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**Safeguarding the Practices of Nursing:
The Lived Experience of being-as Preceptor to Undergraduate
Student Nurses in Acute Care Settings**

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Nursing**

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Abstract

An Heideggerian Hermeneutic approach has been adopted to explore the experience of being-as preceptor to undergraduate student nurses in the acute care setting. This thesis addresses the question: What is the experience of being a preceptor to undergraduate student nurses in an acute care setting? Fifteen preceptor-participants were interviewed twice, with each interview being approximately one hour. Heideggerian Hermeneutical Analysis was used to reveal the experience of preceptors as they precept undergraduate student nurses.

The thesis begins by placing nursing education in an historical, socio-political and professional context that provides the background to current New Zealand nursing practice. Student nurses undergoing their nursing education learn the meaning of being a nurse in many different contexts. This research is situated in the acute care context where both preceptors and student nurses engage in the practice of nursing. The methodological background shapes the way the research is presented to explicate the meaning of being-as preceptor. The four data chapters reveal the preceptors' experience and open with dialogue showing how nurses become preceptors. This is followed by exploration of how preceptors assessed where the student was at, moves to preceptors promoting learning and closes with discussion of how preceptors keep students and patients safe. Many practices were uncovered during the revelations of the preceptors as they disclosed to the researcher narratives of their everyday practice world.

Common themes that emerge from the data include: *Becoming attuned – the call*, *The Emerging Identity of 'being-as' Preceptor: Keeping the student in mind*, *Assessing where the student is at: The Preceptor and Preceptee Working and Growing Together*, and *The Preceptor as Builder of Nursing Practice: Teaching Reality Nursing*. A number of common themes support the relational themes which are of greater complexity. A constitutive pattern, the highest form of interpretation that emerges from the data, was *Safeguarding the Practices of Nursing*. This constitutive pattern lies within every text either directly or is inferred from each participant's dialogue. It contains the central meaning of the thesis. It is constituted from common and relational themes as they present themselves in the analytical process.

In this thesis the experience of being-as preceptor is unveiled through the participants' own words as the researcher takes the reader back to the 'things themselves' as is espoused by hermeneutic phenomenology.

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...Not to have arrived, but to have made the journey...

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CHAPTER ONE

Introduction

When teaching their young to fly, eagles may accompany them, using their primary feathers to create an air current that actually lifts the eaglet. In Exodus 19:4, God states "I bare you on eagle's wings". According to the generic Hebrew word, *bare* is *nâcâh*. Its primary root means 'to lift'. "This is precisely what the eagle does with the wind currents from its wing tips" (Institute in Basic Life Principles, 1982, p.11). It lifts its young as they learn to feel the strength of their own wings in their attempts to fly. The eagle is an analogy that fits well with the registered nurse who is a preceptor to an undergraduate student nurse. Using their practice expertise as their wing span, the preceptors in this study give voice to how they teach, guide and support undergraduate student nurses, supporting them with their strong wings as they gradually feel the strength of their own wings and eventually soar as beginning registered nurses.

The heart of my thesis concerns the clinical teaching experiences provided by preceptors to undergraduate student nurses in preparation for their future practice as registered nurses. As a believer in the importance of students of nursing receiving integrated theoretical and clinical teaching, I have had some concerns related to the reshaped role of the clinical lecturer in clinical teaching in undergraduate nursing education (Dyson, 1998; Orchard, 1999).

My concerns relate to the increasing distance between clinical lecturers responsible for undergraduate theoretical teaching undertaken in a classroom and its application in clinical practice supervised by registered nurse preceptors. Registered nurses are already overburdened with the responsibility and accountability for patient care. To teach students is an additional workload. Registered nurses have always been teachers since Nightingale's day (Bastable, 1997) but teaching students in contemporary nursing is different to patient-teaching and teaching or orientating registered nurse colleagues. Further, the best teachers are those who are motivated to take up a teaching role and not all registered nurses may have the desire to be a clinical teacher for students. Moreover, registered nurses, who are employees of clinical agencies, are often not familiar with the education curriculum that student nurses are learning.

With the move to higher education and the repositioning of nursing education in New Zealand in the 1970s from hospital based programmes to polytechnics and later to universities, there has been a reshaping of the role of the clinical lecturer (Dyson, 1998 & Orchard, 1999). The clinical lecturer who was once closely aligned with students during their clinical learning, currently has less contact with students as a clinical teacher but acts as a liaison person and negotiator of clinical experience for students while on their clinical placement. The clinical teaching for student nurses has been taken up by registered nurse preceptors. Since the mid 1990s, the graduate nurse is required by the Nursing Council of New Zealand to hold a bachelor's degree in nursing to enter practice (Nursing Council of New Zealand, 1999a). Additionally, teachers of student nurses are required to "have an appropriate range of professional and academic qualifications, i.e. degrees in nursing, midwifery or other relevant disciplines" (Nursing Council of New Zealand, 1999, p. 5, 2.4.2).

It is believed by many in the profession of nursing that the removal of students of nursing from hospital schools to being students in a tertiary education programme in the general education system, has resulted in an ever widening theory/practice gap (Baillie, 1994; Rolfe, 1993). In an attempt to overcome the theory/practice gap, various interventions have been employed, such as the lecturer practitioner role in the United Kingdom (Vaughan, 1989). In the New Zealand context, there has been a progressive reshaping of the clinical lecturers' role (Orchard, 1999) and the gradual introduction of preceptorship clinical teaching models (Dyson, 1998). Preceptorship models for undergraduate student nurses are still in their infancy in New Zealand. Little is known about how preceptors, who are primarily employed in a clinical agency to care for patients, manage their preceptor role for nursing education.

The acute care setting is still the most prominent clinical placement where student nurses learn the practice of nursing. This context affects the nature of the research question (Streubert & Carpenter, 1999). Thus, this thesis addresses the question:

“What is the experience of being a preceptor to undergraduate student nurses in the acute care setting?”

Background to the Study

As a student nurse in the late 1950s in a traditional hospital based programme, my nursing education and my nursing practice focused on the physical care of patients, their pathological symptoms and nursing procedures. At the time, nursing appeared to be a continual round of bathing and maintaining bed rest for patients requiring full dependency care. The length of time that patients were in hospital meant that nurses functioned in a predictable manner and adhered to a daily routine determined by the student's place in the nursing hierarchy that supported hospital protocols.

From my junior days, I well recall the helpfulness of those senior nurses who took the time to teach me important nursing techniques and management plans so that I could survive the day to day experience of being a nurse. I also remember how difficult it was for those senior nurse teachers, apprentices themselves, to make time to help those more junior, due to their own heavy work schedules. What stands out from those early experiences, is that I practised better on the days when I was well supported as a student nurse. On those shifts, I felt more secure, knowing that there were senior nurses who were willing to share their knowledge, and to teach and encourage me as I grappled with the reality of nursing practice.

As a registered nurse and a student of nursing undertaking Baccalaureate studies in the late 1970s, I felt the winds of change. Through my studies I came to understand the dynamic nature of nursing, the emergent conceptualisations of nursing as a discipline and its concomitant impact upon nursing practice (Christensen 1998; O'Bryan Doheny, Benson Cook & Stopper, 1997). What became apparent was that not only was the profession changing but also society was altering its expectations of nurses. New understandings of a changing health environment, perceptions of health and perspectives of persons in relation to their health, opened up new horizons in nursing. At that time, nursing was forging a stronger theoretical pathway to establish itself as an independent profession. That is, nursing's field of inquiry broadened to focus upon persons as central to its practices and its services, while nursing actions were expected to be research based, and grounded in an ethical code of practice. Rising consumer expectations, higher education, research and scholarship also increased the self-governance of the profession and shaped standards for nursing practice.

With continuing change both in nursing as a profession and in the context where nursing ultimately took place, I believed there was a vital need to develop a more favourable learning climate, suited to developing competent, caring nurses with a sound theoretical orientation to practice.

As an outcome of my studies, I moved from being directly engaged in practice to a position in nursing education, engaging in both theoretical and clinical teaching. I experienced a gulf that highlighted differences between the expectations of nursing in education and the reality of nursing practice. I began to question how the two worlds of study and of practice, could be better integrated. Increasingly, this question occupied my thoughts.

After my Masters study (Rummel, 1993), with a good decade of theoretical and clinical teaching behind me, unprecedented change and reform in health and education had an impact on nursing education and nursing practice, and affected how associated practices in these two fields were carried out. As a clinical teacher, I noticed an increasing distance between teaching students in the classroom and following through with their clinical learning. The clinical lecturer became a liaison person between an educational institute and a clinical agency. Clinical lecturers relied more and more on their clinical colleagues to teach and supervise students as they applied theory in practice.

In recent years, controversy concerning the distance between theoretical teaching and clinical learning experiences has been rife, with the blame falling predominantly on the education sector (Crookes, 1997). Claims that contemporary nursing students are unprepared for the reality of their profession have been dominant. The separation has been both ideological and real. Kramer (1974), noted that new graduates were unprepared to enter the profession as they faced reality shock. The same call is still heard many years later into the twenty-first century.

It was in my Master's study that I was first introduced to various philosophical views underpinning research methodologies that were conducive to exploring the nature of reality. I was introduced to the writings of Benner (1984), Benner and Wrubel, (1989) and Diekelmann (1988, 1989, 1990a, 1990b, 1991, 1992, 1993a and 1993b). I have maintained a strong belief that a great deal is learned as one engages in practice. As a result of my belief, the idea of gaining a greater understanding of the nature of knowledge embedded in practice (Benner, 1984) and how student nurses

learnt from their practice caught my attention and led to my Master's Thesis (Rummel, 1993).

In that study, student nurses clearly voiced the significance of what they had experienced and learnt from their clinical practice. What was missing though, was the voice of those who functioned as preceptors to undergraduate student nurses in practice. Recognising that clinical tutors were no longer closely aligned to student nurses in their clinical placement, and acknowledging the registered nurse preceptor as the clinical teacher, this study can, for now, be said to be the culmination of a long interest in clinical teaching and the development of the new nurse. Therefore, as a sequel to my Master's thesis, this PhD study and its subsequent findings, make up the substance of this report.

Aim of the Research

The aim of this research is to use an Heideggerian Hermeneutical approach to reveal the experience of being a preceptor to undergraduate student nurses during their clinical placement in acute care settings.

Purpose of the Research

The prime purpose of this research is to understand the experience of, and uncover the meaning for registered nurses of being a preceptor to undergraduate student nurses in acute care settings. At a time when increasing emphasis is upon the demands for skilled beginning nurses entering practice in an increasingly complex health care environment, it seems appropriate that the contribution that registered nurses as preceptors make to nursing education is made explicit. Moreover, towards the latter part of the production of this thesis, a Ministerial Taskforce on Nursing (Ministry of Health, 1998) echoed some of my concerns that "currently, [nursing education] programmes are not producing graduates of a consistent standard, that teaching resources are too thinly spread, and that students are not always receiving appropriate clinical placements" (p. 60). The preceptor's part in nursing education is crucial to developing competent nurses.

An interpretive approach using Heideggerian Hermeneutics has been chosen as a way of uncovering the experience of being a preceptor. The experience of 'being' requires a human science approach to understand how 'being' acts in and on a

world (Taylor, 1989). Preceptors' experiences, captured as narratives in audiotaped interviews, reveal what is most meaningful and significant in their everyday practice while caring for patients and at the same time, teaching, coaching, and helping undergraduate student nurses learn the practice of nursing.

Heideggerian hermeneutic phenomenology is especially suited to understanding human concerns, meaning, experiential learning and practical everyday activity. This approach offers an opportunity to move beyond the traditional ways of knowing and may be considered to be in opposition to the explanatory and predictive methods of natural science (Benner, 1994).

Significance of the Study

It is hoped that this research will make explicit the experience of being a preceptor and address a perceived gap in the literature of what is known about this way of being in the world of nursing practice. This research explores and makes visible what preceptors find most meaningful and significant in being a preceptor. 'Giving voice' to preceptors who participated in this study, will hopefully yield new possibilities for transforming preceptorship and the way preceptors are in their world. Furthermore, the intent in uncovering the lived meanings of the participating preceptors' experiences is to expand and deepen understanding, to inform and, perhaps, transform nursing practice and nursing education. As an educator, I believe an understanding of this experience is crucial to the quality of future nursing education offered to students of nursing and to the quality of nursing care delivered to people who are cared for by nurses.

The Research Approach

The phenomenological approach, used to describe and interpret the lived experience of preceptor participants, is founded upon Heideggerian phenomenology (1962/27) and Heideggerian Hermeneutics. Heideggerian phenomenology concerns itself with the philosophical question of the meaning of Being (existence). Additionally, it is in terms of time that an understanding of Being is obtained. Being can only be understood with regard to a definite mode of time – the "present" (Heidegger, 1962/27, p. 47). Heidegger uses the term 'existence' to describe the distinctive human mode of being or *Dasein* translated as "Being-in-the-world" (p. 13). "Being-in-time" and "Being-in-the-world" are inextricably intertwined.

Phenomenology assumes background meaning, (Benner, 1984, 1994; Benner & Wrubel, 1989; Diekelman, 1989, 1991; Heidegger 1962/27) that comes from being in the world with others. In this instance, the research world includes nursing education and nursing practice. This world is the foundation of the profession of nursing, and it can be assumed that there is a background of meaning that comes from being part of the culture of nursing. This background assumes the dimensions of the profession. The dimensions of professional practice include a theoretical knowledge base that underpins practice and a service orientation, in that there is a desire and a need to provide a socially mandated service for people in society. As well, the nursing profession is founded on an ethical code of practice and professionally set standards of practice that, if violated, will bring about disciplinary action on the basis of malpractice (Taylor, Lillis & Le Mone, 1997). The culture of New Zealand society and the culture of nursing are equally important as backgrounds to this study, as is the immediate culture to be found in the ward environment. Each aspect of culture bestowing an overlay in which the interpretations of this research are embedded; each forming an integral part of the horizon of interpretation in which the study findings have significance.

Background meaning and interpretation benefited from the use of the chosen research methodology, Heideggerian Hermeneutical Analysis, which is briefly introduced to ground the study.

Heideggerian Hermeneutical Analysis: An Introduction¹

Heideggerian Hermeneutic Analysis uses a descriptive, interpretive research approach to come to understand the everyday experiences of the human lifeworld. To be human is to experience a lifeworld that is shared and connected to public experience from which background meanings emerge. These background meanings include language, practices and skills. For Heidegger, understanding is essentially a way of being, the way of being which belongs to human existence. In all human behaviours, not just intellectual ones, human existence is involved in an interpretive relation with meaning (Gallagher, 1992). My responsibility as a researcher is to make the everyday lived experience of being a preceptor to undergraduate student nurses, intelligible to interested readers in order to uncover

¹ A brief introduction to Heideggerian Hermeneutical Analysis is given to acquaint the reader with the study approach at this early point in the thesis. The methodology is addressed in detail in Chapters Four and Five.

shared meanings and common understandings of the lifeworld of the fifteen preceptor participants as they precepted undergraduate student nurses.

Understanding emerges from exploration and dialogue. Meaning is shared and it is through language that reality is disclosed. "It is in words and language that things first come into being and are" (Heidegger cited in Dreyfus, 1991, p. 15). In order for me to understand the lifeworld of preceptors, participants shared with me their experience through dialogue recorded in audiotaped interviews. The transcripts form the data that became the basis for the hermeneutic analysis.

Heidegger (1962/27) conceived hermeneutics in a radically different way of thinking to the traditional approaches. Traditionally, hermeneutics referred to the art of understanding another person's language, particularly written language in the most genuine form so that the author's intent was fully understood by another (Heidegger, 1971). But in Heidegger's analysis of *Dasein* as being-in-the-world there came a change in the way he used hermeneutics so that our comprehension of understanding moved from a "derivative phenomenon to the central feature, the keystone, of human experience" (Hoy in Guignon, 1993, p. 171). By this, Hoy points to the historical evolution of the study of hermeneutics, as discussed in Chapter Four of this thesis, to justify Heidegger's interpretation of hermeneutics. Hoy explains that hermeneutics, to Heidegger, embraces the whole of the person's mode of being-in-the-world. To live is to live hermeneutically.

Heidegger also claimed that Hermeneutic phenomenology "is an interpretation of human beings as essentially self-interpreting, thereby showing that interpretation is the proper method for studying human beings" (Dreyfus, 1991, p. 34). In Heidegger's view, all understanding is circular. To interpret, one must first understand (Heidegger, 1962/27, p. 194). The interpretive process is a dynamic circular process that includes a forestructure of understanding of the activities being studied, and thus it focuses the questions which are of interest to the researcher. Dreyfus (1991) further asserts, that "studying human beings as self interpreting beings demands interpretation within the full hermeneutic circle of shared significance" (p. 203). The researcher is an involved participant in the research process and engaged in interpreting the experiences of the participating preceptors within an hermeneutical circle of understanding.

Pre Understandings and Horizon

The phenomenological hermeneutical approach requires me to make explicit prior to the study, my pre-understandings, beliefs, biases, assumptions, presuppositions and theories (Streubert & Carpenter, 1999) about the experience of being a preceptor to undergraduate student nurses. This is not to hold these at bay but rather to make my own position in the research quite clear, for as an interpretive researcher, I acknowledge that I am an involved participant in the research. That is how I stand in relation to my own world of nursing, research and education and the world I am now turning to, that is the world of nursing practice and the experience of being a preceptor to undergraduate student nurses within that world. The earlier section on 'background to this study' began the process of making explicit my own background within the nursing context.

The Choice of Phenomenology and Hermeneutics

First and foremost, my research is undertaken from a phenomenological hermeneutic perspective which I recognise provides only one perspective in the world of knowledge. Because I believe that the experience of being a preceptor is poorly understood, hermeneutic phenomenology allows me to seek to understand the meaning of the experience of being a preceptor from the perspective of the preceptors themselves. An insight into the world of the participating preceptors was shared with me through our interviews together. Meaning comes through the language that makes explicit the world of others but dwells in the dialogue itself. My interpretation of the phenomenon of being a preceptor to undergraduate student nurses is undertaken within my own horizon of understanding that is influenced by my history and my experiences of being an educator, a registered nurse and a researcher. To come to understand is to interpret. New understandings come from a fusion of two perspectives, that of my understanding of the phenomenon itself and my interpretation of the preceptors' accounts of their experiences. Gadamer coined this interpretive activity through language the "fusion of horizons" (Weinsheimer, 1985, p. 183).

I consider it crucial that an understanding of the experience of being a preceptor to undergraduate student nurses be made explicit if new approaches are to be found to assist preceptors help students learn the clinical knowledge that eventually will allow them to become expert nurses. This belief supports a general philosophy that exists

in the profession that the ultimate purpose of nursing and nursing education is to enhance the quality of health care for consumers.

Beliefs about Nurses and Nursing Education

Student nurses enter nursing because they desire to 'help' people. I know this from a long history of interviewing prospective nurses, but it is also evidenced soundly in the literature (Reverby, 1987). Nurses are altruistic people. I believe it is very important for student nurses who desire to be nurses to be assisted in every way to achieve their aspirations. Society needs nurses - there is a world wide shortage of nurses - and therefore it is very important that nurses are educated to achieve at the very highest level, not only for their own aspirations to be fulfilled, but also to enhance the quality of nursing services that the public expect. I also believe the way student nurses are taught to be nurses should develop and mature their altruistic characteristic so that they become morally mature, able to nurse people in a way that is respectful of difference in a culturally safe manner. Therefore, I believe that at the heart of nursing services, is the nurse's fundamental respect for the human dignity of the person.

I also believe that because nursing is a practice, learning to be a nurse requires student nurses to learn theory and practice related to the real world of nursing practice. The most significant person who can help the student nurse to learn in the practice setting is the registered nurse who is practising nursing and providing nursing services to patients and their families.

Biases

My focus is on the student nurse because I wish him or her to have the best quality nursing education informed by a theoretical background of nursing knowledge. I believe also that the theoretical knowledge "must be informed by real-world experience" (Benner & Wrubel, 1989, p. 5). I consider also that the nurse should be assisted to be critical with that knowledge in order to identify person-centred human needs for nursing care and for the delivery of that care.

I believe that nurses from a degree programme have different expectations to the nurses of former years. These expectations are raised by the very nature of degree programmes, the development of analytical and critical thinking, creativity, and

reflective practice in order to dwell and live in the world of nursing in a thinking and concerned way.

I believe also that the world of nursing practice is a different world in the twenty-first century to that of the twentieth century. Knowledge is accumulating at an unprecedented rate and this means that the profession of nursing, as an emergent profession, must keep pace with change in every facet of its existence, that is in its governance, its mandate as a public service, its knowledges and its practice.

I also believe that valid and reliable research based practice should underpin all nursing care delivered to patients. Nurses should and can give the rationale for their actions based upon sound nursing knowledge.

Assumptions about being a Preceptor to Undergraduate Student Nurses

Because I hold a positive view of the world, I assume that registered nurses are keen to share their knowledge and skills and nurture new nurses. I do not deny however, that I have met registered nurses in my many years of practice and teaching, that do not welcome the sharing of their knowledge and practices with students. I also assume that registered nurses would welcome new nurses into the context of nursing. To an educator, a student is central to the world of teaching and learning. There is a certain entrusting to the new nurse by the registered nurse as their preceptor, of the practices of nursing. These practices are dear to both the preceptor and to the educator. Educators, though removed from close contact with patients because they are engaged in teaching student nurses, still hold the practices of nursing dear. Registered nurses are central to teaching the practices of nursing, as they are experienced in the day to day ward encounters with patients.

For myself as an educator, I assume that preceptors will be passionate about the intrinsic worth of nursing and will teach new nurses nursing as it is practised day to day. There is a need to capture for the student the inherent satisfaction of nursing that is found in the "privileged place of nursing" (Benner & Wrubel, 1989, p. xi); that is, of being a nurse able to care for another and walk beside them through life's crises. Nurses are in a unique position where they may feel the delight of a person who has been critically ill, for example, as they experience their day to day trajectory of recovery and return to health. To be a part of this and to work with the person, and with their family, to see the smallest progress, to sustain hope for recovery, and

to assist in the restoration of health is a privilege. All of this is the worth of being a nurse.

Theories

My theoretical perspective is shaped by my own experiences as outlined, but also from the literature that I read at the outset of undertaking this study. Most of the literature is focused on precepting registered nurses as new orientees to new situations. There is an emerging literature focusing upon student nurses being precepted and a range of literature that seeks to explore the educational background of preceptors, in order to identify who should be a preceptor and to measure the effectiveness of precepting processes.

Much of the literature related to preceptorship is couched in the traditional quantitative paradigm that holds that the world has one reality which is objective and external to the person. In that view, preceptorship is problematic and should be studied by reducing each aspect of preceptorship to a variable to be explored in order to identify cause and effect relationships and to find a solution with measurable outcomes. Regardless of how compelling the knowledge that this style of research produces, the theoretical perspective taken in this research is based upon the phenomenological view that holds that it is in the practices of nursing that relevant theory emerges. Therefore, if one is to understand the nature of precepting, one must study the practice of being as a preceptor.

The phenomenological question seeks to bring to speech that which is taken for granted, that which is hidden, that which is assumed and not given in language. Therefore if all presuppositions are made known at the outset of the research, all that remains is to be found in the exploration of the experience of being as a preceptor to undergraduate student nurses. It is now to that phenomenon of concern that this thesis turns.

The Phenomenon of Concern: The Nature of Preceptorship

New Zealand has undergone reformation in both its health and education institutions.

Nursing, as a practice discipline, requires students of nursing to undertake both theoretical and practice experiences to become nurses (Nurses Act 1977; Nursing Regulations, 1986; Nursing Council of New Zealand, 1999a). Further, emphasis has been placed upon the importance of practical experience in the development of nursing expertise (Benner, 1984; Benner & Tanner, 1987; Benner & Wrubel, 1989; Benner, Tanner & Chesla, 1996; Nehls, Rather, & Guyette, 1997). While the importance of both theory and practice experiences in the preparation of new nurses is undisputed, historical, socio-political and cultural change in New Zealand has altered the way prospective nurses become nurses. With reference to this statement, the complexity and impact of historical events on nursing as a profession, its context and nursing education is addressed in Chapter Two.

One of the direct changes in nursing education has been an alteration of the 'space' in which clinical lecturers work. The clinical lecturer is a registered nurse who is both academically and clinically prepared. The clinical lecturer is a teacher and an employee of an educational institute. The clinical lecturer, as a normal part of his or her role, undertakes both theoretical and clinical teaching and the formal evaluation of student nurses during their undergraduate nursing education. The clinical lecturer has an educational focus.

There has been a lessening of the time spent, and the frequency and intensity of contact between clinical lecturers and student nurses in their clinical placement. Currently, registered nurses in the acute care setting are the main clinical teachers who work beside student nurses as they learn and develop their clinical practice. For many registered nurses, precepting student nurses forms part of their normal practice day. But knowing how intensive it can be as a clinical lecturer to student nurses learning to be nurses, particularly in a context of constant and rapid change, I questioned how registered nurse preceptors manage their time and resources.

The concepts of 'time' and 'space' have particular connotations in phenomenological interpretive research. Time refers to 'lived time' or 'temporality'. Temporality refers to the way we experience and understand time. Heidegger, (1962/27) claims that "being" is time. That is our temporal way of "being" in our world and the way we come to understand ourselves ontologically as "being", is time (p. 39). Temporality is experienced subjectively to include an historical past, an immediate present and a possible future. Heidegger (1962/27, p. 134) describes "space" (spatiality) as "insideness". The kind of space that is constitutive of Being. Being can only be

understood within a world of human relations, events, activities and concerns. Van Manen, (1990, p. 102), affirms and clarifies Heidegger's interpretation of lived space further by stating that "felt space .. appears". To my mind, 'felt space' becomes 'felt' because, for some reason, it focuses our attention more keenly on the day to day events in our lives. Van Manen concludes "that lived space is a category for inquiring into the ways we experience the affairs of our day to day existence; in addition it helps us to uncover more fundamental meaning dimensions of lived life" (1990, p. 104).

Considering lived time and lived space more deeply, I too have lived, worked and been part of societal change. I have experienced the impact of change in my own temporal and spacial context. I have been concerned at the impact of government reforms on the contexts of health and education. My concerns particularly relate to the human cost of change, especially on registered nurses and the increasing demands of their practice in relation to patient care with additional demands upon them from nursing education in mentoring new nurses.

The temporality of our everyday life and the felt space in which we function and meet all our obligations, accentuated for me the challenges that surely exist for preceptors. Managing the time and space constraints of their practices includes being able to create possibilities for learning for the nurses of the future (Benner, 1984; Benner, Tanner & Chesla, 1996; Benner & Wrubel, 1989; Diekelmann, 1988, 1990a, 1991, 1993a). Being a preceptor requires engagement in the practice world where she or he is expert. But it also requires the educational transmission of the precepts of nursing practice to student nurse learners.

My earlier research (Rummel, 1993) revealed what it was like to be a student nurse in the pre-registration experience in acute care settings. Student nurses found the support, guidance, and exemplary learning provided by preceptors to be very important. Student nurses stated that registered nurses who best helped them to learn the practice of nursing were those who were secure in their own lived or felt space of expertise. Helpful preceptors provided opportunities for learning within well-defined limits, and supported students well while they implemented their practice. Yet, the first responsibility of preceptors is to their clients and secondly, to students. How then do preceptors:

- balance their responsibilities as nurses accountable for nursing services

while also being teachers, coaches and guides to student nurses?

- learn from their practice as preceptors? If they do, then how, and what do they learn?
- distinguish when they are teaching and when they are learning?
- know they are being effective as clinical teachers?
- contribute to nursing education?
- contribute to the development of the profession of nursing?

These were some of the questions inherent in this study that led me to ask the research question “What is the experience of being a preceptor to undergraduate student nurses in acute care settings?”

Background to the Phenomenon of Concern

Although there is evidence in literature related to preceptorship, little is known as to how preceptors experience the teaching, guiding and supporting of student nurses who are learning to be nurses. Even less is known as to how registered nurses manage being a preceptor in addition to their regular work as the primary providers of patient care.

In New Zealand where this research was undertaken, preceptorship is a developing component of preparing student nurses for practice. At present, understandings of how preceptors are prepared is predominantly informed from literature from other parts of the world, namely North America. Historically, there is little written in New Zealand related to being a preceptor other than that recorded by Keene (1986) who identified a need for mentors for new graduate nurses or new employees. Keene did not address the concept of preceptorship per se. Currently, some hospital institutions have perceived a need to endorse the teaching role that registered nurses traditionally accepted implicitly while working with student nurses. For example, Dyson and Thompson (1996) reported on a pilot project undertaken between an educational institution and a large hospital that implemented a preceptor model for undergraduate nursing education. Dyson and Thompson’s research offers some insights into the preceptorship processes associated with clinical teaching in a New Zealand context. In 1998, after the data collection for this thesis, Dyson researched the role of the clinical lecturer working within a Preceptor Model. This model was portrayed as a triad involving the clinical lecturer, the preceptor and

the student. Dyson's (1998) research is reviewed later in the thesis.

There is a lack of clarity about the practices of preceptorship and more often than not, in the New Zealand context, the experience is referred to as 'being a buddy'. The term 'buddy' is defined by the Collins Dictionary (McLeod, 1988) as an informal word for friend. As an experienced nurse educator, I do not consider that the term 'buddy' really describes what occurs between registered nurses and undergraduate student nurses in the clinical placement. In fact, use of the term buddy demeans the energy, involvement and commitment that registered nurses put into nursing education as part of their professional responsibility in preparing the neophyte nurse to enter the profession.

It is worth noting here also that at the beginning of this research, in 1995, an informal survey among large teaching hospitals in New Zealand was undertaken. This was to find out if the term 'preceptor' was used to describe registered nurses who taught student nurses regularly. The term was used in one hospital only. The preferred term was 'buddy'. Although many registered nurses are said to 'buddy' new colleagues, 'buddy' connotes meanings of friendship, support, intimacy, and love. It is possible that the common use of this particular word has implications for how the role has been understood and how registered nurses preceptor students. The connotations that accompany the word 'buddy' are at odds with the formalised degree education that prepares novice nurses to enter the profession of nursing. The supportive role of friendship has its place but needs to be integrated into teaching that is grounded in a sound understanding of the principles of education.

The word 'preceptor', as defined by The Collins Dictionary (McLeod, 1988) means to be an instructor or tutor. The concept of preceptorship has been recorded since the 15th century (The Compact Oxford English Dictionary, 1991). In the context of this research, a preceptor is defined as a registered nurse who undertakes one-to-one teaching with student nurses. Preceptors are responsible for guiding and supporting interactions with undergraduate student nurses who are situated on a clinical placement so they can meet their nursing education clinical learning outcomes. The preceptor contributes informally to the student nurse's clinical evaluation by relaying to the clinical lecturer how they believe the student nurse is learning the practice of nursing. The preceptor's role is quite different to the role of clinical lecturer. The nurse who volunteers to precept or is asked to precept students, is first and foremost a clinician who has a primary role of caring for patients.

In New Zealand, the role of preceptor has not been formalised within the clinical agencies' organisational structures. This situation holds for both post-registration and undergraduate nursing education. Most teaching hospitals have, as part of the registered nurses' job description, a clause that identifies an expectation that they will be teachers of patients, colleagues, student nurses, enrolled nurses and health care assistants.

Registered nurses are also supervisors of student nurses, enrolled nurses and health care assistants (Nursing Council of New Zealand, 2000). This supervision is usually implicit in the job description of a registered nurse who is accountable for the safety and quality of patient care. As such, the supervisory role of the registered nurse is to maintain safe nursing services for patients being looked after by members of staff who are less qualified or are students learning the practice of nursing. This supervisory role will involve instructing less qualified staff and students to ensure patient safety. However, the way teaching is understood by the registered nurse is likely to be different to understanding clinical teaching from an educational perspective. In most instances, preceptors have little or no explicit teacher training or education for this role.

At the time of writing this thesis the formalisation of preceptorship does not appear to be a national phenomenon. So, it is important that registered nurses anticipate development of a more formal preceptor role, and work towards a clear delineation of the practice of being a preceptor that is applicable New Zealand wide. Herein lies the problem. Different understandings affect outcomes and, ultimately, professional practice. Role clarification and preparation are critical.

Therefore, it is timely to ask how registered nurses are educated and prepared to take up their preceptor role. At the beginning of this research it appeared to me that there was minimal educational preparation and support given to registered nurses who accepted preceptor responsibility. Yet, the preceptors' input into nursing education is considerable. Preceptors have direct personal contact with student nurses during the clinical placement and are responsible for teaching, guiding, supporting and overseeing students' practice. My concerns are held in the light of many years of clinical teaching. From experience, I am aware of the time that is required for students to forge links between theory learnt in the classroom and practice experienced in clinical placements. Learning how to integrate theory and practice is challenging and requires strong clinical educational support. Facilitating

the connection depends on the preceptor having a thorough understanding of theoretical concepts and how they are applied in clinical situations.

Some nurse educators claim that the separation between nursing theory as taught in the classroom at an educational institute, and nursing practice as experienced in the clinical setting, causes a theory/practice gap (Rolfe, 1993; Speedy, 1989). It is possible that, if this gap indeed exists, it may be perpetuated by the quality of the clinical teaching carried out by registered nurses who have never been trained as clinical educators. An additional consideration is that a theory/practice gap exists because theory originates from scientific tradition founded on the principles of 'knowing that' (Polanyi, 1958). This world view is based on the assumption that the transmission of skills can only be demonstrated. If that view of the world dominates practice this means that practices that are based upon practical activity or 'knowing how', are very often relegated to the unimportant. Related to this latter point, many authors (Benner, 1984; Benner & Wrubel, 1989; Benner et al., 1996; Diekelmann, 1988, 1990, 1991, 1993b; Heidegger 1962/27) claim that knowledge is indeed embedded in practice. This thesis seeks to explicate the knowledge that preceptors embed in their practice.

Further, educational institutes are responsible to ensure that teachers engaged in teaching understand educational processes. Educational institutes are also accountable for the quality of the graduate they produce. Accountabilities include, in the first instance, that the institution must be accredited by the education sector. The New Zealand Qualifications Authority (NZQA) accredits Polytechnics². The Committee on University Academic Programmes (CUAP) accredits Universities' programmes³. Both sectors have statutory obligations under the Education Act (1989) and the Education Amendment Act (1990). Likewise, the Nursing Council of New Zealand, under the Nurses' Act (1977) and the Nurses' Regulations 1986, Regulation 6 (4), requires not only that Nursing Schools operate out of an accredited educational institute, but also grants approval to an institution to provide nursing

² Polytechnics are government tertiary education institutions that primarily focus upon vocational education and training that contribute to the maintenance, advancement and dissemination of knowledge and expertise. They promote community learning and through research, particularly applied and technological research, aid community development (Education Act, 1989, Section 162, ii)

³ Universities are primarily concerned with more advanced learning, the principal one being to develop intellectual independence. They are characterised by a wide diversity of teaching and research, especially at a higher level, that maintains, advances, disseminates and assists the application of knowledge, develops intellectual independence and promotes community learning (Education Act, 1989, Section 162, i, iii).

education. Curriculum approval is granted once programmes are assessed against the Nursing Council of New Zealand's Standards for Registration of Nurses that ensure that the programme complies with all regulatory criteria, leading to a Bachelor of Nursing. Approval of a curriculum includes meeting both theory and practice requirements (Nursing Council of New Zealand: Nursing Department/Schools Handbook, 1999, p. 5-7). To obtain a quality graduate, it takes commitment from both the educational institute and its processes, that must be integrated with clinical experience provided by the health institution and its processes. Both institutions come together to share a dual responsibility for the education of student nurses. It is in the interests of both organisations that the emphasis is on producing a graduate who is competent and able to practice safely at the beginning practitioner level. The evolution of this shared responsibility is rather different to the traditional model of nursing training.

In the past, student nurses learned much of the practice of nursing in the apprenticeship model that focused on learning in the clinical situation. While they were taught theory in classrooms, clinical experience was seen to be the real world of practice and it was acceptable that a large part of student learning would be experiential. Trial and error learning was the normal way of learning. Those beliefs may continue to pervade teaching and learning situations in the clinical setting today. But they may be out of kilter with teaching contemporary nurses how to be safe, yet able to practice quickly in a lifeworld where the pace of life is hectic; and where practice is complex and ambiguous. Being a friend, a 'buddy', to students learning through trial and error may no longer be appropriate.

Many registered nurses are preceptors. This means that they are not only functioning as practitioners, but also, as educators. If preceptors are expected to be instructors to student nurses, surely, instructors teach in accordance with educational principles and processes. The implications of this dual responsibility with its associated accountabilities may be poorly understood. It is as if the past endures in cultural practices by way of inducting neophyte nurses into the profession through a socialisation process that is outmoded in the twenty-first century and incompatible with the degree preparation of the contemporary nurse and its associated expectations.

For me it is important to understand how registered nurse preceptors experience ontologically their part in nursing education. It is envisaged that greater

understanding of this experience will, hopefully, lead to change in the way preceptors precept student nurses. Moreover, it may also lead to understanding more about the preferred relationship between the preceptor in the clinical practice setting and the clinical lecturer in the education setting and how they can inform and support each other to meet their accountability to the student in a mutually satisfying manner. As well, I am committed to aspiring to the preparation of a quality graduate who exits an educational programme not only meeting, but exceeding, societal expectations for nursing services for the consumer of health care.

Summary

This introductory chapter introduces the research question, and addresses the phenomenon of concern, the background to the phenomenon of concern and the researcher's place within it. An interpretive approach using Heideggerian Hermeneutics is the methodology chosen for the study because it provides the possibility to uncover what the participating preceptors disclose as most meaningful and significant to them in their practice. It therefore provides the possibility to enhance others' understanding of the world of the nursing practice and the place of precepting within it. The research structure is laid out in order to guide the reader as to how the research report unfolds. An explication of the situated context that grounds the research follows in Chapter Two.

Organisation of the Thesis

In the following chapters, the thesis unfolds, uncovering the meaning of being a preceptor to undergraduate student nurses. This thesis is presented in ten chapters.

Chapter One has provided a background to the research. The aim, research purpose, and the significance of the study are included. An early introduction to the research approach, Heideggerian Hermeneutic Analysis, has been presented.

Chapter Two sets out to create a picture of the context in which the research is situated, providing background information that shapes the interpretations of the researcher to give meaning and further understanding.

Chapter Three explores the notion of preceptorship in order to come to an understanding of the sociohistorical context that has shaped the emergence of

precepting. In this chapter, literature is reviewed using an hermeneutic approach. The hermeneutical circle facilitates questioning, uncovering themes that reflect common understandings and the shared meanings of precepting, as portrayed historically and currently, within the culture of nursing.

Chapter Four addresses the research methodology. An account of Heideggerian phenomenology and key aspects of Martin Heidegger's philosophy is presented. In particular, Heidegger's concern with the meaning of Being (existence), space, world, and language are explored. A discussion on Heideggerian Hermeneutics, and rigour and interpretations follows. The limitations of hermeneutic phenomenology, specifically thinking and nursing and humanism, are addressed next. The chapter closes with a brief consideration of Heidegger's understanding of National Socialism.

In Chapter Five the research process, the readying phase for the research, is described. The steps inherent in the research process include explication about gaining ethical approval, inviting participation, preparing participants for the research, and processing the data. The validating processes that are fundamental to ensure rigour within this phenomenological hermeneutic study are made transparent.

In Chapter Six the first of the study findings are presented. The first theme, *Being Attuned: The Call*, is illustrated.

In Chapter Seven the second major theme, *The Emerging Identity of being-as Preceptor: Keeping the student in mind*, is explored.

In Chapter Eight the theme that is laid bare is, *Assessing Where the Student is at: The Preceptor and Preceptee Working and Growing Together*

In Chapter Nine the final theme *The Preceptor as Builder of Nursing Practice: Teaching Reality Nursing* is explicated.

Then, in Chapter Ten the constitutive pattern, the highest form of interpretation that emerges from the data, ***Safeguarding the Practices of Nursing*** is brought to light, and illustrated with examples. Finally, the study draws to a close with a discussion of the research findings that are located in the general literature. The perceived

limitations to the method, the implications from the study's interpretations for nursing education and nursing practice are outlined. Issues raised by the findings of this thesis are discussed in the light of the wider context of knowledge related to being-as preceptor to undergraduate student nurses. The thesis is brought to a close with a concluding statement.

CHAPTER TWO

The Situated Context of Preceptorship

Each one hath a world and is a world

(Donne, 1998).

Introduction

This chapter explores the notion of preceptorship, particularly in relation to the situated context in which preceptorship prevails. The context for this research transects government systems and professional boundaries in health and education. Therefore both are addressed in the discussion that follows. In interpretive research, because meaning is always situated, context refers to the historical, political, social, cultural, and in this instance, professional nursing background, in which the experience of the preceptor is interpreted. Context relates to the ways persons are connected in the world and always implies temporality (Benner & Wrubel, 1989). Heideggerian Hermeneutics assumes “being” as situated within a specific temporal context where human concerns and actions are afforded meaning and significance. Background meaning is also part of context. Therefore, for “being” a preceptor, the immediate day to day preceptor/preceptee activities within the temporal acute care context, constitute the temporal world of preceptor practice, within which the interpretation in response to the question “what is the experience of being a preceptor to undergraduate student nurses?” gains significance.

The context under discussion, that which defines the boundaries of the daily lifeworld as experienced by the participating preceptors, relates specifically to New Zealand. First, the context of New Zealand society as a historical, social and cultural background is singled out for discussion. This is followed by a closer look at specific areas of social organisation, such as the health, education and nursing that are the constitutive context in which preceptors practice. Nursing education, as a specialist area within education, and an integral part of the preceptor’s daily lifeworld is addressed. Additionally, the health care context also impacts upon the lifeworld of preceptors as they experience their everyday nursing practice within ward contexts and work with undergraduate student nurses.

Further, the way preceptors are connected to their everyday world of nursing

practice is first and foremost as a practitioner of nursing which brings with it concerns about patient care. Concern, in Heideggerian phenomenology, is also a way people are connected to their world through their involvement in it. Concerns help preceptors to discern that some things are more important than others. Concern is also a reciprocal experience. That is, concern is a “two-way connection” (Benner & Wrubel, 1989, p. 114) between the person and their context. Concerns arise out of understanding situations in certain ways, but also situations define the person because of their involvement within them. For example, the preceptor is not only concerned about their patients but also about student nurses and how they learn to be nurses. Therefore, preceptors’ concerns cut across more than just their world of nursing practice and the health care context. Their concern also covers the nursing education context and education practices that circumscribe the way student nurses learn the practice of nursing.

New Zealand – A Bicultural Society

The characteristics of New Zealand society, its culture, demography, physical landscape, the way it is governed, and the general expectations of how life is lived for the good of individuals and their communities as a whole, are reflected in the preceptors who practice in acute care contexts. Similarly, these factors impact on the students who enter nursing programmes and ultimately make up preceptor/preceptee relationships.

The way preceptors understand the world of nursing practice and nursing education is temporal. Their background meaning comes from their more general past experience of being a member of a family and a society, to their more specific current practice as a registered nurse and a preceptor. It is the way preceptors experience both the current health care and nursing education context which ultimately influences interpretations of their daily lifeworld. It is within this context in particular, the way they themselves have experienced being student nurses, which influences how they view being a preceptor to student nurses.

New Zealand is a democratic, bicultural⁴ society that has a population of 3.75 million people. The Treaty of Waitangi (1840) is acknowledged as a foundational document

⁴ According to the Chambers Dictionary (Schwarz et al., 1993) “Bicultural is “having, containing or consisting of two distinct cultures” (p. 163). In New Zealand the two cultures are Maori and Pakeha (the New Zealander who is European in origin).

for New Zealand society and is recognised legally, in the Treaty of Waitangi Act (1975). This treaty binds the indigenous Maori and Pakeha in a partnership that was set up in 1840 under the Crown, potentially enabling a bicultural society. The Treaty of Waitangi Act (1975) set up the Waitangi Tribunal in 1976 to address those fundamental rights that Maori believe have been violated since the signing of the Treaty in 1840 and which has subsequently undermined their social, cultural and economic development. At that time, the government of New Zealand was concerned that the health status of Maori was well below that of its Treaty partner (Upton, 1991). Maori health status within New Zealand society is poor. This can be traced back to the colonisation process and the separation of Maori from their traditional lands, social systems, beliefs, customs and practices. The government is committed to the Treaty of Waitangi and recognises its role in affecting the health of all New Zealanders, in particular the health of the Maori people. This commitment includes recognising that Maori health development involves Maori self determination, control and strong Maori leadership (Durie, 1994).

New Zealand, as in other places in the world, has an increasing proportion of elderly people in the population. It is estimated by 2040 that 24% of the population will be over 65 years old (Government Statistics, 1997). This fact is expected to increase the cost of health care over time. Longevity is increasing with the lifespan of women still exceeding the lifespan of men by 8.9 years. With advances in medical science, people live longer but may still suffer chronic illnesses. Consequently, many of the patients in hospital are elderly, have chronic underlying medical conditions and multiple systems disorders. Nurses are therefore caring for a vulnerable group of older patients who require more intensive monitoring. Hence, the acuity of the patient impacts upon preceptors to undergraduate student nurses because of the intensity of the supervision that is required to keep both the patient and the student safe.

While New Zealand is a bicultural nation, the government encourages new immigrants, some of whom enter nursing as a career and also become patients requiring health care. They bring to New Zealand their customs and languages that must be accommodated within nursing practice settings and within nursing education programmes. Along with this, the government has emphasised the need for participation of Maori, Pacific Island peoples and other minority groups in New Zealand society (New Zealand Ministry of Education, 1997, Green Paper). Therefore, Maori, Pacific Islanders and men are actively recruited into nursing

education programmes. For these reasons, preceptors precept undergraduate student nurses and nurse patients that reflect this population mix.

The Restructured Health Context

In 1991, the then government, restructured the health system. As the key purchaser of health and disability services, the government acknowledged that they were the main source of funding in service provision (Shiple, 1995). The government operated within constrained resources and set key health gain priorities. These included Maori, Child, Mental, and Physical Environment Health. The government established four Regional Health Authorities (RHAs) as their chief purchasing agent and twenty-three Crown Health Enterprises (CHEs) to provide health services. In this single move, the government created a corporate model for health management separating the purchaser of health and disability services from the provider of those services. The providers had well defined budgets in which to operate on the basis of identified health needs, taking into account the priority areas for public health gains made by government.

The government's desire to increase primary and community-based services meant that more services were to be provided in the community. These community-based services were charged with managing costs. Additionally, the government supported innovation in health services. New providers were actively encouraged to acquire funding from the Regional Health Authority for innovative services. This included Maori health initiatives by Maori for Maori.

The government, as the chief purchaser, set six principles for purchase decisions. These were first, equity of access based upon a fair distribution of health services; second, effectiveness in which to ensure that services resulted in better health outcomes; third, efficiency related to improving cost effectiveness in the light of limited resources. The fourth principle was safety in the provision of adequate systems to ensure that the public was protected from avoidable harm. The fifth principle, acceptability, related to improving people's choice and satisfaction with health services by respecting people's values and perceptions concerning their health. Principle five had at its heart the empowerment of people through respecting their autonomy and right to participate in the service provided. The sixth principle was risk management, which included ensuring that objectives set were achieved within available funding. All of these principles, in particular involves the profession

of nursing, nurses, and nursing services and hence nursing education and how nurses are inducted into the profession. The overriding principle of the nursing profession is one of providing high quality and safe nursing services to those who require them.

Critics of the restructuring claimed that the four RHAs effectively became four different public health systems in New Zealand (Ashton, 1993; Malcolm, 1989; 1990(a) & 1990(b); 1991; Malcolm & Barnett, 1994). What was fostered, as an outcome, was excessive competition, problems with long term planning and the creation of costly bureaucracies (News and Events, Nursing New Zealand, 1996). As the bureaucratic machine took control, hospitals set up their own managerial systems that were business focused. Charge Nurses of wards became budget holders and managers. Bonus incentives were built into salaries and the need for cost controls overtook nursing service development needs. As budgets became the primary focus, nursing employment strategies changed. The obligation to live within the budget resulted in a lack of nursing resource planning. Short-term measures overtook long-term development needs. This stringent environment impacted upon how nurses practised and how preceptors precepted undergraduate student nurses.

As part of the restructuring, the Crown Company Monitoring Advisory Unit (CCMAU) monitored Crown Health Enterprise (CHE) outcomes (Shipley, 1995). This unit focused on the efficiency of CHEs in relation to financial and clinical performance. The accountability for the quality of service provision for dollars spent became a critical. Accreditation of CHEs was desirable but not mandatory. However, accreditation increased prestige and status of a CHE, both important factors in the economically driven competitive environment. The government focus was customer satisfaction. Repeated surveys were undertaken to monitor this. Energies were expended in increasing the monitoring of services rather than in the direct provision of services.

As a continuation of the cost containment, resourced beds determined staffing levels. Often, demand outstripped supply. Reduced bed numbers throughout the country brought increased bed occupancy accompanied with an increase in the acuity of patients. While acuity of patients refers to how acutely ill the patient is and how much skilled care people require, the only measure of acuity within the CHE environment was the pace of throughput of patients. The flow on effect was one of continually high workloads as hospital stays shortened and continuing community

care increased. The documentation required to facilitate these transfers or discharges increased the workload for registered nurses (Keene, 1996). Consequently, registered nurses were less available and not so willing to precept student nurses. Workloads became so intense there was simply not the time to provide students with the support they needed to develop safe and efficient nursing practice.

The Nursing Work Context

Health system restructuring drastically affected nursing work and nursing as a profession. Experienced nurses became disillusioned with the direction the government was taking in the evolving health environment. There was a general feeling of being unheard and undervalued, and fears were expressed for patient safety as nurses left the profession. Experienced nurses believed the working conditions disallowed the very professionhood they valued. Many responded to overseas recruiting drives and relocated to other countries.

As numbers dwindled, the mix of staff on a ward became less experienced and less knowledgeable (News and Events, Kaitiaki, 1996). Junior staff were expected to assume responsibility well beyond their level of experience. Casual nurses were engaged on a daily basis to meet staffing needs. This created an environment of insecurity and work-related stress. The remaining registered nurses who knew the ward environment were few and their energies were focused upon survival and directing the unfamiliar staff mix. Registered nurses who had been educated to provide quality professional services to patients were unable to meet their aspirations. Frustration increased and job satisfaction declined (NZNO Conference Report, 1995). In this context, being a preceptor to student nurses was a low priority.

It is hardly surprising that, in the context of continual change, the work of the nurse became fragmented as competing demands claimed nurses' energies. A contemporary view of nursing as stated by NZNO Social Policy statement (1993, p. 2) states:

Nursing is a specialised expression of caring concerned primarily with enhancing the abilities of individuals and groups to achieve their health potential within the realities of their life situations.

Nurses found it difficult to uphold their central values of caring for patients and

providing patient-centred quality nursing services. The nature of nursing work began to change; nursing expertise was eroded in hospitals as the most senior nurses' positions were disestablished. Expert nurses were made redundant or deployed.

Experienced nurses were for the most part the main supports for new graduate nurses and were sought after to be preceptors to undergraduate student nurses. Experienced role models were invaluable as a source of wisdom to guide those with less experience. Experienced nurses though were undervalued and this resulted in an increasing shortage of experienced nurses over time. This loss extended to potential preceptors (News and Events, Kaitiaki, 1996; NZNO Conference Report, 1995; Underwood, 1994/95). Such losses were challenged by the New Zealand Nurses Organisation (NZNO) that represented a union perspective. That approach may not have taken into account the managerial position of trying to manage restricted budgets in a competitive market that was continually monitored by the Crown Company Monitoring Advisory Unit.

As the senior positions were disestablished, nurses who felt unsupported by the profession experienced a sense of powerlessness. Morale was low. Nurses recognised the reality that there were fewer experienced staff to care for sicker patients in hospitals and in the community, and many patients did not get the health care that they needed (Keene, 1996; O'Connor, 1996). This created a moral dilemma for nurses as they were challenged to provide the services that they believed should be delivered to patients as of right. Equally, registered nurse resources available to precept undergraduate student nurses became another burden for an already over-stretched nursing workforce.

The Technological Context

Technology is now a predominant feature of health care. Since the late 20th century, technological advances have impacted significantly on health care environments and the practice of nurses. The management of technology and health care is viewed by nursing education and health institutions as an essential competence area for undergraduate student nurses. Preceptors are important in preparing student nurses to cope with existing and emerging technologies in nursing services.

Over time, the delivery of nursing care has been reshaped. Nurses assume greater

responsibility in managing the care of people both sick and well. Patients today survive medical conditions that they would not have done two or three decades ago. Sophisticated diagnostic procedures precede intricate medical procedures. The environment where nurses work is diverse, with many technological devices being managed by nurses and patients in the community, which were once found only in the critical care unit of a hospital.

The Legislative Context

The situated nursing work context was further complicated by some significant legislative changes. For reform to be implemented the government enacted a number of influential Acts of Parliament. While it is not possible to address every act in this thesis, the Acts that were influential, because they impacted strongly on the precepting context, will be outlined briefly.

The Employment Contracts Act (ECA), (1991), was singularly the most pervasive and controversial industrial relations act introduced by the Government (Norton, 1996). In the health environment the ECA meant that nurses, for the first time in their history, had to learn to negotiate their terms of employment. Nurses became involved in contractual arrangements, as they learned to negotiate for wages and conditions.

The Privacy Act (1993) was the first of its kind in the world to recognise the right of all people to their privacy. Informed consent and how it was obtained, the giving of or withholding of information and to whom, and knowing how that information was to be used, stored, and retrieved, was the right of every patient. All agencies had to build up information systems in order to comply with the Act. Hospital records and information flow monitoring resulted from this legislation. Patients now had to give their permission for student nurses to be involved in their care, and preceptors had to seek permission from patients for student nurse-learners to be involved in service delivery.

The Health and Disability Commissioner's Act (1994) and its accompanying Code of Consumer's Rights was enacted by government to address the public concerns "that professional self-accountability was not enough to protect the public from inadequate information or treatment" (Cronin, 1996, p. 11). Accompanying legislation was the Code of Health and Disability Services Consumer's Rights (July,

1996). The code was considered so important by the then Minister of Health that it was sent to every registered, enrolled nurse and midwife in New Zealand. The code articulated the rights of consumers to privacy, respect for cultural, religious and social difference, and their need to be effectively informed in order to make choices and give consent for health care. It also gave the consumer the right to complain if they were dissatisfied with the service they received. All nurses were expected to comply with the code in practice. In particular, Right four, addresses the right of people to have qualified practitioners deliver services and there is an explicit expectation therein that patients will be treated with care and skill. This increased the moral imperative of preceptors to seek patients' permission to include undergraduate student nurses as learners in nursing care delivery and also to be aware that the patient had the right to refuse to have student nurses involved in care.

