Land, and Mezirow that builds upon a philosophical understanding of teaching–learning and adult education.

    7.1.1. Access a simulation lab so that hands-on practice occurs

    7.1.1.1. Practise writing notes and orders, giving case presentations and reviewing patient charts

    7.2. Faculty to address the important aspects of nurse practitioner preparation with students, which could include: threshold concepts and the resulting

troublesome knowledge; and, the liminal space that could also include a definition and the characteristics of that space.

Limitations

As with any study, limitations may be anticipated, the most obvious being that of time, skill, money and creativity. This particular study was no exception and was also predisposed to the potential disadvantages imposed by personal bias, analytical creativity and interview technique (Beck, 1993). The length of time during which this study was conducted may also be perceived to be a limitation. Data were collected for a total of 24 weeks. It is conceivable that the depth and richness of the data may have been unduly influenced by this limited timeframe. During this time, the nurse practitioner students taking part in the study were either assigned to preceptorship in the practice setting, had just finished the preceptorship, or had within six months recently completed the nurse practitioner program and had been practicing as a new nurse practitioner.

The preceptors comprised practicing nurse practitioners from a variety of practice settings and had either just finished precepting a student or had precepted a student in the recent past. The faculty members all were currently engaged in facilitating the preceptorship experiences for students and preceptors. The preceptorship was the final major component of the nurse practitioner program and included students being precepted by preceptors for a total of 340 hours.

My own analytical creativity also may have posed a limitation to the depth and richness of the emergent findings (Glaser, 1978). Throughout the research process, personal bias is always a potential overriding factor from the time the problem is identified to the completion of the study. In grounded theory, protection against bias is ensured by the process of delaying final interpretations

until data collection is well established (Glaser, 1978), an approach to data collection referred to as “theoretical sensitivity” (Glaser, 1978). Theoretical sensitivity is promoted by entering “the setting with as few predetermined ideas as possible” (Glaser, 1978, p. 3). It is essential, then, that I am cautious throughout the entire research process in order to avoid unfounded ideas from unnecessarily biasing the emerging findings (Glaser, 1978).

Finally, reliance on the interview as the main data source may have posed constraints and bias. Participants may provide information that they perceive the interviewer wishes to hear (Field & Morse, 1985). In light of this possibility, I took considerable care to conduct the interviews in a neutral manner so that any personal biases, anticipated responses, or any other semblance of influence were not disclosed (Field & Morse, 1985).

REFLECTIONS ON THE PROCESS

This study proved to be a most exhilarating endeavour. While my purpose was to explore how preceptorship helps prepare students to become nurse practitioners, by its very nature this study also afforded a firsthand glimpse into the "real" world of preceptorship within the context of advanced nursing practice. Interviews, for example, permitted me to follow nurse practitioner students as they made the transition from experienced registered nurse to nurse practitioner student and eventually to newly graduated nurse practitioner. I was privileged to witness and learn about the often anxiety-provoking, frustrating and ultimately transformative professional and personal transition that nurse practitioner student's experienced.

This study also provided an opportunity for me to learn about the experience of nurses who generously gave of their time and expertise toward the development of nurse practitioner students. It was important to listen to how nurses juggled their preceptor role with that of practising nurse practitioner, while at the same time accommodating the learning needs of students who required much of their time and attention. Throughout the interview process, I observed that these nurses were deeply committed to sharing their time and expertise with their students. Moreover, they did so with a spirit of joyful enthusiasm and inclusivity.

Key to preceptorship, and therefore to this study, was the role of the faculty member. It was important to explore, through the lens of faculty members, the process involved in preparing nurse practitioner students for professional

practice. It was illuminating for me to witness the commitment these faculty members had to preceptors as well as to students, throughout this critical process. While interviewing these individuals I was fortunate to be privy to their stories of the anxiety some faculty experienced when trying to secure future preceptorship positions, dealing with a student who was not progressing in the program as expected, and their struggles to find time to make site visits.

I also discovered that the preceptorship related theory described by various researchers sometimes did not translate well in the practice area. For example, there is a plethora of literature in which it is stated that faculty should visit students on a regular basis when in the practice setting; however, for logistical reasons (e.g. the number of students) this process often does not always occur. What seems logical to me, then, is for those faculty members who teach in this advanced practice program be assigned a team of support staff to contend with the day-to-day routine administrative duties as well as the organization of the preceptorships. This ongoing support would then allow the faculty to concentrate on curricular development and to ensure regular site visits.

Having practiced for 10 years as a Family and All Ages Nurse Practitioner, when I listened to the stories of these students, nurse practitioner preceptors and faculty members, I at times found myself reliving the anxiety, messiness, and discomfort I encountered when engaged in my own nurse practitioner/outpost nursing education. I could relate in particular to this student's perspective when she queried, "What am I doing!" and "Who am I?" I would have liked to say respond by stating the following, "with time and experience you

will find your identity and you will come to understand what you are doing," but of course I kept silent not wanting to influence the participant.

Frequently throughout the interview process I felt such pride for the students and the preceptors. In terms of the students, I was thrilled to witness their steadfast determination to learn the role of the nurse practitioner and then their eventual transition to the "new who". I was also pleased to hear about the support and networking opportunities they provided for each other in the form of communitas. For the preceptors I was comforted to observe their determination to provide exemplary role modeling for the students and their commitment to their important roles of teacher, advocate, nurturer, disciplinarian, and for some eventual mentor.

In conclusion, this study will contribute to a further understanding of the process involved in preparing future nurse practitioners by way of preceptorship. The knowledge generated in this study about the process involved in preparing nurse practitioner students can open up new possibilities and provide new ways of thinking that will inform the development of new and innovative teaching-learning strategies in preceptorship for students at this advanced level.

REFERENCES

Alberta Association of Registered Nurses. (June, 2002). *Prescribing and distributing guidelines for nurse practitioners*. Edmonton, AB: Author.

Allen, C. (2002). Peers and partners: a stakeholder evaluation of preceptorship in mental health nursing. *Nurse Researcher 9*(3), 68-84

Altmann, T. K. (2006). Preceptor selection, orientation, and evaluation in Baccalaureate nursing education. *International Journal of Nursing Education Scholarship, 3*(1), 1-16.

Amella, E. J., Brown, L., Resnick, B., & Behler McArthur, D. (2001). Partners for NP education: The 1999 AANP preceptor and faculty survey. *Journal of the American Academy of Nurse Practitioners, 13*(11), 517-523.

Annells, M. (1996). Grounded theory method: Philosophical perspectives, paradigm of inquiry, and postmodernism. *Qualitative Health Research, 6*(3), 379-393.

Arendt, H. (1958). *The Human Condition*. Chicago, IL: University of Chicago Press.

Arman, M., & Rehnsfeldt, A. (2003). The hidden suffering among breast cancer patients: A qualitative metasynthesis. *Qualitative Health Research, 13*(4), 510-527.

Author. (1984, 2003). *The Canada Health Act.* Ottawa, ON: Health Canada.

Backenstose, A. G. (1983). *The use of clinical preceptors.* In S. Stuart-Siddall & J. M. Haberlin (Eds.), Preceptorships in nursing education (pp. 9-23). Rockville, MD: Aspen Publications.

Bain, L. (1996). Preceptorship: A review of the literature. *Journal of Advanced Nursing, 24*(1), 104-107.

Baumann, S. L. (1998). Nursing: The missing ingredient in nurse practitioner education. *Nursing Science Quarterly, 11*(3), 89-90.

Beale, J. A., MacGuire, D., & Carr, R. (1996). Neonatal nurse practitioners: Identity as advanced practice nurses. *JOGNN, 25*, 401-406.

Beck, C. T. (1993). Qualitative research: The evaluation of its credibility, fittingness, and auditability. *Western Journal of Nursing Research, 15*, 263-66.

Benton, D. C. (1996). Grounded theory. In D. F. S. Cormack (Ed.), *The research process in nursing* (pp. 123-134). Oxford: Blackwell Science.

Billay, D., & Yonge, O. (2004). Contributing to the theory development of preceptorship. *Nurse Education Today, 24*, 566-574.

Blair, K. (2005). *The 2005 Sourcebook for Advanced Practice Nurses*. Washington, DC.

Blumer, H. (1969 a). *Symbolic interactionism*. Englewood Cliffs, NJ: Prentice Hall.

Blumer, H. (1969 b). Collective behaviour. In A. Lee (Ed.), *Principles of sociology* (pp. 67-121). New York, NY: Barnes & Noble.

Bodgan, R., & Biklen, S. (1998). Qualitative research for education (3rd ed.). Boston, MA: Ally & Bacon.

Bradshaw, M. J., Rule, R., & Hooper, V. (2002). Spotlight on…. A joint junior-senior clinical experience. *Nurse Educator, 27*(2), 56-57.

Bridges, W. (2001). *The way of transition: Embracing life's most difficult moments*. Cambridge, MA: Perseus Books.

Brookfield, S. (2005). Critical thinking. In L. English (Ed.), *International encyclopedia of adult education* (pp. 168-173). New York, NY: Palgrave Macmillan.

Brookfield, S. (2003). Putting the critical back into critical pedagogy. *Journal of Transformative Education, 1*, 141-149.

Brookfield, S. (2001). Repositioning ideology: Critique in a critical theory of adult learning. *Adult Education Quarterly, 52*(1), 7-33.

Browne, A. (1993). A conceptual clarification of respect. *Journal of Advanced Nursing, 18*, 211-217.

Burns, N., & Grove, S. K. (1995). *Understanding nursing research*. Philadelphia, PA: WB Saunders.

Bryant, S. C., & Williams, D. (2002). The senior practicum. *Nurse Educator, 27*(4), 174-177.

Byrd, C. Y., Hood, L., & Youtsey, N. (1997). Student and preceptor perceptions of factors in a successful learning partnership. *Journal of Professional Nursing 13*, 344-351.

Canadian Nurses Association. (2000). *Framework for advanced practice*. Ottawa, ON: Author.

Capital Health Authority. (2001). *Capital Health model for advanced nursing practice*. Edmonton, AB: Author.

Chang, W-C, Mu, P-F, & Tsay, S-L. (2006). The experience of role transition in acute care nurse practitioners in Taiwan under the collaborative model. *Journal of Nursing Research, 14*(2), 83-91.

Charlton, C. R., Dearing, K. S., Berry, J. A., & Johnson, M. J. (2008). Nurse practitioners' communication styles and their impact on patient outcomes: An integrated literature review. *Journal of the American Academy of Nurse Practitioners, 20*, 382-388.

Chick, N., & Meleis, A. I. (1986). Transition: A nursing concern. In P. Chin (Ed.), *Nursing research methodology: Issues and implementation* (pp. 237-257). Rockville, MD: Aspen.

Chickerella, B. G. & Lutz, W. J. (1981). Professional nurturance: Preceptorship for undergraduate nursing. *American Journal of Nursing, 81*(1), 107-109.

Clouder, L. (2005). Caring as a "threshold concept": Transforming students in higher education into health (care) professionals. *Teaching in Higher Education, 10*(4), 505-517.

Coates, V., & Gormley, E. (1997). Learning the practice of nursing: Views about preceptorship. *Nursing Education Today, 17*, 91-98.

Cohen, C., & Musgrave, C. F. (1998). A preceptorship program in an Israeli bone marrow transplantation unit. *Cancer Nursing, 21*(4), 259-262.

College & Association of Registered Nurses of Alberta. (2005). *Primary health care*. Edmonton, AB: Author.

Cook-Sather, A. (2006). Newly betwixt and between: Revising liminality in the context of a teacher preparation program. *Anthropology and Education Quarterly, 37*(2), 110-27.

Corbally, M. A., Scott, A., Matthews, A., Mac Gabhann, L., & Murphy, C. (2007). Irish nurses' and midwives' understanding and experiences of empowerment. *Journal of Nursing Management, 15*, 169-179.

Corlett, J. (2000). The perceptions of nurse teachers, student nurses and preceptors of the theory-practice gap in nurse education. *Nurse Education Today, 20*, 499-505.

Cousin, G. (2006). An introduction to threshold concepts. *Planet*, *17*, 4-5.

Cresswell, J. W. (1998). Qualitative inquiry and research design: Choosing among five traditions. Thousand Oaks, CA: Sage Publications

Crumble, W. M. (2003). Nurse practitioner education: At what level? *Nursing Standard, 18*(4), 33-36.

Cummings, G. G., Fraser, K., & Tarlier, D. S. (2003). Implementing advanced nurse practitioner roles in acute care: An evaluation of organizational change. *Journal of Nursing Administration, 33*(3), 139-145.

Currie, K. (2008). Linking learning and confidence in developing expert practice. *International Journal of Nursing Education Scholarship, 5*(1), 1-13.

Cutcliffe, J. R. (2000). Methodological issues in grounded theory. *Journal of Advanced Nursing, 31*(6), 1476-1488.

Davis, M., Sawin, K., Dunn, M. (1993). Teaching strategies used by expert nurse practitioner preceptors: A qualitative study. *Journal of American Academy of Nurse Practitioners*, *5*(1), 227-33.

DeCicco, J., Laschinger, H., & Kerr, M. (2006). Perceptions of empowerment and respect: Effect on nurses' organizational commitment in nursing homes. *Journal of Gerontological Nursing, 32*(5), 49-56.

Dewey, J. (1938). *Experience and education*. New York: Macmillan.

Dewey, J. (1933). *How we think.* Boston: Heath.

Dewey, J. (1925). Nature, communication and meaning. From Experience and nature, 1925. In L. A. Hickman, & T. M. Alexander (Eds.), *The essential Dewey. Vol. 2: Ethics, logic, psychology* (pp. 50-66). Indianapolis, IN: Indiana University Press.

Dilbert, C., & Goldenberg, D. (1995). Preceptors' perceptions of benefits, rewards, supports and commitment to the preceptorship role. *Journal of Advanced Nursing, 21*, 1144-1151.

Disch, J., Beilman G., & Ingbar, D. (2001). Medical directors as partners in creating healthy work environments. *AACN Clinical Issues, 12*(3), 366-377.