The Nursing Education Context

As the health context was reformed, so was nursing education. Without doubt, historical influences impact on the situated context of preceptorship today. Nursing education in New Zealand has undergone several significant changes since its inception in the late 19th century. For instance, in the 1950s, the World Health Organisation established guidelines for nursing education. The United States of America and Britain revised their curricula accordingly. New Zealand and Australia complied in order to ensure reciprocity for employment purposes for graduates from Australasia (Brown, Masters & Smith, 1994).

In the 1970s, a major change was the transfer of nursing education from a hospital based apprenticeship style training to the general education system (Carpenter, 1971). The Diploma of Comprehensive Nursing programmes were set up throughout the polytechnic system⁵ against the advice of Dr. Carpenter (1971) who recommended that nursing education would be better placed either in advanced colleges of health sciences, or the university. The first two polytechnic based programmes opened at Wellington and Christchurch in 1973 (Department of Education, 1972). These programmes were founded upon a nursing model, rather

⁵ In New Zealand, a polytechnic is a government funded tertiary education provider focussing primarily on vocational education and training.

than a bio-medical model that had traditionally dominated nursing education in the hospital schools (Brown et al., 1994).

This transfer of nursing education was one of the most significant events in nursing in New Zealand. Although the changes were critical to prepare nurses for the future, the transfer was problematic. From a historical position of patients receiving nursing care at the hands of student nurses who were being 'trained' by their more senior counterparts, professional nursing services from 1973 were to be provided by only by qualified registered nurse staff. Although this was the ideal, an all-registered nurse workforce has not been achieved in every area of nursing practice. Hospital based schools continued for some time with the last intake of hospital based students graduating in 1992. This change was gradually implemented. The desire to initiate an all-registered nurse staff for the provision of nursing services brought with it a need for registered nurses to work together as colleagues. A research-based model, *The Nursing Partnership* (Christensen, 1998), was developed to facilitate a New Zealand based theoretical framework for registered nurses to guide nursing practice. This meant that some nurses had been trained in systems that were very different to the modern nursing education context.

The profession was further challenged in the 1990s. A national meeting held in Auckland in 1991 provoked the nursing profession to set a baccalaureate degree as the basic educational preparation for nurses (Vision 2000, Nursing Council of New Zealand, 1991). From this time on, degree programmes were developed to prepare nurses for entry to practice. Again, the move from diploma to degree programmes was gradual. Clearly, by the closing decades of the 20th century, the changing education context was influencing nursing education. Moving into the 21st century, nursing as a practice-based discipline still requires nurses to undertake both theoretical and clinical experiences to become nurses (Bevis & Watson, 1989; Crisp & Taylor, 2000; Nurses Act 1977, Nursing Council of New Zealand, 1999a; Taylor, Lillis & LcMone, 1997). The Nursing Council of NZ (NCNZ) currently requires student nurses to complete 1500 hours of clinical experience in a three year degree programme. Yet, at the same time, the rise in complexity of health care and the expanding scope of nursing practice require nurses to be highly educated with the ability to think critically (Bandman & Bandman, 1995) and independently. In order to be responsive to diverse challenges in their practice, nurses are expected to achieve scholarly skills of a much higher order than the task-oriented requirements of earlier decades in nursing's history. They are expected to be competent in

abstract skills such as critical analysis, creative, reflective thinking, research, writing, and scholarship. Such skills accompany degree education (Education Act, 1989). While these skills are expected of the contemporary nurse, it is debatable whether preceptors who have not been exposed to tertiary degree education have the same scholarly skills.

The Contemporary Nursing Education Context

As pointed out, nursing education straddles both health and education institutions. Hence, there is dual governance from both health and education government statutory bodies as well as from the Nursing Council of New Zealand as to how a prospective nurse becomes a registered nurse, and this impacts on the precepting context.

To register as a New Zealand registered comprehensive nurse (NZRCpN), each nursing student must first achieve degree programme requirements. Polytechnic degree programmes are approved through the New Zealand Qualifications Authority (NZQA) and institutions are accredited to provide these. NZQA resulted from the working group on post compulsory education and training (Hawke, 1988) and was set up as a statutory body to establish a consistent approach to the recognition of qualifications in academic and vocational areas (Education Act, 1989, Section 253). NZQA focuses on the quality and standards of education and provides a framework for national qualifications. The government saw the education sector as a key player in achieving the wider social goals that encompassed a highly skilled workforce and a high growth economy (Green Paper, 1997). Operating within the same tight fiscal environment as the health sector, polytechnic education providers responded to the need for degree development, accreditation, and approval processes for some of their programmes, including nursing. The trend for higher education for nurses has continued. Since 2000, four universities now have undergraduate nursing programmes approved through the CUAP. These are Massey, Palmerston North and Wellington, the University of Auckland and the Auckland University of Technology.

Educational institutes, as part of their accountability to stakeholders and to government, were charged with providing a quality learning environment governed by quality assurance processes. These were developed by educational institutes to meet NZQA requirements and to assure the public that quality education was being

provided. National monitoring enhances international credibility and is important to attract both local and international students into nursing programmes.

Curriculum development is monitored closely by the Qualifications Authority. The development of nursing degrees within the polytechnic sector, meant that a nursing degree curriculum was developed involving essential stakeholders who were interested in the graduate profile. Stakeholders included representatives from the professional and nursing education sector, tangata whenua (original inhabitants of an area), clinical agencies, practitioners (who may or may not be preceptors), students, and faculty staff. As an educator involved in curriculum development processes, it has been my observation that few practitioners, or indeed preceptors, attend curriculum development meetings, as they are too busy providing services for patients. This is problematic, as stakeholders are required to be involved in order to ensure workplace relevance of the curriculum (NZQA Development of Degrees, 1995).

Curriculum development therefore exists in a situated context that is seldom straightforward. It includes intensive consultation that must be fitted around the normal teaching responsibilities of staff and the activities of employed stakeholders and preceptors. The consultation process is time consuming as well as costly. The final product is submitted for examination by an expert NZQA panel that includes the Nursing Council of New Zealand and Universities' representatives. An approval and accreditation visit to the institute involves a triangulated process of audit and monitoring.

The educational monitoring context is affected too by the need for cultural safety in a bicultural society. In 1996, the Nursing Council of New Zealand published Cultural Safety Guidelines. The Cultural Safety Model (Ramsden, 1990, 1993) formed the basis for the guidelines to establish culturally safe practice of nurses. All nursing education curriculum must meet the 1996 standards for Cultural Safety to gain approval from the Nursing Council of New Zealand. The Council has the power to approve or not approve nursing education programmes under the power of the Nurses Act (1977) and its amendments and regulations (1986). The concept of cultural safety relates to the principle by government of 'safety' for the consumer of health care and is therefore of importance to nursing service providers in institutions as well as at a personal professional level. All these situations affect precepting.

The Statutory Context – The Nursing Council of New Zealand

The Nursing Council of New Zealand is the statutory body responsible for administering the Nurses Act (1977) and the Nurses Regulations (1986). Its primary responsibility is the safety of the New Zealand public receiving professional care from the hands of nurses and midwives. It sets out the conditions for, and authorises the registration and enrolment of nurses and midwives on the New Zealand register. As the national registration body, it governs the practice of nurses and midwives and sets standards for nursing education.⁶ Its stated objective is to “enhance professional excellence in nursing and midwifery”⁷ The Nursing Council has set out clear directives clarifying what student nurses must learn in order to meet the basic standards and competencies for registration. While nurse lecturers are familiar with the directives, it is questionable whether preceptors have a similar in-depth understanding of them, or even know of their existence.

The Nursing Council of New Zealand, recognising international trends, commissioned the development of competencies that would clarify the point of entry to the register of comprehensive nurses. The development involved extensive consultation with the professional community beginning in 1995, and culminating in a set of competencies in 1999. “Competencies for Entry to the Register of Comprehensive Nurses” include specific mental health competencies (Nursing Council of New Zealand, 1999a). Generic competencies to be achieved by the student nurse centre on theoretical and clinical experiences. These are communication, cultural safety, professional judgement, management of nursing care, management of the environment, legal responsibility, ethical accountability, health education, interprofessional health care, quality improvement, professional development, and mental health.

Nursing education curricula must embed the competencies within the baccalaureate degree programmes in order to be approved by the Nursing Council of New Zealand and the education provider accredited to offer the baccalaureate degree. Once the degree is completed successfully by the nursing student, and the Nursing Council of New Zealand competencies are demonstrated, the Head of Department of an

⁶ Nurses Act (Reprinted Act [With Amendments Incorporated] as on 1 January 1995).

⁷ The Nursing Council of New Zealand Nursing Department/Schools Handbook for Tertiary Education Institutions offering Pre-registration Nursing Programmes, Competencies for Entry to the Register of Comprehensive Nurses, January 1999).

approved Nursing programme, under the Nurses Act (1977) and Nurses Regulations (1986), holds the responsibility of presenting to the Nursing Council the candidate as a 'fit and proper' person to sit the State Examination. Further, the student has to be a successful candidate in the examination to be entered to the register to practice as a registered nurse in New Zealand. This latter prerequisite has been a legislative requirement since 1901 (Nurses Registration Act, 1901) and continues today.

As this thesis was being written, New Zealand nurses have been engaged in the review of the Nurses Act (1977). Changes to the Act were seen as being important for the Nursing Council of New Zealand to broaden their scope of statutory powers and legitimate an advanced scope of nursing practice at a post registration level. As well, in keeping with concerns raised by the Minister of Health about competency assurance of professional practice, the Nursing Council sought changes to the Act that would assure the public of ongoing competency of nurses providing services to the public. However, during the Nurses' Act review process, the Minister of Health, responding to nursing leadership, set up a Ministerial Task Force to undertake a comprehensive review of nursing in New Zealand to identify barriers that prevented the releasing of the potential of nursing (Ministry of Health, 1998).

As an outcome, of this review, the Task Force made a number of recommendations requiring the Ministry of Health to design new legislation for occupational regulation⁸. The Health Professionals' Competency Assurance Bill, due to be passed into law in 2002, will govern the practice of health professionals, including nurses, and therefore will impact upon preceptors' practice. This Legislation will supersede the Nurses Act. Although the Nursing Council of New Zealand has set the standard that all nurses hold a Bachelor's degree as entry to nursing practice (Nursing Council of New Zealand, 1999a), many registered nurses that precept student nurses are not as well educated as their preceptees. Initially trained as nurses in hospital-based programmes, many of the preceptors are now upgrading their own education for career advancement, bridging their registration to a degree qualification.

The New Zealand Nurses Organisation published policy and standards for nursing

⁸ The Health Professionals' Competency Assurance Bill has been approved by Cabinet, and is currently being drafted by Parliamentary Counsel, and is scheduled to be introduced into Parliament and referred to Select Committee by the end of 2001 and passed into law during 2002. (personal communication, Marilyn Goddard, Principal Analyst, Sector Policy Directorate, Ministry of Health, June 29, 2001)

education in 1994. This document pointed out that those involved in nursing education should be appropriately prepared for the educating role, both professionally and academically. At the same time, the skilled practitioner is of paramount importance to teach student nurses the precepts of nursing practice. Hence the undergraduate student nurse, while learning the practice of nursing may be precepted by a registered nurse who is engaged in the same degree programme. She or he too is developing the same intellectual skills as his or her preceptee. Clinical lecturers are governed by both the Nursing Council of New Zealand standards for clinical lecturers engaged in nursing education programmes and the requirements of the education institute of their employment (Education Act, 1989). Preceptors who are employed by health care agencies are not regulated by either of these regulatory bodies. How then can the preceptor meet the standards required for nursing education if the statutory bodies that regulate nursing students' education do not govern them?

The Clinical Training Context: Changing Structures, Changing Roles

Along with health, the government of the day examined other public sectors as they sought to contain the costs of government operations. The "unbundling" (Coopers & Lybrand, 1994, p. 1) of the costs of medical and nursing clinical training was commissioned as part of the government's exploratory work to really understand the cost of social services to the then Crown Health Enterprises (CHEs). The outcome was that Coopers and Lybrand reported to the Ministry of Health in January 1994, in a report that covered all clinical training, including the identified estimated costs related to comprehensive nursing programmes.

Detailed CHE research of slowdown costs and service benefits in various clinical settings was identified. The figures were drawn from 1992. Costs given were based upon the cost of staff nurses' time "lost" as a result of teaching student nurses. Slow down costs were calculated using the total number of student clinical weeks and on the basis of the staff nurse salary data provided by CHEs at the time.

This detailed cost analysis was significant, as determining "first order" costs that affected clinical training was seen as an area of risk to the financial viability of CHEs. Part of the risk was the cost of employing teachers/trainers and students, although the direct costs associated with them were an unknown quantity. "Second order" costs of clinical training included such things as a greater use of diagnostic

tests, associated with medical student training, and lower service productivity associated with teaching activities.

Until that time the quantification of benefits related to clinical training had been estimated rather than known. From this time onwards, monies have been transferred from vote education to vote health in order to pay the costs of clinical placements for students. With the transfer of monies, so began a much more formalised process of placing student nurses in their clinical placements between service and education providers. Increased costs were incurred by service and education providers for the increased administration of the clinical placement system. Additionally, a significant cost burden was incurred by nursing education providers for the costs of each student's clinical placement. For example, if a student was sick or withdrew from the clinical placement for any reason, it was still a cost to the education provider. Shrinking budgets and increased costs challenged education providers as to how they could offer degree programmes competitively and still hold down student fees, but yet maintain their quality.

Therefore it is not surprising, as an outcome of the extensive government reforms of the 1990s, that there has been a distinct change of role for the clinical lecturer (Orchard, 1999) in the clinical education context. Government reforms and constrained resources for all government funded institutions, including tertiary education institutions, has forced change in the way clinical lecturers work. The traditional close clinical lecturer/student relationship has been replaced by the need to supervise greater numbers of students at any one time. Education providers responded by creatively utilising their scarce resources. They increased the supervisory ratio of student to lecturer in classroom teaching and in clinical supervision of students. But, to maintain the quality of nursing education programmes, and uphold safety for the public and the student, at the early levels of degree programmes to provide a low ratio of students to clinical lecturers in their clinical placements. This then meant that students nearing the end of their degree programme became less dependent upon their clinical lecturers and more dependent upon their preceptors. Although this is how nursing education degree programmes are structured to encourage senior students to make the transition from student to graduate practice, the complexity of the health care context meant that their reliance on their preceptor was considerable. Accompanying this, as part of the creative way to contain costs of nursing education programmes, a number of nursing education providers established joint appointments between clinical

agencies and education providers to precept students. These joint appointees have varying preparations for their role which spans two institutions. This has not been without difficulty.

The clinical lecturing role is most certainly complicated by the government reforms and the call for increased accountability to consumers of various government institutions. For example, student nurses pay high fees to education institutions in order to be educated as nurses. Education institutions then pay health care agencies to have students placed clinically (Cooper and Lybrand, 1994). Health care agencies and education institutes are constantly reviewing budgets. It is possible that in this environment of economic constraint, that accountability for the educational consumer, namely the nursing student, may have been lost.

The Student Context

A diverse group of students reflecting all sectors of society choose to enter nursing as a career. They range from recent school leavers to mature entrants (over 20 years of age). Many mature students must undertake educational preparation before entering a degree programme as their schooling may be insufficient, or it may have been undertaken in a language other than English. In nursing education, the young school leaver, the traditional applicant, no longer dominates. In fact, in most nursing education programmes in New Zealand, the mean age of the student can be above 25 years. This paints a very different picture of nursing students compared to requirements at the turn of the 19th century when the Nurses' Registration Act (1901) was passed. Brown et al. (1994, p. 27) state that "registration demanded certain requirements of persons before they were entitled to have their names recorded: they had to be 23 years of age and have had three years' training as a nurse in a hospital, including instruction in theory and practice". They also had to be single women without children.

Today, the student context is more complex. Mature students have both advantages and disadvantages. They have, collectively, a wealth of life experience, which is very helpful when engaging in a career that requires highly developed interpersonal skills, compassion and empathy. Disadvantages include heavy family responsibilities and financial commitments. Thus their 'lived space' must be balanced with their student responsibility of learning how to be a nurse. An added difficulty can be that the preceptor who is ultimately the student's teacher may be

less mature in age and in life experience, than their preceptee. Further, they may be a new graduate with less than one year experience as a graduate nurse.

All students have clinical learning outcomes to achieve in their clinical placements that are related to a particular area of their nursing curriculum and to the clinical competencies required by the Nursing Council at the end of their nursing education programmes. Depending upon their year of their degree programme, students may, or may not know when they enter their clinical placement, what the scope of their practice or their learning may be or what it may become. They are novices (Benner, 1984) in the world of nursing practice until they have had some clinical experience on which to base their expectations. They require a skilled practitioner to precept them into the life-world of nursing.

Summary

What is evident in this chapter, is the climate of constant change and uncertainty that has been a feature of the situated context in which preceptors practice. Change has extended to every facet of political, social, and cultural life. The need to prepare well educated new nurses while coping with constant change is a continual challenge to preceptors. Preceptors are not employed by educational institutes and are not regulated by either the Nursing Council of New Zealand's nursing education requirements or the Education Act (1989). Yet their involvement in precepting undergraduate student nurses is critical in the light of the health and education reforms and the changed role of the clinical lecturer. The next chapter moves to the literature to create the historical scholarly background in which preceptorship has emerged.

CHAPTER THREE

Review of the Literature – An Hermeneutic Approach

Introduction

In this chapter a hermeneutic approach has been used to review the literature related to the concept of being a 'preceptor'. This strategy is outlined by Diekelmann, Allen & Tanner (1989)⁹. It is a particular philosophical approach of engaging Heidegger (1962/27) and Gadamer (1976) in a hermeneutic circle that facilitates questioning to identify themes within the existing literature. Hermeneutical scholarship focuses on ways of thinking. Thinking is "reflective, reflexive and circular in nature" (Diekelmann & Ironside, 1998, p. 1348). The goal, therefore, of this hermeneutical analysis of the literature is to uncover themes that reflect common understandings and shared meanings of the word 'preceptor', and if and how 'preceptor' as a way of being, has been portrayed historically and currently, within the culture of nursing.

Theme: The beginning

"Where has the term 'preceptor' come from"? which is central to the phenomenon of interest. It is derived from the noun 'precept', from the Latin *praeceptum* referring to a maxim or command. The first located use of the word 'precept' is in Psalm 119, "Make me to understand thy precepts", (Holy Bible, KJV, v. 27, p. 468).

According to Onions (1955, p. 1564), "*praecipere* to advise, instruct" is a derivative from the same Latin origin as "*praeceptor*, teacher; one who instructs; a tutor" in the maxims or precepts. Clearly, instruction and training in certain precepts lie at the heart of the word 'preceptor'.

In searching the nursing literature I was curious to see when the term 'preceptor' first appeared. Myrick (1988) presents an historical overview of the emergence of the term 'preceptorship' rather than the term 'preceptor'. Literature related to the term 'preceptorship' refers to a course of study and practice experience designed to provide a specialised and independent learning opportunity for either registered nurses or student nurses being trained by a preceptor. The first reported research

⁹ The approach is explained by Diekelmann, Allen & Tanner, (1989) in "A Hermeneutic Analysis of the NLN for the Appraisal of Baccalaureate Programs."

on preceptorship in the United States was by Spears (1986) who identified a total of 58 preceptorships for nursing students in 1975. Thus this early literature focused upon the experience of being precepted rather than of being a preceptor. Extending knowledge about the concept of 'preceptorship', Shamian and Inhaber (1985) undertook an extensive review of twenty-one articles including both empirical studies and theoretical literature. This review focused on preceptor programmes, their content and the way preceptors are trained. Their findings, among others, showed that the term 'preceptor' first appeared in the Nursing Indices in 1975 as a classification indicator and by 1988 "there were 17 references listed under precepting in the Cumulative Index of Nursing" (p. 79).

Shamian and Inhaber (1985) had difficulty in drawing conclusions from the extensive descriptive data reviewed, although it was apparent that the preceptor model was popular for both educational and orientation purposes and apparently benefited both educators and clinicians. Schools of nursing education gained because preceptors facilitated better prepared graduates to enter practice who were work oriented. It was clear too, that preceptors were more cost-effective than clinical instructors who facilitated both education and service goals. Schools of education gained because they had a better prepared graduate at no additional cost to the school because preceptors were hospital employees. The hospital gained because they had less staff turnover. Preceptors often reported greater job satisfaction, and patients presumably gained from receiving services from better-prepared nursing staff. The authors also identify that, up until their review, most preceptorship programmes had been established on assumptions that preceptorship was beneficial. They concluded that it was time to prove the value of preceptors and to identify effective ways of training preceptors. Shamian and Inhaber (1985) identified the need to pose research questions to evaluate the preceptorship model, for there was little substantive evidence supporting its benefit.

Being new

During the literature review, the question "how did preceptorship start?" uncovered the theme of being new to nursing practice as an employee. The vanguard work by Kramer (1974) 'reality shock' which addresses why nurses exited nursing was reviewed. Reality shock is the helplessness, powerlessness, frustration, and dissatisfaction experienced by new graduates as they move from the familiar subculture of their nursing school context into the real life-world of practice. The

difficulty seems to lie between the two different value systems of Schools of Nursing and the workplace. The nursing school's values emphasise holistic, individualised patient care and family involvement, whereas the unfamiliar subculture of work emphasises patient safety, organisation, efficiency, responsibility, and co-operation. During the 1970s, employing agencies complained that new graduates from nursing education programmes were not 'employee ready' and education providers complained that employing agencies were not 'user friendly' toward new graduates. A similar cry is heard within the New Zealand context as this thesis is being written. In New Zealand, a national conference addressed this very issue as the problem of retaining new graduate nurses has persisted (New Zealand National Consensus Conference, 1996).

Continuing this theme, other authors indicated that agencies expected too much from new graduates and did not provide satisfactory induction programmes or sufficient support for new graduates entering the organisation as new employees (Blazey, 1995; NZ National Consensus Conference, 1996; Holly, 1992; Myrick, 1988). In order for employing agencies to meet their obligations and in the light of Kramer's (1974) work, preceptorship programmes were introduced and have continued to exist to this day. In fact, their popularity and seeming effectiveness to meet the needs of both employing agencies and academia is expanding rather than diminishing. Hence, there is a continual interest in understanding how the preceptor assists new orientees to adjust to being a new employee rather than how the preceptor assists the new student to learn the practice of nursing.

Theme: Preceptorship as familiarisation and socialisation

Another question I posed was "How do preceptors help?" The literature shows that preceptors have an important part to play in a helping role, familiarising new employees, and socialising new graduates into the clinical agency and the practice world (Burke, 1994; Davis, 1987; Freisen & Conahan, 1980; McGrath & Koewing, 1978; McGrath & Princeton, 1987). The literature can be categorised into precepting the new employee, providing a safe transition from being new to becoming an experienced employee of an organisation. More recently however, literature focuses upon precepting undergraduate nursing students who are moving through an educational process (Chickerella & Lutz, 1981, Dyson & Thompson, 1996; Murphy & Hammerstad, 1981; Plasse & Lederer, 1981).

Chickarella and Lutz (1981) emphasise that one way of reducing Kramer's (1974) reality shock is to introduce students to the real world of nursing prior to graduation. Preceptorships are the ideal way of accomplishing this goal. Chickarella and Lutz adapted Kramer's anticipatory socialisation programme for students to aid their transition from student to graduate nurse as a foundation for a preceptorship programme. The focus of the programme was to induce confidence in the student through a one to one preceptorship experience prior to graduation. A feature of this programme was that the preceptor and the student were assigned to each other for a three month period. Preceptors volunteered their interest to be part of the programme and identified their desire to help students learn. Preceptors stated that they also wanted to improve their own knowledge and skills as well as to demonstrate their leadership and teaching skills. Hospital management reviewed their policies to expand the experiential possibilities for students. Preceptors underwent an orientation programme before the preceptor/preceptee partnership was established. A feature of the preceptor's role was to act as a liaison person with all levels of staff within the hospital environment to facilitate the students' learning experiences. Chickarella and Lutz point out the important advantage of the one to one preceptorship programme is that the preceptor acts as professional nurturer to the novice nurse thus lessening the student's anxiety of learning in the unpredictable clinical context. Davis and Barham (1989) and Hsieh and Knowles (1990) refer to one to one experiences with staff nurse role models who act as teacher and guide to the neophyte nurse and reinforce Chickarella and Lutz's statements.

Another study by Clayton, Broome, and Ellis (1989) evaluated the effect of a preceptorship on the professional socialization behaviours of baccalaureate graduates. Sixty-six senior students participated with half being assigned one to one with a staff nurse preceptor. The other half were allocated into small groups and guided through a ten week practicum. Both groups completed the "Schwerian Six Dimension Scale of Nursing Performance" instrument pre-experience, immediately after the experience, and six months after graduation. The instrument measured various sub-scales: leadership, critical care, teaching/collaboration, planning, evaluation, interpersonal relations, communication and professional development. Research findings showed that while there was no significant difference between groups before the experience, significant differences in favour of the precepted group at six months were evident in all elements except professional development and critical care. Findings from this study supported the preceptor

model of working with a practising nurse in preference to working with a faculty member during the practicum experience in the senior year. Preceptors are well placed to guide students through practice.

While the literature indicates that many preceptors are helpful, the quality of the teaching is important when students are being socialised into practice. For example, Ouellet (1993) using a quasi-experimental design investigated the effects of a preceptor experience on nursing students before and after a four and a seven week experience. A significant difference in the scores between students precepted by a baccalaureate prepared preceptor and a diploma prepared preceptor was reported. Ouellet concluded with some confidence that students received a greater professional socialisation with the more highly educated preceptor. However, the study used a non-randomised convenience sample of 103 subjects and the author acknowledged that the generalisability of the study could not be guaranteed.

It would appear that preceptors help preceptees both formally and informally. In particular, preceptors help ease new graduates, new employees and student nurses into a new environment and support them, as they become familiar with the everyday world of practice.

Theme: Understanding preceptorship

Another question that I asked of the literature was "Who should be a preceptor?" The emerging theme was understanding preceptorship. For example, Tough (1971) points out that the person who demonstrates a successful performance in an occupation knows exactly the knowledge and skills that are necessary for the profession in question. They are the most appropriate person to teach another in a one to one interaction in order to reinforce correct behaviours and to correct errors before they become routine. Tough's view would suggest a focus upon the technical roles of nursing practice. Part of preceptorship practice is being a role model in practice and passing on and guiding the preceptee in the technical aspects of nursing.

In some literature, preceptorship practice is described according to the characteristics of the preceptor in terms of organisational specifications. These include an ability to be a teacher, mentor, guide, director and supervisor of technical nursing activities of the newly hired or transferred employee (Kramer, 1993; Morrow,

1984). For undergraduate student nurses, the preceptor is expected to orientate them to the clinical setting and select suitable patients for them so that students can practice nursing skills safely without compromising patients' therapy. Additionally, the preceptor must supervise new skill performances as students acquire these and use available resources in the environment to assist them to learn. Further, preceptors provide feedback to developing nurses so that neophytes can progress towards becoming fully functioning professionals in their own right (Davis & Barham, 1989).

Because much of the early literature focuses solely on the orientation of graduate nurses who are new to the practice world, (Burke, 1994; Morrow, 1984; Shamian & Inhaber, 1985) it has been used to frame precepting programmes for undergraduate nurses. Research to date focuses briefly on the orientation of new graduates into employment and now emphasises precepting as a supervisory role undertaken by a staff nurse for the undergraduate student nurse. Graduate precepting may be very different to precepting undergraduate student nurses. It is possible that there may even be two types of precepting. Although descriptions of preceptorship vary, understanding preceptorship includes teaching, guiding, supervising, role modelling, supporting, and communicating.

Theme: Being an “ideal” preceptor

According to Piemme, Kramer, Tack, and Evans (1986), persons who are the ideal preceptors should display personal qualities such as patience, enthusiasm, knowledge and organisational abilities. Davis and Barham (1989), claim that an important requirement is that preceptors demonstrate superior knowledge and competency levels gained from remaining in the one clinical setting over time. In addition, the preceptor should have expert teaching and problem solving abilities, and excellent communication skills. An ability to communicate expectations clearly, and to listen to difficulties that students may or may not have as they practise skills, requires patience. Preceptors need to be sensitive to the student in a nurturing and caring way, to assist them to blend selected aspects of nursing education and practice.

The preceptor must be versatile so that they can communicate interprofessionally and with the student. This type of communication is quite different to the teaching style required when precepting the student. The ability to remain connected to a

number of groups of people simultaneously in order to provide effective client care requires skilled communication, if the registered nurse is to meet organisational requirements.

Ideally, preceptors should be selected from registered nurses who are likely to be sensitive to student learning experiences. The perceptive preceptor will appreciate that the skills students require may have been practised only once or twice in a demonstration room. The discerning preceptor will be aware that the student is likely to be highly anxious in the clinical setting (Windsor, 1987). That the student is anxious is understandable. Rarely does the real lifeworld of the clinical setting with all its complexities of day to day service provision to a wide variety of people of all age groupings with varying degrees of illness, dependence and independence, reflect the idealised descriptions of clinical practice in a text. It is the ideal rather than the real that appear in textbooks. It is the textbook that the undergraduate student nurse is most familiar with (Peirce, 1991).

Kramer (1993) claims that nurse managers are the best persons to select the best preceptors. The nurse manager is well-positioned to select the 'ideal' preceptor as he or she understands the strengths and weaknesses of staff members. Bain (1996) challenges that view and states that Kramer's interpretation is based upon an hierarchical model of management, cautioning that such an approach could result in the formation of an 'elitist' (p. 105) rank among nurses. Bain points out that the only formal specification required of a preceptor by the United Kingdom Central Council for Nursing, Midwifery and Health Visiting (UKCC), (1992), is that the clinician be a first level nurse (midwife or health visitor) with at least 12 months post-registration experience in the same field as the new graduate entering practice. That formulation is based on the assumption that anyone can precept others and does not acknowledge that some people are quite simply better teachers and communicators than others.

It would appear from the literature, that there are inconsistent standards used for the selection of preceptors and this likely affects effective precepting. However, attention in the 1990s had begun to focus on the educational preparation of preceptors as an adjunct to personal qualities and capabilities that has been the traditional focus of the preceptor.

Theme: Preparing to be a preceptor

The question 'What educational preparation does a preceptor need?' unveiled another theme about preparing to be a preceptor. The educational preparation for being a preceptor was that the person should have a baccalaureate degree in nursing (Davis & Barham, 1989; Langston, 1990; Ouellet, 1993; Peirce, 1991). More recently, it is considered desirable that teachers of nurses be prepared to the Masterate level (Nursing Council of New Zealand, 1999a). A necessary adjunct to this theoretical background of the preceptor is the expectation that the preceptor will have advanced clinical expertise as well (Kramer, 1993). As reported in the literature, the reality is that there is great variation in the preparation of preceptors. For example, preceptors who work for nursing schools, work closely with faculty members who communicate frequently, and coach and guide more often informally than formally (Dyson & Thompson, 1996; May, 1980; Moyer & Mann, 1979; Murphy & Hammerstad, 1981; Peirce, 1991; Plasse & Lederer, 1981; Zerbe & Lachat, 1991).

Preparing to be a preceptor in a nursing school sounds rather different to Bain's (1996) expectations cited earlier. Nonetheless, Bain (1996) points out that studies by Langston (1990) and Ouellet (1993) suggest that baccalaureate prepared preceptors provide a higher standard of socialisation for neophyte nurses whereas preceptors prepared to a diploma level tend to focus more on the technical aspects of nursing practice.

Hence, throughout the Western world there has been a demand for a high level of education for nurses. Concomitantly, in the profession of nursing, as the educational levels of its practitioners have developed, scientific endeavour too has advanced by way of research, theory building, and knowledge development. This has brought about an accompanying continuing emergence of the profession of nursing as a scientific discipline, that stands independent to medicine with its own unique body of knowledge, codes of ethical practice, service orientation and governance (Meleis, 1997; Taylor, Lillis & Lemone, 1997). It is evident in the literature that the educational requirements have affected preparing to be a preceptor. Today, preceptors must be well prepared and have increased understanding to manage the knowledge explosion in society.

Theme: Being an effective preceptor

Even though so much has been written about preceptorship we do not know if precepting is in fact effective. McGrath and Princeton (1987) claimed to produce evidence both quantitatively and qualitatively to support the effectiveness of preceptorship programmes on staff recruitment and retention. The researchers used an exploratory research design to identify the content for a preceptor programme, but failed to provide their quantitative or qualitative findings in their research report.

A number of studies questioned whether or not the process of precepting is effective. Scheetz (1989) evaluated the effect of a preceptorship programme on 72 Baccalaureate Nursing students (BNS) students. Thirty-two students were assigned to a registered nurse preceptor for ten to twelve weeks and were compared with thirty-two students employed as nurse assistants who acted as a control group. Gains relating to three domains were identified. This included clinical competence, perceived preference of experience, and the development of clinical competence over time. Clinical competence was defined as "the ability to utilise the problem-solving process, apply theory to practice and perform psychomotor skills" (p. 30). Clinical competence was measured pre- and post-treatment using the researcher developed "Clinical Competence Rating Scale" that was administered by head nurses of the assigned units. Data revealed significant gains in the three domains of clinical competence for the experimental group. Both groups reported favourable perceptions of the experience. An interesting finding was that students employed as nurse assistants developed informal relationships with staff nurses on their assigned units in spite of not being assigned to a preceptor formally. The researcher concluded that the assigned preceptors gained both intrinsic and extrinsic rewards from the precepting process. The quality and quantity of feedback, supervision and assistance may have been less in the informal situations. This was seen as a possible explanation as to why there was less gain in competence in the informal situations.

The findings of this study were inconclusive as to whether both the work experience group and the control group had benefited by virtue of the preceptor/preceptee relationship structured for them. The significant outcome factor appeared to be increased opportunity to gain nursing practice experience that lay at the heart of the clinical competence gains. Scheetz (1989) concluded that additional research was

required to demonstrate that a baccalaureate nursing education produces a graduate that is clinically competent. This question is well raised by the researcher. Even more importantly, can baccalaureate education alone lay claim to producing a clinically competent nurse?

Theme: The 'in-betweenness' of clinical teaching and precepting

So far, the literature has focused on understanding precepting from the point of view of the registered nurse clinician working with the student in the clinical agency. Another question that needs to be considered in this hermeneutic analysis of precepting concerns understanding the meaning of clinical teaching.

Myrick (1988) claims that clinical teaching must be afforded equal recognition and status with classroom teaching, research and publications and, in fact, all should run together. She points out that clinical competence for clinical lecturers must become a priority among faculty. She also questions if all clinical instructors are clinically competent and suggests that this may explain graduates' lack of competence. Are Myrick's concerns valid? What is the meaning of clinical teaching? Is there a link between understandings of clinical teaching and the competence of undergraduate student nurses on graduation? I argue that Myrick's questions are worthy of further consideration.

Myrick (1988) criticises new clinical teaching strategies that place the responsibility for clinical teaching squarely on the staff nurse's shoulders. She pointed out that there was little empirical evidence to substantiate their effectiveness for student learning in the practice setting. She also stated that if nurse educators choose to use preceptors to take up the clinical teaching aspect of nursing education, there should be at least some minimal evidence supporting the method. She further asserts that preceptorships should be carefully designed, with well-developed criteria that guide preceptor selection and education, to ensure that nursing education remains in the jurisdiction of nurse educators rather than with nursing service. The 'in-betweenness' of clinical teaching and precepting emerges here. All too often, the preceptor is selected primarily for the convenience of the nurse educator who may not be comfortable in the clinical setting.

The 'in-betweenness' of clinical teaching and precepting is a strong theme throughout this thesis. Registered nurses who become preceptors to undergraduate

student nurses may understand clinical teaching differently to a clinical lecturer's understanding of the role which is grounded in nursing education. This raises questions for me as a researcher who asks, "Are undergraduate student nurses being taught by preceptors who have undergone a carefully designed teaching programme to prepare them for precepting"?

Theme: Theoretical approaches to Precepting and Learning

During the literature review I discovered much literature about teaching and learning. I needed to understand the theoretical approaches to preceptorship. The definition or understanding of 'preceptor' that has dominated the literature till recently is based upon a predominantly behaviouristic view, with the underlying assumption that the neophyte nurse can learn appropriate nursing actions from a preceptor. Much of the scientific endeavour that provides the foundation for curriculum development and nursing education programmes, has evolved from the behavioural school of thought (Bastable, 1997; Diekelmann, 1989; Tyler, 1949). Thus the term preceptor and the practice of precepting have been understood from a behavioural viewpoint. While behaviourism offers a particular perspective of teaching and learning, it is also limited. Precepting new employees or student nurses is a much more complex undertaking than is currently appreciated (Rittman, 1992). For instance, in behaviourism, the preceptee will be rewarded for appropriate nursing actions and will avoid inappropriate actions because of punishment. Thus the expectation is that the nurse seeks to be rewarded for performing correct nursing actions. The emphasis is on action rather than thinking.

Behaviourism has been popular in nursing education, especially in clinical teaching. Many nurse educators supported the view that learning evolved from a natural science perspective rather than the human sciences, which tended to stress the nature of the learning process. The behavioural view of a person perceives that the human being can be studied with the same laws that govern all natural phenomena. Therefore, theories of learning that have been used to describe the concept of precepting have predominantly followed those derived from the natural sciences.

The behavioural perspective (Bigge & Shermis, 1992; Skinner, 1974) views the human being as a passive organism which responds to the stimuli surrounding them in the external environment. Behaviourism assumes that a person's behaviour can be controlled through the manipulation and control of environmental stimuli by way

of a complex system of positive and negative reinforcements. Correct behaviour is reinforced through an appropriate reward. Incorrect behaviour is not rewarded in order to extinguish undesirable behaviour. Learning depends upon the learner changing behaviour as a result of his or her experience. The scientific method, as evolved through the natural sciences as a method to describe, explain, predict and therefore control, was viewed as being an appropriate method for the study of the human organism. Such a position became known as the 'idealist' position. As an outcome of this school of thought, the discourse that has followed in the scientific literature has come to portray meanings of the word 'preceptor' in what has been considered to be an idealist¹⁰ understanding of the term.

Theme: Recognising how learning styles influence practice

One more question asked in this Heideggerian hermeneutic analysis was, "How do preceptors facilitate student learning?" The theme that emerged concerned learning styles. There have been a number of studies related to the explanation of the learning styles used for students in nursing education. Many of these studies have used Kolb's (1984) revised theoretical framework for experiential learning. Kolb's original theory was presented in 1978). Nurse researchers have taken up Kolb's (1984) theoretical framework and its associated assumptions and applied it to precepting, as it seems to have an appropriate fit "in a behaviourally complex learning environment" (Stutsky & Laschinger, 1995, p. 145). Through experiential learning, students learn to actively apply knowledge and/or skills to a practical "real-life" problem that they might expect to face as professionals.

According to Kolb (1984), learning is defined as "the process whereby knowledge is created through the transformation of experience" (p. 34). Kolb maintained that experiential learning involves a four-stage cycle of four dialectically opposed adaptive learning modes. These four learning modes within the cycle are specific to each phase of the cycle. The first phase involves the learner in *concrete experience* (CE) where the learner experiences everyday situations. Feelings about the experience are important then. The second stage, *reflective observation* (RO)

¹⁰ 'Idealist': Entities that exist only as content of the mind which have nothing in common with physical objects. Because of this, it is unclear how interactions between physical objects and the human body (a physical object) can generate ideas. Hence the separation between mind and body. Idealism relates to this position. Beginning in the 17th Century with Descartes (1596-1650), all objects of consciousness were held to be ideas (Honderich, 1995).

occurs when the learner watches and listens. The person is expected to be patient, objective, and make careful judgements before proceeding to action. The third stage moves the learner from the concrete to the *abstract* as he or she *conceptualises* (AC) the experience. Here, the learner analyses ideas logically and systematically, in order to understand the demands made in the situation and the problem solving required to produce an outcome. Now, the learner learns by thinking. In the final stage, the learner learns through doing, by applying their knowledge and skills in *active experimentation* (AE). Kolb states that when nurses are engaged in learning about clinical practice, they pass through all four stages over and over again.

Kolb also described four basic learning styles that address the different ways different people learn. These are what Kolb termed *convergent, divergent, assimilative and accommodative* styles. The *converger* is able to apply ideas and excels at problem solving and decision making. This style fits the Active Conceptualisation (AC) and the Active Experimentation (AE) phase of the cycle. The *diverger* is the opposite of the *converger* where Concrete Experience (CE) and Reflective Observation (RO) is more dominant. The *diverger* is imaginative and can view a situation from a number of perspectives. In contrast, the *assimilator* is generally an inductive thinker and can create theoretical models. The *accommodator* is the opposite of the *assimilator* and emphasises the concrete experience and active experimentation modes of learning. Kolb maintains that members of various disciplines develop learning styles that reflect the actualities of their disciplines that prepare their members to function effectively.

Kolb (1984) upholds that there are five forces that shape an individual's learning style. Personality type, educational specialisation, professional career choice, current job role, and the current task and/or problem are all important. Kolb believes that nurses are usually concrete thinkers, although his view may well have been shaped by the methods of science used to study student nurses.

That nurse researchers have used Kolb's (1984) theoretical framework to study student nurses' learning styles is of interest. There are a number of reasons for this. The most powerful is that, in the absence of appropriate nursing theoretical models that reflected the reality of nursing practice in the 1980s, Kolb's theory offered a rationale for how knowledge was developed through experience. Kolb claims that his theory has a dual interactionist position whereby knowing involves a transaction

between apprehension -a right brain activity - and comprehension, left brain. As such, knowledge emerges from the “dialectic relationship between the two forms of knowing” (p. 101). Kolb offered nurses a more holistic explanation of how knowledge develops from the experience of being engaged in a practice.

An anti-intellectual lobby within the profession came from nurses who believed that nursing as a practice is learnt through experience thus does not require its practitioners to undertake higher education. However, a counter lobby believed strongly in the need to legitimate nursing as a science and an emerging discipline with its own unique knowledge (Meleis, 1997). Meleis also points out that historically, Nursing, on moving into universities, in the absence of its own theoretical development, nurse educators in their quest to develop the discipline of nursing, adopted theories from other disciplines, particularly education, to justify teaching and learning approaches in curricula. Kolb (1984) provided nurses with a theoretical framework to develop scientific explanations for how nurses learnt from experience.

All these issues have influenced how preceptors facilitate student learning. In a practice-based discipline it is almost inevitable that experienced practitioners, as they facilitate learning, will pass on at least some of the traditional ways of thinking and doing to new entrants to the profession.

Theme: Guiding students through practice

Kolb's (1984) framework may have been used extensively by nurse educators, but how is it relevant to preceptors? Using Kolb's (1984) framework to examine the learning styles of nursing students, Laschinger and McMaster (1992) compared student perceptions between the 'environmental press' of actual nursing practice environments and student self-ratings of skill on learning competencies. The perceptions were measured before and following a senior preceptorship experience. The researchers found that a concrete learning style prevailed among all types of nursing students. Generalised results pertaining to Kolb's (1984) learning styles (*accommodative, assimilative, convergent and divergent*) were inconclusive. However, it is interesting that nursing students rated themselves highest on *concrete* competencies and concluded that *assimilative* competencies were of least importance to them for successful functioning in a nursing environment. One could suggest that the theoretical framework used to frame the research could well have

framed the answers too, thus leading to outcomes that support the original theory. Morse (1997) considers the relationship between theory and the empirical world. She states:

Because quantitative theory is “created” prior to commencing data collection, it consists of conjecture and inferences that are tested for correctness of fit with the world it reports to represent after the theory is articulated. Thus by its very nature, quantitatively derived theory is largely hypothetical and inferential. Researchers struggle with the two-fold task of making operational definitions to meet the goals of fit (that is a good representation of the phenomenon/concept they try to represent) and measurement criteria. Because quantitatively derived theory is created for testing, the need to clearly outline the relationships between concepts is essential. Researchers create these relationships to be testable. Unfortunately, this often results in a theory that is intolerant of ambiguity, simplistic and often with convenient, yet arbitrary boundaries .. such theory is often divorced from reality (p. 168).

When preceptors are guiding students through practice they need to be aware that students may change their learning styles depending on what they are learning, the context they are working in and the people they are working with. For example, Itano, Warren and Ishida (1987) researched the adaptive competencies of student nurses engaged in a preceptorship programme. Students rated themselves higher on their concrete adaptive competencies after the completion of the preceptorship experience but did not rate this competency as being of high importance. The preceptorship experience contributed more to the students' development of adaptive competencies than to short term clinical assignments. The students stated that, after their preceptorship experience, they perceived the nursing working environment as being more concrete than abstract. As an outcome of this study, students rated themselves higher on all competencies noted in Kolb's theoretical model of experiential learning. Flexibility in learning style is important for students, as they are required to practice in many areas. Itano et al (1987) noted that Kolb (1984) stated that an “effective learner is able to apply skills from each of the learning modes in whatever combination the learning situation requires” (p. 147).

Stutsky and Laschinger (1995) investigated changes in student learning styles and adaptive competencies following a senior preceptorship experience. Using Kolb's (1984) experiential learning theoretical framework in a pre-and post-comparison study they examined the effect of preceptorship experience using a convenient sample of thirty-seven fourth year baccalaureate nursing students. The

preceptorship experience was defined as “an organised and planned three month learning experience (minimum 288 hours) in which nursing students, together with their preceptor, provided nursing care to clients” (p. 144). The hypotheses tested included the long held view that baccalaureate nursing students would reflect predominantly concrete styles of learning. But this hypothesis was not supported.

Conversely, the findings showed that, following the preceptorship experience, the most frequently occurring learning style was that of converger. This interesting finding could have been due to the researchers using Kolb’s revised learning style inventory created later in 1984 for their pre-and post-test of subjects in this study. In comparison, when Kolb’s first learning style inventory (created in 1978 as cited in Kolb, 1984, p. 236) was used for pre-and post-test, the students were rated as concrete learners. It is possible that Kolb’s learning style inventory (1984) does not accurately measure the process-related knowledge and skills that are integral to nursing practice in spite of Kolb’s claim that for practice professions such as nursing, his four learning modes predominate. Stutsky and Laschinger’s (1995) findings may also have been skewed, as the 1984 revision of Kolb’s “Learning Style Inventory” tool is more sensitive to the intellectual skills utilised in nursing practice. Further, baccalaureate programmes for the educational preparation of nursing students have increased the involvement of higher order thinking skills required in degree education. This is to ensure that nurses are ready to practice in a much more complicated, ambiguous context than that which prevailed in the 1980s. Therefore, Kolb’s theories need to be considered cautiously if they are applied to a very different context than that for which they were formulated.

Theme: Organisational support for preceptors

Kramer (1993) states that nurse managers must be prepared if they are to support precepting programmes. The responsibilities that accompany the preceptor role should be clearly delineated in order for preceptor and preceptee to understand role expectations (Dandrin-Smith & Bower, 1988). Nurse managers need policies and procedures describing the criteria for preceptoring preceptees. But what can be written when so little is known about the practice of being a preceptor? Certainly, nurse managers should indeed be supportive of the role of the preceptor. But should they not be supportive within an informed frame of reference, and how can this occur in the clinical organisation?

The organisation that provides strong clinical support for students is likely to benefit later when better-prepared new graduates enter practice. For example, Dobbs (1988) studied 103 students enrolled in an eight week practicum experience who were assigned to a registered nurse preceptor with at least one year of work experience. Perceptions, values, and esteem of role models were measured by 'Corwin's Nursing Role Conception Scale' pre-and post-experience. The results of this study showed that students had learned to cope with the demands of the clinical role under the guidance of the preceptor. Significant decreases between pre-and post-scores were recorded. This study also showed the importance of work centred clinical role models. Students who made the transition to work centred role models rather than school centred role models had greater decreases between scores than those who remained school-centred or stated that they had no role models.

Similarly, Hovey, Vanderhorst and Yurovich, (1990) described an elective clinical preceptorship that was designed to help students consolidate previously learned knowledge and skills in the practice setting. Preceptors reported that students demonstrated increased self-confidence in the theoretical and practical dimensions of nursing practice and expressed a high degree of satisfaction with the one to one contact with preceptors. Again, the clinical organisation benefits when time and effort are put into precepting.

Theme: Rewarding the preceptor

In the literature, it is evident that there are different views on whether preceptors should be rewarded or not. Precepting is often poorly compensated and unrecognised, despite the additional responsibility it entails (Mooney, Diver & Schnackel, 1988). Cotugna and Vickery (1990) stress the importance of a reward system that acknowledges the contribution that preceptors make to the profession of nursing. This should be a priority when designing any preceptorship programme.

Many preceptor rewards, though, are inherent. Staff nurses benefit from being a preceptor by experiencing professional role expansion. This includes sharpening their clinical skills, developing teaching skills and enhancing their prestige as a teaching clinician, as well as increasing their personal and professional growth, and satisfaction with their career as a nurse. Further, there is opportunity to develop collaborative, collegial networks with nurse educators and nurse administrators, with other preceptors, and with the students that they precept (Davis & Barham, 1989).

Preceptors report a high degree of personal satisfaction while working with students. Various authors (Arlton, 1984; Davis & Barham, 1989; O'Mara & Welton, 1995; Turnbull, 1983) report that registered nurses gain both intrinsic and extrinsic rewards from being a preceptor. An extrinsic reward from an organisational perspective includes increased pay, decreased workload, tuition waivers, and an academic appointment. Conversely, other studies (Laschinger, & McMaster, 1992; Myrick, 1988; Myrick & Awrey, 1988) show that preceptors do not gain extrinsic rewards from the organisational perspective. Rather, many organisations assume that preceptorship is part of the normal role of the staff nurse and it is taken for granted. It can be concluded that rewarding the preceptor is not the norm.

Theme: The preceptor's role in developing clinical competence for the student

One more question raised in the literature review concerned, "What is the preceptor's role in developing clinical competence for the student?" This question is not new and the themes suggest there is a need to understand the meaning of clinical competence more fully. Several years ago there was a call from clinical agencies for greater input from practising registered nurses to contribute to nursing curricula in order to profile the desirable graduate (NZ National Consensus Conference, 1996). For some time now clinical agencies, as service providers, and educators as educational providers, have collaborated to clarify reasonable competencies new nurses should demonstrate on graduation (Gonzci, 1993). This was, and continues to be important, as there is a need for employment-ready new graduates to meet the demands of high acuity patients in clinical settings and lean staffing numbers employed by service providers.

The clinical competence of new graduates is a concern world wide. In Great Britain, Cronk (1994) raises concerns about graduate competence following the likelihood of UKCC (1992) regulating new graduate practice for midwives. The UKCC have stated that following graduation, all new graduates should work alongside an experienced midwife for a minimum of four months. Cronk questions if this is necessary. She believes that, if a new graduate midwife is not fit to practice without supervision after graduation, then questions need to be asked about the quality of the educational programmes.

Similar questions could be asked about the New Zealand graduate nurse exiting

from a bachelor's programme. Because there is no clear understanding of the meaning of precepting, it is not surprising that we are unclear on the meaning of clinical competence. Clinical competence has been defined as "the demonstrated ability to apply the knowledge, skills and attitudes and to exercise the professional judgement which can reasonably be expected of a nurse or midwife in a practice context, commensurate with their qualifications and experience."¹¹ But there is a danger that clinical competence may be defined in relation to a technical nurse performing tasks and skills, rather than a degree prepared nurse who has academic and practical competencies.

Theme: The complexity of precepting

The complexity of precepting cannot be underestimated. In the international literature, Shamian and Inhaber (1985) first cited the difficulties associated with precepting. The authors raised the issue of insufficient preparation for the role. This was followed later by Andersen (1991) who analysed student logs and noted that preceptors managed multiple roles including demonstrating skills, coaching, role modeling, time management, and dialogue. Even though precepting is complex and preceptors have limited training for the role they are still expected to manage the varied demands in an organisational setting and combine this with teaching students.

Theme: Evaluating a preceptor programme

In the New Zealand context, an early study by Keene (1986) recognised that there was a need for mentors for new graduate nurses or new employees. More recently, Dyson and Thompson (1996) reiterate Chickarella and Lutz's (1981) concept of preceptorship in a study initiated to evaluate a preceptorship programme for undergraduate student nurses in conjunction with staff nurses who were trained as preceptors.

In a pilot study within a New Zealand context Dyson and Thompson (1996), explored eight pairs of preceptors/preceptees to evaluate the effect of a preceptorship model of clinical teaching with baccalaureate students. The study aimed to explore the staff nurses' experiences of precepting an undergraduate

¹¹ Nursing Council of New Zealand, Standards for Registration of Comprehensive Nurses, January, 1999, p. 18

student nurse and, in particular, their views, feelings and attitudes to the preceptoring experience. Student nurses were also asked their views and attitudes in relation to the preceptoring process. The Packer model (Packer, 1994) involved nurse educators, staff nurses as preceptors, and student nurses, as well as a clinical nurse educator who was responsible for preparing the preceptors and was jointly employed between the faculty and the clinical agency. In this model, the staff nurses worked with students at the bedside, sharing their skills and knowledge. The staff nurses were involved in the assessment of students, although faculty staff retained overall responsibility for student education including assessment.

The research method was 'qualitative'. An identified methodological approach such as grounded theory, ethnographic, phenomenological or social critical theory was not utilised. Data was collected from unstructured interviews and the data was analysed using content analysis (Field & Morse, 1985) to identify recurring themes, words and concepts. The outcome was the emergence of eight categories from the preceptors' responses, and five from the students' responses. The overall outcome of this pilot study supported the preceptor model as a basis for refined future clinical experiences for students.

Dyson and Thompson (1996) noted that the student and preceptor participants in this research were in a vulnerable position. Care was taken in gaining informed consent to ensure that coercion did not take place, although the faculty employing manager had selected the preceptors. While the findings were overwhelmingly positive for the preceptor model, they must be viewed with some caution. The small sample size, the lack of a clear theoretical framework and ethical issues may have compromised the rigour of the work. This critique is made in the light of research carried out in North America with larger samples, which do not support the New Zealand findings (Laschinger & McMaster, 1992; Myrick, 1988; Myrick & Awrey, 1988; Olson, Gresley & Heater, 1984).

Although the preceptor programme seems positive, it is questionable if any advances have been made at all. For example, thirteen years ago, Scheetz (1989) could not conclude from her study (cited previously in this review), that the gains in clinical competence made by a group of precepted baccalaureate students, as opposed to a control group, were entirely due to the preceptor programme. Scheetz suggested that intrinsic and extrinsic rewards gained from being a member of the participating organisation could well have been the explanation for the success of

the precepted students. Overall, few preceptor programmes have been evaluated, so it is difficult to make reasonable judgements as to their value.