Donnelly, G. (2003). Clinical expertise in advanced practice nursing: A Canadian perspective. *Nurse Education Today, 23*, 168-173.

Duffy, K. (2004) *A grounded theory investigation of factors which influence the assessment of students' competence to practice*. London: Nursing and Midwives Council.

Ferguson, L. M. (1994). Faculty support for preceptor nurses. *Nurse Educator, 19*(6), 6.

Ferguson, L. M., & Calder, B. L. (1993). A comparison of preceptor and educator valuing of nursing student clinical performance criteria. *Journal of Nursing Education, 32*, 30-36.

Festinger, L. (1957). *A theory of cognitive dissonance*. Evanston, IL: Stanford University Press.

Field, P. A., & Morse, J. M. (1985). *Nursing research: The application of qualitative approaches*. Rockville, MD: Aspen.

Finger, S. D., & Pape, T. M. (2002). Invitational theory and perioperative nursing preceptorships. *AORN, 76*, 630, 633-636, 638-642.

Fraser, C. (1999). The experience of transition for a daughter caregiver of a stroke survivor. *Journal of Neuroscience Nursing, 31*(1), 9-16.

Freiburger, O. A. (2001). A tribute to clinical preceptors: Developing a preceptor program for nursing students. *Journal for Nurses in Staff Development, 17*(6), 320-327.

Gessner, R. (Ed.). *The democratic man: Selected writings of Edward C. Lindeman.* Boston: Beacon.

Glaser, B., & Holton, J. (2004). Remodeling ground theory. *Forum: Qualitative Social Research, 5*(2), Art. 4. Retrieved June 13, 2009, from http://www.qualitative-research.net/fqs-texte/2-04glaser-e.htm

Glaser, B. (1978). *Theoretical sensitivity. Advances in the methodology of grounded theory*. Mill Valley, CA: Sociology Press.

Glaser, B. G., & Strauss, A. L. (1967). The discovery of grounded theory: Strategies for qualitative research. New York, NY: Aldine De Gruyter.

Golan, N. (1981). *Passing through transitions*. New York: Free Press.

Goolsby, M. J. (2000). Understanding nurse practitioner preparation. *Journal of the American Academy of Nurse Practitioners, 12*(2), 43-48.

Gray, M. A., & Smith, L. N. (2000). The qualities of an effective mentor from the student nurse's perspective: Findings from a longitudinal qualitative study. *Journal of Advanced Nursing, 32*, 1542-1549.

Gruber, M. (2003). Cognitive dissonance theory and motivation for change: A case study. *Gastroenterology Nursing, 26*(6), 242-245.

Guba, E. G., & Lincoln, Y. S. (1989). *Fourth generation evaluation*. Newbury Park, CA: Sage.

Hall, J. A. (1991). The watcher at the gates of dawn: The transformation of self in liminality and by the transcendent function. In N. Schwartz-Salant & M. Stein (Eds.), *Liminality and transitional phenomena* (pp. 33-51). Wilmette, IL: Chiron.

Hart, A. M., & Macnee, C. L. (2007). How well are nurse practitioners prepared for practice: Results of a 2004 questionnaire study. *Journal of the American Academy of Nurse practitioners, 19*, 35-42.

Hetzel Campbell, S., & Hawkins, J. W. (2007). Preceptor rewards: How to say thank you for mentoring the next generation of nurse practitioners. *Journal of the American Academy of Nurse Practitioners, 19*, 24-29.

Hilton, E. (2002). The meaning of stroke in elderly women: A phenomenological investigation. *Journal of Gerontological Nursing, 28*(7), 19-26.

Hirshfield, J. (1997). *Nine gates: Entering the mind of poetry*. New York: Harper-Collins.

Hockey, J. (2002). The importance of being intuitive: Arnold Van Gennep's *The Rites of Passage*. *Mortality, 7*(2), 210-217.

Hrobsky, P. E., & Kersbergen, A. L. (2002). Preceptors' perceptions of clinical performance failure. *Journal of Nursing Education, 41*(12), 550-553.

Hutchinson, S. (1993). Grounded theory: The method (pp. 180-212). In P. L. Munhall and C. O. Boyd. *Nursing research: A qualitative perspective*. New York, NY: National League for Nursing Press.

Ihlenfeld, J. T. (2003). Precepting student nurses in the intensive care unit. *Dimensions of Critical Care Nursing, 22*(3), 134-137.

Jones, J. M., & Dupree Jones, K. (1998). Nurse practitioner education: Living it, learning it. *Journal of Nursing Education, 37*(4), 176-178.

Kaviani, N., & Stillwell, Y. (2000). An evaluative study of clinical preceptorship. *Nurse Education Today, 20*, 218-226.

Kleinpell, R. M., Faut-Callahan, M., Lauer, K., Kremer, M. J., Murphy, M., & Sperhac, A. (2002). A collaboration practice in advanced practice nursing in acute care. *Critical Care Nursing in North America, 14*(3), 307-313.

Knowles, M., Holton III, E. F., & Swanson, R. A. (1998). *The adult learner*. New York, NY: Elsevier.

Kralik, D., van Loon, A., & Visentin, K. (2006). Resilience in the chronic illness experience. *Educational Action Research, 14*(2), 187-201.

Kralik, D., Visentin, K., & van Loon, A. (2006). Transition: A literature review. *Journal of Advanced Nursing, 55*(3), 320-329.

Kralik, D. (2002). The quest for ordinariness: Transition experienced by midlife women living with chronic illness. *Journal of Advanced Nursing, 39*(2), 146-154.

Kuokkanen, L., & Leino-Kilpi, H. (2001). The qualities of an empowered nurse and the factors involved. *Journal of Nursing Management, 9*, 273-280.

Le Cornu, A. (2009). Meaning, internalization, and externalization: Toward a fuller understanding of the process of reflection and its role in the construction of the self. *Adult Education Quarterly, 59*(4), 279-297.

LeGris, J., & Cote, F. H. (1997). Collaborative partners in nursing education: A preceptorship model for BScN students. *Nursing Connections, 10*(1), 55-70.

Letizia, M., & Jennrich, J. (1998). A review of preceptorship in undergraduate nursing education: Implications for staff development. *The Journal of Continuing Education in Nursing, 29*(5), 211-216.

Lindeman, E. C. (1926). *The meaning of adult education*. New York, NY: Republic.

Lipman, T., & Deatrick, J. (1997). Preparing advanced practice nurses for clinical decision making in specialty practice. Nurse Educator, 22(2), 47-50.

Lockwood-Rayermann, S. (2003). Preceptor leadership style and the nursing practicum. *Journal of Professional Nursing, 19*, 32-37.
Lomborg, K., & Kirkevold, M. (2003). Truth and validity in grounded theory-a reconsidered realist interpretation of the criteria: *fit, work, relevance,* and *modifiability*. *Nursing Philosophy, 4*, 189-200.

Lugones, M. (2006). On complex communication. *Hypatia, 21*(3), 76-85.

Luhanga, F. L. (2006). *The challenges for preceptors in dealing with nursing students engaging in unsafe practices* (Unpublished doctoral dissertation). University of Alberta, Edmonton, Alberta.