Theme: Creating new pedagogies for nursing

Questions about the future of preceptorship were asked. A common theme was creating new pedagogies for nursing. This literature review attests to the predominance of the 'idealist' view of the research that underpins the practice of being a preceptor as a behaviour that can be learnt and mastered. Further, it attests to the preceptee as a person who can emulate the master through observing and role modeling. Those theoretical models discussed earlier that emphasise experiential learning viewed learning as 'cognitive gain' (Diekelmann, 1989). This is consistent with styles of learning that view the world as one to be comprehended, mastered, and controlled. As such, the teacher and the learner have different positions of power (Friere & Shor, 1987). The teacher is the one who 'knows' and the learner is the person 'to know'. In the pursuit of professional competence, an issue that continues to be problematic, it is assumed that the teacher, the skilled and experienced practitioner can guide the neophyte to gain the skills for professional practice. That may have been so in the past, but in times of rapid change the teacher may well be uninformed.

An alternative approach to understanding teaching and learning, a new pedagogy of learning, has been developed by Diekelmann (1990a) who emphasises teaching and learning as practices rather than behaviours to be learnt. Diekelmann proposes a narrative pedagogy that seeks to understand teaching and learning from an 'inside out' perspective. Diekelmann's extensive research over a decade has focused upon narratives from nurse teachers and students explicating the practices inherent in teaching and learning. Using an interpretive approach, "descriptions of common practices and shared meanings are intended to reveal, enhance or extend understandings of the human situation as it is lived" (Diekelmann & Ironside, 1998, p. 1348). The teacher and the learner become co-operative partners in the pursuit of learning. Diekelmann (1989) believes that "the teacher moves from being an information giver and facilitator to the explorer of meanings with students - their understandings of the experience" (p. 37).

Another research study that has had a significant impact on creating new pedagogies for nursing is Benner's (1984) work. In an effort to define and

differentiate levels of practice, Benner observed nurses with a range of experience and interviewed them either individually or in groups. Using an interpretive approach, Benner identified five levels of development that characterise nurse practitioners' practice at various stages of expertise. The levels: *novice*, *advanced beginner*, *competent*, *proficient* and *expert*, are based upon Dreyfus & Dreyfus (1980) model of skill acquisition (Dreyfus & Dreyfus, 1980 cited in Benner, 1984). Each skill is described in terms of skill acquisition. The *novice* is rule governed and is limited in their practice. *Advanced beginners* have limited experience and still require considerable supervision. The *competent* level is achieved usually after the nurse practitioner has had three to four years of graduate experience. A characteristic of this level is that the nurse applies learning, organises work, plans ahead and makes judgements as to what is important, what can be delayed and what can be ignored. At the *proficient level*, nurses perceive situations as 'wholes'. This allows the proficient nurse to anticipate difficulties for patients in advance of events occurring. The highest level is the *expert* nurse. The *expert* is able to grasp situations intuitively, as a whole and focus upon problems immediately. The experts also had difficulty explaining how they arrived at their judgements.

The results of Benner's (1984) research have had a profound impact on nursing education and practice. Clearly, it is difficult for expert nurses to articulate practice-based wisdom. New nurses may struggle to understand the expert's language and explanations of practice, as the expert and the novice each have a differing emphasis. Because of this Urden (1989), has suggested that the expert nurse does not make the best preceptor for beginning nurses because their practice excels beyond the rule governed novice. The best preceptors may be registered nurses who are not yet expert nurses.

Theme: Thinking through practice

Finally, in this review I asked if there are alternative approaches to nursing education? The question opened up a theme revealed as thinking through practice. For instance, an alternative approach to understanding the experience of students, preceptors and clinical instructors was undertaken by Nehls, Rather and Guyette (1997). Nehls et al. drew their interpretation from an alternative way of looking at precepting informed from an Heideggerian hermeneutic perspective. This approach does not observe and categorise behaviours, as is the method of objective science, but rather the researchers studied common practices and meanings as interpreted

by the actors themselves within the context. Nehls et al. revealed how the practices of teaching and nursing are inseparable, transformative, and constitutive of being. The researchers described and interpreted what it meant in an American context to be a student who is precepted and a preceptor to a student. A constitutive pattern called "learning nursing thinking" (Nehls et al., 1997, p. 224) was brought to light. The research revealed how nursing thinking is both taught and learned as a caring practice. Students identified the value of working with a practising nurse and emphasised the importance of developing meaningful relationships. They described the quality of learning as a caring experience. The value of this study is that it is descriptive and interpretive of the shared experience of being a preceptor and being a preceptee. Few studies explicate this process.

In another American study Blazey (1995) used an interpretive approach to identify the teaching practices preceptors used to assist new orientees. She wanted to show how people learn in an informal work environment. The goal of the research was to uncover the lived teaching and learning experiences of eight pairs of preceptors/orienteers by describing their experiences in the natural hospital setting. Three main themes, encompassing the teaching domains of precepting, the tact of precepting and the journey to independence emerged. Within the teaching domain preceptors were engaged in talking and guiding, walking through step by step, showing the skill to be performed, filling in identified knowledge gaps, providing feedback for improving practice, and clarifying future learning needs.

Blazey (1995) confirmed a common theme evident in the literature - "there is a lack of information about how the practice of precepting actually occurs" (p. 4). Until then, training for preceptors had relied upon what was thought to be appropriate (Holly, 1992). Blazey pointed out that at that time there was no research focusing on precepting from the teaching and learning perspective. She also reiterated that the preceptor-teacher has a dual role of attending to patients and to the learner. She noted too that by reflecting on the process of teaching, staff nurses provide valuable insights into effective teaching and enhancing learning. Blazey's research is very important. From the understandings gained, teachers of student nurses now know what to include in their clinical teaching package to establish preceptor education that is relevant, learner centred and focused on relevant knowledge.

Blazey pointed out the limitations of her study, in that it was a qualitative observation using interviewing techniques in a natural setting. The transference of her results to

other sites and populations will be limited by this method that is contextually dependent. Researchers following her should seek out relevance and similarity to the theoretical framework on which her study was based and be aware of specific methodological constraints. Nevertheless, Blazey's research has made a significant contribution to understanding teaching and learning as a practice by explicating the practice of precepting as it occurred in a naturalistic setting. Her work helps preceptors understand more about the processes embedded in thinking through practice.

Summary

From the literature, it is clear that there is little empirical evidence on the merit of preceptorship or preceptorship programmes. Regardless of discussion lasting thirty years or more, because preceptorship is poorly defined, it is hard to make any comparisons on what is effective and what is not. However, there is much theoretical and anecdotal evidence that preceptors and preceptorship programmes are mutually beneficial to both educational institutes and clinical practice organisations. Most of the literature focuses upon the preceptorship of new registered nurses.

The review of literature has defined the concept of preceptorship but not its defining attributes and has identified qualifications desirable for the preceptor that are not universally obtained. The desired characteristics and the expected behaviours of preceptors have been outlined. A few studies have shown the effectiveness of preceptorship models but the empirical reliability or validity of these are questioned. The question of competence on graduation is an ongoing issue. Preceptors appear to have a part to play in providing a solution to this problem. The empirical evidence establishing the relationship between preceptorship and competence however, is absent. Although the concept of preceptorship has been in existence since the 15th century, from the accumulated research it would appear that little empirical progress has been made in relation to its definition, purpose and function. In spite of this, preceptor programmes abound.

Overall, there is a paucity of literature related to the experience of being a preceptor to undergraduate student nurses. As experience is situated and interpretation is context dependent, studies in the United States do not necessarily reflect the New Zealand context. There are no known phenomenological hermeneutic studies that

explicate the meaning of being-as preceptor to undergraduate students in the New Zealand context. This study seeks to address that need. The following chapter describes the ground from which the question, "What is the experience of being a preceptor to undergraduate student nurses in New Zealand acute care settings?" is asked. The research design, the philosophical orientation, the works of Martin Heidegger, and the writings of notable nurse interpretive scholars will be discussed.

CHAPTER FOUR

The Research Methodology

Introduction

This chapter, initially, presents a discussion of Heideggerian philosophy and the historical evolution of hermeneutics. It forms the background to the descriptive, interpretive approach enabling us to think about the lived experience of the participating preceptors from their perspective. Only they can give us the 'inside-out' story of what they experienced as preceptors transmitting the art and skills of nursing practice to undergraduate student nurses. The philosophies of Heidegger (1962/27) and Gadamer (1976) provide a lens through which we can view the participants' stories to reveal what was significant for them in 'being-as' a preceptor to undergraduate student nurses. After the initial discussion of Heideggerian phenomenology it is the bringing of hermeneutics into phenomenology that is described.

Heideggerian Phenomenology

The research method uses a phenomenological interpretive approach to describe and interpret the experiences of registered nurse preceptors who work with student nurses on clinical placement. Registered nurses are responsible for the transmission of the 'precepts' or the knowledge, skills and understanding required for practicing as a nurse.

Phenomenology seeks to reveal human perceptions and subjectivity to come to understand what it is like to experience a phenomenon first hand. In this instance, phenomenology is used to reveal what it is like to 'be-as' a preceptor from the preceptors' own experience, or, in other words, what it means or signifies to them (van Manen, 1990). An inherent concept in phenomenology is 'lived experience'. Coming to know what it means to be a preceptor is best understood by the people who live the experience in their everyday world, with a particular emphasis on meaning and understanding. Those who live the experience, in this instance the registered nurse preceptors, are in the best place to tell about it and to inform others what it is like.

Hermeneutics illuminated both the conduct and the interpretations of the interviews

from the participants that provide the substantive data for this phenomenological study. The interpretive process is based upon the works of Martin Heidegger, a German philosopher, particularly *Being and Time* (1962/27) and his later essays. The works of Gadamer (Weinsheimer, 1985) and van Manen (1990) has informed the interpretive process as well. The works of notable nurse scholars, particularly Dr. Nancy Diekelmann and Dr. Patricia Benner, have provided invaluable insights into the analysis and interpretive process.

In *Being and Time* (1962/27), Heidegger focuses upon the fundamental question of the meaning of 'Being'. This is an ontological question related to the lived experience of being a person. Heidegger states that the essential quality of 'Being' lies in a person's ability 'to be'. "Being-what-it-is" is understood in terms of its "Being"; that is, what it means to be a person (Heidegger, 1962/27, p. 27). Moreover, Heidegger further claims that 'Being' is always situated in the world. "Being-in-the-world" he terms *Dasein* or 'being there' which is our normal mode of existence (Heidegger, 1962/27, p. 27). Contained in this idea is the notion that the physical world is saturated with meaning that is captured in language, embodiment, temporality and space. Heidegger describes all this as the 'lifeworld', which is the real world of our every day living that we normally take for granted.

Heidegger gives three characteristics of *Dasein*: *existentiality*, *facticity* and *verfallen* –(1962/27, p.237). *Existentiality* refers to our humanity in time, that is 'being ahead of oneself'. To be human is to be ahead of oneself, living into possibility. *Facticity* or being 'already-in-a-world' refers to living in the present, and *verfallen*, is about 'being alongside' entities within the world. Heidegger calls this a type of ensnarement. *Verfallen* is being caught up in the everyday world about us without giving too much thought to what is going on around us. In the state of *verfallen*, *Dasein* does not take responsibility for what it does (Heidegger, *ibid*, p. 165, Guignon, 1993, p. 30). All three constituents of *Dasein* have a relationship to time, that is essentially, future, past and present. Heidegger also claims that all three characteristics are unified in his notion of 'care', which is our basic way of being in the world. Our future, therefore, is one of possibility, but within this we are concerned with our own ability 'to be'. Our own being is an issue for us. Moreover, by choosing one possibility another is denied to us. Besides, if we are living into possibility that is ahead of oneself, one is always becoming what one already is.

'Becoming' has a reference to time. Phenomenologically, 'time' is not the linear time

viewed as a commodity, something to be used up for profit. Nor is it a horizontal sequence of events as in the life cycle (Stanfield cited in Denzin & Lincoln, 1994, p. 182). Rather time refers to temporality as constitutive of 'being' ontologically. Time is essentially content, or "the dimensions of lived time" (Kolb, 1986, p. 135). It exists as activity such as 'concernful dealing and attention' (Leonard, 1994). Sheehan, (cited in Johnson, 1997, p. 47) claims that "for Heidegger, temporality connotes becoming, and human temporality entails becoming oneself". Dasein is finite which eventually limits all possibilities. That is, we live toward becoming our own most possibility, our own death.

Facticity is related to Heidegger's idea of "thrownness" (Heidegger, 1962/27, p. 174). We are thrown into 'being-in-the-world'. This means that we are thrown into a world that for us is our history. *Dasein* has a history. Our particular history constitutes our particular set of circumstances. We are born into a specific family and cultural environment at a particular point in history. Ensnarement suggests that one is 'trapped' in the present and 'act or drift' throughout our day to day life. This idea suggests to me that actions are not necessarily consciously deliberate. At any given moment in our life, "all three structures are in play" (Krell, 1993, p. 22).

Embodiment refers to the idea that we live our bodies. We are embodied. We grow up understanding our bodies in our everyday world without thinking about it. In the lived body, subjectivity or our mental idea of our body, includes our physical frame, appearance, mind, emotions, spirit, and capabilities and also, who we are culturally. Subjectivity is always "corporeally expressed" (Benner, 1994, p. 52). We only become conscious of our body when breakdown occurs, for example, when illness strikes or when the habitual body or the one we know and live in becomes different to us in some way.

Space

Space for Heidegger (1962/27, p. 139) refers to a relational space. According to Heidegger, we can know space in a variety of relationships. In terms of *Dasein*, things or entities can be either close or remote. What makes the difference is our concerns about the thing or entity. Heidegger discusses this concern in relation to his "ready to hand" (Heidegger, 1962/27, p. 189) mode of being-in-the-world with equipment. He explains that we come to know about equipment, its uses and its place of storage so that these all become ready to hand as an extension of the self.

Heidegger claims we come to know closeness and remoteness in terms of experience.

World

For Heidegger, 'being-in-the-world' means being human. That is, as people, we are never separate from our world. 'World' here refers to a relational world where we participate in a human world with other human beings within cultural, social and historical contexts (Diekelmann, Allen, & Tanner, 1989). "World is not a collection of objects for a subject; it is the texture of things and possibilities with which we are involved in action and ongoing purpose" (Kolb, 1986, p. 132). In the Heideggerian view, persons live as self interpreting beings in a world where meaning is created for us directly from a background of preunderstandings passed down in language and cultural practices. This background is never completely clear to us but we cannot divorce ourselves from it nor can we ever be free of its influence. Consequently, we cannot withhold ourselves from our background. It is pervasive. We interpret our everyday experiences through a veil of background meaning. Thus both preceptors and preceptees are caught up in the way they interpret their experiences of being-in-the-world of nursing practice as preceptors and preceptees which has been passed down in the language and the cultural practices of nursing.

Language

Taylor (1985) drew attention to the nature of language and its importance as part of being human. He examined the nature of language and the evolution of meaning through the classically held theories of meaning. He made the distinction between the human and an animal. In his view, only the human being has the capability of creating meaning because being human is to be part of a social world where language gains its inherent meaning. Taylor stated that the classical theories of language designated words to identify things in the world, and in so doing, gave them meaning. He disputed this claim, stating that language is much more a product of our being human and being a participant in a social world. We use language to formulate things and in so doing we bring these things into sharper focus.

However, the expressive aspect of language allows for much more. By defining the matter at hand, we also provide a boundary to contrast what a thing is and what it is not. By articulating what we want to say, we also bring the matter into the public

domain. Language enables a shared experience and gives voice to our particular view of the world. Our articulations are also over-ridden by a sense of a moral standard we recognise only because we are human. Only a human being using language can know what language can invoke. These invocations are possible because we are social beings within a societal context. Taylor (1985, p. 270) pointed out that Heidegger uses the term “*disclosure*” to encapsulate these ideas, to bring matters of concern into the light, or to our attention, or to bring them into in the Heideggerian term “*the clearing*”. Language and meaning are intrinsically linked. Allen et al. (1986), explain further:

Meaning resides neither solely within the individual nor solely within the situation. Meaning is a transaction between the two so that the individual both constitutes and is constituted by the situation. This position expects commonalities and recurring similarities and dissimilarities...No higher court than meaning, or deeper explanation than meaning, exists in this paradigm...meaning is not based on private meanings given by individual subjects or on consensus of private meanings (intersubjectivity). Meaning is shared and handed down culturally through language, skills and practices and is directly perceived by the individual. Experience is always already interpreted – it is never perceived as sense data to be interpreted by a subject (p. 28-29).

For Heidegger then, “meaning is that from which something is understandable as the thing it is within a world of human existence” (King, 1964, p. 7). Further, knowledge emanates from persons who are already in the world. The situation includes the “relevant concerns, issues, information, constraints and resources at a given span of time or place as experienced by particular persons” (Benner & Wrubel, 1989, p. 412). Meaning structures are public, and also locally circumscribed. Local culture comes in a variety of forms. The importance of these is that they shape the way we assign meaning and respond to things. For this thesis, the local culture is the practice world of nursing, preceptors and student nurses.

Another characteristic of Heideggerian hermeneutics is that the researcher can never be outside the interpretive situation but is immersed in the situated text. Being-in-the-world as lived and shared by the narratives of preceptors becomes a co-participative experience shared by the researcher. Heidegger, (1962/27, p. 154) claimed that in encountering others, one is “again still oriented by that Dasein which is one’s own”. This orientation is not a ‘subject’ that is separate to others and world as ‘object’. That is, the person is not a self that learns about the world through theoretical detached contemplation. In Descartes’ (1596-1650) view, for us to

perceive, act and relate to the world around us, there must be some internal representation of objects in our minds. This 'consciousness' directs our minds towards objects. Dreyfus (1991) cited Heidegger (1927/62) as on the other hand:

Question[ing] the view that experience is always and most basically a relation between a self-contained subject with mental content (the inner) and an independent object (the outer). Heidegger does not deny that we sometimes experience ourselves as conscious subjects relating to objects by way of intentional states such as desires, beliefs, perceptions, intentions etc., but he thinks of this as a derivative and intermittent condition that presupposes a more fundamental way of being-in-the-world that cannot be understood in subject/object terms (p. 5).

Part of being situated in the world is to experience "horizoning". Horizoning, is created not in the traditional sense of raising our eyes to the place where sea or land and sky meet, and envisioning what lies beyond this point. Rather, its reference is to a temporal world of everyday activity (Dreyfus, 1991; Heidegger, 1962/27). Our gaze (Merleau Ponty, 1962), is not confined to just what we see, but is also connected to the way in which we unravel the historical, for example, the socio-political, cultural and personal meanings that overlay our language, thoughts and actions. These influence our interpretations of our lifeworld. 'Horizon', therefore, as used by Heidegger (ibid), can be understood as the context where experiences and ideas provide for us a backdrop of human existence. The context for my research is acute nursing care wards in two large metropolitan hospitals where preceptors and undergraduate student nurses relate to the world of patients and their particular circumstances, as well as the health professionals that work in that world.

Phenomenology seeks to describe experience as it is lived by the person in every day activity. Heidegger, (1962/27, p. 63) stated "we can understand phenomenology only by seizing upon it as a possibility". That is, being **as** a preceptor, is one possible way of being-in-the-world. For us to understand what it means to be a preceptor, the descriptions of preceptors' practice in this research came from registered nurses who described what it was like to be a preceptor to undergraduate student nurses. Descriptions of practical activity are best captured in stories or narrative accounts of experiences in practice. These stories ensnare the inchoate experience of the nature of their practice as preceptors.

Narrative accounts of nursing practice (Benner, 1984; Benner & Wrubel, 1989;

Benner, Tanner & Chesla, 1996), revealed the expertise that is embedded in nursing practice. Diekelmann (1991, 1993a), revealed the expertise embedded in narrative accounts of teachers. Diekelmann (1991) stated that narratives are emancipatory "because they recognise our expertise, help us to know each other, transform our thinking and help us in creating communities (p. 41). Narratives in this research therefore, give voice to the preceptors as they worked with student nurses in the context of their everyday practice. To further elucidate the importance of narratives, Britzman (1990) pointed out the importance of voice:

Voice is meaning that resides in the individual and enables that individual to participate in a community...The struggle for voice begins when a person attempts to communicate meaning to someone else. Finding the words, speaking for oneself, and feeling heard by others are all a part of this process. Voice suggests relationships: the individual relationship to the meaning of her/his experience and hence, to language, and the individual's relationship to the other, since understanding is a social process (p. 14).

In this research the preceptors gave voice to their experience of precepting undergraduate student nurses using stories from their practice. Crites (1975) noted that the completeness of a story consists in:

The immediacy with which narrative is able to render the concrete particulars of experience. Its characteristic language is not conceptual but consists typically in the sort of verbal imagery we employ in referring to things as they appear to our senses or figure in our practical activities. Still more important, the narrative form reproduces the temporal tensions of experience, a moving present tensed between, and every moment embracing a memory of what has gone before and an activity projected underway (p. 26).

Crites implied that story gives verbal imagery to activity and events in a dynamic interplay as they occurred in reality and as they are recounted by the narrator. The story is then interpreted by the listener, who in this instance, is myself as the researcher, within a temporal context overlaid by a sociopolitical, cultural and personal history.

Heideggerian Hermeneutics

Hermeneutic inquiry, centred on the philosophy of Heidegger, opens up for us a means of increasing understanding of the everyday experience of the participants of a study. Hermeneutics means interpretation. Dialogue and hermeneutic

interpretation increase understanding, but demand from the researcher an attentive listening and a commitment of involvement as a co-participant. Dialogue is ongoing throughout the process of hermeneutic inquiry.

Hermeneutics, as stated in Chapter Three, has been traced back to the early Greeks (Palmer, 1969), the word itself taking meaning from the root words of the Greek language implying a process which gathers understanding through language. A process of explanation and/or translation brings some entity or happening from incomprehensibility into understanding. Historically, to trace the evolution of hermeneutics, the early work of Ast (1778-1841) (cited in Palmer, 1969, p. 76) stands out. In particular, Ast's distinctive contribution extended a previously developed focus on the historical and theological understanding of hermeneutics to a three-fold approach. An interpreter's involvement with the text was, he believed "grasping the spirit of antiquity" which he termed the *geist*. The first task was to grasp the historical aspects of the text or the subject matter and how it is portrayed in language. The second, was the grammatical aspects of the text including understanding the language intent and use. That is the individuality of the author. The third, was the *geist*. This included understanding the text in relation to the view of the author, and "the total view of the age", or the *geist*. Language was imbued with meaning which, to Ast, was a creative and, therefore a spiritual experience; but this experience was in the mind only. Hence Ast was adhering to a Cartesian (Benner, 1984) view of the person. Ast believed that the spirit or *geist* is imprinted on the whole and the parts of the text to form a unity. The task was to grasp the outer and inner unity. Interpretation of text was undertaken according to certain systems of understanding. It is to Ast, that the hermeneutic circle is attributed. Subsequently, the hermeneutic circle became a systematic and circular approach to the analysis and interpretation of texts.

Although Ast's beliefs concerning hermeneutics have been overturned, particularly by Dilthey and Heidegger, as the discipline of hermeneutics developed, some residue of early thinking persists in twentieth century Heideggerian Hermeneutics. In particular, one notion that has survived over time is the idea of what it means to truly understand, which cannot be separated from 'being'. To understand the creative or the spiritual (which can suggest the *geist*) nature of the author's text and the augmentation of this within 'being' is the challenge to the interpreter. Especially important here is the preservation of this by the interpreter in the exegesis of those texts.

This special aspect of hermeneutics, to me speaks of the art form or aesthetic dimension of language and expression of the original author. Preserving the nuances, the inflections of voice, the laughter and light heartedness of some phrases in the text is essential, since this also affects understanding. All of this cannot be shared as richly as the spoken word of the participants. To retain the 'spirit' of the text to reflect my participants' accounts of their practice in 'being'-as preceptors has been a constant challenge to me in writing this thesis.

Interpretive research, based on a philosophy such as Heideggerian philosophy uses data that can come from any texts, as long as they are recognisable in a given context. There has been a long association with Biblical exegesis since the 17th century, and in the 19th century Schleiermacher (1768-1834) extended its definition to signify the art of understanding any expression in language (Palmer, 1969). Such expressions can include, in addition to written or oral language, art works or other forms of human expression.

Heideggerian hermeneutics has built upon the work of Dilthey (1833-1911) who further advanced the use of hermeneutics. Dilthey asserted in 1900 that this method of interpretation can also be applied to acquiring understanding of the cultural aspects of life in contrast to the natural sciences, which focus on explaining the world around us. That is, Dilthey's concern was to understand the happenings of people as they exist in their everyday lives (Polkinghorne, 1983). Dilthey considered that a key focus for human studies was to develop a methodology that transcends the reductionist objectivity approach of the natural sciences to move to an "understanding [of the]... fullness of the expressions of human life" (Palmer, 1969, p. 105). Dilthey's contribution to hermeneutics was the conception of the historical and temporal nature of understanding. Dilthey asserted that man only came to understand himself through history. Understanding, itself, was bound up in history and a sense of past, present and future. The revelation of understanding took place through the workings of the hermeneutical circle. But in the interpretive workings of the hermeneutical circle, meaning is determined through the reciprocal interactions of the parts and the whole (Palmer, 1969, p. 118).

Hermeneutic understanding is applicable to any configurations or patterns of interactive powers in which there is a "relation of parts to the whole, in which the parts receive meaning from the whole and the whole receives sense from the parts" (Polkinghorne, 1983, p. 221). Heidegger (1962/27) elucidated by Dilthey's historical

and temporal understanding of humanity, recast his own understanding of hermeneutics to include the very nature of 'Being'. Heidegger believed that understanding "Being" itself is a unique characteristic of *Dasein's* Being" (p. 32). He used hermeneutics as the "authentic dimensions of phenomenology" and considered this to be essential to understand *Dasein* (Palmer, 1969, p. 126). The purpose of Heideggerian hermeneutics is to seek understanding of what it means to 'be' in the world. Just so, it is the purpose of this study to seek understanding of what it means for registered nurses to 'be-as' a preceptor to undergraduate student nurses.

To complete the historical aspects of hermeneutics and the ontological move that Heidegger, (1962/27, p. 32) made with his claim that *Dasein* was a hermeneutic of understanding, the link between hermeneutics and phenomenology can now be drawn. Heidegger drew from the Greek word *phainomenon*, (that which shows itself, the manifested revealed) (Heidegger, 1962/27, p. 32). To become 'manifest' is to reveal something 'as it is'. It is from the Greek *phenomenon* that the English 'phenomenon' is derived. The suffix 'ology' in phenomenology is derived from the Greek *logos*. Heidegger states *logos* is that which is conveyed in speaking, but more importantly it lets something be *seen* in speech (Heidegger, 1962/27, p. 55). In Madjar's (1991) view, *logos* pertains to a reasoned account of a phenomenon. Van Manen (1990) claims that *logos* pertains to a 'thoughtfulness' in speech. In a deeper sense, *logos* is to make 'being' manifest through language. Phenomenology therefore involves making visible 'being' through speech. As such, its use is apophantic in that it lets something (in this research 'being-as' preceptor) be seen 'as' something.

Further, to let something appear 'as' something it must be allowed to do so by bringing to manifest the thing 'as' it is, that is hermeneutically. The interpreter's task (mine) is to allow it to do so. *Logos* is not a power given to language, but a power that language gives (Palmer, 1969, p. 128). Heideggerian hermeneutics is used in this thesis, therefore, to make manifest what it is to be-as preceptor to undergraduate student nurses. We seek is to breach the gap between the hiddenness and the revelation of being-as preceptor, which is disclosed in the language of the participating preceptors. But language in any form can conceal the meaning of 'Being', so dialogue with and interpretation of the data or transcribed texts of the fifteen participating preceptors is of the essence in Heideggerian hermeneutic analysis.

Interpretation

Interpretation requires some explanation. Hermeneutics stems from Hermes, the messenger of the Greek gods. Its historical derivation came through the exegesis of Biblical texts. Two derivations give rise to hermeneutics. The first "hermeneuein" which means to interpret and 'hermeneutike' (techne) which is the art of interpretation (Honderich, 1995, p. 353).

Heidegger (1962/27) used hermeneutics to understand and interpret *Dasein* or Being-in-the-world (Palmer, 1969). *Dasein* seeks to understand itself and its world in order to see the possibilities available to it. *Dasein* uses language to show something beyond just words, namely being. Gadamer (1976) asserted the linguistic and hermeneutic nature of being human. Weinsheimer (1985) cited Gadamer as stating "Being that can be understood is language", (p. 214). Gadamer clarified his thinking in a footnote on the same page stating:

The principle of hermeneutics simply means that we should try to understand everything that can be understood. This is what I meant by the sentence "Being that can be understood is language" (p. 214).

Gadamer (cited in Palmer, 1969) claimed that hermeneutics is a meeting with 'Being' through language. Hermeneutics focuses upon philosophical questions of the "relationship of language to being, understanding, history, existence, and reality" (p. 42). Hermeneutics brings to light or into the 'clearing' the hidden meaning language evokes. Hermeneutics does not have rules for undertaking interpretations of text rather it has a circle of interpretation and understanding (Leonard, 1994).

Interpretation involves two components. The first is description interpreted within the 'horizon' (Gadamer, 1985) of meaning within the text or transcript. The second is the 'horizon' of meaning from the interpretation of the text. "In reality interpretation requires continuous dialectical movement between the two horizons" (Draper, 1996, p. 49). These two aspects of the interpreter's activities both influence description in the first instance, and secondly, modify my own theoretical understanding of the text.

The hermeneutical researcher is not a passive observer but rather one who engages in an interplay of interpretation with the voices in the transcripts (text) of the

preceptors and the theoretically informed researcher. Thus, the interplay of interpretation allows both voices to be heard (Draper, 1996).

From the interpreter's point of view, there cannot be complete knowledge of the language chosen by an author nor can there be complete knowledge of the person who is the author of a text. Therefore, an interpreter can best move back and forth between the grammatical and the psychological, from parts to the whole and from the whole to the parts of the text during interpretive activity. It is a dynamic, rhythmical process. The hermeneutic process for me was to read and look at the complete transcripts both individually and collectively. Then, as themes, or discreet units of meaning (Draper, 1996) emerged from the reading, I would return to parts of the individual texts to question, interpret, reflect; question, interpret, reflect. Thus, the hermeneutic circle is a weaving motion back and forth (Idour, 1999) from parts to the whole in a continual, reciprocal, interpretive process. This is a time consuming and reflective, reflexive process that continues until I am satisfied that the main themes from the text are being presented in the thesis. The hermeneutic circle is designed in part to replace the linear model of inductive understanding, because the latter is inapplicable to the human sciences (Gadamer, 1985).

Gadamer (cited Weinsheimer, 1985, p. 214) attested to the "fusion of horizons" for the understanding of Being. An understanding takes place when the inquirers immerse themselves in the analysis of the text and allow the horizon of the text to fuse with the horizon of their own awareness and meaning. This he termed the "fusion of horizons". It is in the understanding of being through language and the understanding that everything assumed by hermeneutics is only language, that the fusion of horizons resides.

Heidegger states (1962/27, p. 193) that in all interpretations there is always a forestructure of understanding and an 'as' structure of interpretation. This 'as' is not the 'as' of assertion but rather the apophantic 'as' as something (Dreyfus, 1991, p. 208). Something 'as' something is an occurrence given a definite character. Further, Heidegger (1927/62, p. 192) claimed that the concept of 'meaning' is the whereupon something becomes understandable "as" something. Interpretations are "always already" provisional and 'as' things are self-revealing and historically situated.

The 'as' gets its structure from a fore-having, a fore-sight, and a fore-conception.

The fore-having is something we have in advance of what will constitute the totality of the experience. Heidegger described our fore-having as a “first cut”¹² (Heidegger, 1962/27, p. 191) at an interpretation. Heidegger, (p. 192) stated that we never approach an interpretive situation without presuppositions and assumptions. That is our taken for granted background understanding of the phenomenon of interest which makes interpretation possible. It is an interpretive point from which we have a definite conception of the phenomenon under discussion. In this research, the phenomenon of interest is being-as a preceptor to undergraduate student nurses. Our fore-having gets us started in our interpretive movement.

My fore-having therefore is what I personally, bring as a researcher to the interpretive situation. As a nurse lecturer with seventeen years’ experience in nursing education teaching both theory and clinical practice, I bring my pre-understanding of how nursing students learn their nursing practice. I also bring my knowledge of relationships, observations and experiences with registered nurses who act as preceptors to student nurses. Likewise, I bring my own knowledge and experience of my own clinical practice prior to working with students and with registered nurses as a practitioner, lecturer, clinical lecturer and as a researcher who is familiar with undergraduate nursing education. My knowledge and experience is my fore-having which will influence my fore-sight.

‘Fore-sight’ means something I see in advance, an interpretive lens that affects the way in which I will interpret the phenomenon of interest. It is the lens through which I view the phenomenon. This lens is shaped by my experience and my background meanings, constituted by and constituted through my experience. Historically, these meanings have been transmitted to me through being a member of the nursing profession and a nurse educator. My familiarity with the ‘culture’ of nursing and of nursing education, that is the customs, practices, language and normative behaviour of nurses both in clinical practice and in nursing education, sets up beforehand how I will interpret the experiences of the participating preceptors. This background meaning will influence my interpretation of the fore-sight I should gain from the preceptors’ accounts of their world.

The culminating influence on my interpretation is my “fore-conception” (Heidegger, 1962/27, p. 192). That is I have some expectations of how I will foresee my

¹² Heidegger explains ‘first cut’ as the first slice of a fresh loaf of bread. As the first slice is cut so it determines the shape of the others.

interpretation of being-as a preceptor to undergraduate student nurses. Therefore, my preconceptions of what counts as a question for me and what counts as an answer (Leonard, 1994) sets up in advance how I will enter and move within the hermeneutic circle. Whenever I interpret something 'as' something, my interpretation will be founded upon my fore-having, fore-sight and fore-conception. My fore-structure of understanding, (my fore-having, fore-sight and fore-conception) link my understanding or "meaning" (Heidegger, 1962/27, p. 193) of being-as a preceptor to undergraduate student nurses to my interpretation of their experience. Most importantly, I acknowledge that my fore-structure of understanding is an integral part of my interpretation because of the influence it could have on my interpretation of the participating preceptors' experiences.

The principle of "fusion of horizons" implies that there is no one right interpretation of the text. It fuses the participant's description of their experience with the researcher's interpretation of that experience. Nevertheless, there are particular interpretations of the text that are more probable than others. Kvale (1996) commented that a valid interpretation is defensible. The researcher's task is to formulate, as explicitly as possible, the evidence and arguments which have been used in the interpretation so that the interpretation seems both testable and credible to other readers.

Leonard (1994) pointed out another issue, - the manner in which humans are involved in different situations. Tanner (1997) identified the importance of capturing the semantic structure of everyday practical activity. What, for example, do preceptors actually do while they are being a preceptor to undergraduate student nurses? To make explicit everyday practical activity, Heidegger (1962/27) distinguished three modes of engagement.

The first is the "ready-to-hand" Heidegger (1962/27, p. 135). This mode of functioning is the everyday engagement in practical activity that we take for granted without reflecting upon what we are doing. Tanner (1997) and Horrocks (1998) shared the view that Heidegger's "ready-to-hand" mode relates to being practically engaged in the practice world of nursing. This most basic form of being in the world is experienced holistically within a network of interrelationships. The converse 'unready-to-hand' mode of being is experienced when there is some breakdown in the practical activity or 'ready-to-hand' mode. The final mode of engagement is the 'present-at-hand' mode where the person detaches him or herself from practical

activity and stands outside the context where practical activity has taken place in order to analyse the elements of the situation 'out of context'.

It is the ready-to-hand mode that is the starting point for interpretive inquiry. Interpretation of the text brings with it responsibility for the researcher. As the researcher I must be aware of my own forestructure of understanding that is shaped by my experiences as a nurse, as a theoretical and clinical teacher. The interpretive process ultimately involves writing and rewriting (van Manen, 1990) to reveal the nuances of the experience and to capture the experience historically, culturally and personally in the social context from where it has arisen. The researcher must keep as close to the text as possible recognising that the lived world is disclosed by the preceptors' language as they relay accounts of their practice in their narratives. Plager (1994, p. 77) identifies that the interpretive process aims to remain close to the text to "preserve the temporality and contextuality of the situation". Guignon (1983), identifies:

The measure of the truth of Heidegger's phenomenology is not whether it offers us a correct representation of who and what we are. The measure of truth lies in the way our lives are enriched and deepened through these descriptions. This conception of truth is implicit in Heidegger's interpretation of truth as 'a-letheia' – as 'un-hiddenness', 'un-concealment'. At the deepest level, prior to the correspondence of statements to facts in the world, truth is envisaged as the emergence of a clearing or opening that releases entities from hiddenness (p. 250).

Truth, therefore, is a process of illuminating the preceptors' narrative accounts of their daily lifeworld, thus disclosing and bringing the nature of their experiences (which are, for the most part, hidden), into unconcealment. Or→ hopes to bring the preceptors' accounts into a clearing or into a new light in order to reveal the important work they do. Interpretation seeks to make the preceptors' experiences explicit in order to transform our understanding of being-as preceptor.

Another notion of Heidegger is the "will to power". This notion is of importance in this thesis because technology is part of the world of nursing practice for both preceptors and undergraduate student nurses. Heidegger (1977/55, p. 23) reminded us that technology is a tool that needs wise handling. Heidegger was concerned about what he termed "the will to power" and the nihilism of the modern age. Rather (1990) noted:

The will to power is revealed in techne/technology. "Enframed" by science and technology, natural and human resources of the world (as picture) appear to be an undifferentiated supply Heidegger called "the standing reserve" (1977/55), open to the manipulation and control of powerful persons as self-securing, self-conscious subjects. The danger of "enframing" as a mode of thinking is that all other ways of knowing will be lost and Being will not be allowed to presence as it is (p. 108).

Heidegger's concern was over the dehumanisation of people and that they would become "standing reserve", that is an object rather than a "presencing" subject. Presencing refers to being with another in a way that acknowledges a shared humanity and is of significance in a caring practice such as nursing (Benner & Wrubel, 1989, p. 13). With reference to people as 'object', there is the implication that people have become 'products' of science, a commodity to be manipulated and used by dominant forces. In Heidegger's view, 'being' was always 'at the ready' and he interpreted this as being similar to the military; 'standing at the ready', awaiting the call to action. This idea can be understood in the context in this thesis where preceptors are 'staff'. Preceptors can be seen as merely numbers on a staffing roster assigned to provide services to a number of patients. When insufficient staff are present in the ward context, casual staff are called in to make up the numbers required. People are thus commodities sold to meet the demands of profit and loss, which is consistent with the principles of a market economy. To extend this thinking, a registered nurse and an undergraduate student nurse are equated to an EFT (Equivalent Fulltime) cost or source of revenue to the organisation. This idea can also be aligned to the statement that 'a nurse, is a nurse, is a nurse' (Perry & Moss, 1989). Such an attitude demeans the very person of the nurse, their personhood, their qualities, their knowledge and their capabilities.

The notion of the objectification of the person suggested by the will to power can be related to the subject/object split where the mind is separate to the body, an idea that can be traced back to Descartes referred to earlier in this chapter (p. 70). In the Cartesian view, the knower is separate to what is known. Nature is the sum of known and as yet unknown objects and their laws as in the scientific view of reality (Kolb, 1986). When people become objects of science, people are denied their essential humanity or "Being".

One other aspect of Heidegger's thinking which is significant for this thesis is the notion of "otherness". As we 'be' in the world, we are always with others.

Evaluating an interpretation account

Packer and Addison (1989) identify four evaluation approaches as a way to consider whether or not the researcher has uncovered answers to the question that directed the interpretive inquiry in the first place. These approaches include asking first, whether the interpretive account is comprehensible, that is can the report be understood by a reader. Second, has the researcher provided sufficient external evidence to show their decision trail to substantiate their interpretive account. Third, has the researcher pursued agreement on the interpretation made of the phenomenon among various groups, including the participants in the study. Fourth, can the interpretive account point to future events. In relation to the coherence, plausibility and credibility of the interpretations of the text in this research, Packer and Addison (1989) considered a number of evaluative approaches.

Madison (cited in Benner, 1994) suggested nine principles to evaluate a phenomenological hermeneutic study. These are as follows.

Coherence

The first requirement is that an interpretation is coherent or plausible in relationship to the external evidence provided. Thus my interpretations of the text, as cited in the thesis, must appear coherent to the reader, providing as full an account of the preceptors' real day to day experiences in all its nuances, consistent with the text as cited. Madison (cited in Benner, 1994) claimed that achieving coherence is not automatic, but is fraught with difficulty. Additionally, Madison stressed that the account should present contradictions if present and suggested that the researcher's task is to make the interpretation as intelligible as the text will allow.

Moreover, Packer and Addison (1989) advance a number of approaches to the evaluative nature of interpretive research pointing out the complexities inherent in the nature of interpretation. One approach is for the interpreter to go back to the participants to check that their interpretation is correct. I did this and the participating preceptors from whom I sought evaluation, concurred that the accounts given were a plausible way of understanding being-as preceptor. But Packer and Addison (1989) argued that to validate an interpretation of events as they have occurred at the time of description has inherent difficulties because of the nature of the interpretive act. The "intention-in-action" (Packer & Addison, 1989, p. 282) of

the participant at the time of recording data no longer exists. To ask the participant to recall the intent of their narrative at the time of data collection, is to call upon them to re-interpret their own actions. So whichever way one approaches the coherence and plausibility criteria of validating the text with participants, although their recollection of their intentions at the time are valuable, the meaning of their text, or the accuracy of the account, returns to one of interpretation. Packer and Addison (1989, p. 283) state that however much we try, "we can only understand an author's intention in terms of our own culture and time and so that character of that intention will always remain open to reinterpretation".

Consensus

Second, the interpretation should seek a consensus among a variety of groups including the participants. In the writing of this thesis, consensus has been sought through a number of avenues. First, discussions with my supervisors, both national and international, and their agreement/disagreement with my interpretations of my participants' texts have produced some consensus. Secondly, consensus was achieved by two of the participating preceptors reading the total report to check whether the account of being-as preceptor was plausible to them. Third, consensus was checked again by holding discussions with a number of nurse scholars (cited in the acknowledgement section of this thesis) and readers familiar with nursing education and nursing practice. Fourth, consensus was confirmed by writing a number of papers using my thesis research material while the thesis was in preparation and presenting these at national and international conferences. The audiences, in particular, a group of nurse educators at a conference in Australia¹³, were most approving of the then, emergent findings.

Futuristic

Third, Packer and Addison suggest that, if rigour is to be integrated across interpretations, there should be an assessment made of the account's relationship to future events. I consider this point to be extremely important. The pace of change in the health field is accelerating as a result of science and technology, and advancing knowledge in all professions allied to health, such as nursing, medicine,

¹³ The meaning of being a preceptor to undergraduate nursing students. (PhD work in progress).

Paper presented at the 5th International Qualitative Health Research Conference 7-10 April, 1999, The University of Newcastle, NSW, Australia.

social work, occupational therapy, physiotherapy and radiotherapy are evolving at an unprecedented rate. Advancing knowledge in nursing education continually challenges nurse educators and clinicians to keep pace. Toffler (1970) states that:

The rapid obsolescence of knowledge and the extension of life-span make it clear that the skills learned in youth are unlikely to remain relevant by the time old age arrives. Super-industrial education must therefore make provision for life-long education on a plug in/plug out basis. Learning will be stretched life-long (p. 361).

In the future, we can expect that the advent of formalised preceptorships will become increasingly important for a practice based discipline if graduands from nursing education programmes are to practice in a way that is relevant for a fast paced health care industry. As outlined in Chapters One and Two, the pace of change is relentless and will continue to be so. Therefore, rigorous interpretations must reflect this ever-changing social context. At the conclusion of writing this thesis, Toffler's prediction has come to pass as is shown in the discussion section of Chapter Ten (KPMG Report, 2001).

Limitations of Hermeneutic Phenomenology

There are limitations to Hermeneutic phenomenology. Research using Hermeneutic phenomenology cannot predict future events. However, it's strength lies in providing new insights and new understandings of a phenomenon that can be useful for identifying issues and concerns. These issues and concerns may help in the anticipation of future events and the significance of those events. In this research, it is hoped that through the narrative accounts of the preceptors' practice, new insights and new understandings of this experience will point to new ways of managing this important component of nursing education.

The use of hermeneutic phenomenology though is limited, because the research and the interpretive process is costly in time, involvement and commitment. It involves an ongoing style of ethical comportment¹⁴ toward participants and the validation of the researcher's interpretative processes in order to remain true to the lived experience. The research demands closeness to the text and to the dynamic hermeneutic process. The researcher must identify her own perspective in order to

¹⁴ Benner (1991, p. 2) refers to ethical comportment as "embodied, skilled know-how of relating to others in ways that are respectful, responsive and supportive of their concerns. "Comportment" refers to more than just words, intents, beliefs, or values; it encompasses stance, touch, orientation – thoughts and feelings fused with physical presence and action.

reveal her own source of bias that will impact upon the interpretation of the text.

Heidegger warned the interpretive researcher about the possibility of “covered-upness” (1962/27, p. 60). There are three ways in which ‘covered-upness’ can occur. The first is that a phenomenon (for example, being-as preceptor) can be ‘undiscovered’ in that it can be either known or not known. As stated in Chapter Three, the word ‘preceptor’ has been in vogue since the 15th century and therefore is a known phenomenon. The second, is that the phenomenon might have been known but has become covered up again. This latter ‘covered-upness’ can be partial or complete in that the phenomenon exists and requires little or no further enquiry. In this research, as is shown in the literature review, being-as preceptor has been known primarily in relation to orienting new graduates or new nurses to an unfamiliar area of practice. The third type of ‘covered-upness’ is disguising. It is in this third form that this research is most interested. Concerning this third possibility, Heidegger (1962/27, p. 60) warned of the danger of understanding a phenomenon (for example, being-as preceptor) in an historical and particular way that is accepted as being ‘clear’ to everyone and therefore requires no further justification. This form of covered-upness then serves to discount any new understandings of the phenomenon of interest. It is in this third form of covered-upness that this researcher is most interested. Finally, the covering-up potential in interpretation has two possibilities. Covering-up can be accidental or can occur because the phenomenon of interest (being-as preceptor) is grounded in the common practice of being a nurse.

An interpretive account must remain close to its original text, context and temporality. If the account loses these aspects it loses its essence and appears as a series of assertions as in logico-positive research or the scientific method of inquiry (Plager, 1994, p. 81). In this regard, Heidegger (1962/27, p. 60-61), had this to say:

Whenever a phenomenological concept is drawn from primordial sources, there is a possibility that it may degenerate if communicated in the form of an assertion. It gets understood in an empty way and is passed on, losing its indigenous character, and becoming a free-floating thesis. Even in the concrete work of phenomenology itself there lurks the possibility that what has been primordially “within our grasp” may become hardened so that we can no longer grasp it. And the difficulty of this kind of research lies in making it self-critical in a positive sense (p. 61).

Particular Philosophical Work used in this Thesis

In the interpretation of transcripts from the participating preceptors in this thesis, I have drawn upon Heidegger's (1971) essay: '*Building, Dwelling, Thinking*'.

Heidegger claimed that there is a relationship between *building, dwelling and thinking* and that there is a kind of thinking that results from attention to that relationship. In his essay, Heidegger used the word 'dwell' to describe how we, as human beings, are on the earth. He believed that we must first 'build' before we can 'dwell'.

Heidegger also identified the notion of the *fourfold* in this essay. He referred to the unified presencing of the fourfold of the earth, sky, divinities and mortals – in the 'things'. The 'thing' gathers the world. After reading many commentaries (Edwards, 1998; Guignon, 1993; Heidegger, 1950 (trans Krell, 1993); Inwood, 1999; Kolb, 1986), in my view, Heidegger depicts the *fourfold* as sources of energy and influence. He identifies the four influences as a style of unifying where all essences share equal expanse and no one 'thing' dominates. Here, I have interpreted Heidegger to mean the unity or the holism of the universe. This means that each element requires the others to complete the whole. Where all forces meet, there is a gathering. We experience this gathering-place as subjectivity or lived time and space as 'being' (Kolb, 1986, p. 138). 'Being' here refers to being a community of relationships¹⁵.

To put this notion into the context of being-in-the-world as a preceptor, and being with others within the nursing context, it is difficult to make explicit the complexity of the influences that gather all those involved in health care services. Nevertheless, these influences are the background to the practice of both preceptors and students within the world of nursing practice. I have endeavoured to make these situated, contextual, influences explicit in Chapter Two. It must be remembered however, that normally, we are in the world without an awareness of our background influences. These are simply taken for granted (Benner, 1984, 1994; Benner &

¹⁵ It should be remembered that Heidegger referred frequently in his writing to the romantic epoch which in turn has been influenced by the early Greeks, including Greek mythology and language. He believed that the early Greeks understood "Being" in a poetic way that was subsequently lost in language interpretation. To reflect his thinking influenced by the Greeks, he wrote of the 'gods'. He used a small 'g' for 'gods' or divinities in his writing concerning the *fourfold*. (Heidegger, 1947, in the essay *Building, Dwelling, Thinking* In Krell (trans), 1993) To me, as a Christian, this signifies that he is not displacing God as the Godhead of the trinity in Christianity in his writing, for he was first a student of theology. Kolb (1986, p.191) referred to Heidegger's implying that there would be a modern age where metaphysics and technology will no longer dominate "Being". In this new age, "Being" will come into its own.

Wrubel, 1989).

Being-in-the-world is temporal and situated. The particular era of history for the preceptors as they precepted undergraduate student nurses is significant. There is a circle of interpretation for the preceptor and the student which brings together the historical, socio-political, cultural and personal influences of their own lives as they practice as self-interpreting beings within the world of nursing practice. As well, there is the organisational culture, the local nursing culture, the concerns and needs of the related educational structures, multiple patients, the demands of a linear time frame, and the calling forth of relevant knowledge and skills in the provision of nursing services. The preceptor must first weigh up their own practice requirements for their primary role as a registered nurse and secondarily, teach, guide, support and assist student nurses. In an interpretation of the *fourfold* for this research, I see that all the influences that are background to the practice of both the preceptor and the student, come together in synergy or togetherness to influence the space in which the preceptor dwells in his or her world of nursing practice.

Kolb referred to Heidegger's *fourfold* as a clue to a movement in his overall thought that appeared to address the present or future. It is also interesting to note that the *fourfold* does not appear in his major work *Being and Time* (1962/27). He discussed the inherence of a mirror play of mortals, earth, sky and divinities that constitute the "worlding" of the world. (Kolb, 1986, p. 189). Kolb refers to this postmodern age as a deconstructive age.

'Dwelling' takes place through cultivation and construction. This would imply that building is really dwelling. Heidegger (1962/27) took us back to the original word from which the idea of dwelling stems. In the original translation from the German, *Bauen* is used to mean that we stay in place or remain. Further, a Gothic word *wunian* says more distinctly how this remaining is experienced. *Wunian* is a related word to the idea of dwelling and means to be at peace. If we relate this idea to the preceptors, one could say that the preceptors are assisting the student to be 'at peace' or comfortable with the reality of the world of nursing. In other words preceptors are guiding students to fit well into the world of nursing. Additionally, *friede* (peace) means to free. Epitomised in the derivation of the word *friede* also is the idea of preserving from harm or danger, or in other words 'safeguarding'. Likewise, a related meaning to *friede* is the idea of *sparing*. *Sparing* means that we do not harm the one we spare. The fundamental character of 'dwelling' is *sparing*.

One can only know how to dwell by means of journeying. Undergraduate student nurses learn to dwell in the world of nursing practice by way of journeying within it. To become grounded in the world of nursing is to feel at home within it. The unity of dwelling and journeying appears to be the unity of space and time (Pöggeler, 1989).

Thinking

Fundamentally, Heidegger proposed a new way of thinking about the things that we usually take for granted. Thinking is not linear, systematic, logical nor calculative, but rather, thinking is dwelling in the world. Thinking is never separated from 'Being'. "Thinking is the engagement of being-in-the-world" (Heidegger, cited in Krell, 1993, p. 219). Thinking is captured in the hermeneutic language of stories from the preceptors' practice as they journey with students in the world of nursing practice. This thinking is nursing (Rather, 1990). The stories reveal the 'how' of the thinking of the preceptors. Heidegger placed importance on thinking 'Being' first prior to "the distinction between theory and practice, or contemplation or deed" (Krell, 1993, p. 215). Heidegger drew attention to a hoped-for-change in the history of 'being' from forgetfulness to one of restoring 'being' rightfully to the centre of attention. The forgetfulness Heidegger refers to in the notion of *falling* characterised by ensnarement is related to being caught up in the world without paying attention to 'Being'. That is we drift along.

It is my view that the government reforms (Upton, 1991), which forced changes in health and in education, have caused the relationship between nursing practice and nursing education to 'drift' along, or in Heideggerian terms to *fall* into an ensnarement. That is nursing education and nursing practice have continued as they always have, just keeping things going along without giving much thought to the processes inherent in how student nurses learn the practice of nursing. Heidegger calls attention to the inseparability of 'being' and 'thinking'. This research calls attention to how being-as preceptors is revealed in the thinking encapsulated in the preceptors' own words disclosing their fundamental way of being-in-the-world.

Nursing and Humanism

More recently, Crotty (1996) was highly critical of the way nurse scholars have used Heidegger's writings. He reviewed thirty research reports written by nurse researchers to examine what nurses conceived 'phenomenology' to be. He noted that most consider phenomenology to relate to everyday understandings of

experience. He disputed nurse researchers' preoccupation with the subjective experience of individuals and the seeking of shared meanings and commonalities of experience in a context that is made explicit. In his view, nurse scholars had failed to remain true to Heidegger's thinking. In particular, his criticism was levelled at Benner's (1984), view of the person. His first criticism relates to Benner's account of human beings as 'self'-interpreting rather than, in Crotty's view, Heidegger's 'interpreting' person linked with 'Being'. In Heidegger's view, according to Crotty, the person is an interpreter of Being.

Second, Crotty took issue with Benner's understanding of Heidegger's philosophy concerning the kind of being we are and whether our being is an issue for us. In Heidegger's view, we need to take a stand on this issue. Crotty asked what Heidegger meant and how did Benner understand this notion. Crotty's own understanding was that the answer lies in the way Benner interpreted how 'being' takes a stand on itself. Crotty claimed that Benner interpreted Heidegger's meaning as taking a stand in terms of our common heritage. People make sense and meaning of their lives by way of "self-interpretations embedded in language, skills and practices. 'People', says Benner, 'have direct access to meaningful situations by virtue of education and experience'. To avail themselves of that access is to confront the issue of what kinds of being they are and to take a stand" (Benner cited in Crotty, 1996, p. 93). Crotty claimed that Benner made the complex issue of taking a stand on oneself or 'choice of self' straightforward, while in Heideggerian philosophy, it is a complex decision.