Mamchur, C., & Myrick, F. (2003). Preceptorship and interpersonal conflict: A multidisciplinary study. *Journal of Advanced Nursing, 43*(2), 188-196.

Marfell, J. A. (2002). Clinical practice opportunities for advanced practice nurses. *Critical Care Nursing Clinics of North America, 14*, 223-229.

Marineau, M. (2005). Health/illness transition and telehealth: A concept analysis using the evolutionary method. *Nursing Forum, 40*(3), 96-106.

Martin-McDonald, K., & Biernoff, D. (2002). Initiation into a dialysis dependent life: An examination of rites of passage…including commentary by Frauman AC with author response. *Nephrology Nursing Journal, 29*(4), 347-353.

Matz, D., & Wood, W. (2005). Cognitive dissonance in groups: The consequences of disagreement. *Journal of Personality and Social Psychology, 88*(1), 22-37.

Mayan, M. J. (2001). *An introduction to qualitative methods: A training module for students and professionals*. Edmonton, AB: Qualitative Health Press.

McKimmie, B. M., Terry, D. J., Hogg, M. A., Manstead, A. R., Spears, R., & Doosje, B. (2003). I'm a hypocrite, but so is everyone else: Group support and the reduction of cognitive dissonance. *Group Dynamics: Theory, Research, and Practice, 7*(3), 214-224.

McCann, T., & Clark, E. (2003a). Grounded theory in nursing research: Part 1-Methodology. *Nurse, 11*(2), 7-18.

McCann, T., & Clark, E. (2003c). Grounded theory in nursing research: Part 3-Application. *Nurse, 11*(2), 29-39.

Meleis, A. I. (1993). A call for substance [Keynote address]. *Annual Forum on Doctoral Nursing Scholarship, 22*, 226-262.

Meyer, J., & Land, R. (2006). *Enhancing Teaching–learning Environments in Undergraduate Courses Project: Threshold concepts and troublesome knowledge: Linkages to ways of thinking and practicing within the disciplines* [Occasional Report 4]. Edinburgh: University of Edinburgh, School of Education.

Mezirow, J. (2000). *Learning as transformation: Critical perspectives on a theory in progress*. San Francisco: Jossey-Bass.

Mezirow, J. (1997). Transformative learning: Theory to practice. *New Directions for Adult and Continuing Education, 74*, 5-12.

Mezirow, J. (1991). *Transformative dimensions of adult learning*. San Francisco: Jossey-Bass.

Mezirow, J. (1981). A critical theory of adult learning and education. *Adult Education, 32*(1), 3-24.

Mezirow, J. (1978). Perspective transformation. *Adult Education, XXVII* (2), 100-110.

Mishra, A. K., & Spretizer, G. M. (1998). Explaining how survivors respond to downsizing: The roles of trust, empowerment, justice, and work redesign. *Academy of Management Review, 23*, 738-748.

Morse, J. (2009). Exploring transitions. *Qualitative Health Research, 19*(4), 431.

Morse, J. M. (1995). The significance of saturation. *Qualitative Health Research, 5*(2), 147-149.

Myrick, F. (2002). Preceptorship and critical thinking in nursing education. *Journal of Nursing Education, 11*, 154-164.

Myrick, F. (1998). *Preceptorship and critical thinking in nursing education*. Unpublished PhD Thesis. University of Alberta. Edmonton, Alberta.

Myrick, F. (1988). Preceptorship: A viable alternative clinical teaching strategy? *Journal of Advanced Nursing, 13*, 588-591.

Myrick, F., & Barrett, C. (1994). Selecting clinical preceptors for basic baccalaureate nursing students: A critical issue in clinical teaching. Jo*urnal of Advanced Nursing, 19*, 194-198.

Myrick, F., & Barrett, C. (1992). The effect of preceptorship on the clinical competency of baccalaureate student nurses: A pilot study. *The Canadian Journal of Nursing Research, 20*(3), 29-43.

Myrick, F. & Billay, D. (2010). Student clinical experiences: Responsibilities of student, faculty, and preceptor. In J.S. Fulton, K.A. Goudreau & B.L. Lyon (Eds.) *Foundations of Clinical Nurse Specialist Practice (ch. 21).* New York: Springer Publishing.

Myrick, F., & Yonge, O. (2005). *Nursing preceptorship: Connecting practice and education*. London, UK: Lippincott Williams & Wilkins.

Myrick, F., & Yonge, O. (2002). Preceptor behaviors integral to the promotion of student critical thinking. *Journal for Nurses in Staff Development, 18*(3), 127-133.

Nasir, N. S., & Saxe, G. B. (2003). Ethnic and academic identities: A cultural practice perspective on emerging tensions and their management in the lives of minority students. *Educational Research, 32*(5), 14-18.

Nehls, N., Rather, M., & Guyette, M. (1997). The preceptor model of clinical instruction: The lived experiences of students, preceptors, and faculty-of-record. *Journal of Nursing Education, 36*(5), 220-227.

Oermann, M. H. (1996). A study of preceptor roles in clinical teaching. *Nursing Connections, 9*, 57-64.

Palmer, I. (1983). *From whence we came. The nursing profession: A time to speak* (Chaska N. L. ed.), New York, NY: McGraw-Hill.

Pardue, K. T. (2002). Illuminating the experience of student precepting: Insights and narratives from home care nurses. *Home Healthcare Nurse, 20*, 163-167.

Patton, M. Q. (1990). *Qualitative evaluation and research methods* (2nd ed.). Newbury Park, CA: Sage.

Patterson, C., & Hezekiah, J. (2000). What makes nursing practice advanced? In C. Patterson (Ed.), *Nurse Practitioners…the catalyst of change* (pp. 41-64). Troy, Canada: Newrange Press.

Peirce, A. G. (1991) Preceptorial students' view of their clinical experience. Journal of Nursing Education, 30(6), 244-250.

Phillips, J. M. (2006). Preparing preceptors through online education. *Journal for Nursing in Staff Development, 22*(3), 150-156.

Phillips, N., & Duke, M. (2001). The questioning skills of clinical teachers and preceptors: A comparative study. *Journal of Advanced Nursing, 33*(4), 523-539.

Pickens, J. M., & Fargotstein, B. P. (2006). Preceptorship: A shared journey between practice & education. *Journal of Psychosocial Nursing, 44*(2), 31-36.

Poncelet, A., & O'Brien, B. (2008). Preparing medical students for clerkships: A descriptive analysis of transition courses. *Academic Medicine, 83*(5), 444-450.

Rappaport, J. (1987). Terms of empowerment/exemplars of prevention: Toward a theory for community psychology. *American Journal of Community Psychology, 15*(2), 121-148.

Rappaport, J. (1984). *Studies in empowerment: Introduction to the issue*. New York, NY: The Haworth Press, Inc.

Rittman, M. R., & Osburn, J. (1995). An interpretive analysis of precepting an unsafe student. *Journal of Nursing Education, 34*, 217-221.