Crotty believed that nurse scholars used Heideggerian philosophy with a "humanistic orientation" (Crotty, 1996, p. 95), yet, Crotty disputed that Heidegger adhered in any way to a humanistic view of the person. Heidegger in his *Letter on Humanism*, (Heidegger, 1947 cited in Krell, 1993) claims that humanism is grounded in metaphysics, and therefore does not address the question of 'Being' as ontological. Heidegger writes:

Every determination of the essence of man that already presupposes an interpretation of beings without asking about the truth of Being, whether knowingly or not, is metaphysical. Metaphysics does not ask about the truth of Being itself. Metaphysics closes itself to the simple essential fact that man essentially occurs only in his essence, where he is claimed by Being (p. 226, 227).

For Heidegger, the truth of 'Being' was the authentic self (Heidegger, 1962/27, p. 167), that is, being ourselves. Crotty believed that nursing phenomenology was an adaptation of what he termed traditional mainstream phenomenology. From my understanding, his chief criticism lies with the humanistic orientation of nursing phenomenology, that is a pre-occupation with the 'self' as a prefix to the word 'interpreting'. Crotty firmly adhered to Heidegger's original intent in the first division of *Being and Time* (1962/27). That is, Heidegger's desire to understand the meaning of 'Being'. Heidegger's question, in Crotty's view is a pursuit of an understanding of 'Being' as an individual's subjective experience which cannot be a shared experience.

Heidegger and National Socialism

A much more controversial and darker side to Martin Heidegger's distinguished record as one of the most outstanding thinkers of the twentieth century is his involvement with the National Socialist Party of the Nazi regime. Heidegger was supportive of the Nazi party. Although there are a number of authors' views on Heidegger's involvement with National Socialism, I have taken my stance, from Thomas Sheehan, a distinguished scholar of Martin Heidegger's life and philosophical works, as he wrote in *Reading a Life* (Sheehan cited in Guignon, 1993).

According to Sheehan, although sympathetic, Heidegger did not support the Nazi party philosophy in its entirety but believed the party's anti-communistic stance was beneficial to the German people. He saw Nazism as a way of crushing Marxism and held the view that a strong nationalistic stance, coupled with a belligerent anticommunist socialism was a way of restoring Germany to its former glory and traditions. He was against the pervasive force of what he perceived to be global technology that he believed would bring devastation to man and earth. He felt this was the likely destiny of a Western world reliant increasingly on science and technology as the basis of thinking and action. Heidegger did not uphold the principles of democracy and believed that strong, clear and visionary leadership was required to steer the world in what he believed was an apocalypse, in order to deflect nihilism. Sheehan (cited in Guignon, 1993) and Smith (1996) identified that Heidegger fell prey to Nazism because he adhered to "one central ontological thought and pursued an unchanging vision through out his work" (Smith, 1996, p. 176). Other thinkers have written that Heidegger's involvement in National

Socialism was the necessary closure of that destiny. From beginning to end he remained committed to the need for the re-emergence of tradition-dominated communities. Heidegger eventually came to see that National Socialism would eventuate in nothing of the kind, being, in fact, just another extreme manifestation of the modern, technological longing for domination of man and the earth.

Crotty (1996) raised issues concerning Heidegger's involvement in National Socialism, citing a number of authors' views on the connection between Heidegger's philosophical writings and his political affiliations. I have some disquiet over this debate. However, I concur with Crotty's view that Heidegger "is the most provocative of thinkers. Perhaps more than any other twentieth-century philosopher he has succeeded in stimulating thought in others. His phenomenology may at least encourage us to follow an authentic phenomenological path for our own purposes" (Crotty, 1996, p. 101).

Darbyshire, Diekelmann & Diekelmann (1999) responded to Crotty's criticism that interpretive nursing scholarship has misunderstood the writings of Martin Heidegger. The authors challenged Crotty's understanding of Heidegger's work, considering his analysis to be often narrow and misguided. But they acknowledged the important contribution Crotty made to debate and scholarship that was lost at his untimely death.

Summary

This chapter has discussed Heideggerian philosophy in conjunction with hermeneutic and interpretive analysis. Heidegger claimed that our foundational mode of being as persons lies in interpretation and understanding. We come to understand some of the possible meanings of 'Being' through our own experience of our 'being' within the world. 'World' and 'Being' cannot be separated. One is constitutive of the other and vice versa. Within this we live hermeneutically.

Critics have made a possible link between Heidegger's philosophy and his political affiliations. Nevertheless, his philosophical contribution to the world is undisputed, in particular, his ability to provoke thought and his preoccupation with 'Being' as an ontological experience. It is in his view of 'Being' that being-as a preceptor finds expression in this thesis. Criticism has also been cited at nurse scholars' use of Heidegger's writings that have been linked to a humanistic orientation of the world.

Heidegger divorced himself from this orientation claiming clearly that 'Being' is an ontological experience.

Hermeneutics is discussed as a research method that reveals how one is within one's world through the interpretation and analysis of narratives of 'lived experience', (van Manen, 1990) in this particular instance, of preceptors to undergraduate student nurses. In Chapter Five that follows, the research approach used for the study is elaborated.

CHAPTER FIVE

The Research Process: The Readying Phase for the Research

Introduction

The purpose of Chapter Five is to provide a detailed description of the research process used to uncover what was significant and meaningful for the fifteen preceptors who participated. It is incumbent on the researcher to provide a full exposition of the chosen research methodology.

The focus of the chapter moves on from Chapter Four's detailed discussion of Heideggerian hermeneutics as a research approach outlining the steps inherent in the research process. These include obtaining ethical approval, inviting participation, preparing participants for the research, the data analysis process and validating processes inherent in the rigour of phenomenological hermeneutic research. The final stage, writing the research report, unveils how being-as a preceptor to undergraduate student nurses is made manifest. Van Manen (1990) claimed that it is in the writing and the re-writing that the phenomenon under investigation is brought to speech and makes its appearance. He also felt that, above all, the writing is a "thoughtful" experience (p. 32).

Gaining Ethical Approval

Ethical approval for the research was obtained from North Health Ethics Committee and Massey University Human Ethics Committee. The North Health Research and Ethics Committee confirmed access to likely sites, provided official identification and access to key people who allowed me to recruit possible participants.

Setting the Scene

In order to be well positioned to invite participants to join this study, the research had to be promoted. Selecting the likely participants required me to obtain a 'purposeful sample' (Polit & Hungler, 1995). A purposeful sample meant that I, as the researcher, sought participation from those registered nurses that had been preceptors to undergraduate student nurses. Clearly, only those registered nurses

that had had the experience of being a preceptor to undergraduate student nurses would have direct knowledge of the phenomenon of interest.

A letter of invitation was sent, through the Director of Nursing and Midwifery at several public and private large teaching hospitals, inviting possible participants to volunteer. This process brought one volunteer only.

Copies of a flyer "Are you a preceptor?" (see Appendix One) were given to the Nursing Directors to circulate in wards and in places where registered nurses congregate. On the flyer was a statement of who I was as the researcher, my purpose, and my quest.

On the reception of an expression of interest, an information sheet (see Appendix Two) was sent to the prospective participant. This clearly stated the rights of the participant. It was made clear to the participants that they were able to ask questions of the researcher at any time and, indeed, they were encouraged to do so.

Following an initial poor response, personal contacts were used to find participants. Such an approach is known as a "snowball" effect (Polit & Hungler, 1995). Snowball sampling requires that one volunteer participant approaches another person who might be interested in becoming a participant and asks that person to contact the researcher. As all volunteer participants have their identity protected through a pseudonym, this approach was acceptable ethically to the researcher. One participant agreed to participate in the research in this way.

Two public presentations were set then up with the support of a clinical nurse educator to promote the proposed research study to potential participants. This process brought a very good response. Interested people were asked to contact me privately to maintain their anonymity.

Those participants who confirmed that they were willing to proceed were then asked to sign a written informed consent form outlining the conditions of participation, including the right to withdraw from the study at any time without consequence. These were kept on record (see Appendix Three). This was consistent with the ethical approval process. Consent was voluntary and freely given.

The Participants

Initially, seventeen participants volunteered to engage in the research. Two withdrew before the research began. The remaining fifteen registered nurses, who had worked as preceptors to undergraduate baccalaureate students in their clinical placement, remained constant throughout the research.

The participants' ages ranged between twenty-three years and fifty-five years. Nine of the fifteen preceptors had a bachelor's degree, three having just completed their degree as the data collection began. Two others finished their bachelor's degree during the process of the research. Four of the fifteen preceptors held a Diploma of Comprehensive Nursing. The remaining two were registered general and obstetric nurses. Participants' post registration experience ranged between 10 months and 32 years. Three were male and twelve were female. Five of the fifteen participants had undertaken a short formal preparatory preceptor programme. All the participants were employed in large hospitals, two public and one private, in a large New Zealand metropolitan city.

Integrating Ethical Principles across the Research Process

Confidentiality

Confidentiality was maintained by the prospective participants making contact with me as the researcher by telephone or through a private meeting. Once interest was confirmed, information relating to the nature of their involvement, how anonymity and confidentiality would be maintained, and what it might mean in terms of time and experience was shared. Next, a meeting was arranged to meet face to face in order to develop rapport and answer any questions the participants had prior to the interview process beginning.

An original telephone contact was followed through with a mailed out 'invitation' package. An informed consent form was included. Some of the participants returned their consent form via post prior to their first meeting and interview. Two copies of the consent form were given to the participant; one they kept and the other I hold in a metal filing cabinet at home.

Each participant chose a pseudonym that has been used for all communications, for

the identification of audio-tapes and transcripts, for use on disk, and for all written or oral presentations that have arisen from the research. The identity of the participant was recorded on a list cross-referenced with their chosen pseudonym and was stored securely at home.

The Dictaphone typist signed a confidentiality agreement (see Appendix Four) and knew the participants only through their pseudonyms at all times. The only people who had access to individual tapes were the typist, my two original supervisors, individual participants, and myself as the researcher.

Once the research process was underway and the interviewing began, a copy of each transcript was given to the participant. The transcripts were accessed only by myself as the researcher, my supervisors, and the relevant individual participant concerned. During the research period, I attended a hermeneutic workshop¹⁶. One participant gave permission for an interview transcript to be used for an interpretive exercise in the workshop. Anonymity of the participant was maintained by using the research pseudonym.

Confidentiality issues were ongoing. Sometimes a participant used a student's name during the interview. The natural way in which participants were speaking of practising as preceptors with students meant that it was often easier to refer to a preceptee by name. This was consistent with Heidegger's (1962/27) view that we are "ensnared" in our being-in-the-world. That is, our everyday way of being captures our normal actions as we go about our day to day affairs without too much forethought. Because we are not normally aware of our "thrownness" (p. 175) in the world it was not particularly unusual when the student's names 'slipped out' as the preceptors shared narratives from their practice, but to protect the student's right to anonymity, these names were deleted or changed to a pseudonym in the transcript.

During the research process, an example of a narrative was given to the preceptors as participants in order for them to become familiar with storytelling. This strategy was used to help the participants to reflect and tell stories related to being-as preceptor to undergraduate students. Reflecting on their practice was not necessarily easy. Research participants were much more comfortable with their normal way of being-in-the-world as preceptor registered nurses providing nursing

¹⁶ A Hermeneutic Institute conducted by Drs Nancy and John Diekelmann at Massey University, Palmerston North in 1997.

services to patients. To think about how they were as-preceptors was difficult for them, as it was something that had not been uppermost in their minds. It was no doubt unusual for them to be asked about this experience, as it had been an expected part of their practice. That way of being is well illustrated in the next chapter. An example narrative gave participants an idea of how to think about being-as and how to think about the experience as it was. An example narrative gave participants how to bring the experience of being-as a preceptor to undergraduate students in acute care settings into the foreground of their practice. This helped some participants to understand the meaning of participating in the interpretive approach to phenomenological research.

This difficulty that some participants had is not especially unusual. Crotty (1996) claimed that, working with persons phenomenologically, requires them to be able “to reflect, focus, intuit, and describe as the phenomenological endeavour requires” (p. 176). They need to be people who can be in touch with their own immediate experience, to move between the experience and what has been experienced to describe “what is there” (p. 176). Crotty also acknowledged that this is not an easy task.

When participants were members of highly specialised units, by the very nature of their expertise, maintaining their confidentiality was difficult. This was the situation for one particular participant. In that case any identifying data that would have compromised the participant's anonymity in the research was deleted. I have endeavoured to ensure that it is not possible to identify individual participants, or people, or places to which reference was made during interviews.

Storage of Data

All interview transcripts were kept on disk and on my own computer's database for the interpretive process. At the outset, the software package MARTIN (1991) was used to assist in the interpretive process. In fact, many hours were spent studying this process at the University of Wisconsin, Madison with Dr. Robert Schuster, one of the originators of the programme. However, the need to up-grade software and the incompatibility over time of this programme, meant that I have used my own management system for retrieval and analysis of the data with an updated Windows 98 programme. The second stage of Heideggerian Hermeneutic analysis (p. 104) refers to this process in greater detail. The disks were kept during the research in a

disk container in my home.

I have used the data gathered during the course of the research for the purpose of writing this thesis to meet the requirements of the degree of Doctor of Philosophy in Nursing. The data has also contributed, in part, to five educational papers developed for conference presentations during the research process. Three have been published in conference proceedings.

The final thesis will be also used for education, for educational purposes, for writing further conference papers, and journal articles. It is also hoped that the thesis will benefit those preceptors who willingly gave of their time and expertise to inform the research. Their narratives create the substance of this research.

Risk and Benefits to the Participants

In this research, the risks to the participants were perceived as being twofold. The first potential risk was to any breach of confidentiality. In order to reduce this risk, the participants' confidentiality was assured by the use of pseudonyms by which they are known in all communications during the research and interpretations.

The second risk came through the nature of clinical practice. There was always risk to the participants confidentiality, if at any time in this research, the interviews described an unsafe nursing act either by a student or a staff nurse engaged in the preceptor experience. Incidents of unsafe practice are reported within a clinical agency. Thus there is the potential for identification of the staff member or student concerned if mistakes have occurred. This situation did not arise in this study.

Conflict of Interest

It was acknowledged at the outset of this study that registered nurses who are employees of a clinical agency and also act as preceptors to student nurses in their undergraduate practicum have a conflict of interest. Primarily, they are employed as nurses providing nursing services to clients who require their services. Secondly, they are preceptors or teachers and guides to student nurses. The outcome of this study of preceptors' experience in their secondary role is given explicitly in the data chapters of the research. This conflict of interest was, and continues to be, an ever-present challenge to the preceptors who took part in the research.

During the research process I was working in full time employment as a nurse lecturer and therefore I acknowledge that I have a vested interest in nursing education. To allay difficulties that may have arisen, all preceptors who volunteered to be in this study did not work with students from my employing educational institution.

The Value of the Research

Most researchers hope that the knowledge uncovered from the research will improve practice and the quality of care. I am optimistic that this research will benefit others. My role is to bring forth the contribution that registered nurses make to nursing education as they work with patients and, at the same time, teach, encourage and support undergraduate student nurses. Insights gained should improve understanding and bring about greater recognition of registered nurses' involvement in nursing education. I also envisage that the research will increase understanding of the work through their sharing of their lived experience as precepting undergraduate student nurses.

The Interview Method

Timing of the Interview

The interviews were conducted from mid 1997 to September 1998. They took place after a preceptor had undertaken the initial orientation of an undergraduate student to the clinical setting, that is, the second week of the student's clinical placement. This was to ensure that the preceptor had time to become familiar with the student they may be precepting at the time of interview. There were however, times during the research when participants would not have a student for a period of two weeks. As will be seen in the data chapters, preceptors would sometimes be asked to precept students for one day only. In one such specialised setting, students were assigned for one week only.

Participants were first asked the opening question, "Tell me what it is like to be a preceptor to undergraduate student nurses? Can you tell me a story from your practice with undergraduate student nurses in their practicum that for you illustrates what it means to be a preceptor as undergraduate student nurses learn to nurse?" As preceptors responded to this opening, from time to time searching questions

were introduced to clarify the meanings of experiences, or to extend further their insights. When preceptors were in the right region (Deikermann, 1992)¹⁷ dialogue came freely with lengthy stories from some preceptors who spoke of significant reflection on how they had experienced 'being-as' a preceptor.

Each participant was interviewed twice which lasted approximately one hour in length, although some participants spoke longer. Interviews were recorded on audio tape and then transcribed. The transcripts were returned to the participant for correction or for any comments they may have wanted to make. All participants kept a copy of their interview data. The participants' first interview transcript was used as a basis for the second interview to further clarify or explore any issues that appeared to warrant further exploration. The desire was to capture as fully as possible the preceptor experience.

Interviews took place outside working hours for all participants. The place of interview varied. Twenty-four of the thirty interviews took place at the participants' homes. Two interviews were arranged at my home. One interview was situated at my work place and one took place at a participant's workplace. All interviews took place in private.

Triangulation

Participants were asked to keep a nine-day diary of their experiences while being a preceptor to an undergraduate student nurse during the student's clinical placement. Only three of the participants complied. In hindsight, this request proved to be an added burden to participants who freely gave of their time and experience to fulfil the requirements of the research.

During the planning phase of the research, the diary had been intended as an important source of data for triangulation to improve the reliability and validity of the study. However, Morse (1997) states that such habits are not necessary in qualitative research, as the reliability and validity of qualitative research is inherent in the inductive process. The original hope that the diary would be a 'memory jogger' for participants was not necessary as a second interview met this

¹⁷ I attended the 1992 Heideggerian Institute at the University of Wisconsin, Madison, USA conducted by Dr's Nancy and John Diekelman who taught me that when participants are sharing narratives that are meaningful and are focused on the research question, their dialogue comes freely as a narrative. This is one of the meanings of being in the 'right region' of the research question.

requirement. As well, the significant experiences of the preceptors were readily recalled and shared with the researcher.

Analysis and the Interpretative Process

At an early stage in the research writing process, my first international supervisor suggested I do a hermeneutic analysis of the plethora of literature related to preceptorship as a way of engaging Heideggerian Hermeneutic analysis. This was a helpful way of coming to understand the main themes that occurred in the literature relating to the concept of preceptorship. It also gave me an insight into what had engaged researchers' interests related to the topic. Heideggerian Hermeneutic analysis also helped me to understand historical meanings and what has endured from the past in contemporary nursing concerning preceptorship.

Theme, according to van Manen, (1990, p. 78) refers to an "element which occurs frequently in a text". It is not a "rule-bound process but a free act of seeing meaning". It is a creative process of discovery captured in the process of making sense of the text and is understood as the "structures of experience" (ibid, p. 79). It provides a means of taking hold of the phenomenon the researcher is trying to understand. Finding themes requires the researcher to take an open comportment to the text seeking insights into what it means to live the experience for the participant. This process proceeded in several movements.

Exploring the Transcripts

Transcribed interviews from the fifteen preceptor participants were read and re-read. Each transcription was reviewed for accuracy against the audio tape. The entire set of interviews was submitted to both supervisors from the outset. All transcripts were examined and summarised by the researcher searching to identify the common themes that were occurring across all participants. For example, an early dominant theme was the way in which the preceptor came to be a preceptor. In this first stage of analysis, questions were asked while reading the transcripts to find out what was common and what was different in the way registered nurses came to be preceptors. This required much reading and re-reading transcripts as parts, to reading the transcript as a whole, and considering the whole in relation to the parts. The process is consistent with the hermeneutic analysis movements.

The process of identifying common themes across all participants' transcripts took some considerable time. Involved in this process is the play of thinking, re-reading, questioning myself, questioning the text, and questioning my own understandings of the text, and asking myself why I should choose one theme over another. Checking my interpretations of the text was also important. I followed this through by communicating in writing with my participants using a progress report on the research. I enclosed a copy of the emerging themes at this point, and asked for their feedback.

Similarly, my interpretations were discussed with my primary supervisor during the research process. For example, all participants described how they were identified as preceptors within their ward context. This relational theme forms the basis of Chapter Six, *Being Attuned: The Call*. The early interpretations of this chapter were worked through with my two supervisors who questioned me as to how I arrived at this relational theme among a range of possible themes. In this early work, both supervisors encouraged me to answer the "so what?" question. In this way I learnt to think beyond the ideas that were emerging and to ask further questions of the data as part of the hermeneutic circular thinking process. This activity continued throughout the analysis, writing and rewriting process, culminating in the final thesis.

As a further part of this early identification of themes, as already stated, I attended a Heideggerian Hermeneutic workshop with Professor Nancy Diekelmann and other researchers. As already mentioned, one participant agreed that their transcript be used by a group of workshop students. Lee's (pseudonym) transcript was used for a class exercise in interpretation. From the class, a variety of ideas were elicited. In particular, Professor Nancy Diekelmann identified from that transcript, Lee's ability to engage undergraduate student nurses in 'what if?' questions and to encourage what Lee terms, 'lateral thinking'. Sharing different interpretations with other researchers helped me to be open to the wide-ranging possibilities associated with interpretation.

During the research, my international supervisor (Professor Nancy Diekelmann) withdrew in her supervisory capacity. A new second international supervisor (Dr. Rita Monsen) was appointed. In the last year of the thesis writing, a primary co-supervisor (Dr. Liz Smythe) was appointed. A mentor friend, Dr. Margaret Idour an Heideggerian reader and scholar has assisted through discussion at critical points in

the thesis writing. My primary supervisor and all of these nurse scholars have been involved as research associates in the Heideggerian Hermeneutic interpretive process thus serving to validate the common themes, relational themes and the final constitutive pattern, as they have emerged from the interpretive and writing process.

Searching for the Themes

In the second movement of the analytical process, each interview was read in-depth in its entirety and then coded for themes. Within this process of reading, commonalities discovered across the interviews were gathered into themes. A theme is a shared practice or common experience that emerges within and across interviews (Benner, 1994). Application of the Heideggerian Hermeneutic Analytical process brought to light the hidden meanings experienced by the participating preceptors. The aim here was to engage in intensive study of the data. Overall, textual interpretation proceeded at increasing levels of complexity and involved continuing analysis and refining of meanings until discovery of the highest level of meaning, the constitutive pattern, unfolded.

During this stage keeping track of data was critical and efficient organisation of data was fundamental so that a clear audit trail was available. As already mentioned, MARTIN, a software package developed by Diekelmann, Schuster, and Lam (1991) was used only once to assist in keeping track of the data and early identification of themes from the data. Since MARTIN was written, software packages have moved ahead and the Windows and Microsoft programmes (1998) are not compatible with the earlier version of MARTIN.

An early version of the *Non-numerical Unstructured Data Indexing Searching and Theorising (NUDIST)* computerised data management programme (Richards & Richards, 1994) was also explored but was found to be too detailed to record developing themes usefully. The 1999 version of NUDIST published overcame this problem, but by that time, the technical aspects of managing the data had been completed.

WINDOWS 98 was found to be sufficient for the analyses. Exploring recurring words and phrases used repeatedly by preceptors in context as they shared their experiences assisted the identification of themes within and across transcripts. Using the Edit function and 'find' identified common words used by the preceptors

which were then readily tracked for related topic phrases and the context in which the phrase was used. Initial summaries of the storyline and dominant themes within all transcripts were encouraged by my primary supervisor; these were followed through and stored.

Looking for Similarities and Differences

During this movement I was engaged in looking for similarities and differences. Common themes merged into meanings that became more complex relational themes. Relational themes have a greater complexity of relations and connections than common themes, revealing the inherent meaning of a situation. Multiple meanings are linked together to form a pattern or meaningful whole (Benner, 1994). For example, the relational theme *Becoming Attuned: The Call* has much greater complexity than a common theme such as *leaping ahead*. This is illustrated, for example by observing that the relational theme named above, communicates a particular aspect of the constitutive pattern found in this study: *Safeguarding the Practices of Nursing*. At the ultimate level of complexity common themes and relational themes are synthesised into a constitutive pattern. A constitutive pattern is central to the data and is present in every interview. This is the highest level of Heideggerian Hermeneutic analysis.

Weaving the Themes Together

The categorisation of identified themes is an interpretive, reflective and reflexive process throughout the analytical and interpretive phases. This movement is very time consuming, requiring cogitating on developing ideas, returning to early literature and writing individual interpretations. Excerpts from each participant's interviews were woven into the research to ensure that each person had a voice within the research and each interview had all its themes explicated. I returned many times to each participant's interview, to identify themes that were common in a number or all of the interviews and to question their centrality to the units of meaning emerging in the research. Other themes were unveiled in either single participant interviews or in a minority of interviews. Contradictory interpretations were also present in some texts. These contradictory themes were valuable for revealing tensions in the multiple transcript database.

Substantiating the Constitutive Pattern

Only one major constitutive pattern, *Safeguarding the Practices of Nursing*, was identified and is described with excerpts from the texts used to substantiate the pattern. The interpretive theme for this pattern came from my reading of Heidegger's *Building, Dwelling, Thinking*. The commentary by Krell on Heidegger's *Building, Dwelling, Thinking* (1993, p. 351) of the interpretation of the German word "wunian" was significant in the interpretive process. This moment of insight or discovery is what van Manen (1990, p. 88) warned that one must remain open to. As stated, the constitutive pattern contains a central theme that is referred to across all texts either directly or indirectly. Underlying the common themes, relational themes and constitutive pattern is the deep concern that the 'world' of preceptors and undergraduate student nurses should be experienced as a 'home' and not, simply a 'house' or a place of work (Heidegger, 1951 cited in Krell Ed., 1993, p. 362; Diekelmann, 1991; Idour, 1999).

Confirming the Interpretation

In this movement of Heideggerian Hermeneutic analysis validation of the relational themes and the constitutive process occurs. People who were familiar with the context and the research method were invaluable for validating my ongoing analyses. This included my two supervisors, my mentor, fellow doctoral colleagues, and a master's student. Early findings of central themes were sent via newsletters to the research participants during the process of interpretations along with a progress report on the research.

Early interpretations related to the writing of the first data chapter in particular, were shared with my two supervisors, one of whom is a recognised scholar in Martin Heidegger's philosophical works and its value in nursing scholarship. Extensive discussion occurred, and the interpretations included in that chapter were challenged. These challenges included the depth and breadth of Heideggerian Hermeneutic analysis. It was during these discussions that I acquired insights into what was required of a Doctoral student in the writing of a thesis.

The interpretive process deepened with the development of papers that were presented at a number of international conferences. The value of this was

inestimable. In particular, at one international conference where I shared a developing theme from the thesis with five other presenters, I discovered that there were thematic commonalities across countries. This was encouraging and confirming of the developing thesis.

At this stage, I sought to describe shared practices and common meanings reflected in the developing themes. The goal was to expose any unsubstantiated meanings and inaccurate interpretations which were not supported by the text.

Preparing the Report

The last movement in the interpretive process involved preparation of the final report using sufficient excerpts from the interviews to allow for validation of the findings by a reader. At this point, expert consensus validation was included in the final preparation of the research report. This included returning to a small group of my participants and to my supervisors for validation of my interpretations.

Ensuring Internal Rigour

Internal rigour is also required of the interpretive researcher. Internal rigour addresses the approach, consistency, comprehensiveness and veracity of the interpretation process. Maddison (cited in Benner, 1994, p. 79) claims nine principles are appropriate for the evaluation of phenomenological hermeneutics. These are outlined next.

Comprehensiveness

The account must give a sense of the whole of the phenomenon as it reflects the situatedness and temporality of the participants. I have interpreted this to mean that the narratives cited in this study display a sense of the preceptors' context, their position in that context, and a sense of the present in relation to the past, and to the future in their practice. The notion of 'temporality' is portrayed therein.

Penetration

The account "attempts to resolve a central problematic" (Maddison, p.29 cited in Benner, 1994, p. 79). In this thesis I have interpreted this to mean that the

narratives of the preceptors unveil the experience of being-as preceptors to undergraduate student nurses to answer the research question posed. Previously, the day to day accounts of what it is to be a preceptor has been poorly understood in the New Zealand context.

Thoroughness

The account deals with all the questions posed by the researcher. I have endeavoured to answer the questions raised in Chapter One through the narratives of the preceptors themselves. In Heideggerian phenomenology, “turning to the things themselves” (Heidegger, 1962/27, p. 49), is necessary to understand the nature of the phenomenon. Only the preceptors themselves can answer the questions posed. To restate some of the questions:

- How do preceptors balance their responsibilities as nurses accountable for nursing services while at the same time being teachers, coaches, and guides to student nurses ?
- How do they teach clinical practice to student nurses?
- Do they learn from this process? If so, how, and what do they learn?

The narratives of the preceptors respond to these questions.

Appropriateness

The initial question that was posed at the outset of the study, “What is the experience of being a preceptor to undergraduate student nurses in an acute care setting?” is the opening question to begin a journey of interpretation in finding the answer. The participants’ responses to that question were audio-taped and became the focus for the text and hermeneutical analysis. The questions must be those raised by the text itself. There are many instances throughout the following data chapters that disclose how the text raised questions.

Contextuality

The historical and contextual nature of the text must be preserved. Chapters One and Two of this thesis situate the context in which the preceptors’ experience can be

placed historically and temporally. As stated, the preceptors in this thesis were practising at a very difficult time in the history of nursing and health care delivery in New Zealand. The data was collected at the peak of health care reform during the decade of 1989-1999. The context that situates the preceptors' practice reflects the pressures and the difficulties of that time.

Agreement

The account must agree with what the text says (not attempt a hermeneutic of suspicion), but should reserve room for reinterpretation by showing where previous interpretations were deficient. I take this to mean that my interpretations should reflect the words of the preceptor participants and reflect the horizon of their particular experience. I also have endeavoured to recognise that there are alternative interpretations that a reader may consider valid when thinking about the preceptors' narratives. I am an educator and a researcher but not a preceptor. Although I have inducted new nurses into practice as a registered nurse in former episodes of my practice career, my interpretations of the narratives are made within my present horizon of experience.

Suggestiveness

A good understanding in the interpretive account will raise questions that stimulate further interpretive research. The narratives of the experience of being-as preceptors to undergraduate student nurses certainly raise new questions. For example, "How would preceptors describe their learning from their practice from being-as preceptors to undergraduate student nurses?" Additionally: "What are students' thoughts immediately after being a preceptee and also, six or twelve months later?"

Potential

Benner (1994) stated that "the ultimate evaluation of the account lies in the future, in that it is capable of being extended, that is, insights, tact, and critical discussion are revealed and possibilities uncovered that can be illuminated for future events" (p. 80). I believe that this research offers potential for extending understanding of the phenomenon of being a preceptor. For example: "What is the meaning of partnership in nursing education and nursing practice?" Such a question has the

potential to illuminate the experience of preceptors, and describe what it means to work as a full partner in nursing education, sharing teaching-practice initiatives. It is possible that if preceptors and clinicians develop a deeper appreciation of the theoretical preparation required to deliver quality clinical education to students, closer exchanges between teachers and practitioners might be arranged in the future. The potential to explore the meaning of being a preceptor in particular circumstances remains an avenue for the future.

Summary

Being a preceptor can be understood only from the experiences that come from those who precept. The participants' descriptions of their practice as preceptors requires us to think about how preceptors precept student nurses as they learn nursing practice. Heidegger (1968) claimed, that what calls us into thinking provides the direction for thinking, and what ought to be thought provoking. He also stated, that which calls us into thinking, is that which draws away from us and must be brought into nearness. Therefore what it means to be a preceptor must be brought to our attention by bringing that which is furthestmost away from us into nearness. It is in language, that is in the participants' narratives, that the preceptors reveal their thinking about what it means to be a preceptor.

The meaning of being a preceptor is unravelled through the interview conversations with the fifteen participant preceptors in this study. I have listened and re-listened to these interviews and I have read and re-read the transcripts, to become attuned to the meaning for the participants of being preceptors. What follows are the relational themes, common themes, meanings, nuances and understandings that appeared to me to be contained in the crucible of being a preceptor.

Further, the internal rigour of the process has been explicated. It is through the transparency of the processes of the research methodology, that the reader can follow the thinking, writing and the rewriting inherent in the phenomenological hermeneutic method. In the following four chapters, the findings of the research reveal what it is like 'to be' a preceptor.

CHAPTER SIX

Becoming Attuned - The Call

In the inner tension between illumination and concealment, the elusive word can live. Hermeneutically conceived, the task of inquiry is not to dispel this tension, but to live and speak within it.
(Gadamer, 1976, p. 101).

Introduction

It is an early morning shift and a sleeping ward of patients is beginning to wake. The morning staff is gathering. They include the regular registered nurses as well as several casual staff nurses, and a sprinkling of student nurses. A cacophony of voices is heard, intermingled with laughter, loudness, and softness merging as those 'insider' registered nurses familiar with the ward culture prepare for the new day. But there is silence from those 'outsiders' who are not familiar with the situation. The incoming staff members get a 'feel' for what the day is going to offer as the 'mood' of the gathered people slowly settles. There is a sense of anticipation. And, as the day's events unfold, the 'mood' of the group impacts upon their way of 'being-with-one-another'. Moods, as we know, are both public and private, each influencing the atmosphere prevailing in any group situation.

As Heidegger (cited by Dreyfus, 1991, p. 171-173) claimed, moods "determine not just what we do, but how things show up for us" (p. 172). During the morning, among the group of registered nurses, there are those who will hear and 'hearken' to the 'call' for preceptors. For some of them, becoming a preceptor will be of their own volition, while for others it will be an unwanted imposition. Sensitivities will increase and reflect the private moods held by 'insider' registered nurses that conceal "the restless to and fro between yes and no" (Heidegger, 1966, p. 75) being experienced. An unspoken question influences their mood as they harbour the thought, "Will I have to be a preceptor today?" As they hold their breath awaiting the outcome, the preceptees also wait in the wings, in the "in-betweenness" (Heidegger, 1962/27, p. 461). This is the space that is best described as an "awaiting" or "until then" (p. 461); it exists between the time the question arises in the preceptors' minds and the preceptor/preceptee allocation. So the day begins.

What has been depicted, thus far, is a portrayal of the mood of the staff of an acute care ward readying themselves for the day's activities, especially with a mind to the precepting of the undergraduate student nurse assigned for clinical placement. This

context forms a backdrop for being as preceptor. The setting, the moods, and the experiences are illustrated in the stories of the participating preceptors.

This chapter begins the reporting of the study findings. The relational themes and the common themes revealed in the findings will be described in this chapter and in the following three chapters, Seven through to Nine. This chapter opens with a brief overview of the major Heideggerian concept “thrownness” (Heidegger, 1962/27, p. 173) that opens up the “clearing” (Heidegger, 1962/27, p. 171) within which preceptors’ functional activities take place. This beginning provides a background of understanding for discussion of the common themes that have been identified through textual interpretation. The themes which are explored are *Being Thrown, Unsettledness and Unfamiliarity, Leaping Ahead, Standing Alongside: Remembering being There, Restlessness – The Yes-and-No of Being a Preceptor, Being ‘Not a Proper’ Preceptor, and being a Preceptor: Its Reality.*

Being Thrown

Registered nurses, who became ‘participating preceptors’ in this study, are already “thrown” (Heidegger, 1927/62, p. 174) into the world of nursing practice. This ‘thrownness’ is an unspoken, unaware way of experiencing the everyday world around us. The familiar world for the registered nurses of this study is the context of caring for patients in the acute care setting. This “everydayness” according to Heidegger, (Heidegger, 1927/62, p. 38) is a pre-reflective, uncritical mode of “being-in-the-world”. In the ward context, to be called upon to be a preceptor often means a sudden change of plans and a sense of losing touch with the familiar or well known ways of being a practitioner.

Being thrown into being a preceptor requires opening up of the self to experience the unfamiliar, and preparing the self for uncertain ways of being. Those registered nurses who became preceptors responded to the ‘call’ of precepting simply because the students were ‘there’. As such, registered nurses who became attuned and who hearken to the call put themselves forward into a place where they no longer experienced an easy, or unthinking, everydayness in their familiar world. They moved, or were thrown into a place where they became aware that they were bridging two worlds, - primarily, caring for patients as a practitioner and secondarily, being a preceptor to an undergraduate student nurse and acting as a teacher and a guide. Behind the attunement lies self-consciousness. Heidegger (1962/27, p. 317)

suggests, that as part of the pursuit of self understanding for Dasein, “the call reaches the they-self of concerned being with others”. This then means that “being” becomes self-conscious, therefore, an inauthentic self (Heidegger, 1962/27, p. 169). The ‘call’ refers to the part-open field of possibilities and the way this is unveiled for preceptors (Kolb, 1986). Preceptors enter a new world that beckons but brings with it some ‘unsettledness’.

Unsettledness is an interesting concept. Dreyfus, (1991, p. xii) in his commentary on Heidegger’s *Being and Time*, (1962/27), referred to *Unheimlich* which is translated as “uncanny” (Heidegger, 1962/27, p. 342), but Dreyfus preferred to translate it as ‘unsettledness’. Both translations refer to a feeling of “anxiety”. “Anxiety”, as used by Heidegger, is to reveal the nature of Dasein and its world (Dreyfus, 1991, p. 177) that is “simple and whole”. Preceptors experienced some ‘anxiety’ related to a sense of not being at home in this new world of precepting. Participants disclosed their concerns about the restless movement between the two worlds of teaching and practice. So often, precepting began with little warning. The student arrived as the staff nurses came on shift duty. Suddenly, a student was ‘there’.

It was often left over to the registered nurses to volunteer to precept students. Offers to help came from those who were listening to the call, those who were willing. When the registered nurses came ‘on shift’, a general enquiry would be made as to who would be willing to take a student for the day. Dale (pseudonym) discloses how he became to be a preceptor under these conditions:

It always seems to be the case when we have students, “who wants to take this student” (laughs), and you seem to have a bit of sympathy for them, and you think, well, you know, rather than just land with somebody who doesn’t really want to take the student you say, “well, okay, I’ll take the student and maybe they’ll have a better experience”. So that’s pretty much it. When I see the students turn up I think, yeah, okay, I’ll give them a break (Dale, 1, 1).

In Dale’s statement, there was an implicit recognition of the literal meaning of being thrown rather than the Heideggerian sense of the thrownness of being with others in an unreflective mode of everydayness. Dale shows that students are thrown into the practice setting and they may “land with somebody who doesn’t really want” to precept them. Dale discloses a state of mind toward precepting students that appears open and welcoming, born out of empathy for students. But, what is the

nature of Dale's laugh? Could it imply that Dale sees the whole process as being perhaps embarrassing or uncomfortable? Is this discomfort born out of a memory of living those tense moments when Dale himself was the student waiting to see which registered nurse would be willing to be a preceptor? Could Dale's empathy be born out of the memory of that feeling? His statement that he will give the students 'a break' suggests that he, too, remembers what it was like to be a student and not welcomed in their clinical placement. Dale shows that a preceptor who is open and willing towards students is more likely to be encouraging to students and provide a good learning environment for them.

Jessie remembered all too well what it was like to be literally "thrown on to the wards". This feeling of "being thrown in" is different to Heidegger's idea of "thrownness". Jessie was very aware of the unsettled feeling that pervaded "being thrown in" and in order to prevent students feeling like she did, she showed her concern for the students by responding to the call:

I think the thing for me coming from the UK, I did my training in the old way, I was from the school, I was qualified in the School of Nursing so you were literally in a school. Not like now, you know, the universities and the polytechnics so, - ... and I found it quite an ordeal. I actually look back on my student days with some horror sometimes because I was just literally thrown onto the wards. I was never seen as supernumerary. I was a pair of hands and - and for me that's an experience I'll never forget. And one of the things that I did notice when I came here - I was horrified again that you didn't have this - obviously we changed and developed clinical supervision and preceptorship, so for a good few years in the UK I was a preceptor. And one of the things that I was horrified about when I came to New Zealand is that you have the same sort of thing that I'd experienced. And I thought "God! These poor students!" They used to come on in the morning shift - there'd be five of them - and they'd stand there and they were just ... "Oh! We've got students today! Oh! [J] Do you want to take one?" And then they'd have another person the next day. And another person the next day, and there was no continuation for them. I was quite horrified (Jessie, 1,1).

In the everyday use of the term, 'being thrown into' something means a sudden thrusting into a situation that one does not feel prepared for. The person experiences feelings of insecurity, some distress, unexpectedness, feelings of not being in control, or not knowing what to expect. For some, this would be distressing while others would find it challenging. To be 'thrown onto' the wards as Jessie was is not the easy experience of a relational everyday world of nursing practice as Heidegger's idea of 'being-in-the-world' implies. Jessie recalls an historical past and

senses an 'enduring' (Heidegger, 1977) of practices that would be best overturned. She is concerned that students still have the same experience in the present. She remembers that feeling of being a student and abandoned. It is an uncanny feeling and not forgotten. We gain an impression that the students are placed in a 'lottery' situation while the registered nurses in the setting decide who will take a student for the day.

Jessie paints a picture of the students coming onto a morning shift and just standing 'there'. Heidegger addresses "being there" in his discussion on the word *Dasein*. (Heidegger, (1962/27, p. 26). *Dasein's* "there" refers to a shared world. The preceptors' "there" includes sharing a world with patients and their families, doctors, nurses, student nurses, and other people involved in providing health care services. The shared situation is known as the "clearing" or situation. It is in the clearing that "Being" is unconcealed or comes to light. Heidegger (1962/27) claims that "*Dasein* finds that its being is an issue for it. Its understanding of itself depends upon shared practices" (p. 42).

For both preceptors and students Heidegger's use of 'the clearing' portrays the 'centred' way a particular *Dasein* or being-in-the-world is. *Dasein* also brings its 'there' along with it. That is, the preceptors bring whatever experiences they have had to date into the new situation. In particular, preceptors bring a wealth of nursing experience that comes from "being there" in the world of nursing practice. Students seek to learn the practice of nursing and expect to draw on this experience. As one preceptor put it:

When you're a student you look at this registered nurse and you think – [they] know so much, I know so little. ...And yet, as a registered nurse looking back, ... I think, yes, that is right. But now is the opportunity to tap into that person that knows so much and have the person that knows so much teach the one that knows so little (Lee, 1, 3).

Phenomenologically, students enter a world of nursing practice with a network of relationships that for them is at first unfamiliar, but gradually they come to understand themselves as part of that world where they will feel at home. Eventually it will become to them a shared world of skills and practices acquired through being-in-the-world of nursing practice. This supports the situatedness of *Dasein's* 'being there' (Heidegger, 1962/27). Jessie's experience of temporality, or lived time from the past, helps her to understand how the students may feel in the situated context.

Her memory, which to Heidegger is the gathering of thought, is one of bringing back feelings of dread. She has become attuned to 'being there' and responds to the call. The kind of tensions inherent in 'the call', portray the state of mind or 'mood' of the preceptors as they live the tensions between caring for patients and caring for how students learn to be a nurse.

Unsettledness and Unfamiliarity

In this study the preceptors were clear that unsettledness was perpetuated by unfamiliarity with being a teacher. Many spoke of being unsettled simply because they were unfamiliar with the world of nursing education from the teacher's point of view. Much of this is due to the transfer of undergraduate nursing education from the hospital schools of nursing to the polytechnics in 1973 and to the universities in 2000. The changes that New Zealand has experienced are now a reality throughout the international world of nursing. For example, the United Kingdom introduced Project 2000 to address the revisioning of nursing education. Change has challenged many. The change from a hospital based 'training' to institutes of higher learning has resulted in a perceived service-education gap (Rosenlieb, 1993). Rosenlieb notes that preceptorship programs are now "commonplace" (p. 258) in the United States of America both for nursing education programmes and for new graduate orientation, to ease the transition from student to beginning practitioner. For me, the question arises "Could it be that preceptors are saying that their 'unsettledness' arises from a service-education gap"?

Whatever the reasons for unsettledness, preceptors spoke of their first involvement with students and how difficult it could be for them as preceptors. Part of becoming attuned to the call was not understanding what they were required to do as a preceptor. Sarah, an experienced nurse, shares her experience:

My first involvement with students [occurred] during the first round, and I was still finding my feet myself¹⁸. I found that quite difficult ... as a hospital trained nurse, ... until I talked to them a bit and found out what their experience was in their first year. I found it quite surprising that their nursing skills were actually extremely limited. And I expect it's just the way the training is organised and they haven't had the opportunity to practice them. (Sarah, 1, 4,5)

Sarah instances well the mood of 'unsettledness' and the uncertainty that evokes it.

¹⁸ Finding one's feet is a colloquial expression meaning still becoming competent in the job.

Uncertainty and concern are intertwined. There is some hesitancy therein. Feelings are strong, especially since she herself, is still finding her feet in practicing as a preceptor. This unsettledness comes from a feeling of dissonance, or being caught up in a web of uncertainty, without knowledge of what students have learnt before coming to the ward. Unsettledness is connected to not knowing, and being unsure about expectations of clinical teaching and learning. Although the lack of understanding gave rise to anxiety, nevertheless nurses felt someone had to teach the student and be prepared to guide and support a student engaged in clinical learning.

Sarah was not alone in experiencing her mood of 'unsettledness' owing to unfamiliarity concerning the polytechnic/university nursing education programs and the way "the training is organised" (Sarah, 1, 4) within those systems. In New Zealand, all students of nursing enter degree programmes within the general education system (Nursing Council of New Zealand, 1999a). Contemporary nursing education programmes are founded on different philosophical bases when compared to the historical hospital training apprenticeships. The latter were designed to meet the service needs of the organisation. Hospital programmes originally were based on a biomedical model with a disease focus. In contrast, nursing education programmes in the general education system are founded on the student being primarily a learner gaining a professional education and status.

Several preceptors had trained in hospital based programmes and had come from countries other than New Zealand. They were unfamiliar with the assumptions that underpin traditional degree education organised according to a technical-rational model of nursing education (Schon, 1987) where theoretical and abstract knowledge is valued over practical knowledge. At the same time contemporary students are first introduced to the nursing models of health and high level wellness, before ill health and sickness are studied (Taylor, Lillis & LeMone, 1997). Initially, students learn to promote health and prevent illness in community settings, rather than focusing first on caring for people with illness.

Nursing education has changed to respond to societal needs for universal health care. This has meant preparing graduates who will facilitate shifting care from hospitals to community settings (National League for Nursing, 1993). In the present day, nursing education focuses on community-based, consumer-driven health care at the primary, secondary and tertiary levels. In order to facilitate this move, nursing

students need to be skilled in critical thinking, collaboration, shared decision making, social epidemiological viewpoints, and analyses and interventions at the systems and aggregate levels. Hospital trained preceptors may not be familiar with these requirements.

Also, in the first year of their nursing education students learn foundational nursing skills in the demonstration room and practice these in residential homes, as they work with older persons meeting activities for daily living (Roper, Logan, & Tierney, 1996). Novice nurses provide holistic services for persons in need in a community context. Thus for many students, the first time they enter a hospital environment is when they are commencing the second year of their nursing education. In contrast, in hospital based programs, students are immersed in the hospital setting from the beginning of their training so they quickly become socialised to ward settings. Sarah discloses her uncertainty about how “the training is organised” (Sarah, 1,3). While there have been many changes to nursing education a clinician may not understand the full meaning of the change because, as a clinician, she is not at home in the world of nursing education.

Heidegger (1976), Benner (1984), Benner and Wrubel (1989), and Diekelmann (1989, 1990a, 1991, 1992, 1993a) were all emphatic that since ‘change’ is a constant, it is essential, always, to explore possibilities for new ways of ‘being’. In the previous exemplar Sarah makes clear that, as a skilled practitioner, it was vital to deal with reality which, in this instance, is the transmission of the skills of nursing practice. As an expert-in-practice, although she is unfamiliar with the new nursing education she determines the student’s learning needs and identifies prior levels of experience. That experience though is likely to have been gathered in very different ways from her own. As an example, a student’s starting point may have been working alongside a registered nurse in a rest home. Many students begin learning nursing as nurse aides. This not only gives them first hand experience in caring for people but also provides some understanding as to what nurses do. Many students continue working in a rest home during their nursing education to assist them in paying their fees. This has a dual benefit. The student benefits financially, but also the experience prepares them for caring for patients. In an acute care setting where patient care is the central focus, the student who has had prior experience is an advantage to Sarah as a preceptor.

Leaping Ahead

Leaping ahead is a very important notion that signifies an ability to 'look around' and see the bigger picture rather than just focusing upon the immediacy of the demands in the present. Diekelmann (1991) suggests that meaning is about an ability to look 'upstream' to see what is happening in order to act appropriately in the present. Leaping ahead promotes learning that enables growth of the learner, unlike 'leaping-in' which, however well intentioned, takes over or 'does for' the learner. Leaping ahead leaves the learner 'free for' learning possibilities and fosters independence in learning. Sarah discloses that, as she became attuned and gained more confidence in her preceptoring, she leapt ahead to structure a meaningful learning context.

And so I had a talk with my charge nurse and actually got together a student guide for them to do, because I felt, not these huge expectations, but I felt what they're actually getting was very scattered bits of knowledge, and there was no coherency to it, and unless they were pretty bright, they weren't going to be able to string it together in a way that helped it make sense to them (Sarah, 1, 4).

In the absence of structured guidelines from the educational institute for student learning requirements, Sarah attempts to fill the void. Sarah shows her dedication to nursing as a profession and to the neophyte nurse by leaping ahead to find ways of assisting student nurses to structure their clinical experience. Her goal is to provide some meaningful links between the patients they are looking after and developing the student's clinical knowledge. She attempts to provide a focus for herself and other preceptors. Sarah continues:

The aim was that they should leave the ward with a good understanding of ischaemic heart disease and congestive cardiac failure. [The student should understand] the definition, signs and symptoms, causes, how you make the diagnosis, the treatment, and complications, and tying that in with the patients that they actually look after, using the nursing manuals to access [information] right from the word go. "Oh! They're going to have a cardiac catheter? Get a book and bring it down, see what they're going to do for it!" [I teach them to] use notes, get them into the habit of using the reference aids that we do have available, looking for drugs. They've got some work that they can actually do independently. They've got some idea of which way they're heading. And I mean, there're other things that crop up, but that was kind of the idea and it's very simple, but it just starts on day 1, day 2, just sort of have the objectives every day. But that's what the aim is ultimately (Sarah, 1, 4).

Sarah leaps ahead and seeks to give students a sense of independence and purpose in their clinical placement. Students in this situation learnt the medical diagnoses and conditions, signs and symptoms, treatment, and complications in order to understand the patients' experience of illness and the rationale for their nursing care. They also learnt valuable skills such as accessing information in the ward, the nature of specialised treatments, and what these meant for the patient.

What is concealed is the difficulty, for in "leaping ahead" Sarah may take over what students should be learning. Heidegger (1962/27, p. 159) refers to the notion of "leaping ahead" as one of liberation for the person to be free to be themselves. In so doing, this then frees others to realise their potentiality-for-being. Students who are given specific objectives each day are not in fact free to be themselves, as they are being directed by others, albeit with the best of intentions. In this situation, a paradox (Ross, 1991) is created. Preceptors may give students learning experiences that may or may not be related to their theoretical experience to date. It is possible too that, at an organisational level, the programme of the ward may be at odds with students' clinical learning objectives. Students could therefore be working on two separate schedules for learning, one for the polytechnic/university and one for the ward. This could be both taxing and confusing for students and may jeopardise the attainment of scheduled learning objectives. On the other hand, Sarah leaps ahead as she is facilitating students' learning for the real world of nursing practice. The question arises, "What matters most?"

Sarah, as preceptor, in her concern for student learning, seeks to provide meaningful and related learning in context. As an experienced registered nurse who knows and understands the practice of nursing, she also prepares the student for the reality of the real world of nursing practice. What is concealed to Sarah is that there is an in-between. As an alternative to the technical rational model of nursing education, Diekelmann (1988) pointed out that a phenomenologic model of curriculum searches for some understanding of the world of 'Being' (Heidegger, (1962/27). In Diekelman's view, the use of a phenomenologic model "creates a focus on the lived experiences of clinicians and on introducing students into the clinical world" (1988, p. 142). The orientation is toward the here and now of the situation where the preceptor and the student are central. The rules for understanding meaning are actively constructed by those who dwell within the situation.

Being a preceptor is not an issue for Sarah. She does not imply that she is unwilling to be a preceptor nor that she is unable to meet the challenge. Rather, what lies at the root of her unsettledness is her unfamiliarity with nursing education, which makes her question what she should be teaching the student. She is uncertain how best to meet students' learning needs. Sarah is an experienced nurse, confident in her own practice, but unfamiliar with how nursing education is organized in comparison with how she herself was taught and no doubt, taught herself through experience on the wards. Sarah is aware of ambiguity in the situation and seeks to be "there" as a preceptor and find possibility in the situation (Heidegger 1962/27, p. 219). The question arises "How can nursing education and clinical agencies reduce ambiguity for both preceptors and student nurses?"

Standing Alongside: Remembering being There

However, not all preceptors came from hospital based educational backgrounds. Another way of becoming a preceptor was being familiar with contemporary nursing education programmes. While some registered nurses responded to the call to precept students they were not yet attuned to becoming a preceptor. Some preceptors were beginning registered nurses themselves and well able to remember what it was like to be a student. Memories triggered notions of standing alongside as Kate discloses:

I probably started precepting when I was still quite a new grad myself, when I started in my new job probably. ... About 5 months into the job I unofficially precepted a few students, just a couple of days here and there, and it wasn't probably the ideal situation. I was reasonably comfortable on the ward but ... I hadn't really got to know the job. I actually had a very good new grad preceptor, so I think just mainly because of that I had a better start than most. I think because I hadn't been out for terribly long it makes my perception of being a student better, slightly better. I'm not that far removed from tech, and I do remember what a struggle it was, and how annoying it was to have to check every Panadol, or whatever, with your preceptor. I missed out on the preceptor thing; they hadn't started that at Tech. (See footnote p. 18). (Kate, 1, 1).

Kate is aware that she had not yet come to know 'the job' herself. This was helpful in so far as she could think backwards to when she herself was a student in terms of her practice. In this way she reminisced and recalled 'what a struggle it was' to be a student. Kate also had a 'good preceptor' as a new graduate. Kate's expectation of students are likely to be tempered by her own experience of being a student in the

not too distant past and her own experience of having a 'good preceptor' as someone to emulate. Her own experience is likely to influence how she, in turn, precepts students.

Kate also implies a memory of not feeling ready to precept students because her own practice had not developed sufficiently to precept another. She implies feelings of being ill-prepared to be a preceptor and this was expressed by a number of the study participants. It is likely that her taking up the position of being a preceptor at only five months into 'the job' was due to a need for a preceptor there and then, most probably related to the skill mix of staff available to precept students in the immediacy of the situation. As identified in Chapter Two, staff and skill mix were severely hampered by the impact of the health reforms on the clinical context. As well, the Nursing Council of New Zealand Standards for Education for students undertaking Comprehensive Nurse Education (1999a) require that undergraduate student nurses have a registered nurse as a role model. Therefore only registered nurses could precept undergraduate student nurses.