Robeson, P. (2009). *Networking in public health: Exploring the value of networks to the National Collaborating Centres for Public Health*. Ottawa, ON: National Collaborating Centre for Methods and Tools.

Rosenlieb, C. O. (1993). A profile of preceptorships in baccalaureate degree nursing programs for registered nurses. In N. L. Diekelmann and M. L. Rather (Eds.). *Transforming RN education: Dialogue and debate*. (pp. 256-272). New York, NY: National League for Nursing Press.

Sandelowski, M. (1995). Focus on qualitative methods. Sample size in qualitative research. *Research in Nursing & Health, 18*, 179-183.

Sandelowski, M. (1986). The problem with rigor in qualitative research. *Advances in Nursing Science, 8*(3), 27-37.

Savin-Baden, M. (2006). Disjunction as a form of troublesome knowledge in problem-based learning. In J. H. F. Meyer & R. Land (Eds.), *Overcoming barriers to student understanding: Threshold concepts and troublesome knowledge* (pp. 160-172). London, UK: Routledge.

Scherer, Y. K., Bruce, S. A., Graves, B. T., & Erdley, W. S. (2003). Acute care nurse practitioner education: Enhancing performance through the use of clinical simulation. *AACN Clinical Issues, 14*(3), 331-341.

Schoener, L., & Garrett, M. P. (1996). Faculty: The driving force in preceptorship. *Nursing Connections, 9*(3), 37-42.

Schön, D. (1991). *The reflective practitioner*. Aldershot, UK: Ashgate.

Schreiber, R. A. (2001). The "how to" of grounded theory: Avoiding the pitfalls. In R. S. Schreiber & P. N. Sterns (Eds.), *Using grounded theory in nursing* (pp. 55-83). New York, NY: Springer.

Schumacher, K. L., & Meleis, A. I. (1994). Transitions: A central concept in nursing. *Image: Journal of Nursing Scholarship, 26*(2), 119-127.

Seldomridge, L. A., & Walsh, C. M. (2006). Evaluating student performance in undergraduate preceptorships. *Journal of Nursing Education, 45*(5), 169-176.

Shaul, M. (1997). Transitions in chronic illness: Rheumatoid arthritis in women. *Rehabilitation Nursing, 22*(4), 199-205.

Speers, A. T., Strzyzewski, N., & Ziolkowski, L. D. (2004). Preceptor preparation: An investment in the future. *Journal for Nursing in Staff Development, 20*(3), 127-133.

Sprietzer, G. M., & Quinn, R. E. (2001). *A company of leaders: Five disciplines for unleashing the power in your workplace*. San Francisco, CA: Jossey-Bass.

Stark, S. W. (2004). Preceptor's expectations: An avenue to foster appropriate clinical experiences for advanced practice nursing students. *The Journal of Continuing Education in nursing, 35*(5), 234-235.

Stern, P. N. (1980). Grounded theory methodology: Its uses and processes. *IMAGE: The Journal of Nursing Scholarship, 12*(1), 20-30.

Stone, C. L., & Rowles, C. J. (2002). What rewards do clinical preceptors in nursing think are important? *Journal for Nurses in Staff Development, 18*(3), 162-166.

Strauss, A. J., & Corbin, J. (1998). *Basis of qualitative research: Techniques and procedures for developing grounded theory* (2nd Ed). Thousand Oaks, CA: Sage.

Streubert, H. J., & Carpenter, D. R. (1999). *Qualitative research in nursing: Advancing the humanistic imperative.* New York, NY: Lippincott.

Syx, R. (2008). The practice of patient education: The theoretical perspective. *Orthopedic Nursing, 27*(1), 50-54.

Tanner, C. L., Pohl, J., Ward, S., & Dontje, K. (2003). Education of nurse practitioners in academic nurse-managed centers: Student perspectives. *Journal of Professional Nursing, 19*(6), 354-363.

Tomlinson, P. S. (1996). Marital relationship change in the transition to parenthood: A reexamination as interpreted through transition theory. *Journal of Family Nursing, 2*(3), 286-305.

Turner, V. (1979). Frame, flow and reflection: Ritual and drama as public liminality. *Japanese Journal of Religious Studies, 6/4,* 465-499.

Turner, V. (1977). *The ritual process*. Ithaca, NY: Cornell University Press.

Turner, V. (1974). *Dramas, fields and metaphors: Symbolic actions in human society*. Ithaca, NY: Cornell University Press.

Turner, V. (1969). *The ritual process: Structure and anti-structure.* Chicago: Aldine.

Turner, V. (1967). *Betwixt and between: The liminal period in Rites de Passage*. Ithaca, NY: Cornell University Press.

Tyhurst, J. (1957). The role of transition states—including disasters—in mental health. Paper presented at the Symposium on Preventive and Social Psychiatry, Walter Reed Army Institute of Research, City unknown, State unknown.

Usher, K., Nolan, C., Reser, P., Owens, J., Tollefson, J. (1999). An exploration of the preceptor role: Preceptors' perceptions of benefits, rewards, supports and commitment to the preceptor role. *Journal of Advanced Nursing, 29,* 506-514.

Van Gennep, A. (1960). *The rites of passage*. Chicago: Chicago University Press.

Wallace Stark, S. (2004). Preceptors' expectations: An avenue to foster appropriate clinical experiences for advanced practice nursing students. *The Journal of Continuing Education in Nursing, 35*(5), 234-235.

Williams, M. (1999). Nursing 99, turmoil, transitioning and triumphs. *Connecticut Nursing News, 72*(4), 18-19.

Williamson, K. M. (2007). Home health care nurses' perceptions of empowerment. *Journal of Community Health Nursing, 24*(3), 133-153.

Wood, J. (1997). Conceptualizing advanced nursing practice: Curriculum issues to consider in the educational preparation of advanced practice nurses in the UK. *Journal of Advanced Nursing, 25,* 820-828.

World Health Organization. (1978). *Primary health care: Report of the international conference on primary health care,* held in Alma Ata, USSR. Geneva, Switzerland: Author.

Yonge, O., Myrick, F., Ferguson, L., & Luhanga, F. (2005). Promoting effective preceptorship experiences. *Journal of the Wound, Ostomy and Continence Nurses Society, 32*(6), 407-412.

Yonge, O., Ferguson, L., Myrick, F., & Haase, M. (2003). Faculty preparation for the preceptorship experience. *Nurse Educator, 28*(5), 212-211.

Yonge, O., Krahn, H., Trojan, L., Reid, D., & Haase, M. (2002). Supporting preceptors. *Journal for Nurses in Staff Development, 18*(2), 73-79.

Yonge, O., Krahn, H., Trojan, L., & Reid, D. (1997). Preceptors evaluating nursing students. *Canadian Journal of Nursing Administration, 10*(2), 77-95.

Yonge, O., Krahn, H., Trojan, L., Reid, D., & Haase, M. (2002a). Being a preceptor is stressful! *Journal for Nurses in Staff Development, 18*(1), 22–27.