Kate identifies other issues in her narrative. First, she remembers her perception of being a student and the close supervision that is required. Second, she acknowledges that close supervision, at times, can be frustrating to students who sometimes feel they do not need to be so closely supervised. She also observes that she missed the "preceptor thing" which had not started at the polytechnic. She refers to the movement through polytechnics and more recently, through universities and hospitals to introduce preceptor programmes to prepare registered nurses to become preceptors. While there were few preceptor programs in New Zealand there was, however, recognition of the need for such programs. What Kate shows is that she is open to being a preceptor although she felt inadequately prepared. Kate also understands what it means to be a student. Fears and anxieties experienced by students in the frightening world of nursing practice (Windsor, 1987) are a reality that she has not moved too far from.

Restlessness – The Yes-and-No of being a Preceptor

A theme of reluctance to precept undergraduate students is disclosed in a number of interviews. Potential preceptors were diffident about responding to the call although they appreciated the need to teach students. Reluctance seemed to stem from not knowing what was required by the educational institutions. This created a

restlessness, an ambivalence of understanding the student's predicament, but not wanting to be involved, because of not knowing how to be a clinical teacher.

Kate, Dale, and Lee disclose that precepting students is often left up to them as new registered nurses because they are more likely to know what the polytechnic/universities' nursing education programmes require for student nurses. They know what it feels like to be 'unwelcome' and what that can do for students who feel nervous about their clinical experience. Because all three can remember what it was like being 'there' as students, and knowing that, as students, they were not always welcome on the ward, they hearken to the call to be preceptors.

I had one of the more mature nurses on the ward make the comment, we'll get you to look after a student because you know what's required at the polytech. Not through having any preceptor training or anything like that. Like I said before, sure I haven't been registered long, but I think in some ways that was a sort of "passing the buck attitude" of that nurse because they didn't want to have to take the hassle for the student because I know students turn up on the ward. We've all been through it, those of us that were polytech trained, and even some of the girls that went through the old hospital based training scheme, they said it was very much "Oh no! Here's another student! Who's going to take the student?" And for a person that is nervous coming to a new environment, that's fairly demoralising (Lee, 1, 1).

Lee reveals that the qualification to be a preceptor, in this instance, is that he knows "what is required at the Polytech." It is easier to respond to the call if you understand how to do the job. Knowing what is required at the polytechnic/university therefore has become an important ingredient in the preparation to be a preceptor. Additionally, the idea of 'looking after' the student would suggest that his registered nurse colleagues could see students as requiring 'care'. Such an attitude implies a nurturative or 'mothering' approach to students. According to Heideggerian philosophy, the basic way that we are in the world is one of 'care'. Therefore the way students and preceptors are in the world of nursing practice is one of "care" (Heidegger, 1962/27, p. 235). For Heidegger, we exist in terms of the things that we care about and "for-the-sake-of-which" (Heidegger, 1962/27, p. 116) we act to achieve our purposes. Could it be that registered nurses see student nurses as requiring 'care' as do their patients? How can registered nurses come to appreciate that students are part of the new generation of registered nurses? As such they are an integral part of the world of nursing practice and their educative experience is of importance to the future of nursing as a profession.

Lee acknowledges that his selection to be a preceptor by his colleagues was “not through having any preceptor training or anything like that.” This illustrates the tension between the yes-and-no of being a preceptor. Lee has a clear understanding of himself in the situation and being the authentic self is important. (Heidegger, (1962/27). Lee, in the fashion of being open and true to himself, seemingly questions his own skills and expertise to be a preceptor for he has not “been registered long”. He indicates he feels ‘dumped on’ by his colleagues. Lee describes this as “passing the buck” because others did not want “the hassle” (Lee, 1,1) of having students. He implies that he has been on the receiving end of feeling “not wanted” on the ward and recognises that, for students who are “nervous”, such an attitude is sufficient to disadvantage them in their clinical experience from the beginning. Conventional pedagogy would suggest that such an attitude is not conducive to ‘good learning’. Lee continues with his story:

I’ve been so recent out of polytech myself, been registered for not too long, I still can understand where they’re coming from, confronted with a new environment, and for some it’s the first placement, coming to a busy, very busy, very heavy medical ward, that sometimes can be understaffed. And, they’re suddenly confronted with, “My God!” I’m now representing the Polytech and myself. And I say to them “Well! What do you have to learn? What is in your clinical guidelines? What are the expectations that the Polytech has of you?” [That’s] to then pass the onus back onto them to try to get them to learn to start thinking “Ooh! This is what I’m supposed to learn” (Lee, 1, 1).

Lee’s use of the word “confronted” is interesting. Collins Dictionary (1987) describes ‘confront’ as being faced with a crisis, or being in a battle zone. For students it is like coming face to face with ‘reality shock’ (Kramer, 1974). Placing students in wards in the situated context of an understaffed, very busy, fast moving and changing ward, can be so overwhelming that they literally do not know where to start. Lee clarifies the use of his term “confronted”:

I don’t really know if confrontation is the right word, but in some ways it could be fitting for the environment of coming into a very busy, very acute medical ward. And initially, the dependency of the patients was a shock. I think it is part of the reality shock that we all get told about at tech and that until we actually face it, we don’t really think it’s that bad. And the student came in and for the first two days was just bamboozled by what was happening on the ward and the acuity (Lee, 1, 2).

A feature of the clinical environment as stated at the outset was that upheaval as the health reforms in the New Zealand health care system impacted on the day to day reality of nursing practice. Lee confirms the context of his reality:

Six patients plus a student is quite a load, particularly when you have patients going for procedures. And we can be receiving patients from the high dependency area as well as receiving patients from GP referrals into the ward. Because when patients are received the doctor will have been rung - the registrars or consultants - and the situation will have been explained. Then we just get this patient. We don't know what sort of condition they're going to be in. Some patients could come in walking off the street with their bag packed, just for an overnight stay, whereas other patients may come straight in from the GPs on a stretcher with ambulance officers yelling and screaming in all directions. So — then you've also got the student. (Lee, 1, 7)

Lee's choice of the word "confronted" could be interpreted within Heidegger's claims that we undergo an experience with language. Heidegger (1971, p. 57) states " If it is true that man finds the proper abode of his existence in language – whether he is aware of it or not – then an experience we undergo with language will touch the innermost nexus of our existence". Interpreting Heidegger in relation to Lee's situation would suggest that, in Lee's "innermost nexus of existence" the term 'confronted' presents the ward context as a 'war zone'.

Lee believes that the students are "confronted" with an understanding of who they are in their clinical context. Yes, they know that they are a student but no, they do not know what this means in the real world of practice. The knowledge that they are "representatives" or ambassadors for their Polytechs can be a shock to them. He is clear that the student has an understanding of their responsibility in being a preceptee. He qualifies this statement later in his interview:

I've stressed to students that I have worked with on many occasions, I said "you are a student, I'm a registered nurse — you are practising on my registration. That idea was reinforced and drummed into us at polytech. Think yourself grateful that you actually have a registered nurse that will take you on! And for God's sake! Don't stuff it up because they are the ones that will carry the can!" And ultimately we will carry the can (Lee, 1, 8).

Lee highlights that part of being a preceptor is to make students aware of their responsibilities. That is, that they are representatives of who they are and where

they have come from. They are *dasein* or 'being there' between the world of education and practice. Both carry with them a way of being. That way of being has purposes and concerns. These concerns require them to face up to the privileged position they hold. They are practising or learning to be a nurse in the real world of nursing practice on a registered nurse's registration. Preceptors recognise that this leads to restlessness among their colleagues. This restlessness stems from a reluctance to allow the student who is learning, and who could possibly make a mistake, to practice "on their registration". If they volunteer to be a preceptor then they must face up to the responsibility that the student as a novice in the world of nursing practice is fallible.

Lee is a product of contemporary nursing education and understands that, according to andragogical learning principles (Knowles, 1980), students are motivated to learn to meet meaningful learning goals. Nursing education programmes are conceived and taught within an andragogical learning framework which teaches students that the responsibility for learning is theirs. Lee implies that this awareness should be sufficient for students to focus them on their learning. However, Lee galvanises the student into action by focusing the student on their learning needs.

The theme of *Restlessness – The Yes-and-No of Being a Preceptor* is underpinned by not knowing what should be taught and knowing that students are there to be taught. The issue perhaps is how has "knowing what's required" (Lee, 1,1) come to have so much importance in contemporary nursing education? Who develops the clinical objectives for students? How are the clinical objectives selected? Who is involved; the clinical lecturers, students, preceptors, or all three? What are the advantages and limitations of all these possibilities? If developing clinical objectives was not the major area of concern for clinical lecturers, would preceptors feel that they did not need to know 'what is required' of polytechnics/universities?"

Underlying the tensions is the issue of 'preceptor preparation'. Whereas the preceptors who are recent graduates disclose a lack of preparedness to be a preceptor, there is an alternative issue. A paradox is created, - new graduates feel insufficiently prepared to be preceptors, but they are perceived by registered nurses to be better prepared than hospital-based trained registered nurses because they know how the polytechnic/universities programmes are conceptualized. Senior registered nurses who are experienced practitioners who know best "the job" (Kate, 1, 1) are supposedly unwilling to precept students because they believe they do not

understand “the way the training is organised” (Sarah, 1, 4). The contradictions increase the pressures on preceptors. Although the common understanding of the term ‘paradox’ suggests an either/or position or a polarity, Ross (1991) has suggested an alternative interpretation.

Paradox is in reality a continuum, an integrated unity, whereas a dualistic view of the same material deliberately excludes essential elements that make up the whole. Paradox can be seen as “both-and” and dualism as “either/or”; the elements of paradox refract off each other; they are inclusive of each other (p. 44).

Those registered nurses that undertook nursing education prior to the nineties before the advent of degree programs could feel that there is an education/practice gap that impedes their ability to precept student nurses. This perception could be part of the “hassle” (Lee, 1, 1) seen with being a preceptor. A “hassle” implies annoyance or trouble (Collins Dictionary, 1988, p. 458). This hassle leads the preceptor to struggle with being a preceptor because they are poorly prepared for the role, if at all. These registered nurses do not seem to acknowledge that they ‘know’ the practice of nursing. On the other hand, new practitioners ‘know’ nursing education but do not necessarily know, as yet, the practice of nursing. Ross (1991) suggests that this paradoxical position can be a continuum and include both. The question arises: “How can clinical education be managed to overcome being a “hassle”? (Lee, 1, 1). “How could being a preceptor become a desired and sought after experience by preceptors and clinical agencies”? “How can we best prepare registered nurses to precept undergraduate students”?

If the hospital-trained registered nurse can respond to the call to be a preceptor, the experience is likely to be positive. Over time the restlessness inherent in taking on a new role recedes and is replaced by a sense of reward. Unlike other participants in this study, Jessie brought to the situation her prior experience as a preceptor. As an experienced preceptor, she discloses what she has learned about being a preceptor:

One of the things I’ve learned about being, about a preceptor ... I love that sort of one to one. I really enjoy that one to one contact, especially now because ... a similar thing happened in the UK, I’ve actually had a student for I think it’s about 8 - 10 weeks and now she’s come on as a new grad, and that continuation has just been amazing. And the thing that I’ve learned, we’ve developed such a wonderful relationship. I mean, I know she sees me not only as a preceptor but as a mentor as well, and I know that ... with that

relationship she can come to me with any problems. You know, the other day something was going on at home and she could come to me and she spoke to me about it. And I think that's one of the nice things that comes out of that one to one in preceptorship (Jessie, 1,1).

Jessie's statement reveals that, for her, the value of being a preceptor lies in the quality of the relationship developed in a one-to-one situation. The one-to-one relationship is a characteristic of preceptorship, which is consistently cited in the literature (Chickerella & Lutz, 1981; Myrick, 1988; Rosenlieb, 1993 Shamian & Inhaber, 1985). Knowing and connecting between preceptors and students is a concerned teaching and learning practice (Diekelmann, 1996) that is an important part of a caring and beneficial nursing education experience. Jessie confirms that relationship building is a personally satisfying part of being a preceptor.

Being 'Not a Proper' Preceptor

Not all preceptors lacked preparation to be a preceptor. Some had undertaken a preliminary preparation. Florence discloses how she became attuned to being a preceptor:

(It) was half an hour, not even that, probably 15 minutes with a lecturer. I don't know who it was, saying here's the information, here's the booklet, here's what we teach, we do this preceptor triangle, you know, model thing, there it is, yada yada, read it, here you go, bye. So of course it got filed (laughs) where everything else gets filed that isn't immediately relevant when you're working full time and studying yourself. And I found it about 6 weeks after that particular student had left, I have just read it for the next one. I haven't been sort of a proper one (Florence, 2, 4).

What Florence discloses is that her lack of time to read and comprehend the information she received disadvantaged her and she feels that she has not been able to be a 'proper' preceptor. The hurried preparation epitomises the priority order that she was able to give to her preceptor preparation when compared to her more important work of patient care. The question arises, Does a registered nurse need to read a model on how to be a preceptor in order 'to be' a preceptor"? Heidegger (1927/62) would not have us think so. Being-as preceptor is a way of being and therefore a way of *Dasein's* 'being-in-the-world'.

An idealist philosophy of education stresses ideas as the centre of specific subject

matter. According to this philosophy, a preceptor will learn how to be a preceptor, from having a good grasp of the specific subject matter related to being one. This form of learning is 'idea centred'. It is a conventional teaching/learning theory (Benner & Wrubel, 1989) and is used extensively as a theoretical basis for educational programmes. An extension of this philosophy focuses on the learner and the environment where learning will take place. The student must want to reach out and learn. Idealists emphasize that one cannot know the real world as it really is. Conceptualisations are therefore helpful to assist us to 'know' reality theoretically to prepare us to control our environment. Likewise, the learning environment must be structured to assist a learner to learn and gain knowledge. In this view knowledge is incremental and builds upon relevant structures (Ausubel, 1968). There must be a time and a space put aside to optimise learning. Further, learning is measurable and is evidenced in a change of behaviour (Tyler, 1949). From this perspective, Florence fell far short of the ideal. She did not even have time to open the material for her to contemplate the ideas that were to instruct her how she should become a preceptor.

To carry this ideology further, in the androgogical perspective (Knowles, 1980), time should have been set aside to introduce the model to the preceptors. The introduction should have been at a leisurely pace in order for them to have time to assimilate the information, ask questions and then to think about the concepts within the model. They should then have had time to reflect on the fit with their current practice. Such a model sits apart from the real world of nursing practice. Though features of the model might appear relevant but it must be tested in the reality of the practice world in order to gauge how it fits with reality. The hustle of the preceptors' day to day activities made such an approach irrelevant for they did not have time to try the fit of the model to their preceptor practice. If formal preparation of preceptors is to have any value, the preceptor programme will not only take time, but also, must be meaningful to those who wish to undertake it.

Being a Preceptor: It's Reality

Preceptors stated that they did not always have a choice to precept students. It could be said that the organisation demanded that some preceptors respond to the call. At the same time there were some staff on the ward who refused to precept students at all. That meant that those who did not mind precepting students, those who were attuned to students, were given responsibility for them. Robyn discloses:

Because I am a senior nurse on the ward, often you don't actually get a choice about being a preceptor, whether it's for students or a new graduate. We have students every couple of months. There have been a couple of staff nurses on the ward who just refused to be a preceptor, for various reasons. And so that leaves it for the rest of us. And it is very tiring, very exhausting, to always have someone there with you. Especially in the early days, when you're trying to sort out where they're at and how they practice, and you know, what their understanding is, because everybody's at a different level. Even if they're 3rd years. But you always have to – I mean I know that you should always practice to the best level every single day that you're at work. But when you have a student you have to really, really be careful what you do. Because you know that someone is watching you, and you are a role model. And, you know, they can easily pick up bad habits from watching someone who doesn't do things properly (Robyn, 1,1).

Robyn raises a number of issues about the reality of being a preceptor. First, she identifies that there is a lack of choice whether to be a preceptor, observing that some registered nurses 'refuse' to be preceptors. But because of the need for preceptors for students the willing staff nurse takes up the responsibility. Robyn also discloses the unsettling feeling of being closely watched, and the responsibility that this entails. The responsibility of being a role model for students is well recognised both in literature and in Staff Nurse job descriptions. Robyn also identifies what this responsibility means. She must always be meticulous in her practice, because she is conscious that the novice is watching and learning. She feels the weight of this mantle not only in preparing the new nurse but in maintaining standards of nursing practice as a professional accountability. The mantle is heavy at times and can be exhausting. Role theory (Bandura, 1977, 1986) is contrary to an ontological way of being in the world. When one adopts a role, one becomes something. Role theory involves a more experienced nurse demonstrating desirable professional attitudes and behaviour to a less experienced nurse (Bastable, 1997). This is a different idea to being-as something (Heidegger, (1962/27). In Heideggerian terms, Robyn lives her 'being-as' preceptor as a way of being-in-the-world. "Identity" for Heidegger is the appropriation of one's Being (Heidegger, 1969, p. 39).

Simultaneously, as Robyn discloses, preceptors sense that they are being watched by students but they are also "keeping an eye on" students (Sarah, 2, 2). Watchfulness phenomenologically is a form of 'concern'. This concern is a shared experience. 'Watching' is a part of learning as students develop their clinical

expertise (Rummel, 1993). The experience of being watched brought the preceptors' practice into awareness. Once preceptors were self-conscious about their practice, they experience their practice as "unready to hand" (Heidegger, 1962/27, p. 103) and the everyday feeling of being at home in the world diminishes. Further, to be 'thrown' into the world phenomenologically is how we are within it pre-reflectively. It is so absorbing as part of our everydayness, our actions and interactions are transparent to us (Heidegger, 1962/27, p. 233). Once a preceptor felt self-conscious about their practice, perhaps the most tiring of all is that the preceptor is not experiencing the everyday mode of 'being-in-the-world'. Rather it is because they are experiencing themselves consciously as 'being thrown' into a new world as a preceptor. This new world was 'unsettling' to them as they did not feel their authentic self. This reflects a world in which they are not feeling 'at home' (Heidegger, (1962/27, p. 234).

Another significant issue that emerged was having continuity for students. This was controversial. Not all preceptors believed that continuity was important. Some felt that although there were many advantages in having continuity, there was also disadvantages. Some stated that it was inevitable that there would be a reduction in continuity because of the preceptor's and the student's different time-tables. Sue states:

Often they don't get the continuity of the preceptor because with morning and afternoon shifts, their shifts don't correlate with anyone else's really. So they have all kinds of people precepting them, which is – probably, not ideal in one respect, that they don't get continuity, but in another respect it's probably quite good. They get different viewpoints. They've not just got one person's opinion being told to them. By having different people with them they learn different things from different people, which I think is good (Sue, 2, 2).

In conventional pedagogy relationship building and providing continuity for the student creates a better learning environment than a discontinuous stream of different people who will have different styles of teaching and guiding students. On the other hand, Sue embraces innovation. Phenomenologically, part of our 'thrownness' is relating to others in a shared world. 'Being there' with others, means a whole range of ideas and practices will be shared. Sue believes learning different things from different people is an advantage for students rather than their being confined to one preceptor holding one opinion. In contrast, Jessie believes one on one relationships have many advantages as they assist the preceptor and the

student to relate to one another as people first. Jessie understands that nurses are real people with real people problems that can impact on how *Dasein* is in the world. Both viewpoints are part of the paradox as outlined by Ross (1991).

Another part of becoming attuned to the call and understanding the meaning of being a preceptor was the realisation about busyness and temporality. There were times when preceptors just simply did not have time to precept the students, as patient care took priority. For the preceptors this experience brought some surprising outcomes:

When I was working on one ward, we were busy, it was the tail end stage of winter and we were flat stick. And for the first three days all the student nurses did was basically, essential cares. We didn't have time to teach them anything else because we were busy. And the students were told that you're going to be going into a busy area. It's a busy time of year. The ward that you're going to is short staffed. We, at that stage actually said, "Look, we can't take students!" But it actually turned out to be really beneficial, both for their learning and for ours also, because it showed us that what we were teaching the students just through the course of our normal day to day work and duties, they were actually able to learn (Lee, 2, 4).

Diekelmann (1988, p. 146) points out that "clinical knowledge cannot be taught; it can only be demonstrated. It is personal, and it can only be acquired through experience. Thus expertise in nursing education is the use of 'knowing that' knowledge to aid the development of 'knowing how' knowledge in the context of nursing practice". Lee shows that students learn in spite of preceptors not having time to teach them how to be in the world of nursing practice. He explains that the nurses were "flat stick". By this he means very very busy. Temporality as lived time taught Lee that students learn just from being part of the world of nursing practice and this experience can be mutually beneficial.

During the dialogue with participants it was clear that there are changing expectations of the preceptor. Some preceptors had been part of a formalised preceptor programme to prepare preceptors better to precept students. Emma shows that she is aware that assessment of students' clinical learning is a new expectation of her as a preceptor. She shows this in her statement:

I think it was hard for the first time because I wasn't sure what to expect, It's been a while since I was out of Tech. and it wasn't our

role anyway. Our role hasn't been as an assessor of students and that was partly what was expected of us as a preceptor. So it was hard to know what was expected of them for us to actually assess and to know how to direct them to get what was expected really. I think we sort of just did the best we could and as I've gone along and had a couple of other students I've found that side a little bit easier (Emma, 1, 1).

In spite of a brief preparation to be a preceptor for some, preceptors spoke about the difficulty and the uncertainty of the expectations for their practice. Many of the preceptors referred to their own preparation as nurses as being the only guide for them in their practice as preceptors. Emma says, "it's been a while since I was out of tech." With changes to the clinical work environments for registered nurses and to the working environment of clinical lecturers, Emma identifies that there are new expectations of preceptors. She says "it wasn't our role anyway – our role hasn't been as an assessor of students and that was partly what was expected of us as a preceptor" (Emma, 1,1). Emma alludes to changes that have taken place in nursing education and discloses that the memory of her own nursing education programme is no longer sufficient.

Again, the paradox surfaces. The clinical lecturer is accountable for the assessment of the student (Myrick, 1988), and this position is consistent with the literature from countries other than New Zealand. Educational institutes (Education Act, 1989) are accountable for ensuring the competence of the graduate exiting a programme (Benner, 1984; Nagelsmith, 1995; Nursing Council of New Zealand, 1999a; Swendsen Boss, 1988; Toliver, 1988). That accountability requires clinical lecturers to guarantee that their assessments of students are grounded in the normative practice of clinical agencies. This situation has become increasingly important owing to the ever-expanding ratio of students to clinical lecturer. The clinical lecturer nowadays has little time to spend with each student and therefore relies more heavily on the preceptor to gauge how the student is progressing. Clinical lecturers and preceptors have given the preceptor a voice in the assessment process to ensure that students are safe in their practice. For the most part this is an informal process. At the same time students are keen to be competent and safe in their practice to ensure their registration and employability.

However, Emma points out is that "it was hard to know what was expected of them for us to actually assess" (Emma, 1, 1). Like Lee, Emma intimates that she did not know what the student's clinical objectives were and therefore she did not know

what was to be assessed to show the student's learning. Emma's statement suggests that she does not 'feel at home' in her precepting regardless of being briefly formally prepared. She also implies that she feels alone in her precepting.

As already pointed out, technical rational models of nursing education emphasise knowledge as a correspondence between theoretical concepts taught in the classroom and their application in the clinical setting of nursing. In such a model, knowledge is viewed as instrumental and learning is measurable. It is also necessary for the preceptor to be totally familiar with the educational learning outcomes so that there can be congruence between clinical agencies and educational institutes expectations of the student. Such a model requires close communication and collaboration between preceptors and clinical lecturers. Unless this occurs, uncertainty and ambiguity will persist.

Questions arise such as: "How can nursing education be structured so that the preceptor is clear as to what is expected as an assessor of students"? "How can we structure nursing education so that nurses like Emma do not feel 'alone' but instead feel as though they are an important contributor to the developing professional"?

As an alternative to the correspondence model of education, Diekelmann (1988) in a phenomenological dialogical and meaning model of curriculum, learning for the student is relational and personal within a context. It is demonstrated when relevant clinical judgements are made, showing that the student has grasped the meaning of the situation for the patient and can demonstrate the most appropriate response in the patient's interests. Because the clinical environment is ever-changing, learning and the expression of that learning changes from situation to situation and is meaningless out of context. Therefore, the preceptor who works alongside the student is the best person to know how the student is progressing and whether they are acquiring clinical expertise. In such a scenario, Emma would appreciate that it is the demonstration of her clinical knowledge that is most valuable to the student and will assist the student most in developing their clinical expertise (Diekelmann, 1988, Rather, 1990).

Despite the changing expectations a number of preceptors who hearkened to the call to be preceptors were able to visualize a possible future for their students and the profession of nursing. They were aware of being part of something much bigger that was liberating to them and to students. Dale discloses a way of being that is

personally satisfying and gives an awareness of the contribution that preceptors make to the continuity of the profession of nursing. Dale reveals:

I guess, you get a lot of kudos out of it .. you're part of something bigger, because those people are going to go on, and they're going to be registered nurses, and I'm going to have an effect on that, I'm going to help them to be registered nurses. And they're going to go on and they're going to help a whole bunch of diverse people, which, you know, is pretty mind-blowing when you look at it in that context (Dale, 1, 1).

Summary

The lifeworld of preceptors reveals “the restless to and fro between yes and no” (Heidegger, 1966, p. 75) in making the decision to be preceptors. This restlessness came from an ‘unsettledness’ about a new way of being in the world where most did not feel at home. A revealed lack of willingness and the inability of some registered nurses to be preceptors has been disclosed. Thus the reality for preceptors is a conscious feeling of ‘being thrown’ into being a preceptor.

The ways of being a preceptor uncover a number of tensions. These tensions disclose at their heart, a belief by preceptors that they are not educationally prepared to be preceptors. A paradox is uncovered in that the experienced registered nurses who became preceptors believe they do not understand contemporary nursing education. These nurses are valuable as preceptors because they know nursing practice. But they do not necessarily know nursing education. New practitioners, on the other hand, believe that they lack knowledge of the practice world but they know nursing education. Paradox, as used in this chapter, claims that both their preceptors’ perspectives are of value to the students.

Organisationally, preceptors have expressed a concern about the lack of preparation to be preceptors, lack of choice, lack of structured guidelines, and lack of clear expectations for student clinical learning from educational institutes. What is concealed is an ‘aloneness’, with a lack of inter-institutional communication in what should be a joint venture in nursing education. At a personal level, preceptors’ empathy for students is grounded in their memories of what it was like to be a student in another time and place. Those preceptors who related to how the student may feel as they entered their clinical placement for their clinical experience, were more willing to hearken to the ‘call’ to be preceptors.

Despite the fact that formalised preceptor programmes have been introduced by some hospitals, preceptors in this study felt uncertain of their role, because of perceived new expectations for the assessment of students from nurse lecturers. New expectations have evolved from change and reform at both the practice and the educational levels. These changes have compelled innovation that has not been formally recognised, forcing adaptations at the preceptor/preceptee level to fit the moment.

The chapter also reveals the complexity inherent in preparing new nurses. It requires a grasping of the complexity of nursing education inter-institutionally with a willingness to listen to the concerns of preceptors. A mutual commitment from clinical agencies and educational institutes to precepting student nurses is needed, yet this seems to be very difficult to get right. In spite of difficulties, some preceptors expressed satisfaction at being preceptors, even though they found it an exhausting experience. Exhaustion came from the constant vigilance required to supervise student nurses in busy complex ward contexts. It is 'how' preceptors apply vigilance in their many practices that the next chapter addresses.

CHAPTER SEVEN

The Emerging Identity of 'Being-as' Preceptor: Keeping the Student in Mind

Travelling in the direction that is a way toward that which is worthy of questioning is not adventure but homecoming (Heidegger, 1956, p. 180).

Introduction

Registered nurses, in responding to the call to be preceptors to student nurses begin to forge an identity of being-as preceptor. The relational theme of *The Emerging Identity of 'being-as' Preceptor – Keeping the Student in Mind* is explicated in this chapter. 'Identity', here does not refer to an emerging image of oneself as occurs in a psycho-social crisis of personality development (Erikson, 1950). Rather, in a Heideggerian (1969, p. 14) sense "identity" refers to a "letting belong together" which is called 'the event of appropriation'. Identity is not a forced or imposed perception taken up by a preceptor but the preceptor coming to the place "where one belongs" (Heidegger, *ibid*, p. 14). This place is where the preceptor begins to experience what it is to be a preceptor in addition to being a registered nurse - bringing the two together in a unity of being.

A number of common themes emerged related to the two groups 'belonging together' as preceptors and students of nursing. In this belonging together, preceptors, as both registered nurses and clinical teachers worked alongside students in order to enhance the student's possibility for learning. When the unity of being-as preceptor and being-as registered nurse merges, it is as Heidegger (1956, p. 180) claims, "a homecoming" for the preceptor. In this, their identity as registered nurses joined with their identity as preceptors. In a Heideggerian sense, registered nurse 'as' preceptor was called forth.

The preceptors gave voice to the difficulties they experienced in precepting a diverse group of students. This included being-as preceptors to students who were more mature and older than some of the preceptors, and to students who came from a variety of ethnic backgrounds where English was not their first language. As well, preceptors encountered enthusiastic and unenthusiastic learners. A number of common themes develop the relational theme of *The Emerging Identity of 'being-as' Preceptor – Keeping the Student in Mind*, the first of which is *Being-as Preceptor*:

Being-as Preceptor: Gifting Time to Share

Particular students stood out who required extra effort to help them to learn the practice of nursing. Preceptors gave their time to students in order to assist them to achieve. Rebecca shares a narrative of precepting a student.

I had a great experience with a second year student, who I had for about – I can't actually remember, 4 or 5 weeks and she was a student I knew from the beginning because our clinical nurse educator talked to me about her, that she had not achieved in her previous clinical experience, and she was someone, when I first met her [was] very anxious. Very nervous about the whole experience and where she needed to achieve, and she needed to impress. And I thought, she came across early on in those first few days, she'd sort of babble away, trying to impress me with her knowledge, sounding very confused (laughs) about what she was talking about. And I'd sometimes just look at her in absolute astonishment, I mean her stress levels must have been enormous (Rebecca, 1, 2).

Rebecca's background understanding is that her student has not achieved to date and she recognises that her student's past is likely to affect how she will 'be' in her clinical placement. Rebecca continues:

I was very aware of wanting her to relax. And [that is] my personal belief about education. I mean you can't learn unless you're feeling good about yourself, and I like to give lots of positive reinforcement for things I see them doing well, and I like to really try and help them feel good about themselves early on. Because I think when you're feeling confident and good, you do well (Rebecca, 1, 2).

Rebecca's way of being-as a preceptor is to be mindful of giving her time to first understand the 'being' of her student and to 'let be' (Heidegger, 1971). She also notices that other nurses do not necessarily provide the same caring environment for students to learn. As an educator, students often disclose that they do not feel welcome in their clinical placement. Rebecca reflects this antagonism as she continues:

I see other nurses being quite hard on their students and being very judgmental – they can't believe how much they don't know and ... "Surely I wasn't like that!" There's a real perception that Tech. students are so dumb these days. There's this real thing, they still don't have enough clinical experience ... I don't see that myself (Rebecca, 1, 2).

Rebecca discloses a commonly held misconception among registered nurses in the clinical context who perceive nursing students as 'dumb'. Since the transfer of nursing education to the tertiary education sector in New Zealand in 1973, there has been a perception among some registered nurses who are graduates of hospital schools of nursing, that nursing education in the tertiary sector is inferior to the former hospital schools. This opinion is also shared among some senior citizens of the general public who are used to hospitals as places which heal the sick and 'train' nurses. Hospital schools prepared nurses for the hospital context. Many nurses do not appreciate that today undergraduate student nurses receive a broader education that includes an increased emphasis on health promotion, primary health care and the community context as the proper place for patients to convalesce. Nurses are most likely to work in the community context in the future. The failure to see the broader picture is the likely reason for the continuation of the myth that nurses are ill prepared and 'dumb'.

Rebecca reveals that the learning and teaching environment should uphold a student's feeling of self worth. The humanistic tradition in education, (Rogers, 1961) of creating a climate where people develop a sense of self-worth attempts to "recast the power relationships between teacher and students by defining learning as a psychological event" (Diekelmann, 1990a, p. 300). In her exploration of alternatives, Diekelmann is informed by Heideggerian texts, and recasts nursing education as *Caring, Dialogue and Practice*. Diekelmann noted that nurses do not teach as teachers do. Clinical nurse teachers are informed by their nursing practice. Rebecca confirms that her being-as preceptor is informed by her caring practice as a nurse. She creates a caring learning encounter and dialogue in which she embraces her student as a learner, who can then ease into learning.

I also believe, what I've just said, that I see other nurses being quite hard and their students don't succeed as much as they could, I'm sure, because they're in this total stressed state, and not feeling good. So, this student I really worked on – the other people were perceiving her as not achieving. And her tutor, I thought, was being quite tough on her too. And by the end of her experience they actually questioned me giving her an achieve level...that was coming from Tech. Because I was giving instances, I was giving feedback to them of how I felt she was doing well. And at the end of it there was such a feeling of them not believing me that I got other people I was working with, who had worked with the student, and actually got written statements from other people to support that. That was a valuable instance (Rebecca, 1, 3).

Rebecca shows an aspect of being in-between practitioner and preceptor. Here she stands in-between her student and her colleagues and her student and the student's tutor. Her preceptor identity is strengthened by her advocacy for her student. Nurses can be 'quite hard' on students and this may affect the 'way' the student learns. If prejudice prevails, a judgement may be given "before all the elements that determine a situation have been finally examined" (Gadamer, cited in Annels, 1996, p. 707). It is possible that the registered nurse's attitude will jeopardise the student's chance of success. This may be further complicated by the student's tutor who, too, does not believe the student can achieve.

The question arises, "Is there a mistrust between tutors and preceptors in relation to student achievement?" "If so, what is the ground for this mistrust"? Preceptors and tutors need to create a context, a platform of trust where students can be allowed to 'let learn'. Rebecca recognises this and her thoughts echo Heidegger's (1954/1968) ideas that "teaching is more difficult than learning because what teaching calls for is this: to let learn. The real teacher, in fact, lets nothing else be learned than learning" (p. 15). If a preceptor is to share meaningfully, students need to be drawn in and helped to feel comfortable in the world of nursing practice. How can students learn if they are battling closed minds from the very professionals whom they wish to join? If students feel unwelcome or if prejudice prevails which works against student achievement, how then can the nursing profession recruit and develop new nurses?

Being-as Preceptor: Encouraging Students to 'Let Be'

In the emerging identity of being-as-preceptor the preceptor prepares the context for the student. In this way the preceptor stands in-between and is mindful of negative attitudes of colleagues concerning student nurses. Rebecca states that nurses have a "collective responsibility" to situate students in the world of nursing practice that values them as the nurses of the future. The preceptor therefore prepares a safe space for students. Rebecca continues:

Just talking about that collective responsibility, I think we all have on our Ward to students, and we all recognise it, that relates quite closely to the person I was talking about who wasn't achieving and I think, left our ward feeling really good about herself and her experience, and supported by us as a team in that we all got together and wrote feedback. On the good stuff now. She was as confident at her level as [she could be] (Rebecca, 1, 3).

Nurses are responsible for creating a context where the student then can experience a 'letting be' (Heidegger, 1971). Heidegger claims that 'letting be' is important for feeling at home in one's world. Only when students feel 'at home', can they fully take up the opportunity for learning that is provided in their clinical placement. In 'letting be', there is an abiding which grants the possibility for students to 'let learn'. In that abiding, Rebecca continues to forge her identity as preceptor in that she ensures that there is a feeling of belonging together, for the student, herself and the other nurses in the context .

Rebecca points out that her student "was as confident at her level as [she could be]". Preceptors had in mind at what level students should be for the year of their nursing educational programme. She shows a mindfulness that not all student nurses are going to learn at the same pace. Rebecca continues:

She [her student] had a close friend who was working on another one of our surgical wards on the same floor...they were both Maori students, and this other nurse was having a really hard time with her preceptor....I just walked in one day that her friend was in tears, and had had a really bad experience...She explained the situation she'd been in... there's ways to give feedback to people, that you don't have to reduce them to tears. There's ways to be supportive, I think, and not leave someone with a bad feeling about what's just happened. This person seemed to be quite negative and she actually was given a non-achieve at the end (Rebecca, 1, 7).

Rebecca stands in the in-between space observing both negative learning experiences for students and poor precepting behaviours from her colleagues. She continues to build her identity as a preceptor by identifying a belief that there are many ways to give feedback to students. For Rebecca, her philosophical perspective influences the way her being-as preceptor to students is called forth. Rebecca points out that the two students who required extra effort were Maori. Nursing particularly wishes to recruit Maori nurses. As discussed in Chapter Two, part of the government health strategy to improve the overall Maori health status is to educate Maori nurses to promote health among their own people. Rebecca continues:

How wonderful it must be for the Maori patients and their families to see a Maori nurse, to be cared for by a Maori nurse, just in the way of feeling good about their experience, and hopefully making it all the more positive (Rebecca, 1, 8).

Students will not be helped to learn if they feel unwelcome and unsupported. Preceptors need to be taught ways of giving feedback to students so that the students are not destroyed in the process. The question arises: "How can nurse educators and preceptors work together to ensure that 'feedback' is given to students in a way that does not 'reduce them to tears'"? How can nurse educators and preceptors ensure that students leave their clinical placement feeling good about themselves?

Preceptor-as-Being Open to Students from other Cultures

As preceptors worked with students they continued to forge their identity as preceptors in that they were continuously mindful of them. They were surprised and challenged by the diversity of the student group. A common dilemma felt by preceptors and educators alike is how best to create a teaching and learning context that will facilitate students' learning when they are from a culture other than the dominant mainstream European culture.

Being new members of New Zealand society, if students do not have English as their first language they lack the shared understanding that is taken for granted in a culture where language is richly embedded in background meanings. Heidegger (1971, p. 77) discussed the nature of language and the language of being and reminded us that 'being' precedes language. Students who have English as their second language are not only learning to be nurses, which itself requires learning the language of nursing and how 'to be' in the culture of nursing, but also learning 'to be' New Zealand citizens. Being-as preceptors in this situation required a particular tactfulness. Kate discloses:

My student is from a different culture and she's struggling with [the] English language, so she needs a lot of extra help, which can be frustrating, because things that I think are rather simple and that probably she ought to have encountered are not so simple to her. And it's the English. .. I do find that quite hard. She's really quite good, but I just find the misunderstanding of English, and often the way she talks to the patient, it's just how it comes out, I sort of go ooh! (Laughs).. I find she's got a very good understanding of the theory side of things, it's just some of the practice-based stuff that she finds tricky (Kate, 1, 3).

Preceptors noted that students from other cultures needed a lot of extra help that could be frustrating. The 'way' extra help was needed required a heightened 'watchfulness' for the preceptor, to ensure that the student was safe in their practice. Preceptors were sensitive to students' difficulties that were embedded in language. The lack of words, shared meanings and understandings, could be perplexing, as the student could have theoretical understanding but lack practical knowledge. Perhaps English-as-other-language (EOL) students easily learn "the theory side of things" from a textbook but struggle with practice which is embedded in the background context of the dominant culture of the society. This culture also shapes the practice of nursing? Kate observes:

I've noticed it when we're checking out medications together. I just check her out, whether she knows what she's giving. Because you know, that's pretty important. And she does seem to have quite a good command of that knowledge. I say, "So why do you think he's getting this? [Why] is he getting analopril?" And [she says] he's got a whole long history of hypertension and that sort of stuff...If she's checked out the notes properly, which she's pretty good at, she says "Oh! That's because of the heart. And he's got high blood pressure", and stuff like that. I think her knowledge is actually quite good, but sometimes it just doesn't show. .. I was talking to the CNE [Clinical Nurse Educator] today about her, because I started to get a little worried when she said, "What is an IDC [indwelling catheter]?". I said this to the CNE and she said, "Well, perhaps she's never come across an IDC before". I said to her, "Well I've tried to think back to when I was year two [student] and tried to remember would I have known what an IDC was?" (Kate, 1, 3).

Two questions arise from Kate's thinking. The first, "Did the student know what an IDC was, as an object in her own language, but simply didn't know the English word for it"? The second question was as Kate's CNE asks: "Perhaps she's never come across an IDC before"? Kate thinks backward to when she was a second year student and questions herself as to what she would have known at this point of her own nursing education. This 'thinking backwards' was one way preceptors gauged how the student was doing. Thinking backwards was a feature of the preceptors who were themselves students in the not too distant past. Although students literally have to 'learn the language' of the culture of nursing in order to function within ward settings (Rummel, 1993), foreign students coping with English as another language encounter a double conundrum. They must learn both the normative language of citizenship and the language of the profession. Preceptors were aware of the students' difficulties but they were even more mindful that they needed to ensure

that students were understanding instructions and were not endangering patients. Kate is reassured by the way her student comports herself in the learning context.

But the thing that calms me about the girl is that she does actually come and ask, rather than battle on by herself and make unsafe practice (Kate, 1, 3).

Kate builds her identity as preceptor by noting the learner behaviours that all of the participating preceptors revealed as important for students. That is, for the student to ask questions. Preceptors gauged that if students were asking questions, they were interested and involved in the learning opportunity. When students ask questions, it keeps them safe in practice. Questioning shows an openness to learning through remaining on a path of thinking (Heidegger, 1971).

Being-as Preceptor: Coping with Staffing Crises and Precepting Students.

Preceptors were often confronted with staffing shortages and also the need to precept not only undergraduate students but also new graduate orientees all at the one time. Jane discloses:

Yesterday for me when I came on at 7 o'clock we had a less number of staff nurses to the number of people that needed orientating – we had two third year student nurses and two new graduates and one orientating staff member. And so for me I had a new grad and a third year student nurse. They appeared to be at the same level, so for me it wasn't too much more stress than having just one student nurse and with my third year she is actually picking up things really quickly and has a good knowledge base and understanding of what we do and why we do it. And so I could quite happily put my trust in her looking after one patient solely that had had a lap cole [laproscopic cholecystectomy] about 5 days ago and she'd seen her come through and was practically independent and I helped her with another man that required a bit of assistance with his chest trauma and the new grad focussed on another lady that had come back from surgery that had three infusions running .. and I sort of stood back and could assist the two of them which actually worked quite well and I think the quality of care given didn't alter at all (Jane, 1,1).

Jane reveals the frenetic context in which being-as preceptor was called forth. Preceptors were situated in a world of nursing practice which was fast moving and complex. The increased acuity of patients, the rapid throughput of patients and the multiple demands made upon them as preceptors to induct new staff but also precept students all at the one time created a burden for each working day. The work of the preceptor not only constitutes the preceptor and the student preceptee

but also their patients. The preceptor in their in-betweenness stands between the patients who are in the world of nursing practice, and the students who are in transition from the world of nursing education to the world of nursing practice. An important point that Jane makes is that she was able to trust her student to provide nursing services and feel that the quality of health care did not alter.

Quality of health care is an important issue raised by Jane. Nurses must provide services to people in need of health care being mindful of their nationality and ethnicity yet in a culturally safe manner (Ramsden, 1990; Nursing Council, 1996). Jane refers to the legal requirements of the Health & Disability Act, 1994, and its accompanying Code of Patient Rights, 1996 which outlines not only patient rights to quality health care but also the consumer's right to complain if the quality is not as expected. Students need to be aware of the contemporary environment in health care that demands not only good quality nursing but also an awareness of the cost of health care. Indeed, Heidegger (1955/77) claimed that due to the pre-eminence of technology (*techne*), people and things have become what he coined 'standing reserve'. 'Standing reserve' here refers to humanity as a technical object. A cost dominated world (Heidegger, 1927/62) of nursing practice can deprive a person of their being human. Students are constantly challenged by the conflict between the ideals they learned in the classroom and the reality of everyday practice in the clinical context. The preceptor therefore bridges the 'in-betweenness' of students' ideals and practice realities. Students will enter the world of nursing practice as nurses where cost effective health care will be paramount. Alongside this, however, is the need to uphold the humanity of Being.

Experiencing Being-as-Preceptor: The Uncertain-Place

Another factor that emerged from this research concerned preceptors being 'unsettled' when they encountered students many years older than themselves. Lee discloses being in an uncertain place in his discovery that mature students can be challenging and requires an approach that recognises their maturity and greater life experience. Lee shows how he "attunes caringly" (van Manen, 1991, p. 98) to each unique individual.

A different approach is needed with these type of students in the way that you're dealing with them, because I was actually dealing with one student nurse who was old enough to be my mother, and I found that quite challenging in some ways because here I was talking to a person that had been a mother herself, she actually had

children that were older than I was, and so there's a different tactic required when dealing with them (Lee, 2, 1).

In alluding to the different "tactic" required when dealing with mature students, Lee notes the challenges, thus provoking a thoughtful uncertainty:

It is quite challenging. I try to sort of suss out the person in a way, get the way that they're thinking because some of them - I have spoken to colleagues in the past, - some of the more mature students have looked down on the younger registered nurses, from a point of view of I'm old enough to be your mother, why should I do that. ... I was brought up to respect my elders by my parents, and [do] respect them, and in some ways I still have - I think it's sort of having respect for those mature students (Lee, 2, 1).

Lee discloses perspicuity in his way of thinking in that he wants to attune himself to the student's way of thinking. He reveals that he "susses" out the person by trying to work out the way they are approaching their learning in the situation. Lee shows his sensitivity to his mature student in that he creates a respectful place for learning by acknowledging what the student brings to the situation:

And they come with a greater range of life skills and they've been places and they've seen more, and they've done a lot more than what some of the younger students have that have gone straight from secondary school to polytechnic training - they've gone from one institution to another. Whereas, these more mature students - they've raised a family and they've worked in different areas and they've got other skills which they can give and they can be more tactful in some ways when dealing with the patients on their ward (Lee, 2, 1).

Lee, in building his identity as preceptor, is open to gathering and welcoming the mature student, recognising the gift the mature student brings to the profession of nursing - a background of life experience that is valuable in their nursing practice. Lee discloses the value of these skills but also a disadvantage of maturity:

Some of the mature women can often relate a lot better to women of their own age. And yet in other times ... in a couple of cases I've seen they've sort of talked down like a mother would to her teenage son. The sort of you know, don't do that, because I'm your mother's age and I'm telling you not to do that. And yet again, because they've been mothers themselves, when we have some of the younger teenage patients on the ward, they can deal with it, because they know the way that the teenage mind is working. ... And from that point of view it is, it is interesting just seeing the dynamic (Lee, 2, 1).

Lee highlights the attentive 'watchfulness' that emerges from 'seeing the dynamics'. He thoughtfully observes students and is interested in watching them work. Part of his emerging identity being-as a preceptor is learning comportment for himself as well as for students. The uncertain place for Lee in being-as preceptor is how to precept the mature student effectively. He embraces a 'watchfulness' that many of the preceptors spoke of as they observed students in their clinical placement. In 'watchfulness' the preceptor is constantly alert as to what the student is doing even when the student is not being directly observed. What must be 'taken-to-heart' in nursing education is the nature of the 'watchfulness' and its importance in protecting the interests of students and patients.

The discreet 'watchfulness' is linked by Heidegger (1954/68, p. 12), in his essay *The Question Concerning Technology*, to a number of words derived from *Wahrheit* (truth). Truth for Heidegger is *alethia* or 'unconcealment'. Lee's watchfulness is a covert action that is concealed from his students but 'unconcealed' or brought to the light in the narrative. This watchfulness emerged from almost all of the preceptors' transcripts. Heidegger points out that the stem of *Wahr* is used to connote a 'guarding and attentive watchfulness'. *Wahren* (to watch over and keep safe) is related to *bewahren* (to preserve). Lee's story uncovers the theme of 'watching over and keeping safe' that pervades the safeguarding practices of the preceptors. Lee shows that he has a fundamental attitude of openness and respect[fulness]. The action of being-as respectfully caring towards students gathers and embraces them as part of being-in-the-world (Heidegger, 1962/27) of developing professionals.

Being-as-a-Preceptor to Students who find Learning a Struggle

Preceptors disclosed other areas of being-open to students who were struggling with learning. Rae talks about how she worked with a struggling student.

She [the student] picked probably one of the most difficult ladies in the ward to look after because she wanted to sort out, I guess, the nursing process, and work out a plan for the patient. But she went off and did it by herself and then brought it back, to make sure that she had included everything ... She'd actually thought the process through from beginning to end and I think [she] was probably a fairly perceptive person and - she'd actually thought of a lot of things that some nurses wouldn't even think about, to the extent of thinking that it was still quite windy, the weather ... She had an understanding of the problem. She'd done a fairly comprehensive care plan including

hygiene, food, nutrition, activities of daily living - like being dependent, non-dependent and that sort of stuff - medication, she was really interested in the medications and working out what worked with what and what didn't work with what, and - and she was generally interested all round. And I would say probably what came through was the fact that she probably wasn't the brightest student intellectually but relationship wise she was really excellent. And was really keen to learn (Rae, 2, 1).

Rae notices that the student shows an ability to think and creatively plan nursing care for her patient. Rae may be challenged as to how to focus her student on the most salient points required for the care of her patient. Rae adds:

...just really very enthusiastic about what she was doing. So that was really nice to see, actually. I mean, and I guess that she shows up some of the nurses that maybe are a little more intellectually clever but not as caring. Oh, the nurses that just sit there with their heads in the books and think that they know it all, and really don't have to actually get out there and work with patients (Rae, 2, 1).

Rae raises two issues. The first is the enthusiastic student. All of the participating preceptors believed that enthusiasm was a chief characteristic required of students. Enthusiasm also motivated the preceptors to be involved in teaching students. The second was that preceptors disclosed situations where students appeared to lack interest in their clinical placement. Preceptors expected students to situate themselves in the world of nursing practice as involved participants keen to learn. When this did not happen, preceptors expressed frustration. Rae shows the in-betweenness of being both the hands-on registered nurse and the teacher preceptor. In building the identity of being-as preceptors, some theoretical orientation toward adult learning principles and being open to the significance of individual learning styles is important. If individual learning styles are not taken into account, students may appear to struggle because they may actually require a different precepting style, for example, one that encourages movement from the books to the patient. Rae continues:

There was one girl who was sort of semi-interested and you have to say semi-interested. ... She was basically just never very keen about being here. I think she's just nursing to get a qualification to do something else (Rae, 2, 4)

Rae raises an important point that affects the emerging identity of being-as preceptors. What do preceptors do to cope with students who are disinterested in

learning to be a nurse while they are on their clinical placement? As a researcher, I asked Rae: “So – how do you work with a student like that”? Rae’s response:

Well sometimes you basically drag them along by the scruff of their neck. Well I mean, if they’re so bad, I mean you actually just have to level with them. There’re people that would like their place and their opportunities. And sometimes I think it’s a mind-set because it’s a small ward and they think that you’re not going to learn anything here ... I mean every sort of day at work’s a learning opportunity if you want to take it as that but if you’re just here because you’ve got to *do your time* (Rae, 2, 4).

Rae suggests a way of coping is to “drag them along by the scruff of their necks”. Rae’s colloquial phrase reveals a reasoning in-betweenness that rests upon a conventional view of the pedagogical teacher/student relationship. The teacher is to teach and the student is to learn. Inherent in this position is power relationships, the teacher having more power than students. She points out that the disinterested student excludes others who may like the chance of the clinical placement. But Rae discloses a deeper concern, that some students seem to have a closed “mind-set” toward learning. From the preceptor’s gaze, they appear to be “do[ing] time” (Rae, 2, 4).

The researcher understands that Rae refers to a student “doing time” meaning a student who is not interested in learning the practice of nursing. The student arrives at his/her clinical placement to gain the clinical learning hours stipulated by the New Zealand Nursing Council’s terms to sit their state examination but does not fully engage in the learning available in the clinical placement. The student is ‘doing time’ rather than ‘being’ time. ‘Being’ as ‘time’ would mean that the student would ‘live’ time (Heidegger, 1927/62). That is, the student would engage herself in learning to be a nurse. Our being is the ‘content’ of our lives that includes our present experiences framed by our past and the future as possibility. For preceptors, students who are ‘doing time’ appear to be wasting their time by closing off possibilities for the present and future for themselves as nurses. The preceptors put forward a variety of reasons for why students may lack interest. These included the nature of the clinical setting, the lack of technical activity and, perhaps, excitement. Rae continues:

I guess it’s whether they [students] just see that nursing is just drips and drains and machines, or whether it’s actually nursing people with a long-term illness where there’s not an instant cure (Rae, 2, 4).

Rae discloses difficulty with forging the identity of being-as preceptor in that there seems to be a failure of the critical preceptor/preceptee relationship. It may be that the student and Rae just fail to connect with each other in an enabling teaching/learning encounter. If that feeling of belonging together is not made, then a natural sequel is that the student may be less responsive. It must be said, however, that it is well accepted that students as novices see nursing as technical or concrete acts of nursing (Benner, 1984). If students are able to use the technical aspects of nursing, such as being able to monitor machines, they measure their own progress in becoming a nurse in their ability to 'do' things. If there are few technical tasks involved in caring for people with long term illness, then a student who is still learning to value a person-centred approach to nursing may perceive that there is nothing to do. A student who has not yet learned the art of communicating with patients with ease may not appreciate fully what the clinical placement offers. Eventually, the student may become bored. In being-as preceptor, there is a challenge in finding a way of reaching the student. But the question remains, how do preceptors deal with disinterested students? Should preceptors 'level with them'? Is leveling a 'closing down' on the possibility for learning to occur? Is the solution to students 'doing time' as Rae states, "dragging them along by the scruff of their necks"? (Rae, 2, 4).

Students enter their clinical placement to learn the practice of nursing so that they are competent practitioners on graduation. If students do not "own up" (Heidegger, 1962/27, p. 232, 233) to their own "thrownness", perhaps nursing is not their career choice after all? When Heidegger uses the words "own up" he refers to *Dasein* (Being-in-the-world) as genuinely 'oneself'. That is, one exists as an "authentic" self (ibid, 1962/27, p. 232). If students keep safe by "keeping their heads in their books instead of getting out there and working with patients" (Rae, 2, 4): how then can they embody being a nurse? Being a nurse means working with people. But it must be remembered that students are at home in the world of books for they have come from the world of nursing education. As yet, the world of nursing practice is not yet home for them. They too, are experiencing the in-betweenness of the restless to and fro between yes and no, the moving between the world of theory and the world of nursing practice. Some may feel more at home in the world of books than they do in the world of practice. But the fact remains that both are required for the student to emerge as a safe nurse. The question arises then, as to who should take the

responsibility for 'leveling' with the student? Does nursing education, in regard to current teaching practice, consider the responsibility for leveling with the student should lie solely in the domain of the lecturer as it has traditionally been? Alternatively, should it be a shared responsibility to tell students that the preceptor's and the nurse educator's expectations of the student are not being realised?

Being honest with students that they were not meeting expectations was always a difficult one for preceptors, made more so when the student was unsafe in their practice. Managing the two worlds of nursing practice and nursing education requires of preceptors an awareness of the demands of both worlds.

Preceptor as Coping with Stressful Situations: Writing a Bad Report

Preceptors spoke of stressful situations that arose when they needed to write a 'bad' report on a student. Scully relates a story of precepting a third year student working in an Emergency Department where breakdown in meaning occurs.

So we had this student, and the nurse that was looking after her said, "Well, she'd like her to focus on something", and she [the student] said, "I'd like to focus on suturing". Well [the staff nurse] said she took a step back and said "Well no, I don't think so, how about we look at wound care"?

Well this girl must have taken great offence at that and the nurses that evening didn't realise that she went away off home sick. She came back the next day and then the tears started to me about how I think your nurses have obviously got a problem, they don't want me here, and if you can just find out if it's something I've done. And I said, "well, wait a minute" – in fact I said, "I'd like to talk to your tutor". "I find that very bizarre that you can just say thank you very much, she'll find you another placement when she hasn't even spoken to me about this. I'd be very shocked if that was the case".

Scully points out in her story that preceptors encounter students who have their own ideas about what they want to learn. The student has self-selected learning outcomes which are not shared by the registered nurses in the clinical placement. This student chose to focus upon suturing, but suturing is not ordinarily a nurse's practice in the New Zealand context. It is usually a doctor's practice although specialised units, such as in the emergency department, skilled advanced registered nurses will undertake suturing as a post registration specialised skill. But for a third year student it is not a skill required to become a registered nurse. As an alternative, the registered nurse focused the student upon wound care which is an

entirely appropriate learning opportunity for the student aligned with what would be expected of her from her clinical experience. Although students are encouraged to set their own objectives for their learning in their clinical placement, particularly nearing the final aspect of their nursing education programme, the preceptor who has the experience and knowledge of what students would benefit most from learning, tries to guide students in their selection of learning experiences. But Scully points out that this student took exception to her suggestion. Scully continues:

So anyway, the tutor rang me that night and said, no, that's not what she'd said at all. She'd said to her ... if it was that distressing [and] that she was so upset, that ... maybe we can change. So what we arranged was for them to come in and have a talk with me, and any other staff that might be involved. And so I talked to the other staff and there'd been another incident with another nurse whereby she'd observed her injection technique was not up to scratch. And she'd thought well, she'd just give her a little bit of a lesson and she tried to explain something. Well, this girl completely went on the defensive - "I know how to give injections" ...

Scully continues the theme of managing the difficult teaching/learning encounter. The student might have known how to give injections but her experienced preceptors would have had their own style of practice and, most likely, have given a lot more injections in their practice than the student at this point of her nursing education. Scully carries on with her story:

Quite a few of the nurses had said to me they didn't think her technique in injections was that good, and maybe she hadn't had a lot of experience. And all we were wanting to say was, you know, get some practice and maybe if you did it this way. And nobody from my nursing staff's point of view felt there was a problem. So I said well, you know, and we talked it out, and she decided she'd come back for another week. ... So I thought great, she'll come back for her last week and she'll give it her all. Well. Her whole attitude was even worse in the last week. She hung back, every day she'd say, "Oh! There's not much happening! I might go home early." And I was shocked, because I sort of thought she'd be really trying to impress ... [But] this girl just wants to get finished and the last week was even worse – and the last day, she went off sick again. So in actual fact I had to write and say that her initiative did not improve, it in fact got worse and – I've never written a bad report on a student, I always try to up their good points. But I didn't. I felt I had to be honest there. And when I talked with the tutor about the suturing and that, I don't think it [was appropriate] – Oh, [and the tutor said] "But you know, whatever they want to experience ...". And I was saying "Well, we'd be quite happy to show her the techniques and things". But, I think it got into a thing that it was the buzzwords that they use, like focus meant something at Polytech – that it didn't mean to me. "Oh, but at Polytech it means ..." and I thought well, you've got to realise that we're not working at your

Polytech. And that word doesn't mean that to me or any of the other nurses ...

Scully identifies a feeling that many of the participating preceptors shared, that there was a lack of effective communication between the registered nurses in the clinical placement, the clinical lecturer and the student. Because of this apparent separation between institutions, there was a lack of shared meaning between clinical lecturers and preceptors. This creates an in-betweenness between the clinical lecturer, the curriculum outcomes for the student that are not made overt to the preceptor, and the learning possibility inherent in the clinical situation. Such a situation creates the potential for breakdown in meaning rather than enhancing effective preceptor and preceptee relationships. Scully continues:

I found that the problem was, it was a personality thing with this girl, the fact that on the exterior she'd be very, very confident, I can do anything. But in actual fact I think underneath she was quite ... insecure, and she wanted to appear like she could do it.

Preceptors had their own way of considering how they should precept students. A prevailing theme was that they knew the importance of the clinical learning opportunity to students and wanted to give students the best opportunity they could provide. When students did not appear to value the learning opportunity as the preceptors considered they should, preceptors were perplexed as to how they should overcome difficulties. Scully continues:

.. my view is that you nurture them for the first week, and then you stand back a little bit and let them go for it. And — because I believe in having a lot of initiative's really important, but —. What I said to the tutor and my biggest concern with that student was that, to me the key to nursing is communication. And if she's not able to communicate with her colleagues, and seeing that she was in a position where, you know, maybe she was intimidated by registered staff, and they do work quite autonomously in their practice and maybe she had difficulty... that if she couldn't communicate with them, then how was she going to communicate with a difficult client, you know?

..You know, it's only one step away from patients really, and I had a real problem with that. And she agreed with me ... because I think you need to be fully focussed in clinical ... because it's so important, and you want to give somebody your all. But you know, that's the common theme I find, that they are uptight about some exam or, or their focus is, I have to do an assignment on someone. Their first thing is to find somebody straight away to get their assignment done (Scully, 1, 2).

In the story, Scully paints a picture of how breakdown occurs. In the phenomenological view of stress, 'breakdown in smooth functioning' (Benner & Wrubel, 1989) has occurred between Scully and the student. Both Scully's and the student's concerns are defined differently. 'Concern' describes the intensely human way of being in the world. Embodied understanding and background meaning can account for how the person is in the world. How Scully is in her world as a preceptor is that she understands that a student at a certain stage of her nursing education should be concerned about genuine learning needs related to developing practice in order to gain the skills to be a nurse on registration. Scully's self-understanding of the situation is different to the student's self-understanding of her situation. Both preceptor and student are in a shared world of clinical practice but their differing interpretations lead to misunderstandings and the meaning of the situation is disrupted. When meaning is disrupted, people experience stress (Benner & Wrubel, 1989).

One of the challenges that preceptors face is to select learning experiences for students that are related to their on-going level of developing practice. These learning experiences are related to the student's theory learned back in the classroom which is geographically distant to the clinical placement. But preceptors are not as familiar with the curriculum as the clinical lecturer is and therefore it is important for the clinical lecturer to establish very good communication platforms with the preceptor in order to facilitate the best learning opportunity for the student. Sometimes the student's aspirations are inappropriate for their level of development and the preceptor needs to reign the student in to develop a more realistic focus. The student does not always welcome this process.

Scully shows how she believed that by working through the difficulties and giving the student another opportunity, she thought that the student would return to the clinical placement enthused but this was not to be. The student then reveals how she is in the situation.

Her first thing that she said to me when she came and asked whether she could come, was I've got 10 months and so many days, and then I'm registered ... and I thought, oh, that's awful. Because I remember feeling like that and I always relate it to, "how did you feel"? And I remember thinking, I get that bit of paper, I'm a registered nurse, I'm it. It's the be-all and end-all – and of course then I came out and I started as a new graduate, and I realised that it was the beginning point! That's when you begin your practice! I can relate to that.

Scully thoughtfully identifies with the student. Scully steps back into the same place where the student now stands. She faces up to that feeling. But then Scully 'leaps ahead' to show how she has moved in her thinking when she compares herself to her student. She recognises now that graduating was a point of possibility rather than an end point. The student cannot see from where she stands that the conclusion of her nursing education provides a possibility for new horizons.

One of the responsibilities that preceptors hold inherent in the identity of being-as preceptor is that they are the safeguarders of the safe practices of nursing and, by implication, the safeguarders of patients' safety. Scully, as preceptor, stands in the in-between place of weighing up whether she should be honest in her report concerning her student. Writing a bad report is not something she wants to do, but she believes it is her responsibility to do so. Part of the identity as preceptor is that it requires owning up to the possibility that some students may not ever be ready to provide safe nursing services. Discernment is required of the preceptor collaborating with the nurse educator. Both are the gatekeepers for the profession of nursing. The Nursing Council requires its registered nurses to be "fit and proper" to practice (Nurses' Act, 1977). In being-as preceptor, Scully bears the responsibility for accuracy in her appraisal of her student. But, the ultimate responsibility for the progression of the student rests with the educational institute. What is apparent is the loneliness of Scully in being-as preceptor as she writes her report.

Being-as Preceptor: Encouraging Students to Think in Practice

When preceptors took up their precepting responsibility they found it difficult to balance their working days in order to have adequate time for the needs of both practice and nursing education. The identity of the being-as preceptor required a union of the two. Lee discloses a thoughtful approach to being-as preceptor and shows how he encourages a student to think and link theory to practice:

I like to just have about half an hour with the student to actually find out what they want to learn on the ward, so I can tailor their education and my teaching around that need. It starts prompting them to think. For example, with my second year student, I was having to slow the student down and get them to sort of think, hey, look at where you're going, look at what's required, not just superficially. Just try and calm down and spend a bit of time with your patient and get to know a more rounded approach to the patient. It was hard to try and do that because we were so busy. But I did manage, I got the student to sit down and look at the patient as a whole, not just the medical ailment, which was what the

student was tending to do (Lee, 2, 2).

Contemporary nursing education places importance on critical thinking. 'Critical thinking' is part of education reform (Gallagher, 1992). Paul (1993) defined critical thinking in the traditional sense as "a systematic way to form and shape one's thinking. It functions purposefully and exactly. It is thought that is disciplined, comprehensive, based on intellectual standards and, as a result, is well-reasoned" (p. 20). However, critical thinking in nursing can be 'messy' (Kataoka-Yahiro & Saylor, 1994) as nurses face complex situations where linear rules of logical thinking do not seem relevant. Lee demonstrates how the ideal and the real rarely work out in practice. It is far more useful to first understand the patient in context and then try to understand what the student knows in relation to the patient. Lee conserves time for precepting by focusing the student as he directs the learning task. Lee continues:

I got [the student] to sit down and basically look at the patient - it was a chronic obstructive respiratory disease patient, so sit down and just think about what can be involved with that in the disease process. And the student drew a list of 3 or 4 things. And I got the student to expand, to think on each of those 4 things, - each of those 4 areas that the student highlighted. I got the student to think about, to go further and to look at each one and to identify further issues within that issue and out of each of those sub-issues. I got the student to think about an issue for each one of those, so off each issue I was getting the student to think more laterally on how, for example, the impaired oxygenation would result in anxiety.

I said to the student, "Well, where from the anxiety?" "What would that lead to?"

"Well they wouldn't be mobile because of the anxiety associated with shortness of breath". "And because they're immobile what is going to happen?" And he says, "Oh their skin integrity will break down because they won't be getting out of bed". And I said, "What's part of the skin integrity breaking down?" "Oh, deficiency of nutrition". So I said, "Okay. Now looking from that, where would you go from deficiency in nutrition? Where would you go from there?" And he said, "Well, you know, you look at the social surroundings when the person went home".

So I got the student to think far more than just the medical problem, and to think laterally - I was trying to get the student to think from the point of view of not here and now curing the problem, but preventing the problem from occurring again. And that's where I was aiming, was to try to think 6 months down the track. How will this person be managing? Or, when they go home, how are they going to manage? And I said to the student, "Well... looking at the person's history... And I said to him, "Go and just sit down and continue

working on this brainwave that you've got. And I'll come back in 10 minutes then we'll go and have a sit down and talk to the patient and gather some more information - because you never know there may be him and his wife may not be coping at home. He may need some home help or perhaps we could refer them to the social worker". So then the student sat down and was beginning to think more laterally. (Lee, 2, 2).

'Lateral thinking', coined by De Bono (1967), emerged in efforts to overcome the rather nebulous term 'creative thinking'. It is "thinking concerned with changing concepts and perceptions; [which] are historically determined organisations (patterns) of experience" (De Bono, 1985, p. 141). Lateral thinking is based on informative behaviour in active self-organising information systems. It is designed to help the thinker to cut across patterns of thinking instead of just following along them. The thinker is encouraged to create a new pattern and when this seems to make sense, there is the 'aha' effect (De Bono, 1985, p. 141). Lee discloses a questioning approach in getting the student to think 'laterally' and also the time consuming nature of provoking thought. But the question arises, can 'thinking' occur on demand? Heidegger stated that we live in the world 'thinkingly'. Is the student not already thinking?

Using an alternative phenomenological approach in encouraging students to think engages us first as a person within the nursing world. Such an approach to thinking is that one remains within a context in a dialogical way in which one seeks to understand and find meaning (Diekelmann, 1993). Lee embraces the questioner's task to engage the student on a purposeful path to thinking where they are underway. Heidegger states, "whenever we are questioned we are provoked to think of a response – we are in the world thinkingly" (Heidegger, 1968, p. 37). To think is to be human. Lee shows how he sets up the possibility to engage the student in thinking but it is time bound. "I will come back in 10 minutes" (Lee, 2, 2).

The phenomenological view of time is not a linear sense of time, as Lee would have us think. Heidegger states "we don't go to thoughts, thoughts come to us" (Heidegger, 1971, p. 22). In contrast, time is temporal. Significance is how time shows up. Heidegger, (1968, p. 45) reveals that the nature of thinking is not easy to understand. He points out that:

The real nature of thought might show itself, however, at the very point where it once withdrew, if only we will pay heed to this withdrawal, if only we will not insist confused by logic that we already know perfectly well what thinking is. The real nature of

thought might reveal itself to us if we remain underway.

Lee, as a preceptor, will find that whether the student can think in ten minutes will depend on how significant the student considers the matter is and whether it provokes thought. If the latter is grasped, then the student's thought will be 'underway'.

Benner et al. (1996, p. 311) claimed that "disengaged, analytic thinking, that is standing back from a situation, is a useful strategy for the beginner who is flooded with anxiety or emotion". Benner et al. wrote that what is of concern about the current emphasis on critical thinking and its attendant assumptions in nursing education is:

It can cover over the possibility of embodied knowledge; the role of emotion in skilled judgement; the skill of involvement, and the role of narrative understanding a patient's experiences (1996, p. 314).

It is important to help the novice student to link abstract knowledge with the concrete in the immediacy of the situation (Benner, 1984). Lee shows how the preceptor as teacher and the preceptor as registered nurse belong together in the identity of being-as preceptor. Lee encourages students to see the relationships between items of disorganised knowledge learnt by way of anatomy and physiology, sociology, psychology, and nursing knowledge to create a relational form of knowing that is relevant to the person in their clinical context.

Lee also shows the intensity of being-as preceptor to undergraduate students. He shows that 'getting them to think' is time consuming and that is only one of the activities that engages him. Lee's 'time consuming' investment in the student is an investment in the future of nursing. Lee shows a way of precepting students through provoking thinking in the meaningful context of practice for both the preceptor and the student. Lee also works to develop the student's clinical expertise to ensure the provision of quality patient care, a government accountability requirement of the health professional.

The question arises "how can clinical placements be structured to allow preceptors time to assist students to 'think' in today's cost-driven health care environment? As shown in Chapter One, nurses now work in high-speed environments, with lean staffing levels and high acuity patients. The profession of nursing must value preceptors like Lee who invests time to help students to think meaningfully. That is

to 'think nursing' (Rather, 1990) and to provide safe nursing care based upon a dialogical relationship between the theory that they learn in the classroom and the practice that takes place in the clinical context. Nevertheless, being-as-preceptor is time consuming and Lee is conscious of the time it took out of a busy practice day to promote the student's thoughtful approach to their practice. Lee discloses:

In some ways you know, that is very much the teaching of what we do, — and that is very, very time consuming. Just sitting there talking to the student took three quarters of an hour (Lee, 2, 2).

Being-as-Preceptor and Finding-a-Place for the Competing Demands

There are other factors such as trying to fit in practical skills, overseeing patient care and making sure that the student is providing appropriate care to meet the patient's needs, that challenge preceptors finding a place for the competing demands of the clinical context. Preceptors are employed to provide patient care within an organised period of either an eight-hour or a twelve-hour shift. Students are on the wards for eight hours and three or four days of a block of three or four weeks dependent upon the school of origin's negotiated clinical timetable. Both patient care and learning outcomes are chronologically determined rather than temporally determined. That is patient care assignments must be completed by nurses within a determined time frame as does student learning outcomes. Students have specific learning outcomes to achieve within a determined time frame. Temporal refers to time that includes the past, present and future. For students learning to be nurses, preceptors are teaching students to develop the nurse of tomorrow. But, preceptors also are required to meet chronologically determined patient care outcomes at the same time.

While the preceptor grapples with the competing demands of being-as preceptor students too face competing demands from the educational institution. Scully discloses that another aspect of emerging identity in being-as a preceptor involves coping with students who have different priorities to those of the preceptor:

This is a common thing that I find with the students (and I can relate, when I think back to my student days), is that I think they need to forget about what's happening at Polytech or what exams are coming up. They need to focus — because they have a very small amount of practice and you want to give it your all and you want to really enjoy it and you want to learn from it. And forget about whatever assignments are due or whatever exam —because

I think you need to be fully focussed in clinical because it's so important. But you know, that's the common theme I find, that they are uptight about some exam, or their focus is, I have to do an assignment on someone (Scully, 1, 2).

Scully is judicious in the way she precepts students but she is mindful that her own priority is that students should embrace the importance of learning the practice of nursing. She discloses that students are pre-occupied with exams and assignments instead of focussing on their clinical experience. Maybe it is the pressures of their theoretical learning that keeps students noses in their books. The question arises: "How can learning demands on students be sequenced so that learning priorities are congruent between the preceptor, the student, and their nursing education requirements"? What Scully also shows, is that she is open to learning herself, and learns from the student.

Preceptors, as registered nurses at times, encountered demands from their own practice that they believed would be great learning opportunities for students. When this happened and the demands of practice overtook the demands of being a preceptor, they were mindful of students and suggested that "you just get in the corner and just watch what happens" (Scully, 1, 4). Preceptors would then find time to go over the happenings later, but often, they found students' minds were elsewhere. Scully discloses:

I remember being disappointed one day because we had somebody come in who had an AA, you know, abdominal aneurysm which had burst. [The person] came into flaps and it was all on ... Everybody going, we put his bag of fluid through on the rapid dispenser which was just new, we hadn't used it much, and ... I'm thinking [about the student] "Oh", I said, "*you* just get in the corner and just watch what happens". And, all hell breaks loose when something like that happens and we're running up to CT or we're taking him straight to theatre, and it's all [on] — ... And I said, [to the student] "I'll explain it all to you later, do you realise what's happening? And I'm thinking, I don't want to forget them! And everybody's yelling, you know, and the doctors get a bit carried away. And I'm thinking, "oh, now this would be really [great for the student] — I mean — at the end of it, [the student says] "oh, I just need to get that assignment done. And I said *what!* .. she was a good student too. And this, I think was her elective before State, and she was more worried about studying for her State final, really. I don't think she saw it as being a big deal, and I thought "*well, that's great!*" I'd be so excited, you know, if something really exciting is happening! (Scully, 1, 4).

What is apparent from Scully's narrative, is that students and preceptors often differ in what they consider important. It could be that the activity is so rushed that the student is overwhelmed by all the activity. It could be that the actual practices performed by nurses and doctors are poorly understood as yet. It could be that the activity in the situation was so sophisticated that the student does not even try to engage in it, thinking that they would only get in the way. Whatever, the student is thinking, to Scully's mind, the student is not engaged with what Scully considers is 'so exciting'. She is astonished at the student who is not absorbed in the drama of an emergency. A competing priority from the world of nursing education over-rode the learning opportunity offered by Scully. Scully says that 'she is a good student'. Yet, a good student wants to pass her examinations. Perhaps the student's priority right now is the examination rather than the excitement? Whatever the student is thinking, to Scully's mind, the student's way of being-in-the-world remains incongruent with her own. Perhaps this is part of what is concealed in the in-betweenness for students and preceptors and perhaps this is part of getting to know students. Knowing the student and creating a bridge to gather students from their world of nursing education into the world of nursing practice is part of the skill called forth in preceptors.

Preceptor, Dale, echoes the previous student's thinking, possibly because, as a recent graduate, he has not moved too far from the world of nursing education. He says:

I think in a lot of instances, and this I take from what students have said to me, is that they just want to pass. They're there, they have to be there, and in order for them to become registered nurses they need to pass. Whereas the tutor is there and they want the student to learn. So - I have to kind of be a mediator in that relationship, and I have to teach and also pave the way for the student to be able to pass that module.

I think you don't realise, well I can only talk personally here, I didn't realise the value of the experiences that I had as a student until I was a registered nurse. And even then it's not straight away. It's not until you encounter particular situations further down the track, after you've completed your training and you're out there and you're doing, how valuable some of the things you learned as a student were (Dale, 2, 8).

Dale makes an important point. The student's mind is often preoccupied with passing. That is their priority. It may not be for some time that the experiences they have encountered as a student become meaningful.

Living-a-Life-as-a Preceptor-Meaningfully: To-ing and Fro-ing

As the demands of being-as a preceptor to students became more significant to the preceptors and their identity as preceptors grew stronger, the restless to and fro between balancing the demands of their practice and the demands of teaching students intensified. If opportunity presented itself in the practice day, preceptors grasped moments to help students to apply their theory in practice. Lee discloses:

There was one student recently that was a mature student, and I got her to come in with me and do a complete nursing assessment on a patient. It was one of those rare occasions where it was quiet and I said to her, we've got the ultimate opportunity to do a care plan from start to finish with complete nursing assessment, diagnosis, planning, implementation and evaluation, all of it. I said you can implement your nursing theorist, I said you can do an A grade exemplar on this patient.

Students' ability to apply the nursing process in nursing situations has been a requirement of the Nursing Council of New Zealand (1999a). Lee grasps an "ultimate opportunity" for the student to use a patient focussed total plan of care for her patient and challenges her to do an "A grade exemplar". Lee shows the required tactics to achieve this outcome. He first of all gains consent from the patient and solicits the patient's involvement in the learning situation.

Prior to it I'd actually been and seen the patient and said "Look, this is what my intentions are because we've got students" and the patient was more than willing, was quite happy to pass on some of the knowledge that they had. So once that had been okayed with the patient, gained consent from them, I went and grabbed the student and we sat down for about 20 minutes. The student was really keen, was willing because I was able to spend the time with her.

And we used a heart failure patient. And I was able to get the student [set up]. I got her to brainstorm on everything that she knew about heart failure. And she came up with quite a list as to the signs and symptoms of heart failure, the differences and went briefly over the medications the patient would be on. And we went in there and she sat down and interviewed the patient as to the reason they were in hospital, cardiac history and the family, whether they were married. And I said to the student, I said, "Right, come out from there with all that information". I said, "I want you to brainstorm and write down everything that patient has told you, write [it] down". And so the patient — so we sat down and drew up the patient and everything possible. I said, "Now, you've got all the pieces of the jigsaw, now you've got to put them in the right place". And so we sat down and basically went through the assessment, the nursing assessment, the diagnosis. I said, "Okay, what are we going to do?"

How are we going to go about planning our care? How are we going to implement it, and the evaluation of our care?" And the student went right through and over about 4 days — she went home every night and worked, as well as being a mother, a full time mother, she was able to come out with this perfect 1500 word exemplar. And it was just incredible. I said to her, I said, "That is a very, very high standard and you should feel very proud of it!" (Lee, 2, 6).

Lee discloses how he involves himself, the student and the patient in the learning challenge. Out of her 'brainstorming' the student developed an holistic care plan for her patient. Inherent in the learning challenge, Lee recognises that, as adult learners (Knowles, 1980), mature students have high expectations of themselves. Lee also states that he "pointed it out to her tutor, and the tutor was very proud of it". Lee also ensures that his student's clinical lecturer sees the high standard of work that the student has accomplished. The relationship between Lee, the patient and the clinical lecturer creates the circle of learning. Lee derives personal satisfaction from the situation as he states:

Afterwards I sort of thought great! You know, I've finally managed to get across that it's just a lot more than drugs and the medical problem. Because I said look, you've included the family in there and how the family's coping. And how her husband is coping with it. I said you've included the medication and what we're doing and how to monitor it. I said you've done everything textbook (Lee, 2, 6).

He also gives feedback to the student on how well she has done. In this, Lee shows the student a future of possibilities. The skills inherent in her planning can be transferred to new nursing situations. He goes on:

Today it's a medical complaint, ... your next placement could be surgical ... and then you look at it from a surgical point of view. From a surgical point of view there's different things to bring into consideration, but you've still got all that same social background, ..and that's a big part of our work. (Lee, 2, 6).

Lee discloses the skill of involvement (Benner et al., 1996) required in contemporary nursing that includes an holistic patient-centred health care that takes into consideration the social background of the patient in the planning of care. He states that it is a "big part of our work". Government primary health care initiatives require the health professional to consider health outcomes for the patient and their quality of life. The professional must take into account the patient's life-space as they recover and how they will manage in the future. The emphasis is on keeping

the patient well and to preventing readmission to hospital. Lee continues:

And as it so happened, because of her going into more of the social things, the touchy-feely of nursing that she found that her and her husband weren't coping at home and so the appropriate services were made contact with so that the transition from hospital to home was made a lot easier and that they would have the appropriate services to get them over her recovery at home and convalescence at home. And if it be required, just further continual community support to prevent the re-admission, that's what I said, you know you're setting the services up so the patient won't come back into hospital (Lee, 2, 6).

Lee's practice as a preceptor is to walk the talk. His teaching tactic reflects holistic person-centred care and what this means in the real world of nursing. He identifies the 'touchy-feely' of nursing meaning the connecting through caring concern to the patient in their life's situation. Lee also homes in on the way the student becomes the professional. Lee encourages the student to be the decision-maker and take her place as the nurse by stating "you put yourself in the position of dealing with every patient". Lee continues:

She'd produced a high quality piece of work that [in which] she was able to include herself. Instead of "the nurse" she was able to put "as a nurse, I will" and "from my experiences I was able to". I said move away, [from writing] ..."the nurse" and put "I" because ... you want a first account experience, ... put yourself in the position of dealing with every patient. Think of what you would do, not what the book would tell you to do. And from then on I saw her adopt that approach. And I really felt great, she's doing well. And she did really well in our placement (Lee, 2, 6).

Lee highlights the rewards inherent in the identity of being-as a preceptor. Engaging students, patients, preceptors and tutors in a meaningful learning circle that is not 'book based' but 'reality based'. This ultimate precepting experience illustrates the intrinsic rewards in developing the professional (Cotugna & Vickery, 1990; Davis & Barham, 1989; O'Mara & Welton, 1995; Turnbull, 1983). What Lee discloses is the 'how' of that involvement and the commitment required to call forth meaningful learning. The challenge is establishing meaningful circles of learning that ground learning in the practice of nursing. In this way, the possibility of developing students' professional identity and competence is enhanced.

Summary

Dwelling in the world of nursing practice was 'home' for preceptors as-registered

nurses but not yet 'home' for them being-as preceptors. Precepting undergraduate student nurses required dwelling in the world of nursing education as well as clinical practice. As preceptors forged their identity they uncovered the many facets of being-as preceptor to students that required the skills of the teacher as well as those of being-as registered nurse. New aspects of their practice emerge as preceptors recognise that their relationships with students were different to those required for patient care.

What stands out in this chapter is the preceptors' lack of a coherent approach to teaching and learning in the clinical context. Identity emerges for the preceptor by trial and error learning that is at odds with the educational requirements of clinical teaching. The chapter shows the many and varied ways preceptors forge an identity of being-as preceptors to undergraduate student nurses. It also reveals the in-between space between clinical lecturers and preceptors. Phenomenologically space is closeness or remoteness in relationships. Preceptors appear to experience a lonely place in the world of nursing education.

Preceptors revealed an attentive watchfulness as a way of being with undergraduate student nurses. As the preceptors recognised the need to relate to students in their diversity, new possibilities were opened to them in being-as preceptors. A significant finding is that preceptors encouraged students in "learning nursing thinking" (Nehls et al, 1997, p. 224) by assisting them to relate their theoretical learning to their practice in context.

CHAPTER EIGHT

Assessing Where the Student is at:

The Preceptor and Preceptee Working and Growing Together

But where danger is, grows the saving power also (Heidegger (1977, p. 28).)

Introduction

Using the hermeneutic 'as', this chapter sets out to disclose how preceptors be as-safeguarders through a constant process of assessing where students are at. This occurs as preceptor and preceptee work together. In the words of many of the participating preceptors, by assessing where the student is at they were able to identify potential danger in practice to both students and to patients. But as Heidegger stated (1977, p. 28) "where the danger is, grows the saving power also". Heidegger clarified his use of the word "save" within this context. He states that "save" means not to save something from ruin but to "fetch something home in its essence in order to bring the essence for the first time into its genuine appearing". Preceptors, in the world of nursing practice, demonstrate their "saving power" (ibid, 1977, p. 28) by showing how, in their practices, they help students to learn in context.

Heidegger (1962/27) claimed that as we 'be' in the world, we dwell in the world of everydayness in relationships with others and entities or things. Because we dwell, we build. This chapter reveals the 'how' of the dwelling of preceptors in the world of nursing practice as they work together with preceptees. In the dwelling, preceptors created a place for undergraduate student nurses in their practice with their patients by working together to develop the students' practice. In this sense preceptors create a "lived space" (van Manen, 1990, p. 120) by gifting time to dialogue with the student, observing and demonstrating many of the practices of nursing to engender a feeling of belonging in the world of nursing practice.

Being as-Preceptor: Assessing where the Student is at

Assessing where the student is at is done both covertly and overtly. It is also done sequentially and at various points throughout the student's clinical placement. An important part of knowing where the student was at was 'knowing the student'. Emma identifies that knowing the student is a precondition to assist the student's

learning process. The following narrative portrays how the preceptor establishes “where [the student] is at”.

What I tried to do with my students was find out “where they were at”, what their aims and goals were and just direct them a little bit. What I found really good about the preceptor programme was that because you've got that one student for the majority of time, you get to know them. You get to know what their capabilities are and actually get to know the kind of person they are and the best way to teach them and to push them a little bit. When you had a student in the past you would not know where they're up to. And, depending on the kind of student you had they could hide behind that in a lot of ways. When you know what they're up to you know what you can send them off to do by themselves. You know what they're aiming towards and that you can continually keep focusing and pushing them that little bit further all the time. (Emma 1,1)

Emma points out the advantages of a concerned practice of nurse teachers (Diekelmann, 1993) that of ‘knowing and connecting’ with the student because the relationship sets up possibilities. These possibilities include the preceptor considering the best way to teach the student as well as being able to “push them a little bit” (Emma, 1, 1). The questions arise: “Is there the idea in Emma’s statement that ‘knowing and connecting’ with the student is the precursor for learning to occur? What are the consequences therefore of a system of preceptoring students on a one-day basis as revealed in Chapter Six? How can the preceptor know and connect with a student in such a short space of time”?

In Emma’s statement she reveals that knowing and connecting are important for the preceptor to identify how best to help the student’s learning. She comments that, in the past, when the preceptor did not know where the student was up to, the student ‘could hide behind that a little bit’. Emma suggests that the consequences of not knowing the student is that preceptors have little idea of the student’s capabilities, and, this at times, can be an advantage to a student who may not wish to be challenged in the learning context. Preceptors therefore cannot know either how to connect with the student’s level of knowledge or how to challenge them to extend it.

The preceptor therefore is in the best possible position to assist the student by keeping a constant mental log of the student’s progress. The continuous preceptor/preceptee relationship is essential here. Once the preceptor is satisfied in knowing “where the student is at” according to the clinical goals and intentions, then the preceptor can extend the learning further, and even encourage some independence. As Emma states, “then they can go off on their own and do a little

bit". Rebecca gives a good example as to why preceptors emphasise their need to "assess where the student is at". Rebecca tells her story:

There's a very strong memory of an instant where she [the student] learnt a lot, and I learnt a lot actually. We were in a six bedded room and on an afternoon shift, and she had gone around and done all the obs.[observations] - 5 o'clock obs, for all these women. There was one woman who she'd taken a temperature of, and her temperature was 37.7 at 5 o'clock. And she didn't tell me that. And I didn't check. ...I made the assumption that at her level as a second year nurse she would know norms and would know when something's out of the norm to let me know. But in this instance when it came round to 9 o'clock before the next lot of 4 hourly obs. was due, this particular woman...started [having a] rigor. I immediately started cooling her down, we got some fluid therapy for her and [student's name] was watching all of this. And in the midst, getting the house surgeon and getting things done, getting blood cultures taken, and a fan, and getting Panadol into her, I found out that her temperature had been up at 5 o'clock and [student name] hadn't told me. And so, later on that evening, once we'd sorted it out, the rigor [had] stopped and [I had] sorted out the situation, talking to the student, I said I had assumed that she would tell me things that were out of the norm, so that was a learning experience for me. ...I think she knew it was abnormal, but not as a concern, really. So she learnt that a temperature of that nature, I could have given Panadol and I could have assessed the person to see where the temperature was coming from. She was a woman who previously hadn't been febrile at all. She was in for a bowel obstruction. Then looking at her once she'd started [to have the] rigor, she had an IV [intravenous] site which had become infected, and it was tracking up her arm, and that was pretty obviously the site of infection, although we investigated other things. If I'd known that I would have looked into that. And probably would have seen that site and got something done about it. Because she still had fluids going into it. So that was big learning experience for both of us. Something she'd never forget. Something I'll never forget either (Rebecca, 1, 3).

Rebecca's story of assuming that she knows "where the student is at" shows the importance of an actual assessment. Rebecca thought that a second year student would know a normal temperature range for her patient. Rebecca's assumption is grounded in her expectations of second year students. Perhaps, nine out of ten students have that knowledge. However, there is always the possibility that there will be the one student who does not. Rebecca shows how the student who did not report the abnormal temperature can be clinically unsafe and therefore endanger the patient. Preceptors check the student to identify "where they are at" because of experiences like that outlined by Rebecca. Rebecca's student either did not know the normal range for an adult's temperature, or if she did, did not know when she

needed to report abnormalities to her preceptor. Rebecca states that she thought the student knew that the temperature was abnormal but was not 'of concern'. A close reporting relationship between the preceptor and the student is essential if the preceptor is to trust the student. The trusting relationship is essential for the preceptor to entrust patient care to the student (Rummel, 1993).

As Rebecca assesses the patient seeking to identify the causative factor for the rigor the student becomes an observer. She also 'thinks aloud' in her narrative saying that she "could have given Panadol" to the patient to prevent the rigor and she would have ensured a change of intravenous site due to the noticeable infection present. She shows the student her process of analysis identifying the problem so that the student will understand the seriousness of the situation for the patient. The preceptor shows the preceptee how clinical judgements (Tanner, 1993) are made. Rebecca states that she learnt a lot and so did the student. Often, when things go wrong, the learning is more acute for everyone.

It is important to remember that undergraduate student nurses are learning the practice of nursing. Practice in response to a person's health needs is not an exact science. While students are assessed by their preceptor as being safe to undertake particular practices of nursing independently, it is also important for them to develop self confidence in their own abilities. As Heidegger says, "where the danger is, grows the saving power also" (Heidegger, 1977, p. 28). In the preceptor assessment "there grows the saving power" that encompasses the recognition of the student's capabilities and "pushing" them along to extend their knowledge and skills in the practices of nursing. There is a fine line between pushing and being sure the student has sound knowledge.

Being as-Preceptor: Weighing up the Student

One of the first ways of assessing where the student was at was 'weighing up'. Sarah discloses:

[He was a] very nice young man. He was obviously very enthusiastic and I was looking at him and weighing him up and asking him did he know what he was going to do (Sarah, 1, 2).

One of the first things that one notices about Sarah's statement is that she has appraised the student in a 'weighing up' stance and states that her appraisal is that

the student is a “very nice young man” and “obviously very enthusiastic”. The very first thing that preceptors encounter is the student’s attitude. Preceptors spoke of the importance of students being enthusiastic to learn. An enthusiastic student means that they want to be there. An enthusiastic attitude is ‘catching’ and motivates both the preceptor and the preceptee in the teaching and learning encounter. It is in this reciprocal relationship as they dwell together that the growing of the saving power will occur. By weighing up the learning needs the preceptor will be able to assist the student to grow in understanding their practice.

Preceptors have a picture in their mind of where the student should be at for their level of learning. Sarah portrays this in her ‘weighing up’ or ‘word metaphor’ (Taylor, 1985) where there is the suggestion of a pair of scales with balancing dishes for the positive and negative aspects of the student. Many of the preceptors felt that enthusiasm was crucial. Preceptors used the level of enthusiasm of students as a yardstick to gauge their openness to learning. Heidegger (1927/62, p. 191) would say that preceptors have a fore-having, or grasp in advance what the student should know, from their dwelling in the everyday world of nursing practice and working with many different students (ibid, 1962/27, p. 80). Sarah illustrates this well:

I was just keeping a bit of an eye on what was happening. And I heard several comments about the fact that they [the students] didn’t always appear to be using their time to spend with patients, that they were in fact sitting down going through books etc and doing background work and not always taking the opportunity [to be with the patients]. And — I’m sure there’s a variety of reasons for that. I did have in mind that when I was back on the ward I would just make sure that I would, if I was on duty, get hold of whichever student was working (Sarah, 2, 2).

Sarah portrays another form of ‘watchfulness’ as identified in Chapter Six. Sarah shows that she keeps an eye on what is happening with students, all the time weighing up. In this way Sarah shows her concern for students. As stated in Chapter Four, she also portrays the manner of thinking as ‘being’. Heidegger claimed that as ‘being’ is, so is thinking. Being and thinking are never separated. Sarah hears the criticism that the students are with their books rather than being with the patients. She states that there may be several reasons for that. Sarah’s intuition is very likely that the student either does not know what to do, is fearful to take action without direction because of knowing of the ‘danger’, or may even believe that there is nothing to do. Students take every opportunity to catch up on their theoretical learning. But also, students know the world of ‘books’. That is their

everyday 'being-in-the-world'. She continues to weigh up the students and her watchfulness is one relative to 'the saving power' (ibid, 1977, p.28).

Preceptors are aware that students are supernumerary members of the ward team and are placed in the clinical setting to link theory with their practice. Students are in the world of nursing practice as students of nursing. The questions arise: "Should there be time for students to read their books while they are on their clinical placement?. Does Sarah's observations reflect the idea that nurses should always be busy with their patients? Does this thinking pervade nurses' ideas of student nurses learning to nurse? Where is the opportunity in the students' clinical placement for theoretical learning to be given a place? How is theoretical learning linked to clinical practice and by whom? Do preceptors and clinical lecturers assume that by placing students in practice they will automatically link their theory and practice? Should there be space for their 'books'? Should there be a lived space for preceptors, students and books? Should students have time for their books or writing up their logs, or should they be always busy with their patients? Is the 'busyness' that the students appear to lack, an 'enduring' from the past"? Heidegger states, "all essencing endures" (ibid, 1977, p. 30). "Is it the nature of nursing and of nurses to be 'busy, busy' and if so, should preceptors perpetuate this notion"?

Being-as Preceptor: Knowing and Connecting with the Student

Assessing where the student was at included identifying if the student knew what they were in the clinical area for. If the preceptor was to be-as the safeguarder of practice she needs to know and connect with the student (Diekelmann, 1993). This particular theme is significant, as one of the difficulties that preceptors encountered was that students often did not know what they were in the clinical placement to learn. Sue brings to light the meaning:

A lot of students come in with enthusiasm and they want to learn as much as they can without really knowing what it is that they need to know. Which is quite exciting for us, really, ... to be able to be the guide for them. Otherwise, I think they'd just learn everything (laughs) and they'd get overloaded because a lot of it - because I work in a specialised area - students are often quite keen to know more than what they need to know (Sue, 1, 1).

Sue, as a preceptor is working with first year nurses. She recognises that, in order to safeguard the practice of nursing, the student needs some direction to their

learning. She notices that:

[The student] is keen for procedures rather than people, and just always wanting to go off and see things, and they see things being done but not quite so keen to do the sort of hands on sitting and talking and listening, and those sorts of things (Sue, 1, 1).

Preceptors gently guide students to focus on their clinical learning goals. Students are often caught up with a natural curiosity of the new and exciting clinical environment, which is ever changing. Sue draws attention to students being keen to observe procedures rather than become involved in actual clinical practice with people. “Is this because students are taken up with the novel? Or, are there deeper fears that while they are merely observing they cannot do anything wrong”? Students are all too aware of the responsibility that is ‘the danger’ when one is working with live human beings. Perhaps observation keeps them in a safe place? In my previous research (Rummel, 1993, p. 118), students discussed their clinical experience in terms of it being “scary” and sometimes “freaky”. These “scary” and “freaky” situations arose out of the students’ inexperience of being involved in complex clinical situations where they were out of their depth. Preceptors understand this and therefore know and connect with the student, guiding the student in order to keep both the patient and the student clinically safe. The challenge is to make students’ learning experiences less “scary” while still providing sufficient challenge for them to engage in learning.

Sue is mindful that if the student is left without guidance they have the potential to become ‘overloaded’ which then would then hinder them meeting their clinical goals. Sue shows her safeguarding of students in this way. By ‘overloading’, Sue is referring to the information processing model (Hilgard & Bower, 1966) where too many items are being processed at once in short term memory, which inhibits the person from either processing these effectively, or storing relevant information in long term memory, resulting in forgetting. Information is then not available for retrieval. This model of processing information comes from a view of teaching and learning that begins with students being taught theoretical facts about nursing in the classroom divorced from their practical application in practice. With reference to this view and ‘overloading’ students, Benner (1996, p. 9) identifies:

When we stop giving a unidirectional privilege to theory and science, we can coach students to engage in the lively and rigorous teaching/learning that moves a student from clinical innovations, dilemmas, and questions to a search of the extant theory and

science, engaging in dialogical thinking that can enrich both the practice and the science.

Benner implies that students need to be actively 'coached' into a dialogical relationship with theory and practice in order to learn from both in a way that is mutually enriching for theory and their practice. Students therefore need to engage in their practice rather than merely being an observer. Sue is keen for students to engage with their patients. In this way a dialogical relationship with theory and practice is more likely to occur. The questions arises: "How could preceptors become the coaches for students to initiate a dialogical relationship between their theory and their practice"?

Being as-Preceptor: "Checking and Double Checking"

Related to preceptor as safeguarding practice and 'assessing where the student is at' lies the theme 'checking and double checking' that emerges as a central practice of preceptors. Preceptors were constantly vigilant in checking that the student knew what they were in their clinical placement to learn. Also, they were checking that students had the appropriate knowledge to carry out their practice, The preceptoring practice of "assessing where the student was at" involves a complex array of 'checking' as Emma discloses. It also gives the preceptor an indication that the student knew 'where they were heading'.

[The student] goes off and she starts writing up her plan and looking at her notes and things so I go to her and check her, check her knowledge, check what she's looked in to, what her plan is to see if there're any gaps so that I know when she comes to me and says "I've" [done this or done that] - I say to her "What is your plan for this patient today?" and she goes, "Well, I need to do this, this and this at this time he needs to have this done and this done" and I can see that she does actually have an idea of where she is heading, and that her assessment of her workload and her plan for that patient is actually quite sound. So that gives me an idea of that side of things. Let's say if you have got a dressing that needs doing, if I don't know if that student is capable of doing that dressing I will either get them to [do it], depending on their confidence. [Or], I will get them to watch me do it, or if they are happy to go ahead and do it, they can do it themselves and I will watch them. And then I get an idea that they are quite capable of doing this dressing. Next time they can do it by themselves (Emma, 1,1).

Preceptors need to know if students know where they are heading. What Emma shows here is that she is checking out the student's capabilities in a double planning

process that includes her own and the student's plan for the day. Emma shows that she also checks on her student's capability to undertake a patient's dressing. Emma has a plan in her head as to how she can ensure that the student and the patient are kept safe during the learning experience.

Dale also talks about how he 'double checks' where the student is at. He has a covert style of 'checking' and prefers not to let the student feel that they are being 'double checked'. However, Dale had made his assessment and feels confident that he knows where his student is "at".

When we started off, yeah, sure. I needed to get a feel of how accurate she was with those skills. But also I didn't want to destroy her confidence. So if I had a patient — we had a couple of patients there, like we had one patient that was a pre-op patient, he'd come in the morning and he wasn't going to surgery until the following day. And we had a couple of baseline blood pressures already on the guy. And this particular guy I'm thinking of at this stage, he was a reasonably healthy middle-aged guy. So I just said to go ahead and do all the observations, and I just had a quick flick back later on to check to see how she went. And she was spot on. So rather than continually sort of coming along and double checking, I felt that it was a good idea to let her have a bit of autonomy just to feel confident in those basics and then, once you're confident with your basics you can move on from there (Dale, 1, 2).

On many occasions, preceptors spoke of observing students undertaking technical skills as a means of 'where the student was at'. Technical skills are the most overt and readily measured. In fact, for the most part, it is the technical skills that students seek to be good at (Rummel, 1993) because they think that if they can show technical competence, then this is how a good nurse is measured.

During the process of 'checking and double checking', if the preceptor is to be-as preceptor and safeguard practice she/he will need to ensure some mutual planning of the work of preceptor/preceptee. This requires that the preceptor involve the student in 'writing up her plan' and 'keeping notes'. But she also writes up her own plan. She likes to check if they have a 'sound idea of what is expected of them'. Having clear expectations of the student was something that the preceptors emphasised and many noted that often, students did not have any clear idea of their learning goals. Emma refers to the student "writing up their plan". A practice of preceptors is "planning". In her dialogue, Emma discloses that preceptors plan their own work, plan the student's work and then plan "together" work, that is the student's and the preceptor's work together. This planning process took place

continuously throughout the precepting process. Emma continues:

Well initially like I say I always try and go for the chart to start with so I know that they have a sound idea of what is expected of them. I try and give them a little bit of a leeway so that they can go ahead and do that themselves. But, I will I also write myself a list of what is expected so that I can *double check* that they are doing things or [to make note] if I have to prompt them to do things - antibiotics are due at such and such a time. I tell them at the beginning of the shift that they are responsible for the whole patient care. And I expect them to come to me to ask because they know they can't do it and that I have to and that they are responsible for the care. So, they have to tell me when they want it done. I try to be quite directive with them as well (Emma, 1, 2).

Emma discloses that she 'is quite directive as well'. Emma ensures that the student knows what is expected of them and that they are aware of the responsibility they have for the 'total care' of the patient. She says that she expects them to come to her and ask about things they cannot do. Emma is therefore explicit about her expectations of how the student and the preceptor will work together. She 'double checks' that the student knows and she knows that patient care will go according to the plan. In this way she once more discloses how she is alert to potential danger and the way she safeguards her patient, herself and the student. 'Checking' and double checking' is a continual practice of preceptors recognising the 'danger' inherent in novice practice.

Being as-Preceptor: Thoughtful Engagement in Guiding Students

In this next example Emma shows how she helps the student to identify the key aspects of nursing practice, that is, patient care. In this example it is clear that being- as preceptor and thoughtful engagement in guiding students involves thinking.

I had her [the student] for the first time before my days off last week, and I sort of went about it the normal way that I would, tried to find out where she was at. I think we allocated her 3 patients, went over the workload with her. During the day — I found things were a bit difficult. I thought that she was doing a really good job ... she talked to the patients. She always dealt with the emotional aspects, but she seemed to be quite closely tied in with that, and also making sure they were clean, and the beds were made, but forgetting the other things that needed to be doing. She'd do the obs and all that sort of thing. But — one lady in particular had cellulitis in one leg and on the doctors' round the doctors had asked that she have a

TED stocking put on the other leg. And — I reminded her several times, sort of thought prompting might help, but she never actually did it. Even by the end of the day it hadn't been done. And I think because she was more tied into that emotional side of things, she couldn't seem to break away to the fact that that needed to be done. So, shortly before morning tea she said, "Oh, can you give me a hand to make this bed?" And I said, "Well no, because I think that from here you need to try and prioritise a little bit more. You need to think about what's more important than making beds, It's the least important thing. So you've got a lady there who's got cellulitis and that leg's weeping, and I think you'd be best to go and do the dressing on it first and get the TED stocking for the other leg. I'd thought about how to tell her, you know, she needs to prioritise without making her feel that she was doing a bad job, but just to try and guide her a little bit (Emma, 2, 1).

Some cares are medically prescribed. While the emotional care of the patient is important, there are also other actions that must take priority for the patient's overall wellbeing. The patient had a serious infection that requires attention. Emma shows how she guides the student to undertake the technical aspects of nursing that is, to attend to the care of the wound and to prevent further complications with the application of the TED stocking. In this way she safeguards the patient. Emma also shows how she is careful not to destroy the student's confidence. She states how she "thought about how to tell her". Here Emma shows how being as-preceptor involves thinking. Not only in what she is doing but how she is engaging in her practice as a preceptor thoughtfully. Heidegger, would consider the way Emma is authentic in her practice of being-as preceptor in her being-as nurse. Heidegger considered that authenticity is the ability to be oneself. Emma is concerned for her student. Just as she cares for her patient, so too, she cares for her student. Being authentic as *Dasein* or being-in-the-world as preceptor is to care (Heidegger, 1927/62, p. 322).

Being as-Preceptor: "Together Work"

Much of being-as preceptor involves 'together work', that is the preceptor and student working together, so that the student will acquire confidence and be able to build their own practice. Heidegger reminded us that as we dwell in the world we also dwell with others. As we dwell, we build (Heidegger, 1971, p. 148). Dale shows how he assesses where the student is at by trying to "work out in his head what it is the student should be capable of" and "what it is I think they should be doing". Dale shows how he dwells in the world of nursing practice. He embraces a

circle of care, preceptor, patient and student. Dale shows the way he assists his student to build her practice. He includes the patient in the learning context, informing the patient that the student and the preceptor will be 'working together'.

I have my allocated patients, and I start working out in my head what it is that that student should be capable of and what it is I think that they should be doing. And we'll start off on that track. We'll go and approach, say, a particular patient — we might have a patient that's had a tonsillectomy, in fact that's exactly what I did on the first day, we had a patient that had had a tonsillectomy. And we went and approached that patient. And I identified myself, I identified the student, and I said we're going to be "working together". So immediately I was building a rapport not only between myself and the student, but between the student and the patient as well, and getting to build that confidence of the student being able to work with that patient (Dale 1, 2).

Dale shows that he is open to the student's learning. He considers particular aspects of his work, his allocated patients, and then decides what the student should be capable of. It will depend upon the level of the student, whether the student is a first, second, or third year student as to the nature of those expectations. It also will depend upon the preceptor's nursing education background and their memory of what it was like for them at that particular level of their nursing education in order to set an intellectual yardstick by which to gauge the student. The preceptor therefore never accepts a student on neutral ground. By the very fact that they themselves are in the world of nursing practice and have been a student themselves, there is an assumed level from the start for that particular student.

At a philosophical level, Heidegger (1927/62) stated that our interpretation is always grounded in something that we have in advance, our fore-having (p. 191). Preceptors have a memory from their own student experience that becomes a gauge for the student being preceptored. For Heidegger, interpretation is based upon what we see in advance, a "fore-sight". In the fore-sight, the preceptor has an idea in their mind of what they should be seeing in the student at their level of capability. As stated in Chapter Four, Dale's fore-having and fore-sight determines his fore-conception and therefore how he will assess his student's capabilities and set his expectations of her. Therefore, preceptors are never without an assumption of an expected level of capability from students.

Dale's exemplar shows how a preceptor 'works out in their head' where the student

should be at, as he prepares for together work. Dale then introduces himself and the student to the patient. This is a purposeful encounter in order to build rapport with the patient and the student. Here we see Heidegger's notion of "building" (1951, p. 348 cited in Krell, 1993) from dwelling in the world. Dale expresses how he builds rapport with the patient and the student and draws the patient into the learning situation. He does this in order to establish a relationship with the patient, the student, and himself.

The preceptor as safeguarder thus sets up a learning circle to reassure the patient that the student is not working alone but alongside the skilled registered nurse. This learning circle is very important for the student because by law in New Zealand, the patient has a right to a qualified practitioner to provide the health service (Health and Disability Commissioners Act, 1994). The patient is also introduced to the idea that the preceptor and the student will be 'working together' in order to provide the nursing care required. Straightaway, the patient is involved in the learning situation and likely feels reassured that the student is being supervised in their process of learning and at the same time makes a place for the student to learn.

Preceptors recognise patients' rights to be self-determining in the provision of nursing care. That is their right to autonomy. Nursing involves working closely and intimately with people. Nurses, by right of their professional role are socially sanctioned to accomplish work that acknowledges the humanity at very personal levels. With reference to this idea, Christensen, (1998), in a grounded theory study identified the concept of 'anonymous intimacy'.

Anonymous intimacy refers to the idea that nurses enter and leave the patient's private space on many occasions during encounters in an experience of hospitalisation but to both the patient and the nurse their relationship seems continuous. The socially sanctioned right as a professional person is automatically given to nurses and other health professionals involved in health care. Preceptors are aware that this right could be violated once a third person is introduced into the nurse/patient relationship. Therefore in order to uphold the person's ethical right to autonomy, the preceptor safeguards practice by gaining permission from the patient for the student to enter this very intimate space.

Dale continues to show how the learning environment and the relationships thus established allowed him to continue to assess the student:

And so, we'd go on through the duty and I'd get the student to start doing bits and pieces like taking blood pressures and temperatures and start identifying how well she was able to do those particular tasks. And, she was, very, very good at [that]. And we'd go on. And then later on in the duty this particular patient that I had in mind actually had a bleed. And so [we moved into] this particular kind of routine that you go through when a patient starts to bleed as with any post-op complications. And this particular patient had quite a moderate bleed, if you like. So we raced off and we got the ice packs, and we got the ice chips, and we took his blood pressure, and all the rest of it. [We] got the house surgeon in, and as we were waiting for the house surgeon to come in we gave the patient some morphine to lower the blood pressure. I was keeping in mind all the things that I was doing and why I was doing them, and then at a later stage in the shift I worked through that whole scenario and explained to the student what I had done and why. And we had the same situation happen again, but from that point it was really a situation where I was able to get the student to think not just directly on that this is a patient and these are the tasks that we're doing, but these are why we are doing these tasks (Dale, 1, 2).