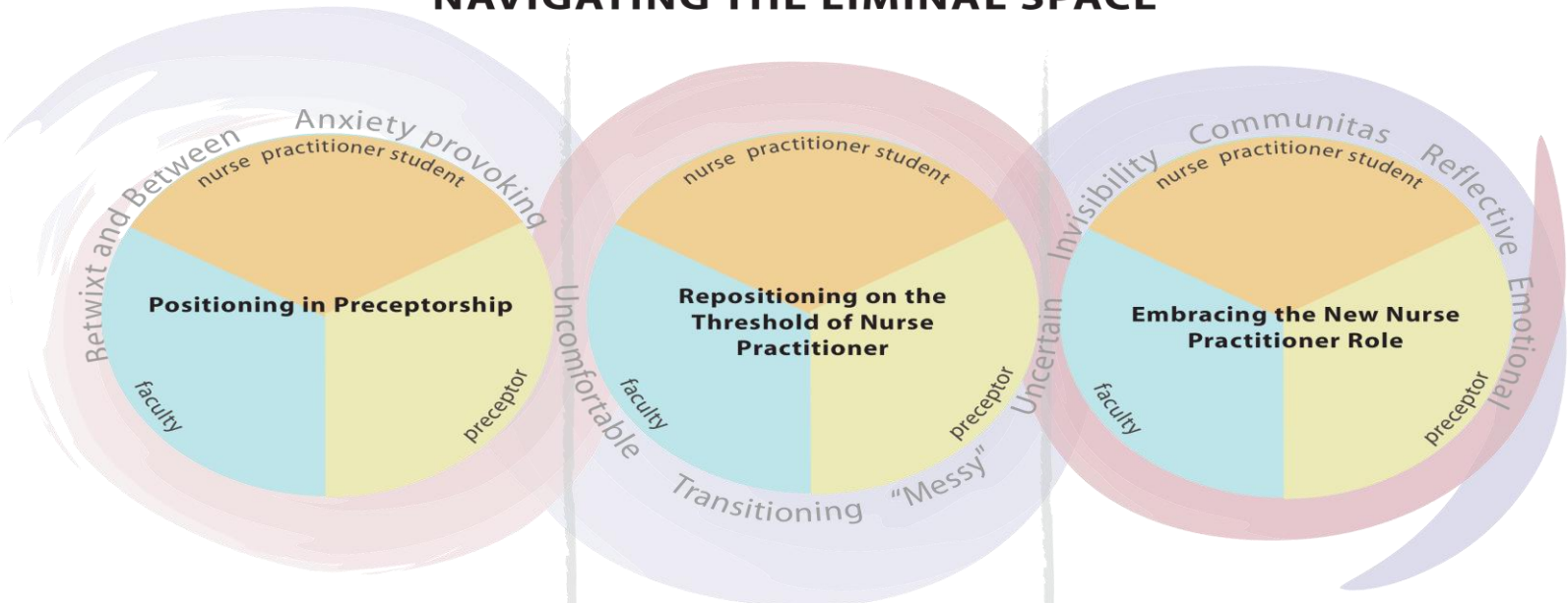
Yonge, O., Krahn, H., Trojan, L., Reid, D., & Haase, M. (2002b). Supporting preceptors. *Journal for Nurses in Staff Development, 18*(2), 73–79.

Yonge, O., & Myrick, F. (2004). Preceptorship and the preparatory process for undergraduate nursing students and their preceptors. *Journal for Nurses in Staff Development, 20*(6), 294-297.

Yonge, O., Myrick, F., & Haase, M. (2002), Student nurse stress in the preceptorship experience. *Nurse Educator, 27*(2), 84-88.

Zimmerman, M. A. (1995). Psychological empowerment: Issues and illustrations. *American Journal of Community Psychology, 23*, 581-599.

PRECEPTORSHIP AND NURSE PRACTITIONER EDUCATION: NAVIGATING THE LIMINAL SPACE



Working Through the Rites of Passage

- Identity formation
- Cognitive dissonance:
  - oDiscomfort
  - oTroublesome knowledge
- Making their way through
  - Having time
  - Engaging in collegial interactions
  - Acquiring role clarity
  - Being a student
  - Learning the role

Becoming Socialized

- How language is used
- Negotiating
- Being supported:
  - Networking
  - Challenging and being challenged
- Incorporating and building a knowledge base
  - Clinincal experience of the students
  - Credibility of faculty members

Becoming Affirmed (again)

- Transitioning: Experienced registered nurse to nurse practitioner student to new nurse practitioner
- Empowerment:
  - Comfort and confidence
  - Recognition; Respected
  - Self-reflection

Emerging As Transformed:

Shifting Perceptions:
- Increase in public relations with physicians and registered nurses

Natality: Emergence of the 'new who'

APPENDIX A

LETTER OF INFORMATION: STUDENTS

Research Project: *Educating Nurse Practitioner Students in the Preceptorship Experience.*

Investigator:

Diane Billay, RN, BN, MN, PhD (c)

Faculty of Nursing

3rd Floor Clinical Sciences Building

University of Alberta

Edmonton, AB

T6G 2G3

E-mail: dianew@ualberta.ca

Phone: (780) 718-3270 (business)

Co-Investigator:

Dr. Florence Myrick, RN, PhD

Faculty of Nursing

3rd Floor Clinical Science Building

University of Alberta

Edmonton, AB

T6G 2G3

Phone: (780) 492-0251

Introduction

You are invited to participate in a research study. The proposed research can increase our understanding of preceptorship in preparing nurse practitioners for their role. My name is Diane Billay. From 1995 to 2005 I was a nurse practitioner, having practiced primarily in Northern communities and with marginalized populations. Currently I am pursuing a PhD in nursing in the Faculty of Nursing at the University of Alberta. The preceptorship model of

clinical teaching and learning has been my area of interest since 1998, and is the area I have chosen to study for my PhD Thesis.

Background/purpose of the study

Preceptorship is a teaching/learning approach in which learners are individually assigned to expert practitioners in the practice setting. The purpose of this arrangement is to provide them with daily experience on a one to one basis with a role model and resource person who is immediately available to them. The purpose of this research, then, is to examine the process used in the preceptorship experience to prepare nurse practitioner students for their future role in professional practice.

Procedure

If you decide to participate, you are likely to participate in only one individual interview, although later you may be asked to participate in one to two follow-up interviews. The initial interview will last between 60 to 90 minutes, and arranged on a date and at a location convenient to both you and I, and at a time outside your normal work schedule. Subsequent interviews could last anywhere from 20 minutes to 60 minutes in length. All interviews will be audio-recorded and I will take notes. Immediately after each interview, audio-recorded interviews, handwritten field notes will be transcribed and analyzed. As well, there may be the opportunity for observation. This will allow me to observe you and your preceptor in the clinical setting.

Privacy and confidentiality

All information collected will be held confidential (or private), except when professional codes of ethics or legislation require reporting. The recordings and notes will be kept in a locked filing cabinet and only I will have access to them. The final report of this study may include some of your words but your name or identifying information will not appear. Your name will also not be used in any presentations or publications of the study results. To the best of our ability you will not be identified in any way. The information you provide for this study will be stored in the Faculty of Nursing, at the University of Alberta, for at least seven years after the study has been completed.

Consent

It is up to you to decide whether or not you want to take part in this study. If you decide to take part you will be asked to sign a consent form. If you decide to take part you may choose not to answer any of the questions or discuss any subject in the interview if you do not want to. You may withdraw from the study at any time with no penalty to you.

Benefits

There will likely be no direct benefits from participating in this study. However, following completion of this study, it is possible the results will assist nurse educators, faculty and preceptors in their efforts to improve the educational programs of nurse practitioner students in Canada.

Risks

There are no foreseen disadvantages or risks to taking part in this study.

Use of data

Only I, her thesis supervisor and the transcriber will review the transcripts or written notes. The recordings of the research interviews will be destroyed once the study is completed. I intend to publish the results of this study in nursing journals and present them at professional conferences. A summary of the findings would be available to you upon request.

Future use of the data

The information gathered for this study may be reviewed again in the future to help us answer other study questions. If so, the ethics board will first review the study to ensure the information is used ethically. If you would like more information about the study, or would be interested in participating, please complete the bottom of this form and return it in the attached, stamped envelope or call at 718-3270 and leave a voice message. I will contact you by phone to answer any of your questions.

Additional contacts

You can contact the Associate Dean of Research, Dr. Christine Newburn-Cook, at (780) 492-6764.

Thank you for reading this information sheet and your consideration.

Sincerely,

Diane Billay, RN, BN, MN, PhD (c)

I would like to be contacted for further information about participation in Diane Billay's study 'educating nurse practitioner students in the preceptorship experience.'

Name:

Address:

Email:

Phone number: **(Home):**

(Cell):

Best time to telephone:

APPENDIX B

LETTER OF INFORMATION: PRECEPTOR

Research Project: *Educating Nurse Practitioner Students in the Preceptorship Experience.*

Investigator:

Diane Billay, RN, BN, MN, PhD (c)

Faculty of Nursing

3rd Floor Clinical Sciences Building

University of Alberta

Edmonton, AB

T6G 2G3

E-mail: dianew@ualberta.ca

Phone: (780) 718-3270 (business)

Co-investigator:

Dr. Florence Myrick, RN, PhD

Faculty of Nursing

3rd Floor Clinical Science Building

University of Alberta

Edmonton, AB

T6G 2G3

Phone: (780) 492-0251

Introduction

You are invited to participate in a research study. The proposed research can increase our understanding of preceptorship in preparing nurse practitioners for their role.

Background/purpose of the study

Preceptorship is a teaching/learning approach in which learners are individually assigned to expert practitioners in the practice setting. The purpose of this arrangement is to provide them with daily experience on a one to one basis with a role model and resource person who is immediately available to them. The purpose of this research, then, is to examine the process used

in the preceptorship experience to prepare nurse practitioner students for their future role in professional practice.

Procedure

If you decide to participate, you are likely to participate in only one individual interview, although later you may be asked to participate in one to two follow-up interviews. The initial interview will last between 60 to 90 minutes, and arranged on a date and at a location convenient to both you and I, and at a time outside your normal work schedule. Subsequent interviews could last anywhere from 20 minutes to 60 minutes in length. All interviews will be audio-recorded and I will take notes. Immediately after each interview, audio-recorded interviews, handwritten field notes will be transcribed and analyzed. As well, there may be the opportunity for observation. This will allow me to observe you and your preceptor in the clinical setting.

Privacy and confidentiality

All information collected will be held confidential (or private), except when professional codes of ethics or legislation require reporting. The recordings and notes will be kept in a locked filing cabinet and only I will have access to them. The final report of this study may include some of your words but your name or identifying information will not appear. Your name will also not be used in any presentations or publications of the study results. To the best of our ability you will not be identified in any way. The information you provide for this study will be stored in the Faculty of Nursing, at the University of Alberta, for at least seven years after the study has been completed.

Consent

It is up to you to decide whether or not you want to take part in this study. If you decide to take part you will be asked to sign a consent form. If you decide to take part you may choose not

to answer any of the questions or discuss any subject in the interview if you do not want to. You may withdraw from the study at any time with no penalty to you.

Benefits

There will likely be no direct benefits from participating in this study. However, following completion of this study, it is possible the results will assist nurse educators, faculty and preceptors in their efforts to improve the educational programs of nurse practitioner students in Canada.

Risks

There are no foreseen disadvantages or risks to taking part in this study.

Use of data

Only I, her thesis supervisor and the transcriber will review the transcripts or written notes. The recordings of the research interviews will be destroyed once the study is completed. I intend to publish the results of this study in nursing journals and present them at professional conferences. A summary of the findings would be available to you upon request.

Future use of the data

The information gathered for this study may be reviewed again in the future to help us answer other study questions. If so, the ethics board will first review the study to ensure the information is used ethically. If you would like more information about the study, or would be interested in participating, please complete the bottom of this form and return it in the attached, stamped envelope or call at 718-3270 and leave a voice message. I will contact you by phone to answer any of your questions.

Additional contacts

You can contact the Associate Dean of Research, Dr. Christine Newburn-Cook, at (780) 492-6764.

Thank you for reading this information sheet and your consideration.

Sincerely,

Diane Billay, RN, BN, MN, PhD (c)

I would like to be contacted for further information about participation in Diane Billay's study 'educating nurse practitioner students in the preceptorship experience.'

Name:

Address:

Email:

Phone number: (Home):

(Cell):

Best time to telephone:

APPENDIX C

LETTER OF INFORMATION: FACULTY

Research Project: *Educating Nurse Practitioner Students in the Preceptorship Experience.*

Investigator:

Diane Billay, RN, BN, MN, PhD (c)

Faculty of Nursing

3rd Floor Clinical Sciences Building

University of Alberta

Edmonton, AB

T6G 2G3

E-mail: dianew@ualberta.ca

Phone: (780) 718-3270 (business)

Co-investigator:

Dr. Florence Myrick, RN, PhD

Faculty of Nursing

3rd Floor Clinical Science Building

University of Alberta

Edmonton, AB

T6G 2G3

Phone: (780) 492-0251

Introduction

You are invited to participate in a research study. The proposed research can increase our understanding of preceptorship in preparing nurse practitioners for their role.

Background/purpose of the study

Preceptorship is a teaching/learning approach in which learners are individually assigned to expert practitioners in the practice setting. The purpose of this arrangement is to provide them with daily experience on a one to one basis with a role model and resource person who is immediately available to them. The purpose of this research, then, is to examine the process used

in the preceptorship experience to prepare nurse practitioner students for their future role in professional practice.

Procedure

If you decide to participate, you are likely to participate in only one individual interview, although later you may be asked to participate in one to two follow-up interviews. The initial interview will last between 60 to 90 minutes, and arranged on a date and at a location convenient to both you and I, and at a time outside your normal work schedule. Subsequent interviews could last anywhere from 20 minutes to 60 minutes in length. All interviews will be audio-recorded and I will take notes. Immediately after each interview, audio-recorded interviews, handwritten field notes will be transcribed and analyzed. As well, there may be the opportunity for observation. This will allow me to observe you and your preceptor in the clinical setting.