Dale shows how he works together with the student as he manages the emergency of a patient with a post-tonsillectomy 'bleed'. He also shows how he maintains a momentum in his practice that keeps the patient safe but at the same time he is 'keeping in mind' what he is doing and 'why' he is doing it. He does this so that he can explain his actions to the student later in order for the student to learn how he makes clinical judgements. As a preceptor, he demonstrates professional practice to the student as well as, later, using the shared experience as a platform for teaching and learning.

Dale illustrates clearly that part of together work involves 'keeping in mind'. Keeping in mind means that the preceptor is always conscious of the student either observing them or of being aware of their practice to use it as a focal point for teaching. Practices are always situated (Benner, 1984; Benner & Wrubel, 1989; Benner et al., 1996; Diekelmann, 1988, 1990a, 1993; Heidegger, 1927/62,). From time to time, the preceptor needs to take immediate action to ensure the clinical safety for the patient. In these situations, the preceptor will focus solely on the patient but will 'keep in mind' their practice in order to teach the student, once the patient is clinically stable and the emergency managed. Always uppermost in the preceptor's mind, is the safety of the patient.

Tanner (1993, p. 21) described learning clinical judgement as being involved in the "semantic structure of everyday practical activity – what people actually do when

they are engaged in the everyday tasks of life". She draws upon Heidegger's (1962/27, p. 105) ready-to-hand mode to illustrate how clinical situations are understood as a "network of interrelated projects." Thus Dale draws upon the situated learning and the ready-to-hand¹⁹ learning experience of the student and the preceptor together to focus student learning post-situation. The shared experience then can be reflected upon together for learning purposes when time permits. Heidegger (1962/27) stated that we are in the world in a pre-reflective mode of being. Such a situation for Dale and his student demands a reflective mode. Dale must therefore keep in mind the experience in retrospect. In this way he moves into Heidegger's notion of the experience becoming "unready to hand" (p. 103). This latter mode refers to some problem or breakdown occurring in the ready to hand mode. For Dale, the problem will become the focus for the student's learning.

If students are to have confidence in their developing skills, they require some 'freedom' or 'leeway' to practice without feeling as though they are constantly under scrutiny. Heidegger referred to this notion as "freedom to" and "freedom for" (Heidegger, 1962/27, p. 232). Heidegger, however, is referring to this notion in a way that relates the 'Being' that is freedom to be one's authentic self. Once one is free to be one's authentic self, then one is free for future possibilities, that is "freedom for". Students must earn the right to have some 'freedom' by first showing that they are able to undertake accurately, the basic skills of nursing. Benner (1984) claims that the student as a novice must first learn the foundational skills as practical rules in order to be a safe practitioner. Learning the theory and then practicing the theory so that experientially, it becomes practice, facilitates this. Dale gives the student some 'autonomy' or some freedom to practice to develop her confidence in the basic skills in order for her to 'move on'. He also feels comfortable knowing that his student is carrying out those foundational skills accurately. In this way he is giving the student freedom to claim the practice as her own and therefore to be authentic and opening up the possibilities.

Preceptor as Following Through

Some preceptors worked with first, second, and third year students. These preceptors were able to assess more accurately 'where the student was at' for their

¹⁹ Ready to hand is referred to in Chapter Four. It refers to Heidegger's notion of a familiarity with equipment in that it becomes meaningful in its use. The equipment itself is used unconsciously and becomes an extension of the body. Other writers, (Horrocks in Edwards, 1998; Tanner 1995) uses Heidegger's notion to refer to a mode of engagement with every day practical activities.

level of educational preparation as Bernie discloses:

We work with all, we even have the first ones, they come with their tutor but they just come from 5 to 9 I think it is for a couple of afternoons a week. And then first year, second year and third year. We have all levels. And it's really important to know what level they are, so that you can plan what type of care that they can give.

Researcher: Do you find that a bit of a challenge, working with the three levels of students?

Yes I do, but I think that all levels still do some of the same things but I like the nurses to tell me what they've been studying because if they've been doing diabetes, well then you can incorporate that in. Or if they've been doing congestive heart failure or something, you can incorporate that in as well. So it's important for you to know at least some content of their curriculum so that you can help them with their learning process. I must admit not all staff are ... that keen (laughs) you know, I think because sometimes you've got your own workload and then you're planning the workload of the student as well and you follow through. So you work as buddies. But by the time they get to third year they are wanting patients of their own, second and third year, an individual patient. So you plan the work with them and then follow it through step by step and make sure they complete it all (Bernie, 1,1).

Bernie laughs as she makes the reference to 'not all staff are ... that keen you know'. She recognises that for me, a researcher employed in nursing education, such a statement may not be what I want to hear. Bernie's honesty is an important part of interpretive research in order to ensure that I (as a researcher) understand what it means to be a preceptor to student nurses. That is, she recognises that as an educator, naturally my interests lie in student learning. However, not all registered nurses share my enthusiasm for student learning nor want to precept student nurses.

Bernie continues the theme of 'assessing where the student is at'. She implies that there will be different demands made on her throughout her day, dependent upon the level of the student whom she is precepting. Not only is the preceptor planning how their own practice can facilitate student learning by delegating parts of it to the student in a way that is safe and meaningful in relation to their level of nursing education, but Bernie intimates that they also need to "follow through". (Bernie 1:1).

Preceptor as being Vigilant

The practice of “following through” is closely related to two other related practices, ‘keeping an eye on’ and the practice of ‘noticing’ (Lee, 1,6; Sarah, 1, 1). Such practices emphasise the constant vigilance of the preceptor. Vigilance refers to a watchfulness which is purposeful but which students are not always aware of. This watchfulness takes place as part of the safeguarding of both the student and the patient as they become involved with the care of patients. Vigilance includes being attentive to the student in that they are either assessing where the student is at or checking and double checking on the student’s practice.

Not only is Bernie vigilant but she discloses also that she has a dialogical relationship with all three levels of students in assessing ‘where they are at’. Additionally, Bernie shows awareness of her need to have “at least some content of their curriculum” so that she can help them with their learning process. Bernie also needs to know the student’s level so that she “can plan what type of care they can give”. Furthermore, Diekelmann (1988) drew attention to the curriculum as dialogue which is most meaningful to students when their learning is relational. That is for the student to ‘see’ relevance of the theory in the practice and to have a dialogical relationship between the two. An important part of the preceptors practice should be the linking of the theory to the practice. Are links in practice made to theory? Rebecca discloses:

You don’t often get the opportunity to have a conversation about [that]. That actually happens more at morning tea [or] lunchtime. And you’re talking about a certain client and ... there’s problems, outstanding social problems or emotional problems. You get a good idea of the student, their awareness of things and how they view the world. I mean, you know, your philosophy of life is so important in a job. How accepting they are of things (Rebecca, 1, 6).

That preceptors do not have time to assist the student to learn relationally is of concern, particularly if the student is having a series of “isolated meaningless experiences” (Sarah, 1, 1). Rebecca shows that as a preceptor she is careful to try and find time when she can link practice to theory. She shows that conversation is in the context of patient care at morning tea and lunch-time in which case discussions usually centre on “outstanding social problems”. She notices that the students view of the world is important as it influences how they might practice. She

implies here that there are multiple worldviews such as the notion that social problems could be seen as the patient's fault or they could be seen as a result of society. She is interested in how students perceive 'social problems'. "Is Rebecca implying here that some practical situations excite learning, so much so, that conversations continue at morning tea and lunch times? What message does Rebecca's statements portray? Or, are the practices and theoretical links that are foundational for meaningful learning experiences relegated to the only moments that preceptors and students get time to think about them? What changes are needed in nursing education to reduce the possibility of meaningless learning for student nurses"?

Sarah shows that part of the vigilance of the preceptor in their attentiveness to the student is seizing the opportunity for the student to learn about practice by passing on 'practical' tips. Sarah reveals this practice in discussing her practice with a student.

I think I've probably mentioned, I've got together a student nurses' package and he was working his way through and ... he knew the sort of patients he wanted to look after which I thought was quite good. So I gave him three patients, one of whom was going to be discharged, and I said there'll be an admission and you can have that admission. And at the point I had a look at him and he just had his piece of paper. And I said, do you ever make notes or anything and he looked at me a little blankly and I suggested that he always have paper, unless he had one of these wonderful memories, and write down everything anybody said. And I told him that I do that still and it's a very good habit. So we talked a little bit about just that aspect, you know, those practical aspects of practice. That you can really wind up with egg on your face when people say something to you and ... somebody else can talk to and you'll forget that first thing that was said. And sometimes it can be quite crucial. And I was quite impressed because he actually spent the rest of the day writing down everything I told him to do (Sarah, 1, 2).

Sarah shows how the preceptor is ever vigilant in seeking out the 'the teachable moment'. The most meaningful moment is situated in the student's practice. She notices that the student takes up her suggestion and continues with this practice throughout the remainder of his day. In a behavioural sense (Tyler, 1949), he has learned.

It is also interesting to note that, as already observed in Chapter Four, in the absence of clinical learning guidelines, preceptors took it into their own hands to

create student learning packages. Sarah is impressed that her student knows “the sort of patients he wants to look after”. She teaches the student the importance of making notes and keeping a written record of what he must do. This is to help him complete the tasks of nursing and not forget. As an expert nurse, Sarah knows from her own experience that despite the best of intentions, nurses become sidetracked, as they go about their work. Many demands are made upon them and it is easy to forget to do something that is quite “crucial”. Sarah emphasises the critical nature of much of the information that nurses must deal with in their day to day practice. The preceptor safeguards nursing practice by preparing the preceptee for the real world of nursing.

Preceptor as Creating a Sense of Purpose

Creating a sense of purpose is a practice of preceptors similar to that of the student ‘knowing where they were heading’ Sarah also shows the importance of having a plan and a receptive student. She discloses:

One of the patients I'd given him was a real cutie, she was 92, a little dot of a lady, but she was a sweetie, which I thought was a good opportunity for him to do some total care. And I had in mind that I was going to put him under pressure a bit, that there would always be at least one and preferably three or four things for him to do. Nothing crucial, but just that he wasn't going to meander through, he was going to have a sense of purpose about the day and I talked to him several times during the duty, saying now this is going to happen, how far have you got with this. Have you got that patient's bed ready, after the patient, because somebody's going to be coming in, and just pushing him a little bit. And I thought he was really receptive...He'd given the lady a shower ... and she'd responded very well to him because I had wondered a little bit, I mean it's not what every 92 year old lady imagines it will be. But they'd obviously established a good relationship and she was sitting in her chair. And I looked at her and I said, “And have you done her teeth and hair?” knowing he hadn't done her hair – that was quite obvious. So probably if he hadn't done the obvious thing he probably wouldn't have done the un-obvious thing. And he said, “Oh no!” I said, “You do that then”. I felt that these things are actually really baseline things, that if we can get them into that first acute patient they will stick. But if they don't get taught then it's not going to be there. And I think it's an extremely important part of their practice. We talk about patient-centred care but I'm not so sure patients would agree we're delivering patient-centred care. If you ask the patient what they think is a priority, you will find hygiene and comfort at the top of the list. I was actually very impressed with his reception. I could see he was very actively enjoying his day and feeling like as though he was really nursing

because he was rushing around a little bit (Sarah, 1, 3).

Sarah's student is a first year student. Everything is new to the student. She teaches the student the importance of hygiene and comfort centred on the person and reinforces the statements made by Dale on the importance of the student mastering basic skills in nursing practice. She notes the student and the patient had developed rapport and that she had wondered how a 92 year old lady would take to a young male student attending to her hygiene, although she does not voice this to the student. Sarah implies that there is always a risk in allocating students to patients. The reason for this is the 'person' factor. The 92 year old could well reflect Victorian values of yesteryear where it would have been inappropriate to have a male nurse being involved in the intimate washing care of a female patient. However, she shows that both the student and the patient have developed a relationship that is mutually beneficial.

Sarah shows how she directs the attention of the student to the details of care – “the patient's hair and teeth” (Sarah, 1:3). Sarah also views that by creating a plan of action it gives the student a sense of being a nurse “because he was rushing around a bit”. (Sarah 1:4). Nurses have a reputation of always “being busy” and to “rush around” seems to epitomise the nurse. She then reveals her real purpose of the exercise is to ensure that the student has a sense of purpose to their day. She reveals this in her statement that “he was not just going to meander through his day” and that he learns the bases of nursing, the comfort, and hygiene of the patient.

Benner (1984) claims that 'caring' is primordial to nursing but she also claims that patients want competent nurses who can combine caring and competence in the delivery of care. “Rushing around” does not always imply competence. It can mean that one is “rushing around” in ever decreasing circles and not accomplishing anything. Students come to understand the world of nursing by being in it. As stated, the clinical area at the time of this research was very busy and severely understaffed. Sarah shows the student that she sees the tasks of nursing as those actions that are fundamental to the comfort of the patient. Caring is the core of nursing. Caring is the moral imperative of the nurse. Watson (1998) views the 'tasks' of nursing as the 'trim' of nursing which although they must be done, do not reveal the true nature of nursing which is to be caring toward the patient. The issue here is the visual metaphor (Taylor, 1985) of the nurse 'rushing around' attending to things but perhaps failing to keep the patient centre stage. Christensen (1998)

showed that nurses can attend to technical matters such as intravenous therapy in checking rates of flow and seemingly, ignore the patient. Sarah has a sense of purpose as she is teaching her student that the patient is central to the student's care and that the patient's comfort must be his primary concern.

Caring as the essence of nursing has been disputed by a number of writers (McCance, 1999). Some researchers interpret the word as an emotion, some interpret it as an action, and some combine the two. Heidegger, (1962/27) claimed that to 'care' is a fundamental way of being in the world. Without someone caring for us, the human being, the most dependent of all species, we would not survive. Benner and Wrubel (1989) drew on Heidegger's work, claiming that caring is primary to healing. It is the ontological interpretation of caring as Heidegger uses it that Sarah is referring to. Later in her interview, Sarah draws attention to the notion in nursing, that due to the academic advancement of the profession, task nursing is supposedly less popular:

Task orientation often seems to be a bit of a dirty word in nursing but I think that that's not always fair, because those tasks are about people. And if they're not done there's going to be a gap somewhere (Sarah, 2, 4).

Sarah raises another important issue that "tasks are about people". Sarah captures first what it is to be human and second what it is to be a nurse. Sarah's teaching moves forward easily due to the receptivity of the student. Sarah's student is learning how to care in a meaningful context. The foundational skills he would have learned in the demonstration room are becoming 'lived experience' (van Manen, 1990). At the same time his preceptor is inculcating a sense of responsibility:

I found he was acting out on the directions that I'd given him, and using his initiative within those parameters. We talked at one point. It was about developing your own responsibility for practice. It's often a good idea to do what you're directed to do while you're developing your practice because you must always take responsibility for decisions that you make. You must decide for yourself what you are actually going to do, because you're the one who will actually be responsible for those decisions. I try to use opportunities like that for teaching. I mean you say that in the classroom, but I think when you're standing there by a patient with a piece of paper, that he's going to be actually legally responsible for I think there's a reality there that comes home (Sarah, 2, 4).

Preceptors develop responsibility for making sure that students understand the

professional dimensions of practice that occur in the clinical lifeworld. Classroom teachers can teach the law and ethical principles theoretically but only in the practice situation does the reality of the responsibility and accountability take hold. The Nurses Act (1977) identifies the educational experience that nursing students must have, but there are an ever increasing number of Acts affecting nursing as the practice world becomes increasingly litigated. Preceptors are generally purposeful in ensuring that students recognise the legal responsibilities and accountabilities for practice early in their career. Once the preceptor is satisfied that learning is developing, they then give the student the 'freedom to' learn.

Preceptor as Enabling Freedom to Learn

All students need some 'freedom to' learn. This means that the preceptor must 'let go' and allow the student to practice on their own. Preceptors give students freedom to learn when they are satisfied that they have "assessed where the student is at" and feel comfortable that they can trust the student with the preceptor's patients.

I think it's an experiential thing, being a preceptor, you have to learn to let go and let the student [do it] and not take over, but just give a bit of freedom to learn. Because there's been so many instances where I've been left and I've learned from those experiences and I think sometimes you have to let go and let the student go in there but know that it's controlled and know that I'm there and if she needs some support (Jessie, 1, 1, 2).

In my Master's thesis, a theme of a 'push/pull' process (Rummel, 1993) of the student developing as a nurse was evident. This is a complex process where the preceptor must 'let go' and the student must feel the pull of the practice to be drawn into it. The student must first be confident in their abilities and feel sure that they can manage. The preceptor must be confident that the student is safe. The student must feel supported and that the preceptor is 'right there'. Jessie's narrative that follows discloses the push/pull process when the student is given the "freedom to" learn.

It was an emergency situation where this patient came back from a routine angiography - I mean, we get very blase, oh angiography, fine, he'll be home later on today or he'll be home tomorrow. But he wasn't. He developed complications. And the student identified these complications. He developed a huge big haematoma in the site. It was the puncture site. She recognised it and she actually

said to me, and again hopefully I give that sort of air that she can do that, she said I want to control this situation and I want to, if I can, be in sort of control of this emergency. And I said, oh well that's fine. Okay, let's just go through what you need to do. And you know, she did everything perfectly. ... We were quite fortunate because obviously the doctor and the consultant were on the ward at the time. So we're running round getting everything organised but other people wanted to step in and take over so I sort of had to control that situation and say no, this is J's baby. She wants to work through it. But sometimes it's quite difficult and I see it with some of the younger girls who are sort of preceptoring, that you know when things like that happen they take over and they don't let the student take control and learn. And I know afterwards, talking to 'J' and reflecting back on it, she said she'd never forget that, she's learned so much (Jessie, 1, 1, 2).

As an experienced preceptor Jessie gives the student space and time to learn. Jessie has learned from her own experience of precepting how best to precept undergraduate students of nursing. She has learned that you must give a student some freedom to learn, and space to take control of a situation. Granting freedom to learn is grounded in a trusting relationship. Jessie states, it is "an experiential thing, being a preceptor, you have to learn to let go". Jessie implies that there is a certain amount of ineptitude and risk present in providing the student with the 'freedom to learn. Experience has taught her this. Jessie also shows that the risk is a calculated one as she states "but know that it's controlled and know that I'm there and if she needs some support".

Preceptors recognise that backup is present in the form of doctors and the Registrar. As an experienced preceptor, in this instance, Jessie implies that although she trusts the student, she isn't 'letting go' of the situation. She concedes the situation to the student rather than giving over entirely to the student. The student has her support but also there is back up if Jessie and the student need it. Benner et al. (1996) called this practice 'delegating up'. If problems arise, expert nurses know that they can call in back up in the interests of patient safety. Jessie is aware of the back up present in the ward if at any time the patient's safety could be compromised.

Jessie then turns her attention in her interview to the attitudes of nurses to simple diagnostic procedures. She states that nurses can become unconcerned about routine procedures and treat these as minor and therefore trivial in comparison with perhaps other patients' health problems in the ward situation. She implies in her statement "we get very blasé, oh angiography, fine, he'll be home tomorrow" that

she is teaching the student that nurses can become blasé about what appear to be simple diagnostic procedures, but here is a situation, where things can go wrong. The lesson is: be careful, what may seem to be a simple procedure can have an unexpected outcome. Very often, as the focus for their clinical learning, students are given patients who are undergoing minor procedures, because these are seen as 'safe' learning experiences. Nurses need to be reminded that it is a person who is undergoing a minor procedure and each person will respond as a unique individual to the situation.

Benner and Wrubel (1989) contrasted two views of the person. One view is that the person is seen as a machine and as such is subject to mechanical faults. In this view, the diagnosis is the focus of the medical and nursing actions rather than the person. The outcome of this view is that there is a stripping away of the human characteristics of the person, resulting in the person being viewed as an object. In this view, when the machine breaks down the medical care, and by association nursing care, is focused upon the medical diagnosis rather than the person.

In contrast, Benner and Wrubel drew upon Heidegger's (1927/62) phenomenological view of the person who is seen as a self-interpreting being within a world of relationships. In this view people seek to make sense of their world and their experiences in order to understand. People act out of their concerns because things matter to them. In this view, therefore, the man undergoing the angiography is a person who, no doubt, is concerned about the diagnostic test and its outcome. In the latter view, the nurse is equally mindful that it is a person undergoing an angiography.

Jessie also shows how the student identifies that the "minor" procedure brought complications:

He [the patient] developed a huge haematoma [a contained blood collection]in the site – it was the puncture site – she recognised it (Jessie, 1, 1, 2).

Jessie implies here that the student, monitoring her patient after the angiography noticed the haematoma had developed and also recognised the emergency situation. The student asks if she can 'manage' the emergency. On occasions students are placed in situations that can be beyond their level of competence. A skill of being a preceptor is to recognise the student capability, to provide some

challenge in the learning situation, to recognise a readiness to learn, and to keep both the student and the patient safe. This is the practice of safeguarding.

Jessie shows in her narrative that she displays an 'air', to her student that 'she can do that.' She demonstrates the preceptor/student interplay as to how the student gains the 'freedom to learn'. The teacher has made a judgement call based upon the learning opportunity in context, knowledge of the student and the patient and, perhaps, her experience of similar situations in the past.

In returning to the narrative again, Jessie displays an 'air' of unspoken assent that 'J' may use some initiative of her own. The 'air' that Jessie refers to is a type of space so that the student can experience some freedom. She intends to give the student some space to learn. She conveys this message in the context of the teaching and learning encounter by her 'air' or her stance to her student. The 'air' that Jessie refers to also is unspoken so the student recognises that she has that freedom. This unspoken message is familiar to the student. She has met it before as she works together with Jessie. The student is open to the opportunity and 'seizes the moment'. The student, given her space to learn, states that she "wants to take control of the situation - if I can be sort of in control of this emergency".

An important aspect of the situation is that the preceptor also knows that it is controlled. The student knows that the preceptor is her back up and she knows that the preceptor is there if she needs some support or help. The freedom to learn for a student is very important but also the student must feel that he or she is not alone or abandoned. Not only does Jessie give her an 'air' of confidence but she makes sure that the student will have success in the situation. She does this by checking the student's planning in the situation by stating, "let's go through what you need to do". Jessie, therefore, in giving the student freedom to learn keeps a tight rein on the learning opportunity.

An important practice of preceptors is assisting students to 'plan out' how they will act in a situation ahead of a patient/nurse encounter or a procedure. By allowing the student to work through the situation as a 'plan' both the student and the preceptor are aware of what nursing actions will take place. In this way the preceptor is checking the knowledge level of the student, an understanding of how that knowledge will be put into action and what the outcome is likely to be. It could be said that Jessie has developed a theory based on her knowledge of the student's

capabilities and the appraisal of the learning challenge. She is confident that the student can manage safely the learning challenge based upon an articulated plan of action worked out between the preceptor and the student. In doing this, the preceptor shows that practice can be theory generating rather than deduced from theory (Benner et al., 1996).

As the narrative continues, Jessie also shows how she holds tight to the learning opportunity for the student by resisting the desire of others 'to take over'. Jessie states that other staff wanted to step in and take over "so I sort of had to control that situation and say, no, this is J's baby". Later in the interview, I [the researcher] asked Jessie why the staff wished to 'take over' from the student. Was it because the staff believed the student was not capable of handling the situation or was it because they wanted to be in on a 'drama'? Jessie's response was that "nurses love the drama, do you know what I mean?" (Jessie, 1,7).

As an advocate for her student's learning opportunity Jessie shows how she resists others from taking over the situation thus pre-empting the student's ability to work through the situation in the interests of 'being free to learn'. By doing this she re-inforces her commitment to the learning opportunity for the student and tests out her theory. It is easy for nurses who are expert in their practice to take over a complicated situation. Jessie has weighed up the situation and has decided that the student is capable of working through it and that the patient will be safe throughout. In order for her to make this decision she must not only know the student but also the patient. If we consider Jessie's action at a philosophical level Heidegger, (1968, p. 15) pointed out that the "real teacher in fact, lets nothing else be learned than – learning. ... The teacher is ahead of his apprentices in this alone that he has still far more to learn than they - he has to let them learn." Jessie shows how she 'let her student learn'. In response she has her actions validated by the student saying that she said she'd never forget that, she's learned so much (Jessie, 1, 1, 2).

In this narrative Jessie shows the interplay between herself, the student, the patient, and her colleagues in context to allow learning to occur. First, she had a relationship with her student that had developed over time as they had worked together for eight to ten weeks. Second, Jessie conceded a learning opportunity to the student that she displayed by giving the student what she described as an 'air'. The student was empowered sufficiently to want to take control of the situation. Jessie talks through with her student the student's plan of action. Jessie must have been satisfied that her student 'J' was equal to the challenge. Jessie protects the learning opportunity for 'J' by being her advocate when her colleagues wanted to

take over. Jessie holds tight to the whole situation, giving the student a conceded opportunity to learn. In this way, 'J' had the freedom to 'learn'. The student at the conclusion states "she'd never forget that, she's learned so much"(Jessie, 1, 8). Later in the same interview, I asked Jessie how she knew that her student was capable of managing the emergency. Her response:

I think you have to know your student. You have to know your student's capabilities and if I didn't know that she was capable of doing it, I wouldn't put my client in that situation (Jessie, 1, 8).

Jessie shows that her practice of precepting reflects a certain level of involvement with her student that assures a knowledge of the student's capability. Benner et al. (1996) discussed the 'skill of involvement' necessary for nurses to work with patients in a context of mutual trust which assists patients to make progress toward health goals. It could also be said that there needs to be a 'skill of involvement' between preceptors and preceptees in context to take hold of the possibility of optimising the learning opportunity. In this narrative Jessie shows that involvement is born out of a close relationship between the student and the preceptor and the mutual trust that has developed between them. Within this there is room for negotiation for students to speak up and identify manageable learning opportunities which can extend responsibility and accountability in practice. From this relationship springs the freedom to build the student's capabilities of becoming a nurse.

The question arises, if the profession requires competent new graduates from nursing schools, what are the prerequisites for competence to be obtained? Rummel (1993) showed how pre-registration students identified an optimal learning environment as one where registered nurses are confident in their own abilities, display a confidence that encircles and supports students, and give students freedom to learn within well defined limits. These pre-requisites were present in Jessie's narrative and emanate from a continual dialogue between the preceptor and the student. The dialogue is established over time as the preceptor opens up learning opportunities for the student.

Summary

Preceptors are ever vigilant. They are constantly assessing and weighing up where the student is at. Preceptors also keep a mental log of the student's learning experiences and search out opportunities for learning. At the same time they

engage in a continuous system of checking, whereby they check the student's knowledge of their patient, and the student's capability to carry out nursing care to their standard for practice. They then "follow through" by checking and double checking that the student is safe in their practice. As Heidegger stated, 'where the danger is, there grows the saving power'. Once preceptors feel confident in a student's ability, they grant the student some space to learn freely. This freedom to learn is one where the preceptor concedes room for learning but at the same time keeps a tight rein on the situation, providing support, guidance, and control for the student throughout. All the while the preceptors are aware of the danger of students learning on live patients. In their vigilance to safeguard both students and patients they hold a tight rein on learning situations at all times. In this sense the preceptors as the safeguarders of practice are the gatekeepers and the standard bearers for developing new nurses. The constant vigilance required of the preceptor is exhausting. In the next chapter the preceptor as the builder of nursing practice is presented.

CHAPTER NINE

The Preceptor as Builder of Nursing Practice: Teaching Reality Nursing

To build is in itself already to dwell. Building as dwelling unfolds into the building that cultivates growing things (Heidegger, 1971, p. 145-146).

Introduction

Dwelling in the world of nursing practice as a preceptor has many facets. As shown in Chapter Eight, preceptors are the standard bearers for developing new nurses. The building of nurses is a long and at times arduous process. Chapter Nine addresses the many aspects of how preceptors build, cultivate, and grow the nurses of tomorrow. As such, in their building they were preparing the way for students to become new graduate nurses, able to practice nursing safely and skillfully. Preceptors live and speak the practices of nursing. In this sense being-as preceptor is embodied as preceptors gather students into the reality of the world of nursing practice.

Being-as Preceptor: Enabling Student Learning Through Engaging the Patient

A practice of preceptors is to involve the patient in the student's learning. Engaging the patient in the learning process requires the preceptor to manage the learning situation skillfully and ethically because the patient is inevitably present. Preceptors whose main focus is with the patient and their health outcomes engage them in such a way that they feel part of the student learning process. Gaining the patient's permission to allow students to undertake a procedure, or to observe surgery or diagnostic tests, is part of students' routine surgical learning experiences. Preceptors set out to make students' experiences as interesting and informative as possible which includes negotiating with the patient, and the surgeon or physician, and theatre staff, and gaining written consent so that students can attend procedures as observers. Such observations provide students with a familiarity and a fuller understanding of the depth of the patient experience and increase awareness of the extent of trauma to the body and the impact this may have on patient recovery. Learning about these complex issues takes the student into a place whereby he or she can care empathetically for the patient post surgery.

Gaining the patient's permission to allow students to practice procedures requires

an approach that engenders confidence between the patient and the student. The preceptor teaching reality nursing is the person who prepares the ground in order for this to occur. Emma, in caring for a patient post-operatively, shares how she involves both the patient and the student in the learning context:

We recently had a man who needed his bag to be changed - his stoma bag, he had a rod in his. So that was a little bit more unique than just a bag change. He needed his readyvac removed. The readyvac had been having a lot of ooze from it and it would need to be bagged once the readyvac came out so, I felt that changing a stoma bag with the rod would be difficult for her so I did it myself but talked her through it. I gave her some education with that and then I talked her through removing the readyvac. And then putting the bag onto the patient's stomach to catch the flow through the hole we had left. Of course the patient was involved. We had to get his permission. The student had never pulled out the readyvac before so we had to make sure it was alright with him and he was right there (Emma, 1, 2).

Being-as Preceptor: Enabling Students by the Practice of 'Talking Through'

Emma reveals another common practice of preceptors: 'talking through' that was identified first by Blazey (1995). 'Talking through' takes place at many points throughout the day to day practice of the preceptor. It is an intrinsic part of involving the patient because it occurs prior to procedures and during procedures. The practice of 'talking through' allowed students to build practical knowledge by practicing skills in a safe and supervised situation that engenders confidence. 'Talking through' also allows preceptors to develop confidence in their ability to successfully teach students.

Often, 'talking through' preceded procedures in a process of questioning and answering. The practice focuses upon a particular patient and procedure thus involving the preceptor and the student working together. The practice also takes time to accomplish and will usually occur in the preparation room of a ward. The preceptor will question the student as to why a procedure such as catheterisation would be undertaken in order to check out the student's knowledge base. Students can either answer well or require some 'prompting'. 'Talking through' allows the preceptor to pass on practical tips that would empower the student in the real situation. This engenders camaraderie between the preceptor and the student and also safeguards the patient and the student in the lifeworld of clinical practice. Florence presents an exemplar of how practical tips are communicated to the student in the practice of 'talking through' as a student undertakes the

catheterisation of a female patient:

And I said, "This is [the student]. She's working with me today. Either she or I will be able to help attend to your needs today". And she asked the patient really well. She said, "Look, I'm a nursing student I'm learning. Would it be okay if I catheterise you?" And she explained what it meant and what it was for and she was good. She said why the doctors wanted it, or why we nurses wanted it in, and it was a nursing decision, to put it in, and how she would benefit, and that sort of thing. And the patient was quite happy for her to do it. That was really good, because sometimes they just absolutely don't want to know.

I said to her, what we tend to do is we just bring a whole pile [of catheters]. We bring like four. Because once we're all sterile we don't want to have to go — if you're by yourself especially, you get very annoyed. So I said to her just grab four and she had to ask the size. And I said, Well basically we start with a size 14 and then with really big women we'd go up one or down one, depending. So we could take one of the other size on the other side of it as well, just in case. And then, just extra KY gel", that sort of thing, and an extra pair of gloves. And we told her that there were two ways of doing it. There's the way you double glove. And you do everything that way, or you wash your hands so they're sterile and then do one step and then wash them again and put your gloves on and do the second part. I said it was up to her which way she did [it]. And we talked through her rationale for choosing which way that she did [it], and she gave me a good rationale, and she did use the double glove one, which is actually the ward protocol now (Florence, 1, 5).

There were many instances where preceptors shared similar instances, 'talking through' procedures away from the patient. But also, 'talking through' occurred between the preceptor and the preceptee with the patient. Preceptors talked a lot with students and patients as they worked together in a shared practice world.

Preceptor as being-with and Showing the Student How

The preceptor as a builder of nursing practice appreciates that they must show and teach students at one and the same time. As stated in Chapter Six, preceptors work with students who are in their first, second, or third year. Although the knowledge and experience required at each level varies there are commonalities across all levels. For example, some of the commonalities relate to the general aspects of caring for a person with hygiene needs. Preceptors adopt different approaches of being-with students depending on the developmental learning stage of the student. As such, beginning students are sometimes in a 'panic' when they are faced with

patient's needing care that they are learning. This means that preceptors are often faced with a 'panicking' patient and a 'panicky' student. Bernie discloses:

She [the student] was a bit panicky when a patient couldn't breathe. [She] didn't quite know what to do and came rushing at me (laughs). So — it was a very good lesson for me to show her how to calm a patient and how to sit a patient up correctly with a respiratory problem. So Mary [pseudonym] and I went to the patient. The patient was on oxygen and quite slumped in the bed, and neck crooked, because they'd been sitting up for breakfast and they'd slid down. Hadn't eaten any breakfast, and that was another thing, that was another part of the lesson that I moved on to. So we had to do a shoulder lift to lift the patient and prop her pillows. A very good way was to stack, you know, not to make a hollow of the pillows, because then that actually makes them very concave and not enough support. But to elevate the bed, stack the pillows up and rest the arms on the pillows so that there's a good open air space, lung space to take in the air. And we went on to give the patient a nebuliser. So that was — it was a lot of lessons all in one, really (Bernie, 1, 2).

Bernie in her story relays the detail in which she cares for her patient and her student. She shows the student not only what to do in the situation but how to do it. As she does so she is talking through the situation with the student and the patient. She is teaching the student the importance of the correct positioning to ensure the therapeutic effect of the nebuliser would be maximised for the patient. As she shows the student, she is also intervening to alleviate the patient's distress. These actions are occurring simultaneously. Bernie continues:

But the main thing was to allow the patient's shoulders to be relaxed and to know that they had their arms supported and allowing the air space to be as open and direct as possible so that the oxygen and the nebuliser could work.

Researcher: So as you're doing this, Bernie, you're talking Mary through this process.

I was showing her. She wasn't sure how to do a shoulder lift. It was quite a complex situation because the patient was panicking and she didn't quite get the message of how to do it. But we did get the patient up and later we practised that, you know, to get your shoulder in right to do a shoulder lift because it's by far the easiest way on your back.

So to do that we had to pump the bed up, so you're not bending over and straining yourself, tell the patient what we're going to do to lessen their panic, reassure the patient at the same time. I tend to if anyone's really distressed, you know, just touch them, especially across their shoulders, and to relax them a little bit. Once we'd got her sitting up and her arms supported then you know just a gentle

stroke down the arms and talking it through just like, just gently relax, you're sitting in the right position, you've got your oxygen on and, just a general reassurance of the patient. And then putting the nebuliser on and showing her how to mix it and what rate of flow. We use a little pipe nebuliser, not so much the masks because there's been quite a lot of research showing that the patient breathes it in and it's a much better response, whereas with the mask a lot of the vapour escapes. So this patient was really distressed, they can't hold it, so that was a job that the student could do (Bernie, 1, 2).

Bernie illustrates how she uses the student's 'panic' constructively. She gets the student to hold the nebuliser. She positions the student along with the patient so that the student can presence with the patient. She does this in a very practical way by showing the nursing actions that will reassure the patient and help the student to observe her patient closely. Bernie continues:

I said it's no use you bending your back and being uncomfortable so you draw a chair up next to your patient and you're sitting eye level to eye level just holding the nebuliser, supporting it for her. And in that way you're actually able to touch the patient or be close to the patient and give words of reassurance, and you're comfortable. You're not sort of overpowering that person; you're on a level. And it's actually a good way of building a rapport with somebody.

Researcher: So you brought all of that in to that teaching situation.

Into one little teaching situation. Once the nebuliser was through - it's a big process because nebulisers when people are having them regularly, they tend to leave like a film in the patient's mouth. So that was another thing, that's a routine thing to do, to rinse their mouth out and it just needs to be water, give them a little sip of their water in their glass, swirl it around their mouth ... and then to put back the nasal prongs. And that was another lesson, showing her how to do it (laughs).

Researcher: Putting the nasal prongs on?

The nasal prongs on. You know some patients will take them off and put them on the wrong way, and they'll put them around their head. But this particular patient, [It's] just positioning it right, so that it's not too tight, they can move their head and it's not putting strain on the ears, and if they're very frail, to even put a little bit of cotton wool at the top of the ears.

Researcher: What was Mary's response to that teaching?

I think she was quite relieved really, to know that somebody was there because they do look very scary when somebody's gasping for breath.

And you really can't reason with a person when they're gasping for breath. They immediately need assistance. You can't ask them any questions because they've got no breath to answer. So you've

really got to assess the situation and help the patient first. Then later you can ask questions about things.

Researcher: So when you had finished with that person and with Mary, as you moved on with Mary to other people and even onto other experiences, did you notice that Mary was able to demonstrate those things in caring for others?

Yes. And I noticed that it left her in very good stead in giving people nebulisers in the future ... And I noticed that was something she did (Bernie, 1, 2).

Bernie knows that a patient gasping for breath looks very “scary” (Rummel, 1993, p. 118) to a second year student. Students use words such as “scary” to describe frightening episodes in their nursing practice. Bernie, from her experienced perspective has seen many patients having breathless episodes. She knows that the student is unlikely to have seen any. She takes into account the student’s distress as well as the patient’s. In this way, Bernie intervenes to relieve the ‘panic’ for both the student and the patient. She also ‘notices’ that the student has incorporated her teaching into her practice for the future. Preceptors gauged their effectiveness as teachers by ‘noticing’ if the student had in fact, taken up into their practice what they had learned.

Being-as Preceptor as Patient Advocate

When preceptors work with students they mediate between the ideal world of theory and the real world of practice. Part of the real world of practice is that people are encouraged to accept responsibility for their own health. Because of this nurses are aware that patients have individual choice. There is an emphasis on quality of life as well as a greater emphasis on the reality of cost containment in health care. The clinical reality is that patients, or their family, are asked some time in their hospital stay, if they wish to be resuscitated should a critical episode threaten their life during their hospitalisation.

It is the doctor’s responsibility to ascertain the patient’s wishes related to ‘Not For Resuscitation’ (NFR) orders or, if the patient is incapable, a close relative is asked on the patient’s behalf. Understandably, doctors do not find this an easy task. Nurses who work closely with the patient during the twenty-four shift are, for the most part, the people who have to carry out the person’s wishes. In the absence of a NFR order, nurses are obligated to begin resuscitation.

Nurses, because of their close association with patients on a day to day basis, are often more aware of the patient's level of health and quality of life and at times, their wishes, which have not been recorded in the patient's notes. Nurses are well positioned to be advocates for their patients and respect their patients' wishes.

Students however, coming from the classroom background, often find this reality of practice ethically challenging. The student has been taught that a NFR order is very much something that the patient should initiate and doctors and nurses should maintain a beneficent and non-maleficent comportment toward such a critical decision. They therefore consider that such a decision should not be made in a way that appears casual but must be given the respect that a person's life commands. Florence shows her preceptee the meaning of being an advocate for her patient and the reality of NFR orders in practice.

We had one patient who was regularly admitted when I was nursing with the student, and the patient said that she wanted to be NFR and the student couldn't understand why. I said to her well, read her health history, read what is actually wrong with this lady. She has several chronic illnesses, she's a very unwell lady, and if she wants to be NFR that's her decision. I said if you or I want to be NFR that's also our decision and we can be NFR. It's a patient choice. But what happened was the doctors decided that she was psych.[sic] because she chose to be NFR...So she couldn't be NFR so she was for resus. And the student was still with me with this. And then they wanted her to go downstairs for a procedure which required consent and they went off to get consent. They brought it back and they said we've got consent. I said it doesn't count. And the student's looking at me going what are you on about. I said if you say she's psychiatrically unable to sign or say she's NFR, she's also unable to sign consent. So I was sticking up for my patient's rights at the time. And I talked to the student afterwards and said this is why I did what I did. I did it because I believe in her right to be NFR and I don't believe just because she chooses to be NFR she has a psychiatric problem. But if they're going to go that line, then I'm going to go the hard line as well. She can't sign consent for a procedure. So the [medical team] backtracked. She could sign consent for the procedure, and she got to be NFR. She was real happy. She's still alive, and she's back in hospital again. But she got to choose (Florence, 1, 9).

Florence shows her student how she ethically comports (Benner, 1991) herself in her practice to uphold the patient's right of choice. She shows her student that what is required on paper for health care, such as informed consent, may be just 'lip service' to a regulation. But person-centred ethical nursing practice requires the registered nurse to be totally focused on the patient and the meaning of ethical care for that patient. The meaning of practising ethically may require stepping out of a comfort zone and challenging a multidisciplinary team member or members to

substantiate their reasoning as to why they have made a particular decision if the nurse believes that the patient's rights are not being upheld. Thus Florence here demonstrates to her student, the nurses role in upholding a uniquely nursing perspective within a multidisciplinary team context. Further, Florence also demonstrates that her contesting of the medical team's decision intervened in their decision making in the interest of her patient. On both accounts, Florence demonstrates to her student an important nursing principle in action.

Being as-Preceptor as Letting Students Grow

Preceptors are mindful of the need to prepare students to be competent when they enter the workforce as beginning practitioners. When learning experiences emerge unexpectedly from practice situations preceptors grasp opportunities to let students grow. Jane shares how she works alongside a student to let her student 'grow' as a practitioner.

My third year student did a dressing on a lady who had a right hemicolectomy. And about 6-7 days down the track her wound dehiscd, completely open. Like we get little wounds that just sort of break down a bit but this was completely open, bowel exposed and what not. And we worked through it together really. She had all the tools and was gloved up and it was just basically doing the wound assessment, what products you need to pack it with and how to dress it basically. The only time she got into difficulty was when she had to probe the kaltostat right up underneath some sutures that were left in. So that was where I jumped in and had to take over. I tried to talk her through it but she couldn't – she had to see it done. She had five clips still left in the upper aspects. And so – it had all opened up at the bottom so we packed as far as you could pack. It tracked all the way underneath. But when you haven't done it before and it doesn't stop you think, oh God. [How far do I go here]. But you do come to an end eventually. And she had a feel as well (Jane, 2, 1).

Jane paints a graphic portrait here of a student who felt confident in doing a complicated dressing when Jane gifts her with a learning opportunity to let her grow in her practice, all the while supporting the student who is stretching herself in a learning encounter. The student is able to manage the wound assessment, choosing the products, and dressing the wound for what she could see. As soon as she is required to 'pack' the wound where she could not see, her courage fails her. But Jane provides the back-up and takes over showing her how to explore the sinus so that she can 'feel' the length and width of what she could not see. Much of nursing is an embodied experience. Her feeling will complement her visualising the sinus

and will assist her to do the wound next time. In fact Jane later states "She feels now that she could probably do it by herself" (Jane, 2, 2).

Other preceptors spoke of stimulating student growth by making a conscious decision to challenge a student. This challenge will occur only if the preceptor thinks the student is capable of further growth and development. Florence shows how she challenges a second year student to care for a client who has complex nursing care requirements.

One patient we had with the student I was really impressed, I said to her now we've been together for about two days and I'd shown her the ward and that sort of thing. I said you can either have an ICD patient that isn't too much work, or you can have the one that's a challenge. And I will help you with the challenge, but you can have the choice. I was really quite impressed, and I thought okay, I've got to watch this. This patient had an IDC, a blood transfusion, IV fluid transfusion, faecal catheter, she had five lines anyway. And the student – she walked into the room, and she sort of scratched her head, and she looked at everything and she looked at me and said, "Okay, I can do this". And she was good. She did chunk it down in each machine, which is what we do too. She did ignore the patient too, a bit, but hey! She took the challenge. And she broke it down into each machine and she went to check the blood - that's fine...She checked the IV fluids and that was fine. She went through and she checked all these machines, and all these bits and lines coming out. Some people will just walk in the room, especially students, because they're allowed to and they go "Oh! I can't do this! I'll take the easy patient!" even though we as nurses can't say, "Oh! I don't want that patient" (Florence, 1, 10).

Florence shows how the student assesses her patient and the nursing responsibility and claims "okay, I can do this"(Florence, 1, 10). Florence elaborates on how the student assessed the situation by breaking down the machinery into one machine at a time. Florence observes that the student did not 'talk' to the patient. Benner (1984) notes that the novice nurse can only focus on part of practice at any one time as this occupies their full attention. Later, as the novice becomes more familiar they can then shift their gaze to take in more of what is going on in the situation. The student no doubt, was concentrating so much on the machinery that she could not talk to or take in the patient much at all.

In Heideggerian terms, the student in this situation first experienced the unready-to-hand mode of being in the world of nursing practice (Heidegger, 1962/27, p. 103).

As time progressed, the student was then able to focus more on the patient than the machines. It could be said that the student eventually experienced the machinery being ready-to-hand (Heidegger, 1962/27, p. 105) and became more comfortable with it. She could then appreciate her patient more. Florence however, acknowledges that machinery and its location within the person and the worry of dislodging lines or machinery bothers registered nurses too. This is the very matter that Heidegger was concerned about. He felt that technology, or what he termed “the standing reserve” would objectify the person thus reducing *Dasein* or their being-in-the-world as a subjective experiencing person.

The complexity of modern day health care is that technology is a reality for the very ill person. Nurses know the meaning for the person living with the machinery and it can become the focus of professional attention at the expense of the patient. Familiarity with the machinery takes time and for a student nurse it will take even longer for they are only in a clinical area for part of their time. As time progresses the student becomes more comfortable caring for the person and the machines.

As the week progressed she talked more to the patient and was less worried about the machines. Initially she was quite worried about pulling something out. Which, okay, is a worry for all of us. We tend to be a bit more careful when people have lines everywhere. So, yeah, she was a lot more careful on her first day than she was on her last day. Not to say that she wasn't careful on her last, she was just more realistically careful (Florence, 1, 11).

The complexity of the patient's health status and the nursing care required for the patient by the student is illustrated in Florence's story. Here Florence reveals the dual responsibility of teaching the student and caring for very sick patients. She again reveals the vigilance required by preceptors keeping a close eye on the student. Preceptors letting students grow into the practice reality must constantly weigh up whether or not the student can manage a challenging situation safely both for the patient and themselves. This is a constant risk for preceptors. Their judgement is critical to ensure the patient's safety but also for the development of competent practitioners. The preceptor tries to meet both demands for the safe care of the client and effective learning for the student. Satisfaction comes when both are realised. Florence continues:

And she wrote the patient's notes. And I said – just write them on a piece of paper first so we can go over them together and see if

there's anything that we could have added or anything that's not really necessary to say. And she wrote the notes and she did really well. She broke – because not even all nurses break the notes down into little bits, like blood transfusion completed, IV fluids continued type stuff. She did, she wrote it all down and she did everything quite [well]. And the next day, I said to her, "Would you like to care for the same patient again?" and she said, "Yeah!" So she took the same patient – who'd got more unwell. And she cared for that patient right up until she finished. And she actually got a thank you on the thank you card from the patient's family (Florence, 1, 10).

Being-as Preceptor: Helping Students to Cope with Reality of Death

Florence reveals another practice of preceptors that is to debrief students and themselves when very sad events happen. Debriefing is a very important practice that assists nurses to cope with sadness and grief day after day, in their every day world of nursing practice. Florence shares how she talked with her student:

We just went away and talked together. .. We talked about what we would have liked to happen, how could we get that to happen next time. Like we called doctors, we called surgical teams, we tried to get surgical teams up to review the patient. The medical team tried to get surgical up to review and by the time they did review him it was too late. Like, he had so much blood out and so much new blood in that his body just went and shut down totally. But they did transfer him to the Department of Critical Care [DCC] and he died 12 hours after that. .. He didn't die on us, which I think probably would have been better if he did. But it would have been much better for her and probably for me too. But I just have a bit better coping strategies for him to die on the ward where she was because there wasn't anything they did in DCC that we weren't doing on the ward at that stage. But it's sort of unfinished. ... So the closure was that we went and talked and we had a cup of tea and talked about what could have been done, why what happened happened so what were the actual physical things that went wrong and why they went wrong. Because he was having all the blood in, what happened to his body, and why he started rejecting it. ... We do that a lot on our ward anyway, we debrief each other either at lunchtime or tea time or whenever we've got time (Florence, 1, 11,12).

Florence shows that in her debriefing session with the student, both revisit the care of the patient. From the story, it can be seen that there were many platforms of communication between professional groups. Timing was all-important and Florence shows that eventually 'it was too late'. There is a danger in health care because of increasing specialisation, that the communication between professionals can interrupt good health care for the patient. Such a situation is of concern as the

professionals are there to meet the public good and provide relevant timely health care. The service orientation of the professional must be focussed on the patient.

In Florence's story, she states that the patient died twelve hours later in the Department of Critical Care. Both she and the student felt a sense of lack of closure. They imply a sense of loss and sadness. Florence also alludes that she could cope better than the student could for she has had more experience in coping with death and loss. The emotional work of nurses takes a toll on their being because emotions epitomise our human proclivity (Lawler, 1997). Florence helps the student to grow from her experience through reflecting back on it and hopefully, helps the student to understand the reality of nursing which includes both life and death.

Precepting as Drawing Attention to the Meaning of Power Play

Precepting did not only mean that the preceptor worked with the student to teach them the practice of nursing but could also involve pointing out aspects of the student's behaviour that are seemingly undesirable professional attributes. The preceptor as the standard bearer for nursing practice wishes to pass on appropriate attitudes in patient/nurse encounters in order for students to learn the meaning of being a professional nurse in a variety of settings. Preceptors needed to be vigilant watching out for students struggling with difficult learning situations. Preceptors helped students to understand that in specialised settings, there are protocols that need to be learnt to prevent disempowering the patient as the student learns the practice of nursing in a psychiatric setting. Victoria reveals her experience of precepting a male student in a psychiatric ward.

I've precepted quite a number of young male students and with one in particular, there's a real power dynamic going down in a psychiatric hospital, especially in a locked ward where the nurses hold the keys and the patients don't want to be there and you've got to be really aware of it all the time. And you've got to acknowledge it and be very very careful not to abuse it. One in particular I'm thinking of, [a] young male nurse I think the power aspect is that they like it, he liked it too much. He liked that power.

[He] enjoyed giving directions and enjoyed saying no, and that sort of thing. And it was difficult. I had to talk to him about it, about the power situation and recognising his own feelings. ... The nature of power, the nature of powerlessness, about empowerment and all those sort of things and ... encouraged him to explore his own feelings about that. I think he was ... well I put it in very broad

terms initially, and he sort of agreed with everything I said, and in the end I actually had to get a bit more specific and make it clear that I was actually talking about some aspects of his behaviour that were untherapeutic to say the least. And he got quite defensive. Which was why I tried to do it gently and talk about power in a wider perspective. But it was, it was a difficult thing. But it never really resolved and I don't think that student will choose to do psych anyway because I don't think he was — well I don't know, he enjoyed the power aspect of it but I don't think he was particularly happy in the area. I think maybe his enjoyment of the power aspect was to do with feeling uncomfortable with people that were thought disordered anyway. And he felt if he had power then it was safe (Victoria, 1, 3).

The very different nature of psychiatric nursing is quite frightening for new students to nursing. Victoria is working at keeping the student and the patient safe in a situation where reality is fluid. Differing perceptions can mean that the student and the patients perceive reality differently. Power here refers to the legitimate use of power and the illegitimate use of power. The legitimate use of power is that those with mental illness require the protection of those nursing them who understand their illness and know that certain behaviours will restore them to health and to be allowed home. Illegitimate use of power is when someone like a student sees that the idea of keys is one of a 'jailer' to keep those who are mentally ill locked away from society. Victoria understands the difference between these sources of power that arise out of perceptions of the skilled and the unskilled. It is this differentiation that she is teaching the student.

Being-as Preceptor: Working with Students Hitting Reality

As the preceptors worked with preceptees they were conscious of building the nurses of the future. In order to move this process forward another practice of preceptors was ensuring that the student understood the reality of the nursing. Some students did not always take their professional responsibility as seriously as they might. Preceptors grasped opportunities to hit the student with the reality of nursing. The student hitting the reality of nursing is not always a happy person. Sarah reveals one such situation:

When the reality of practice actually makes demands that you may be not prepared for, with a student who is going off at half past nine and came up with a big smile to say, oh, she was off, and I said, "Good, good! Have you written your report?" "No". No she hadn't. And I said, "Well you actually need to because you've been doing

the care of that patient". And she said, "But it's half past nine". And I said, "Yes, I know, but you've been doing the care of that patient, so you actually need to write up what you've been doing". Her face was a picture, because she didn't want to be there. You know, half past nine was her finishing time and she was out of there, and it was a real struggle for her to actually stay. And I must say, she didn't do it very graciously (laughs). But then I can certainly [understand that. There's] a couple of times when I've been ungracious too! But I could see for the first time there had been that real conflict. You know everything was lovely, but for the first time there was the conflict of reality hitting, and that she actually had to do something she didn't particularly want to do. And I think, we all have to come to a place with that, you know, where you actually have to stay on. However much you want to go off, and its time for you to go off, you actually can't go off. And that's what I think that nursing is about. And it's the unexpectedness of it, I think. She wasn't prepared for it (Laughs) (Sarah, 1, 14).

There is unexpectedness about nursing practice that holds the potential to interfere with the best-laid plans. In the exemplar Sarah states that the "student's face was a picture" (Sarah, 1, 14). For the first time in hitting reality the student recognised that she carried responsibilities for documenting nursing activities in relation to patient care and if she had not done it in the previous eight hours she needed to stay later to follow through. This professional responsibility is a legal requirement. Students often think that their student status gives them freedoms that are not reality oriented. Sarah teaches her student that reality nursing is accountability-based. While preceptors are engaged in teaching the student about the reality of nursing practice on a continual basis sometimes the lesson is not learned by the student until something happens to bring the lesson home. Such was the case in Sarah's exemplar.

Another aspect of teaching reality nursing that emerged in this study was the adeptness of preceptors to adjust their precepting approach depending on the level of the student. Preceptors weighed up students by observing how they behaved in the ward and interacted with patients. They became adept at recognising the different levels of students from their observations of their practice. Florence draws a clear picture:

The third stage [student] you can teach the tricks to. Like, if you really want your patient to have a shower and you go in there and you say to them, "Would you like a shower?" and they're not inclined to, they'll say "No!"... The trick that we've learned and we use, is "Would you like a shower or a bath today?" And you're giving them

a choice – and generally they'll say, "Oh, I'll have a shower" or "I'll have a bath". But you teach that to third years. Whereas you can't teach that [to the second years] because seconds are so idealistic and they want everything perfect! And reality nursing is not perfect! *Reality nursing* is some things don't get done because we don't have time, and they get passed on and passed on to the next shift until somebody does.