Privacy and confidentiality

All information collected will be held confidential (or private), except when professional codes of ethics or legislation require reporting. The recordings and notes will be kept in a locked filing cabinet and only I will have access to them. The final report of this study may include some of your words but your name or identifying information will not appear. Your name will also not be used in any presentations or publications of the study results. To the best of our ability you will not be identified in any way. The information you provide for this study will be stored in the Faculty of Nursing, at the University of Alberta, for at least seven years after the study has been completed.

Consent

It is up to you to decide whether or not you want to take part in this study. If you decide to take part you will be asked to sign a consent form. If you decide to take part you may choose not

to answer any of the questions or discuss any subject in the interview if you do not want to. You may withdraw from the study at any time with no penalty to you.

Benefits

There will likely be no direct benefits from participating in this study. However, following completion of this study, it is possible the results will assist nurse educators, faculty and preceptors in their efforts to improve the educational programs of nurse practitioner students in Canada.

Risks

There are no foreseen disadvantages or risks to taking part in this study.

Use of data

Only I, her thesis supervisor and the transcriber will review the transcripts or written notes. The recordings of the research interviews will be destroyed once the study is completed. I intend to publish the results of this study in nursing journals and present them at professional conferences. A summary of the findings would be available to you upon request.

Future use of the data

The information gathered for this study may be reviewed again in the future to help us answer other study questions. If so, the ethics board will first review the study to ensure the information is used ethically. If you would like more information about the study, or would be interested in participating, please complete the bottom of this form and return it in the attached, stamped envelope or call at 718-3270 and leave a voice message. I will contact you by phone to answer any of your questions.

Additional contacts

You can contact the Associate Dean of Research, Dr. Christine Newburn-Cook, at (780) 492-6764.

Thank you for reading this information sheet and your consideration.

Sincerely,

Diane Billay, RN, BN, MN, PhD (c)

I would like to be contacted for further information about participation in Diane Billay's study 'educating nurse practitioner students in the preceptorship experience.'

Name:

Address:

Email:

Phone number: (Home):

(Cell):

Best time to telephone:

APPENDIX D

CONSENT FORM TO PARTICIPATE IN THE STUDY

Preceptor, Nurse Practitioner Student, and Faculty member

Title of project: *Educating Nurse Practitioner Students in the Preceptorship Experience.*

Investigator:

Diane Billay, RN, BN, MN, PhD (c)

E-mail: dianew@ualberta.ca

Phone: (780) 718-3270 (business)

Supervisor:

Dr. Florence Myrick, RN, PhD

Phone: (780) 492-0251 (business)

Description of the project: Each participant will be required to engage in at least two and possibly three audio-recorded interviews. The initial interview will take approximately 90 minutes. Subsequent interviews may take as long as 60 minutes. You may be observed in the clinical setting.

Do you understand that you have been asked to be in a research study?	Yes	No
Have you received and read 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? You do not have to give a reason.	Yes	No
Has the issue of confidentiality been explained to you?	Yes	No
Do you consent to be interviewed?	Yes	No
Do you consent to being audio taped?	Yes	No
Do you consent to being observed in the clinical area while precepting or being precepted?	Yes	No

Do you agree to have your data reviewed at a later date?	Yes	No
Do you give permission to me to revisit your data for future analysis-pending Ethics approval or review?	Yes	No
Copy of consent form to be left with participant		

This study was explained to me by: _____

I have read and understand the above information, and agree to participate in this study.

_____ _____

Signature of Participant: Printed Name:

Date _____

I believe that the person signing this consent form understands what is involved in the study and voluntarily accepts to participate.

_____ _____

Signature of Investigator Printed Name

Date _____

APPENDIX E

DEMOGRAPHIC DATA FORM: STUDENTS

1. Code: _____
2. Gender: Male_____ Female_____
3. Nursing Education (check all that apply): Diploma____ Baccalaureate_____ Master_____ Other_____
4. Post graduate education acquired:
5. Continuing education acquired:
6. Education other than nursing: (Please list if applicable)
7. Total years of nursing education:
8. Brief description of work experience and major responsibilities:
9. Total years as a nurse practitioner student:
10. Time line of your education: (E.g. when you obtained your initial nursing education, and subsequent education with dates)

APPENDIX F

DEMOGRAPHIC DATA FORM: PRECEPTOR

1. Code: _____
2. Gender: Male_____ Female_____
3. *If nurse*: Nursing Education (check all that apply): N/A_____ Diploma____

   Baccalaureate_____ Master_____ Other_____
4. Education other than nursing: (Please list if applicable)
5. Total years of nursing education:
6. *If physician*: Medical education: N/A_____

   (list)_____
7. Education other than medicine: (Please list if applicable)
8. Total years of medical education:
9. Post graduate education acquired:
10. Continuing education acquired:
11. Brief description of work experience and major responsibilities:
12. Total years as a preceptor:
13. What levels of nurse practitioner student have you preceptored?
14. Have you precepted students other than nurse practitioners? Yes_____,

    No_____

    If yes, what kind of student _____
15. Briefly describe how you have been prepared for the preceptor role

16. Time line of your education: (E.g. when you obtained your initial nursing/medical education, and subsequent education with dates)

APPENDIX G

DEMOGRAPHIC DATA FORM: FACULTY

1. Code: _____
2. Gender: Male_____ Female_____
3. Nursing Education (check all that apply): Diploma____

   Baccalaureate_____ Master_____ Other_____
4. Post graduate education acquired:
5. Continuing education acquired:
6. Education other than nursing: (Please list if applicable)
7. Total years of nursing education:
8. Brief description of work experience and major responsibilities:

9. Total years as a faculty member:
10. Have you been prepared as a nurse practitioner? Yes_____,

    No_____. If yes, when: _____
11. If the answer is "yes", are you currently on the CARNA Advanced Practice

    Roster? Yes_____, No_____

Briefly describe how you have been prepared for the role of faculty member in the preceptorship relationship?

APPENDIX H

INTERVIEW GUIDE: PRECEPTOR

Examples of 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.

1. Tell me about your role as a preceptor.

2. Describe for me the skills you think you as a preceptor require to prepare a nurse practitioner student.

3. If preceptor is a nurse practitioner:
    a. How are teaching nurse practitioner students different from teaching other nursing students?

    If preceptor is a physician:

    b. How is teaching a nurse practitioner student different from teaching an intern or resident?

4. Describe for me a typical day of precepting a nurse practitioner student.

APPENDIX I

INTERVIEW GUIDE: STUDENTS

Examples of 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.

1. Tell me about your role as a nurse practitioner student.

2. What are your expectations as a nurse practitioner student in this preceptorship experience?

3. Describe for me the skills you think your preceptor needs to prepare you for your nurse practitioner role.

4. How is the nurse practitioner student different from other nursing students?

5. Describe to me a typical preceptorship day.

APPENDIX J

INTERVIEW GUIDE: FACULTY

Examples of 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.

1. Tell me about your role as a faculty.

2. What are your expectations as a faculty in this preceptorship experience?

3. Describe for me the skills you think you as a faculty require to prepare a nurse practitioner student?

4. How are teaching nurse practitioner students different from teaching other nursing students?

5. Describe to me a typical preceptorship day.