[With second years] they sort of want to do [everything and I have to say] — it's okay, you've got one patient. They can do everything for that patient, and they sort of look at you and you're trying to do what you can for five other [patients]. And they say "Why haven't you done ... and why can't you do? ... why are you handing this on?" And – you try and get them to realise that ... time management is really, really important and when you've got one patient time management is easy; when you've got two it's not too bad depending on how bad the patients are. But when you've got six, or when you've got three really heavy ones, it's quite hard to manage your time. You write it down, or you do something, to try and teach them some ways to get some time management. And some people write it down. And you notice a change from the second years, they'll write the patients name – the second years will grab the stickies and they'll write everything out again – and they'll write the condition in full – their past health history and they write everything on this paper, and it's sort of about 8 o'clock before they're ready to go and start their work, and then they have to go back and write down all their work they have to do, and they'll write 7 till 7.10, shower. But your patient might not want a shower then, and so you sort of go to the next one and you organise it round, and they'll write it down. And the pre-reg ones, they're a little bit more flexible (Florence, 1, 5, 6).

Clearly, an important part of teaching reality nursing was conveying to students how to manage their time. Students hitting reality often did not appreciate the complexity of nursing work and they certainly did not understand how demanding preceptoring was for the registered nurse that carried a full caseload of patients and a student-learner as well. Jane discloses how preceptoring students is tiring work and the level of the student does make a difference:

It's more tiring, I think, having a second year student than a third year student. Just because of the level that they're at, and the change that they go through in that twelve months is wow! A second year comes in and the whole ward experience is so overwhelming that any kind of intense nursing care, I think, just goes a bit over their head. And they're there to learn just the basic stuff at that stage anyway. But you do find that tiring because you have to simplify a lot of what you do for them, and explain it right back from the beginning (Jane, 1, 3).

Jane discloses one of the reasons precepting is tiring is that she needs to simplify things a lot for the second year students. One of the espoused values in New Zealand nursing education is for students to have extended clinical learning experiences to complement the theoretical work in the classroom. The tension is in how this can be accomplished without burning out preceptors. The reality of practice is tiring in itself and teaching a student on top of that can be fatiguing. Preceptors are already busy with client care so that when students enter the clinical setting, preceptors are mindful of, as Lee (1,7) states “you’ve also got the student”. To date, this personal toll on the preceptor is outwardly disregarded by clinical agencies. Rebecca discloses how she experiences her dual responsibility. She states:

Often when it’s very busy, I’m feeling very torn between the need to be teaching [and the patient]. And teaching takes time, explaining what I’m doing. Yeah, often I do put a lot of pressure on myself that I need to be giving more to the student when there’s all the pressures of just what I have to do for the client, or what we have to do. That does make it quite stressful.

Rebecca discloses that from her experience as a preceptor she is:

Learning more to — in those busy situations, just allow the student to watch me, or observe. And I think, for myself, I know observing someone doing something is a valuable learning experience, not just having things explained and being talked about, I find myself it isn’t often valuable until you do it yourself. Until you’re in the situation, until you’re having to think it through, the rationales for doing something, it isn’t actually learnt really. I get quite excited about [teaching] — I enjoy the experience, of being an educator, and in those times where I do have time to talk about my thinking and what’s going on for me, like talking about that with my student, I do really enjoy that when there’s time to do it (Rebecca 1, 2, 3).

There can be little doubt that for many precepting is stressful and time consuming and, according to the participants in this study, is taken on by those who are committed to safeguarding the practices of nursing. While students hitting reality nursing may struggle as they adjust to competing demands, they are privileged as they leave and return to their classrooms while the preceptors must return to their wards day after day and be ready to take on another group of students in new learning encounters.

The Fishbowl Room – Preceptor as Taking ‘Time out to put in’

There were moments in preceptors’ practice when they needed to take time out with a student to reflect and explain practices that had occurred when the preceptor felt that the student had been left out. Even though preceptors had prime responsibility for their patients, they could get caught up in a set of sensitive circumstances surrounding a patient’s admission to hospital which included the patient’s family. In these circumstances, the preceptor would work with the patient and the patient’s family through the crisis while the preceptor’s preceptee was not so involved. However, in the working partnership between preceptor/preceptee, the preceptee was aware of the patient and the family’s experience. In these situations, the preceptor would keep the student involved at a distance and felt a responsibility to pass on to the preceptee how they had managed the crisis situation. When there was time, the preceptor would find some space for teaching. Jane reveals this practice:

I introduced myself and the student [to the patient and their family] and said that the student will be back to just do your care. They were a Maori family and so I felt that they didn’t really need our support as such, we just needed to do what we had to do because they were supporting each other. I think she knew what had been going on the day before, but she had stayed right out of it. I think the knowledge of what had happened the day before – when she went in to care for this patient, she also knew when to just leave them alone. And when I walked past, I could hear her talking to him. ... She had made a connection with him as well. And then the rest of the family turned up. She left them well alone. Because the grandson had died in a car accident and so they were going to see him. She [the student] came to me and said the family’s all there, it’s not appropriate to try and take him to the shower - and I said “that’s fine”. She recognised that. And when the family had gone she went back in and said “what shall we do now, what do you want to do now?” And he [the patient] was all keen to get up because he knew that the sooner he got up, got mobilising, that he may make the tangi in time.

And after it was all over I spoke to her in our fishbowl room and I said to her “I’m sorry if you felt left out today”, and she said “No, I didn’t”. She knew that it was something that only my charge nurse and myself could do. ... but she’d seen it all happening and she’d learnt quite a bit on the side as well (Jane, 1, 8, 9).

The student had learnt vicariously by listening and watching her preceptor and her preceptor’s charge nurse. She was able to act in a culturally appropriate manner because she was aware that there were certain protocols that needed to be observed. Jane, her preceptor, took a mental note not to leave her student out so

she arranged for 'time out to put in' explanations in order for her student to also share in the special moments that occur in the practice of nursing. This illustrates well that although students are assigned to preceptors students can and do learn in many other ways, from different people and patients and families that they encounter in the clinical space. Sometimes students take time out to put into other forms of learning.

They [students] do spend quite a bit of time writing up their logs and sometimes – I know they have to accomplish quite a lot of things, but sometimes when they don't know what to do they just sit down and I think that often in the ward it's good for them to get as much experiential time as possible. I know that they do have to have time to write on the ward (Bernie, 1, 4).

Bernie believes that the students' time should be taken up with gaining experience in the practices of nursing working with patients. But she also is aware that they 'do have to have time to write'. Preceptors observed that the students spent considerable time writing their logs and often wondered what they wrote about when they took time out for this different form of learning activity. Ross's (1991) paradox again would show up the tensions inherent in the preceptor/preceptee relationship. The preceptor wants the student to learn as much as they can, whereas the student has 'student work' to do because they are preparing for nursing practice for tomorrow. Both preceptor and preceptee's concerns are important. Both must exist side by side. For the most part, preceptors are not party to the discussion that occurs between the clinical lecturer and the student even though the preceptor has been an integral member of the clinical learning context. The writing up of logs or journaling is an expected practice for the baccalaureate student. This process of reflection is an important adjunct to their theoretical learning and is seen as a central part of developing the professional person (Schon, 1987). It also serves an even more important function in that, with lessening lecturer numbers in clinical practice, it provides the clinical lecturer with some idea of what the student has found significant in their learning. In this sense the clinical log is used as a tool to develop the developing professional's thinking. Written logs about clinical practice also help clinical lecturers to focus discussion in order to broaden or deepen the learning of significant situations for students. In other words clinical logs are a functional catalyst used by educators to fill in the 'gaps' to reduce the space between what the clinical lecturer observes and does not observe. The question arises however, why could the preceptor not be party to students' reflections on their practice? It could

be a learning context for the preceptor, preceptee, and the clinical lecturer. It has potential for increasing the professional possibilities for all of the parties engaged in nursing education.

Reflective practice is a fundamental part of reality practice for nursing in the twenty-first century. Reflection is a standard that must be achieved for registration as a nurse in New Zealand and is a standard for advanced practice. The skill develops slowly for students, for many are not used to thinking back on their experience. As Heidegger (1971) stated, thinking and being belong together. Thinking in context is necessary for learning that is meaningful and to develop one's own professional practice. Preceptors are constantly thinking either for or about the student and how to gather the student in to the real world of practice. Preceptors think in action but students take time out to think on action (Schon, 1987).

Being-as Preceptor: Walking the Talk

In the future, health care will be more focused in the community. Rae discloses the importance of students being prepared for community practice. She emphasises the importance of teaching the precepts of safe practice in relation to communicable disease. In this, she grasps the importance of 'walking the talk'.

I think that's important for students to realise too, that there's things that they have to do when they choose an area of work whether they like it or not, that they just have to do. If somebody's got infectious x they stay in a negative pressure room and if they come out they need to wear a mask. Or if we go into the room we have to wear a mask. I think they find it hard to understand that they have to wear a mask because they feel like it's claustrophobic. And what does it matter any rate? Well if you could actually see the germs floating round in the air they might have a different perception of it. We cover that in the terms of the fact that x is a long-term disease and you've got to take your pills every day for a long time to get better. And because I've worked in infectious diseases I think there's always a stigma round infectious diseases. If you don't get better there are consequences which impact the whole community if a person doesn't treat their x properly.

I think the hard part for students here is when we've got people that are infectious that aren't sick that have to be in hospital. And I think they perceive us to be almost a little bit harsh at times because we make people stay in their rooms with masks but yet they don't appear to be ill. And it's the whole thing of being careful, but not

being chaotic about it. And not sort of running into crisis every time you have to put a mask on. And just seeing it really is the protection for what it is. But [we also need to be] consistent with what we're doing with people and not sort of saying, "Well, no it's not really that important and they're just a bit overboard here" (Rae, 2,6).

Rae emphasises that special areas in nursing require learning specifics to keep students safe in a context where patients have a communicable disease. When students struggle to understand the reality of practice, walking the talk and role modelling serve as reminders of the serious nature of many illnesses. Students can be slow applying theoretical ideas in practice especially when there is a ward requirement that inhibits children under the age of fourteen years from entering the ward.

I think that's really hard for students and that it is a harder concept to teach them is the whole thing about not having children under fourteen years. They think we're being really cruel. They do. They think it's really cruel and because they're taught in nursing schools, or we perceive they're taught in nursing school, that the whole family is important. And we know the whole family's important, but there're some times where there're some issues that come between the whole family being important and not important. And it is really hard on some of the Pacific Island races and the Maori race where the grandchildren are really important. And [it's hard] especially if the old person with x is the one that's been the caregiver. But the whole thing is that children under fourteen have a less well-developed immune system and are more likely to get the disease. And then [the students] throw at you, "Well, [what] they've been living in the same household as the kiddie?" It's a matter of being consistent. ... I mean the whole thing [is] about teams working together and being consistent and having a really good rationale for why you do what you do (Rae, 2,6).

Rae shows that in safeguarding nursing practice she must teach students the reality that there are certain safety behaviours that nurses must adopt. For students, it is a matter of learning these, as the expected behaviours are intrinsic to the management of communicable disease. Importantly, Rae shows that it is a collective responsibility to 'walk the talk' if learning is to be effective. That is, if it is something that is done as a background practice, it is accepted as 'the way things are' by those who are in the neighbourhood of learning. Rae also implies that there seems to be some lack of clarity of what is taught in nursing schools and the reality practice of nursing. Rae points out the reality of the theory practice gap.

Being-as Preceptor: Feeling Alone in the World of Nursing Education

As pointed out in Chapter Two, Government reforms have altered the way nursing education and health care agencies function. Both lecturers and nursing staff within hospitals have experienced the change in that they are expected to do more with less. What is of significance is that the changes have occurred stealthily leaving both preceptors and lecturers to work out new ways of managing nursing education in clinical placements. New partnerships are emerging but many, as yet, are still seeking ways to facilitate student learning. Rebecca discloses the burden of responsibility:

And these days where the tech tutor isn't around, and it's, you know, it's you as the registered nurse doing so much of the teaching in the clinical situation. Yeah, you're it really. [You're the one who has to] make sure that they get what they need to learn out of the situation and often it is stressful. And often it adds to the stress of my day (Rebecca, 1, 1).

Jane adds to what Rebecca states is stressful being-as a preceptor by reiterating the theme of isolation and uncertainty of not knowing whether preceptors are providing what is needed for the student.

So a lot of it - it's all left up to us really. Especially if some people don't want to precept. But the way staffing is they've had to, especially second year students. And I think that makes it more difficult, because if you're not willing to have a student there and willing to teach them, or if you don't know if you're teaching them properly, then I think that can add more stress and it also impinges on their whole experience. So from that point of view we don't have that much support really (Jane, 2, 3).

Jane and Rebecca express feelings of being left alone and being uncertain. Clearly precepting is stressful. As referred to in Chapter Six, stress phenomenologically refers to a disruption of meaning. Preceptors experience a way of working with lecturers from the Polytechnic/University that is different to their own experience of being a student. Instead of finding help from clinical lecturers they feel "that it is left up to us" (Jane: 2,3). This lack of educational support for precepting is meaningful. How can this situation be addressed?

Even though a number of the preceptors spoke of their isolation from lecturers from the educational institute, and despite the challenging, changeable, chaotic nature of the practice reality, they still maintained they enjoyed their experience of being-as a

preceptor to undergraduate students. Many felt that if they received more support, the experience would be even more worthwhile. Jane comments:

As staff nurses we're supporting the students all the way but there's very little support for us in the role. Nothing. That probably makes this more ... well, [it] makes me more angry anyway. [It's to do with] the fact that all the work that we put in is not actually being recognised. The students say, "Oh thanks, see ya". And that's the last that you really hear from them, or see of them, and then along comes another one. So I think it's a bit sad that there's not that support there for us. People like me are expected to have answers just like that all the time (Jane, 2, 3).

Jane and Rebecca show the dual burden of responsibility that preceptors carry. Jane continues:

It's a big responsibility. Because you sort of think maybe your workload eases up a bit but it doesn't. You're actually constantly watching and making sure that they're all okay and things that take you half the time have taken longer and ... But you've still got to make sure that you're out the door on time, and that you've handed over and that everything's documented, and ...I find that quite difficult sometimes (Jane, 2, 3).

Lee continues the theme of being busy, being short staffed but still accountable for patient care and student learning.

Particularly when we are busy and if we're short staffed, you know. I'm carrying a full patient workload as it is, plus a student and plus trying to give the student direction and guidance. [That means] getting them to think about where they are at their practice, trying to fit in practical skills they need to get involved in, as well as overseeing their patients. And making sure that they are providing appropriate care to the patient needs. So it is very time consuming (Lee, 2, 3).

Several preceptors expressed concern at the lack of lecturer contact. It was hard to feel supported as a preceptor when they were left very much on their own. This situation enhanced the 'unsettledness' that was disclosed in Chapter Six. Jane goes on:

We don't have the lecturer come in. Like, when I did my [programme] the tutor came in and took the student for a while and ran through questions and looked at files and stuff. Whereas, now, we don't have that. It seems to be solely up to us. And that's actually really difficult because it's hard to determine whether or not you're giving the student exactly what they need, if you're giving them too much and if you're focusing at the right level (Jane, 1. 3).

Lee, Rebecca and Jane illustrate the demanding but uncertain nature of being as-preceptor. There were feelings of being undervalued for the efforts made in the interests of student learning. Precepting was viewed as being physically and intellectually draining, and very time consuming. But not only this, it is also placed preceptors in an uncertain place in that preceptors found it difficult to know if they were providing a suitable clinical experience for students.

Experiencing Precepting as being-as “Doubly Accountable”

The theme of being doubly accountable pervaded this research. Florence disclosed preceptors felt that they were doubly accountable in that they were accountable for the student as well as the patient. Florence illustrates the reality of practice:

It's resting on our shoulders and that's bad — well it's not bad enough - that's our job and we do it. But when we have to be responsible for a student on top of that [when we are] looking after our patient, then we're doubly accountable, because we're accountable for that student's actions as well.

Around giving medication sometimes, especially IV ones, they all want to do the IV medications and whatever the tech rules are - I can never figure them out, they keep changing - but if it's under our direct supervision and it's okay with us for them to do it, I think they are allowed to do it. So we did it one day, and I did the same thing as we do when we're precepting a new grad, you have to know what the drug is and what you're giving. And that was okay. She gave the drug and that was fine. And then I came back, I don't know where I'd gone to, and she said, "Oh, I've flushed that drug". And I said to her, "You're not actually supposed to do that without me there because I've got to know what you flushed it with. Well, what did you flush it with?" And she'd connected him back up to the fluids that he was on and flushed him with dextrose/saline, which is not usually recommended for a lot of medication. So we checked out the medication and it was actually okay. It wasn't recommended but it wasn't detrimental either, and I said to her, "It's really good that you want to learn this stuff, but this is actually over and above what you have to do to be registered. You also have to sit another exam to do this. And I do really need to be here when you're doing that". She was trying to help ...

Sometimes we have to explain that to them, that we are responsible for these patients. And it's quite hard to do, it's not easy. Especially when you're having a really busy day, and like the student wants to do something, and you want the student to do something, and we all know what it was like when we were students (Florence, 1, 2, 3).

Florence identifies the tension in preparing competent nurses of the future. In teaching reality nursing preceptors acknowledged that students needed to learn

specific skills but they also needed to be safe. Florence states that students try to help but students are unaware of the 'give and take' situation that prevails as they learn the practice of nursing. The in-betweenness, that ever-pervading "restless to and fro between yes and no" (Heidegger, 1966, p. 75); the dis-ease in managing the patient's safety and gifting the student the practice to prepare them to be competent nurses co-exists. Despite this, preceptors concede what is expected of them as Florence continues her dialogue:

And all of a sudden when she's registered she's expected to be able to know how to do it, no sort of hand holding, nothing, unless you've got very supportive staff on your ward, you're just expected to know how to do it and go in and do it, bang (Florence, 1, 2, 3).

Dale continues the theme of what students need to learn and identifies a need for movement in nursing education to prepare students for the twenty-first century:

[There is a] hospital policy which allows students under the supervision of a registered nurse to give intravenous therapy or intravenous medication whilst they're in their second or third year. There's not a lot of focus on intravenous medications or therapy for students. [That] is a real shame because it's only a couple of years down the track and they're going to be using those tools in therapy of a patient and if they don't start getting it from the very start they're on the back foot once they get out there.

[It's about] focussing on the gap between what the students are getting and what they need. And I guess there's a whole bunch of stuff. And it's really — it's really [being] caught between a rock and a hard place, I guess, where there's stuff that you know that the students should know. There're skills that they should have. And if they can't take somebody's temperature, pulse, and blood pressure in second year then they're really in trouble. They may not be perfect at it, they may need a bit of practice, which is understandable, but if they're having trouble doing it, then... you tend to focus, I find I tend to focus on going over those sort of things if I notice [problems] when I'm working. You know, I was really lucky with the student that I had that she was very proficient with those basic skills, which just made it — it was marvellous, absolutely brilliant. And like I was saying before, the more confident you are the more confident you're going to be in going that step further and learning something new. And as she was confident with those skills I could think, well, what else can I go on with? Yeah, we didn't get as far as I would have liked to if we'd had, say, two or three weeks together. Then I could have gone a lot further into things like IV therapy, not necessarily her performing the giving of the medications but everything surrounding it up to that point. Yeah, because you come out of your training, well I feel that you come out of your training and you're in a situation where — you know, where do I start? Where do I start? Because your focus has been so greatly on the academic side of things. Everything counts towards a

mark. And so the practical experience does get left behind a wee bit. It's really easy to demonstrate to a different clinical tutor, every time you're out in a clinical placement, the same thing. So I don't know — I tend to have this assumption... I almost let the student lead the way (Dale, 1, 2).

Dale continues exploring a theme about the student's readiness to practice. He states that when students come out of their "training" they don't know where to start. He also states that there is a "gap between what they get and what they need". It is true of today's health care system that technology in health care is dominant. As stated in Chapter Two, it is a predominant part of contemporary nurses' practice and as such, students need to be prepared for the possibilities inherent in the future. Dale implies that there is a gap between nursing education and their nursing practice. Preceptors are all too aware of the need for the student to be given every opportunity to "practice your practice" (Sarah, 2, 1) in the reality context. Sarah once again draws attention to the in-betweenness; the tension between theory and practice:

I think [students need] a little bit of theory and then jumping into some practice.. I mean practice I think sometimes means exactly what it says, practising – *Practising your practice*. And communication skills, all those sort of things, I mean they can only be practised and I think they're quite different in hospital as a nurse... I think knowledge without some practice hooks to hang it on is actually very hard to really retain (Sarah, 2, 1).

Sarah discloses her belief that if knowledge is not linked to practice it is hard to retain. Later, Dale reiterates this thought:

I think there's that real comfort zone when there's somebody there with you all the time. You can turn to [your RN] and say, "Am I doing this right? What do we do now?" Then there isn't a hang of a lot of anxiety going on for you because you're not holding the baby, so to speak. Your patient is the main focus (Dale, 1, 2,3).

Dale advances the prudent thought. Preceptors carry the responsibility for the student's practice, keeping the patient safe, all the while safeguarding the practice of nursing. The student is cushioned from the reality of carrying the responsibility for their actions when the preceptor is keeping the student safe in reality practice. Eventually, however, the reality of being 'the nurse' and the accountability that accompanies that existence will be their own. The student's eventual authenticity

'being-as-a-nurse' on graduation is reliant upon the preceptor committing themselves to 'being-as-a preceptor' to students.

A question remains for nursing education and nursing service agencies of how to develop students' practice safely while keeping patients safe but meeting the challenges of continual change in health care. At present, the preceptor is the person who carries this burden. As Kate claims, there is a certain evasiveness that a student can get away with but eventually, the reality of day to day practice as a nurse will be grasped.

You don't know till you do it. You don't know the whole picture until probably six months after you've been a new grad. The year three [student] is getting a grasp of it, you know, they teach you about holistic nursing and considering the patient as a whole. And some - some people get the grasp of that pretty early on. And some people are still task-orientated till the end of their student days and then realise that, oh, hang on, I do actually have to be around this patient for eight hours and I can't go to a tutorial half way through (laughs).. You've got to come back tomorrow, you can't run away. And your four weeks won't be up (Kate, 1, 6).

Experiencing being-as a Preceptor – Letting the Student Lead the Way

Preceptors reveal that working with enthusiastic students was a 'biggie' for them (Dale, 1, 4; Florence, 2, 5; Jessie, 2, 4; Lee, 1, 5; Rae, 1, 2; 2, 1; Rebecca: 1, 6; 2,1, Robyn, 1, 1; Sarah: 1,13; Sue, 1, 1; Victoria, 1, 5). It was much easier for preceptors to be builders of nursing practice when they were able to work with well motivated students who were keen to learn as much about the practice reality as possible. If students were enthusiastic then preceptors had no difficulty teaching them as much as they could. If they found that the student was not enthusiastic then preceptors did not go out of their way to teach the student. As Dale observes, the student who is not enthusiastic would not take up his time at the expense of his patient's care:

If they're really enthusiastic and they want to learn new things then I'll teach them as much as I can. But if they're not enthusiastic and they don't want to learn new things then they're wasting [time]; not so much wasting my time, it's no skin off my nose, I'm there anyway. I get paid for the eight hours, and I'm going to make sure that my patients get the best possible care that I can give them. And I'm going to ensure that my patients aren't going to be compromised by that student being there. And if that student doesn't want to push

themselves or learn anything new, fair enough, but I make sure that's not at the expense of my patient (Dale, 1, 3).

This chapter has shown the diversity and the flexibility of preceptors as they teach and learn from working with undergraduate student nurses. Preceptors too learn from their practice. Many issues arise from the accounts of the preceptors to show the tiring and responsible nature of precepting practice. Can the tiredness come from being challenged in their own learning? What do preceptors learn from being a preceptor? Can this learning be captured and used to enhance the practice of precepting students? Does Heidegger's statement (1954/68, p. 15) "the real teacher, in fact, lets nothing else be learned than learning" include the preceptor who, also, is learning how to be a preceptor? Diekelmann (1995)²⁰ asked when did teaching become asundered from learning? Diekelmann's comment is thought-provoking.

What is equally shown is that preceptors must still maintain their primordial way of being in the world of nursing as a registered nurse. Thinking about how preceptors are in their world, Derrida, cited in Krell (1993, p. 367) states "thinking is that which we already know we have not yet begun to do". The way participating preceptors uncover the challenge they face daily to balance their many responsibilities provokes thinking that we need to begin to do if the profession of nursing is to sustain the practice of nursing. In this chapter, the many ways preceptors 'be' with students have been disclosed.

Disclosure raises many questions about issues and we are left wondering how preceptors manage to meet the many demands placed upon them. Ross's (1990) paradox is repetitively relevant. Demands of safe practice from the patients' point of view always take priority. But providing quality care from an organisational point of view is important as well. *Both* are an inescapable part of the preceptors' day. *And*, added to this is the additional responsibility of students learning the practice of nursing. All of this "for-the-sake-of-which" (Heidegger, 1962/27, p. 232) is for students attaining their chosen career and engaging in an ongoing solicitude for the profession of nursing.

²⁰ Notes from class "Nursing Scholarship and Approaches to Interpretive Phenomenology by Dr's Nancy and John Diekelmann, 1995, Four Day Short Course, 14-15 December and 18-19 December, Victoria University of Wellington, Department of Nursing and Midwifery.

Preceptors are concerned for students as people and as students, caring for and about them both personally and professionally. Preceptors reveal the importance they place on ensuring students learn the precepts of nursing. In this way they safeguard student nurses as developing professionals and equally safeguard the profession from students who may have not made the best career choice. Heidegger (1971, p. 73) stated “to experience something is to attain it along the way by going on the way”. Through the way, preceptors embody **being-as** a preceptor.

We should be reminded once more of what is concealed in the meaning of in-betweenness. That is, preceptors exist in a lifeworld that reflects the in-betweenness of one institution and another reality where preceptors, students, and clinical educators are caught in the everyday world of nursing practice in the clinical context. What needs to be grasped and taken to heart is another question that is raised by the preceptors. This question is perhaps the most important of all to being as-preceptor. It influences the complete experience for preceptor and preceptee. Sarah reveals:

I was talking to a guy last year and he was saying that the hospital gets paid for students. And I was talking to him about it later and saying, “What happens to the money?” I actually never did find out what happens to the money, but it certainly didn’t arrive on the ward. Like he was talking about the cost to the hospital, he was coming out with this amount. And I went around and I thought about it, and I thought, it doesn’t cost the hospital a cent. It doesn’t! It costs us [registered nurses] time and it costs us energy. And it costs us patience. But it doesn’t cost the hospital a cent!

I think that it’s really quite unfair. The students are paying, and they’re still [expecting] you know, to get the attention. Not that it’s a bad thing, the things that we’re asking them to do. It’s good experience for them. But at the same time, really, by rights, if I was paying I would think, “Well why isn’t there a nurse specifically assigned to spend time with us?” Which I [do] think. Where does the money go?

I mean I think, if I was a student, I think I could feel aggrieved on some of the days that we have on the ward where it’s busy. [The students] are not the priority. I don’t think that’s fair, but the patients are always going to be the priority, and that’s the way it is. I don’t think it’s fair to the student. I mean you can take them around with you, and they can do a certain amount of things, but there’s nothing like when you’re busy. It takes time and energy to teach somebody and that has to just go by the board. And I think that’s hard on [the students] (Sarah, 1, 9).

Sarah leaves us with important questions. Should and could the money go to preceptors to lighten their load? Or could the money for clinical learning go to assist preceptors in their education in the interests of our future nurses? What are the rewards for the preceptor for the very real contribution they make to nursing education and to the practice of nursing? Should rewards just be intrinsic? That is, is it fair to assume that all registered nurses gain satisfaction from helping a student to learn? Should there not be some extrinsic reward also?

Summary

This chapter has revealed how the preceptor dwells in the world of nursing practice assisting the undergraduate student nurse to “build” their practice. As preceptors worked with students they recognised that there was an inherent need to challenge students in the learning context. As they assisted the students to develop practice, preceptors involved patients in the course of learning, and needed to be prepared to confront the student with the reality of day to day work and the accountability that accompanies professional practice. Preceptors also needed to be able to draw attention to the deeper meanings of specialist practice such as psychiatric nursing and caring for people with communicable disease. The practice of safeguarding both the student and the patient is paramount and is a constant vigil for the preceptor.

All this took place in a context where clinical lecturers were conspicuous by their absence and where the lack of support from the educational institution was noticeable. All the while, preceptors as builders of nursing practice continued to carry on and spend their time teaching reality nursing to students as well as nursing their patients. There can be little doubt that the narratives shared in this chapter reveal that being as-preceptor requires the registered nurse to be willing, flexible, versatile, energetic, knowledgeable, highly organised, and a sensitive communicator, but above all, committed to safeguarding the practice of nursing. As such, the preceptors in this study stand out as being the standard bearers for developing new nurses.

CHAPTER TEN

The Research Findings: The Meaning of the Experience of being-as Preceptor to Undergraduate Student Nurses

Where thinking finds its way to its true destination, it comes to a focus of listening to the promise that tells us what there is for thinking to think upon (Heidegger, 1971, p. 75).

Introduction

In this chapter the significant findings of this study are presented. They find accord and discord simultaneously as they are discussed in the wider context of knowledge. Implications for education, practice and research are addressed, and limitations from the study are identified along with recommendations that emerge from the research as a way forward for the future.

Heideggerian Hermeneutic Analysis does not seek to bring forward finality but rather to make visible the meanings inherent in the participants' stories. This chapter seeks to reveal what lies before us. This is aptly expressed by Heidegger (1968/54, p. 217) as what we need to "take-to-heart" in order to learn from the preceptors' experiences. What is revealed by the preceptors is that the phenomenon of being in the world 'as preceptor' to student nurses is different to, yet part of being in the world as a 'practitioner', because the preceptor is situated in an in-between space in which she or he is safeguarding the practices of nursing and of students. There are differences in interpretive emphases depending upon which vantage point one holds, or one's 'gaze'.

Merleau-Ponty (1962) discusses 'gaze' as the lens through which we view the world. I focused through the educational lens as I listened to the narratives of the preceptors. Naturally, my interests lie in understanding the precepting experience as registered nurses assist novice students to learn. The preceptors' gaze however, focused upon patients and providing safe, competent, quality nursing care to meet patient health needs. Contradiction exists here in that the preceptors carry heavy responsibilities for both patients and students at one and the same time. Ross (1991) has shown us that a paradox is not an either/or situation but rather an integration of both-and. Therefore, recognition of the both-and situation is required for registered nurses to practice in the complex context of acute care, which reflects multiple realities. There, the preceptor walks between two worlds, and is engaged in balancing between the reality of practice and the world of nursing education.

Making meaning of these experiences within the hermeneutic circle of understanding does not produce an ideal way of knowing but is the “expression of the existential fore-structure of *Dasein* itself”. (Heidegger, 1962/27) states:

In the circle is hidden a positive possibility of the most primordial kind of knowing. To be sure, we genuinely take hold of this possibility only when, in our interpretation, we have understood that our first, last, and constant task is never to allow our fore-having, fore-sight, and fore-conception to be presented to us by fancies and popular conceptions, but rather to make the scientific theme secure by working out these fore-structures in terms of the things themselves (p. 195).

The fore-structure of understanding is presented to the reader in the scientific theme that has originated in the Heideggerian Hermeneutic Analytic scheme, secure in the working of the fore-structures described in Chapters Six to Nine in order to bring the reader back to “the things themselves” (Heidegger, 1962/27, p. 195). By returning to the place where we have started we have traveled full circle. There is no beginning and there is no end to a circle of understanding, but rather, there is only a place for further questions. As Heidegger states, “questioning builds a way...the way is one of thinking” (cited in Krell, 1993, p. 311). What calls for thinking is the interpretation that I have made from the numerous possible interpretations of the meaning of being-as preceptor to undergraduate student nurses. The researcher, though, also recognises that the reader will bring personal interpretations to the circle of understanding depending on their own experiences and horizons of understanding.

Phenomenological hermeneutical enquiry is time, space, and context bound. Before we move on, the reader needs to be reminded that this research took place during the height of the health reforms in New Zealand in the mid-1990s when the health care system was in crisis. The situated context of precepting was fraught with the constant change that pervaded the restructuring context. Disputes, strikes, ward closures, ward combinations, the directive to do more with less, featured at the forefront of the acute care setting. Registered nurses faced many demands in their day to day work place and those nurses who became preceptors had more responsibility thrust upon them. Not only were they responsible for caring for patients in the fluid sociopolitical context of healthcare, but also they were expected to respond to a changing education context that affected the way they precepted students. Therefore, understanding the meaning of the precepting experience

requires us to retrace the path we have traversed and revisit the 'way' being-as preceptors emerged as the study participants lived and spoke within that changing context. In this way the reader moves into the clearing where the meaning of being as-preceptor is revealed.

The Constitutive Pattern: Safeguarding the Practices of Nursing

The constitutive pattern encompasses the key ideas permeating all data (Diekelmann et al., 1989). The constitutive pattern emerged from intensive hermeneutical analysis of all the texts and was apparent across the data. The pattern, *Safeguarding the practices of nursing* encapsulates the central theme of the thesis and constitutes the meaning of the precepting experience.

'Safeguarding' comes from the German word "*friede*" which means to keep safe from harm or danger. From this position of safety, concepts from the German word "*bauen*" meaning to dwell, to cultivate, to grow things, and to build, (Heidegger, 1971, p. 149) become especially significant. It is argued that these key ideas pervade the language of the preceptors, either directly or indirectly.

It was apparent in this research that *Safeguarding the practices of nursing* emerged as the preceptors became attuned to the call to be a preceptor. While many preceptors were thrown into the precepting role almost unwillingly, others appreciated that someone had to 'dwell' with students learning the practices of nursing. Dwelling is about staying and lingering with others. Dwelling is also about drifting and it was evident that some preceptors were reluctant to become preceptors but merely drifted into the experience. As the preceptors worked with students over time many became involved in deepening relationships with their students. This forged an emerging identity of being-as preceptor as they learned to cultivate students. Preceptors safeguarded nursing practice as they 'cultivated' students by encouraging, fostering, helping and nurturing them in the real life world of practice. As the preceptors became more experienced in being-as preceptor they learned to 'grow' students, to extend and stretch them, thus advancing them in their practice. Preceptors safeguarded the practices of nursing by working alongside students and ensuring that they were prepared to meet standards of practice. Eventually, preceptors emerged as the 'builders' of nursing practice as they developed students further and drew them into reality practice. Being-as preceptor

was therefore about controlling practice and strengthening the students' understanding of how to function in the everyday clinical world.

The Four Chapters (Six – Nine)

In this study the narratives lay open the essence of 'being-as' preceptors. In being-as preceptors, they dwell, cultivate, grow, and build the preceptee as the central focus of the preceptors' experience.

Safeguarding is laid out in the four chapters that constitute the pattern of being-as a preceptor. In Chapter Six, *Becoming attuned – the call* relates to registered nurses dwelling in the world of nursing practice and responding to the call for being-as preceptors to students in their clinical placement. Chapter Seven, *The Emerging Identity of 'being-as' Preceptor: Keeping the student in mind* relates to preceptors cultivating their own identity of being-as preceptors as they worked with students meaningfully in the world of nursing practice. Chapter Eight describes *Assessing where the student is at: The preceptor and preceptee working and growing together*. Preceptors constantly assessed where students were at in order to evaluate their readiness for learning the practice of nursing. Further, as preceptee's responded to the careful watchfulness of the preceptor, a reciprocal growing in the preceptor/preceptee partnership was experienced. In Chapter Nine, *Preceptors as builders of nursing practice through teaching reality nursing*, facilitate the preceptees' experience of the real world of nursing.

Dwelling, cultivating, growing and building connect precepting to the preceptor's existence ontologically. To exist is "to have actual being; to live; to occur; to continue to live, *especially* in unfavourable circumstances" (Schwarz, 1993, p. 590). Existing also means surviving (The Collins Thesaurus, 1984). There is little doubt that as the preceptors work in the in-between space between the world of nursing practice and the world of nursing education, they "continue to live in unfavourable circumstances" and in many instances survive, as they precept students. The preceptors' language therein reveal that they are caught in their being-as preceptor in an in-between space of being both the registered nurse and the preceptor. The in-betweenness experienced by the preceptors in this study is somewhat different to the traditional meaning of in-betweenness in which nurses are situated in between other people - the patient and the physician (Engelhardt, 1995). The preceptors reveal in their language that, because they walk between the two worlds of practice and education which are two very different situated contexts, they develop an

awareness that they need to safeguard the practices of nursing. The language is significant for “the language of being is still the most resonant language we have” and “the beauty of such language carries a transformational power” (Ross, 1991, p. 61).

The hermeneutic process reveals that being-as preceptor is a difficult experience for registered nurses because in reality they are torn between three masters. First, preceptors are professionally accountable for caring for patients. Second, preceptors are responsible to their employers to uphold the organisational standards for quality of practice. As registered nurses, preceptors are expected to practice nursing to uphold the interests of public safety in health care. In a resource strapped environment that is undergoing continual restructuring (for health reforms have not stopped), this is not an easy way of “being-in-the-world” (Heidegger, 1962/27, p. 33). Health reform remains a continuous process at the time of writing, in 2001 as the government sets up District Health Boards as part of its new health strategy (Ministry of Health, 2000). Third, preceptors must endorse the standards of nursing education and students’ clinical learning experiences. In this latter area there are accountabilities to the student that are prescribed in the Education Act (1989). There appears to be a gap here between education and practice or, in Heideggerian language, an “abyss” (Heidegger, 1962/27, p. 192) where there is no firm ground. It is this gap that causes preceptors to become conscious that precepting is about safeguarding the practices of nursing.

Exploration of the in-betweenness of being in the world as-registered nurse and as-preceptor reveals that the way preceptors are in their world is one of solicitude. Preceptors step into the in-between world of clinical teaching because of their solicitude for student nurses as well as their desire to safeguard the practices of nursing. “*Fürsorge*” (Heidegger, 1927/62, p. 157) is translated as solicitude and is explained by the translators (Macquarrie & Robinson, 1962) as having a type of “social welfare” connotation. It is underpinned by a sense of ‘care’ of a more universal sense than the close caring that occurs in a kinsman relationship. In this sense then, the preceptors care for and about students in a general sense rather than according to the specialised form of care as in a formalised teaching/learning relationship. Preceptors as registered nurses are primarily employed for patient care and are therefore in the world of nursing practice in order to care for their patients. If we consider that “*Dasein*, being-in-the-world” (Heidegger, 1927/62, p. 33), is always first and foremost an holistic experience, and if we accept that one

comes to understand oneself through being-in-the-world with others (Heidegger, 1962/27, p. 154), then there are immediate issues arising from the duality of responsibility and accountability that the preceptor holds. This includes responsibility and accountability for their practice; both for their own practice in relation to patient care and for the student's practice in their patient's care.

In this study, some preceptors voiced their concerns that they were unprepared to precept student nurses. This feeling of unpreparedness can be interpreted in a number of ways. One way is that the preceptors felt that they had insufficient education to prepare them to be preceptors. Another is that the precepting process has been ill considered or not thought out between the educational institutes and the ward placements. Preceptors live frenetically because of so many demands being made upon them in their day to day patient assignments. Thus their unpreparedness relates to their ethical sense of believing they are unable to provide the quality care they wish to for their patients. This moral sense carries over also into precepting undergraduate student nurses. Preceptors believe they cannot do justice to the student's clinical education because of so many other demands. As shown in Chapter Two, registered nurses are now fully occupied caring for patients because patients are older and sicker when admitted to acute care facilities and because of staff shortages.

The current arrangements between educational institutes and clinical agencies do not seem to recognise that 'being-in-the-world-as-preceptor' to undergraduate student nurses calls forth specialist practice that requires nurses to have had educational preparation as teachers. In this study, precepting which involves clinical teaching, the means by which nursing students learn the practices of nursing, comes second to nurses who become preceptors. For preceptors their first priority is their patients. They are however, ever mindful of their responsibility to the students and student nurses matter to them. Even when they are too busy to work closely with students they are always thinking about them. As shown in Chapter Four, thinking and being cannot be separated. Right across this thesis it has been highlighted that each day the preceptor is caught in the 'in-betweenness' of "the restless to and fro between yes and no" (Heidegger, 1966, p. 75). This 'in-betweenness' is a temporal issue of an "awaiting" (Heidegger, 1962/27, p. 461).

'Awaiting' is time related, and as such, highlights a restless indecision as to whether the preceptor can manage to precept a student and provide quality nursing to their patients at the same time. 'Awaiting' is also influenced by familiarity with the immediate context in which the patient is the priority and by staffing numbers and the skill mix of the staff rostered to provide patient care. The preceptor must first weigh up their being situated in the world of practice before they decide to be-as preceptor. Therein lies the tension in that in reality registered nurses cannot do both jobs adequately. But if registered nurses do not precept student nurses, how will the practices of nursing be safeguarded?

Therefore, the in-betweenness of the precepting lifeworld can be seen as an 'abyss' (German *abgrund*) (Heidegger, 1927/62, p. 194). *Abgrund* is derived from *grund* with the English derivative 'ground'. *Abgrund* literally translates to "earth going down (wards)" (Inwood, 1999, p. 82) and refers to the place where one is without ground, groundless or without firm foundations. When on *abgrund*, one must take a 'leap' to gain firm ground. Ground and groundlessness in Heideggerian thought relate respectively to meaning and meaninglessness. The groundlessness influences 'being-in-the-world-as-preceptors'. The question arises, are registered nurses in an 'abyss'? With groundlessness, they are on unsafe ground and if they do not move they may fall. But preceptors do not see their precepting as meaningless, but as meaningful. What is missing or what calls us to thinking (Heidegger, cited in Krell, 1993, p. 217) is that an abyss ordinarily is seen as 'nothing'. Nothing is 'no thing'. Because there is little attention paid to precepting in the organisation of registered nurses' work, it could be viewed as 'no thing'. It is 'no thing' because we do not know what precepting means. There has been little time for thinking, as precepting to date is grounded solely in 'doing'.

'Thing' has a particular connotation in Heideggerian language. 'Thing' *versammlung* (Heidegger cited in Krell, 1993, p. 355) is old German for a gathering and it specifically concerns a gathering to deliberate on a matter of importance and concern. In this study the matter of importance is that being-as preceptor to undergraduate nurses is every 'thing' to the students as it embodies their aspirations and career. To the preceptor it is also some 'thing' that they must find time and space for in their everyday world of nursing practice. Betwixt 'everything' and 'something' lies the in-between space and it is there that preceptors safeguard nursing practice.

The Relational Themes Supporting Safeguarding

The relational themes that support the constitutive theme have been presented in the previous Chapters Six – Nine. Many common themes make up a relational theme that contribute to the over-riding essence of the thesis which is ***Safeguarding the Practices of Nursing***. Safeguarding the practices of nursing is understood better when safeguarding as dwelling, cultivating, growing, and building is connected to becoming attuned to the call, safeguarding as encouraging relationships with students, safeguarding as working together as one, and safeguarding as teaching reality nursing practice are considered. The significance of the findings within each chapter is the ‘things’ (Heidegger, 1976, p. 174) that matter. From the rich data, ‘things’ that should gather our gaze follow.

Safeguarding as Becoming Attuned: The Call

The relational theme *Becoming Attuned: The Call* identified how attunement was played out for a number of the participating preceptors concerned with dwelling with students in order to safeguard the practices of nursing. The findings uncovered many tensions. It was evident that many registered nurses are reluctant to respond to the call to precept students and those that did, felt unsettled, indeed out of tune, in the new way of being in the world. Therefore, the assumption I made at the beginning of the research, that all registered nurses would be keen to be preceptors and share their knowledge with student nurses, was not upheld. Restlessness reflected an underlying nervousness at being-as preceptor as it was clear that all too often the preceptors were expected to cope with a completely new experience for which they had little or no preparation. Being-as preceptor placed expectations upon registered nurses that they felt inadequately prepared for. It was evident that many registered nurses either drifted or were forced into the precepting experience.

Inherent in the relational theme of ‘becoming attuned’ is “mood” Heidegger (1962/27, p. 172). Mood refers to how people are in their world, that is, their state of mind. As stated, the preceptors were situated in a context of constant change and health reform. The “restless to and fro between yes and no” (Heidegger, 1966, p. 75) that preceptors experienced emanated from the question, should I precept or should I not? Reluctance to be a preceptor stemmed from feelings of unease about the clinical educational way of being-in-the world that was different to the lifeworld of everyday practice. It was in the betweenness of yes and no that preceptors dwelt,

not understanding the full possibility inherent in being-as preceptor, but nevertheless keeping students safe. This raised awareness of the need to be constantly noticing, or watching, or keeping an eye on students, that was an added burden when the staff nurses were already over-stretched. Added to the 'restless to and fro' was the temporal concern for preceptors of being betwixt preceptor and nurse. Their first priority was patients.

Uncertainty was revealed in becoming attuned to the call and was present because being as-preceptor was interspersed with a sense of 'aloneness'. While some participants drifted into being as-preceptor many experienced it as being thrust into a very new role. It was a baptism by fire and an experience that was shaped by trial and error learning. Taking on an extra role was compounded further by the fact that the preceptors did not necessarily know what level students were at, or what they had been taught. Insecurity founded on a lack of information undermined the extra energy needed for student teaching that was taking place in a changing context. This was complicated again by the fact that nursing education was changing and few preceptors understood the current requirements. There appeared to be little effort made by regular clinical lecturers to acquaint them with these requirements. In fact, in this thesis and throughout the data, there is a noticeable lack of mention of the clinical lecturer who ought to be the *consistent link person*, (Dyson, 1998, p. 109), between the educational institute and the acute care context, and hence with preceptors, when students were on their clinical placement.

Because of these circumstances the more recent graduates had little choice in dwelling with students, as they were more likely to have students thrust upon them. There was an assumption that the new graduate could preceptor students because they were attuned to contemporary nursing education and understood what the Polytechnic/University wanted. This meant that older registered nurses who might have volunteered to be preceptors may have felt that they were 'not good enough' to precept students. Some participants suggested that they were not good enough in the sense that they were not sure of the knowledge they should have or what intellectual skills were required of them, despite the knowledge they had of the practice of nursing. The practice of nursing is the everyday work of all registered nurses who hold a practising certificate. But the questions are asked: "Is any staff nurse who is willing to take a student for the day a good enough rationale to precept student nurses? Should there not be other criteria apart from willingness?" The Nursing Council of New Zealand require clinical lecturers to have a Master's degree

to teach on a Bachelor's programme. Davis and Barnham (1989), and Greenwood, (2001) suggest that preceptors should have a Master's degree also. In this study, none of the preceptors had Master's degrees, six had Bachelor's degrees and two were studying towards their Bachelor's degree.

Levels of experience affected being-as preceptor and how the preceptor became attuned to the call. On the one hand, even though some preceptors were experienced practitioners with many years of nursing practice they were so busy with the demands of patient care that the added responsibility of precepting was of concern. On the other hand, some of the preceptors held little post-registration experience and coped with the situation as it presented itself, but did not feel 'at home' in their world being-as preceptor. They hardly knew 'home' because they were still finding their own feet. These preceptors were not, however, unwilling to be preceptors; they simply believed that new, and extra demands were being placed upon them and they did not feel adequately prepared to meet that challenge. Thus the reality for the preceptors was a conscious feeling of 'being thrown' into being a preceptor.

To be 'thrown' into the world phenomenologically is not a conscious experience. For preceptors to identify feelings that portrayed an experience of 'being thrown' in a literal sense meant that the experience for many was quite stressful. Despite the multiple tensions, those who hearkened to the 'call' seemingly had an implicit desire to contribute to the development of the new nurse. In this way preceptors 'safeguarded' the profession of nursing by dwelling with students as best they could.

Safeguarding as the Emerging Identity of being-as Preceptor: Keeping the Student in mind

In another relational theme: *the Emerging Identity of being-as Preceptor: Keeping the Student in mind* meant that preceptors cultivated their identity of being-as Preceptor. Being-in-the-world is always being "there" with others (Heidegger, 1962/27, p. 173). While preceptors were first and foremost registered nurses, part of cultivating an emerging identity of being-as preceptor required that they recognise the diversity of the student population and what that meant to them in their precepting. In a Heideggerian (1969) sense 'identity' refers to a "belonging together" (p. 14). For preceptors it was making the identity of being-as preceptor their own. Identity is not something that one takes up in a conventional 'role' theory

(Erikson, 1968) but requires that the preceptor come to a place where one belongs in their world. Identity is feeling at home as a unity of being.

What stands out in this study is the way that preceptors cultivated the desire to understand students in order to help them to learn. This cultivation did not happen in a vacuum. Encouraging relationships with students was forged through their experience of being-as preceptors. Student diversity was especially challenging, and possibly emphasised why the preceptors engaged in safeguarding the practices of nursing. Preceptors acquired different teaching tact to facilitate clinical learning as they learned to work with more mature students and those who came from different cultures. An awareness of Maori and their unique place in New Zealand society and the importance of gathering Maori nurses into the profession was appreciated by some. Safeguarding emerged as the preceptor cultivated an attentive watchfulness, a nurturing way of being that respected the uniqueness of the individual undergraduate student nurse as she or he learned the practices of nursing.

As preceptors cultivated their identity, they engaged students in dialogue between the students' theory and their immediate practice. Some preceptors encouraged students to establish meaningful links in a relational form of learning in order for their practice to be theory generating rather than theory relating (Benner, Chesla & Tanner, 1996). Such practices by preceptors encouraged students to develop critical thinking as they began to discriminate between what knowledge they needed to know and what was 'nice to know' in the immediate care of patients. As preceptors cultivated the students' ability to make links, the active merging of theory and practice assisted students to learn situated nursing knowledge as it is embedded in the practice (Benner, 1984) of nursing. It was evident that preceptors gained satisfaction as they saw students excited by their newfound knowledge. Because of the preceptors' enthusiasm, they, in turn, excited the students who could literally 'see' their knowledge coming to life. Additionally, preceptors recognised that their ability to engage students in a dialogical form of learning from the students' practice brings the ideal and the real together as one. As preceptors encouraged relationships with students and successful teaching encounters were experienced, their identity of being-as preceptor grew stronger.

Being-as preceptor to enthusiastic students was a positive experience and reflected a way of being-in-the-world that unified preceptor and nurse. It was clear that preceptors' teaching practices mirrored their nursing practice in that they cared for

students as they would their patients. While the participants worked to relate to students, they also spoke of colleagues who did not always welcome students and were uninterested in nurturing them while they learned. Frustrating or unrewarding experiences for preceptors impeded cultivating the identity of being-as preceptor. Some registered nurses were unwilling to be involved with students who spent only a short time in a clinical placement. These preceptors expressed their concern that precepting was time and energy consuming and if the student was not particularly interested in learning, they did not wish to waste their time. Students who did not achieve, created extra work, and preceptors were pushed even further when there was a mismatch between the students' theoretical and practical ability. In fact, one preceptor expressed annoyance at the fact that the clinical lecturer had not revealed to them that a student was having difficulty achieving. Yet, a few preceptors realised that some students would take longer to learn practice. If the preceptor believed that the student was genuinely interested in learning to be a nurse, then it was evident that concerned preceptors helped students' achieve which continued to cultivate their identity of being-as preceptor.

Thus, preceptors experienced both joy and distress as they developed relationships with students. Revelations from preceptors about students who were seemingly uninterested in learning in their clinical placement were of concern. Preceptors struggled to give time to disinterested students who were 'doing time'. It is possible that those students confirmed the preceptor's commitment to nursing and emphasised even more the need to safeguard the practices of nursing from those who had little interest in being nurses. Under these circumstances, the cultivation of the preceptor identity was diminished as the registered nurse, as safeguarder of the patient and the profession of nursing, would take precedence. Nonetheless, the findings reveal that overall, preceptors in this study sought ways that would safeguard the preceptor/preceptee relationship in an effort to support the novice nurse as they learnt how to nurse.

Safeguarding as 'Assessing where the student is at: the preceptor and preceptee working and growing together'

The relational theme of *Safeguarding as assessing where the student was at: the preceptor and the preceptee working and growing together* emerged and was highlighted because preceptors were constantly checking on students. Preceptors were constantly aware of their student charge and the expectations they had of

themselves to prepare the nurse of tomorrow. What stood out is the vigilance of the preceptor as they sought to 'grow' the student in the practice of nursing. The preceptor was always mindful of the student, even if they were not working directly with them. The preceptors disclosed that they were ever aware of extending and developing the students, preparing them for the reality of the practice world that they would soon enter. Some considered that the students were not being prepared appropriately through their nursing education for the highly technological world of contemporary nursing.

Working together meant a growing union between preceptor and student with the preceptor gaining an overall impression of the level of competence of the student in order to 'push them a little bit' to grow their practice. Establishing the students' readiness for learning meant that preceptors spent considerable part of their day directly and covertly observing students' practical skills. Preceptors were always ready to 'jump in' if the student got into difficulty with patient care. In this way, preceptors kept in mind the dangers inherent in the novitiate by constantly assessing where they were at. The preceptors' monitoring of students' progress was to know how best to stretch and grow them as they learned. Practices that preceptors engaged in, as part of the growth process in working together included weighing up, checking and double checking on students, keeping a mental log of students' learning experiences and searching out new learning opportunities. The over-riding intention was keeping the student safe in practice but underlying this was extending them and growing them to be competent nurses for the future. The vigilance of the preceptors from their constant watchfulness and challenge was revealed as part of the exhaustion that the preceptors felt as they juggled many differing demands of their lived world of nursing practice and being-as preceptor.

In working together with students, preceptors simultaneously had to grow into the union by becoming more involved in the assessment process. Preceptors spoke of the expectation from clinical lecturers of a greater participation in the summative assessment of students' clinical competence. This new expectation seemed to take place in a vacuum without the background knowledge of curriculum requirements and with little support from clinical lecturers except when the preceptors' assessment of the students' practice was out of kilter with the clinical lecturers' expectations. So in growing the students, they also had to grow themselves as preceptors by learning about educational processes as they went. Moreover, for preceptors to deal with matters that were concerning them, there seemed difficulty in

acquiring the clinical lecturer support they needed. Preceptors have always been involved in clinical assessment of students which has, up to this point, been formative rather than summative. This new requirement is not unreasonable, for clinical lecturers based at the polytechnic or university who now supervise greater ratios of students while students undertake their clinical learning, spend minimal time with each student. Therefore, in fairness to students, preceptors would spend more time with students and would know more accurately how the student is progressing in their clinical practice than clinical lecturers. Moreover, preceptors disclosed that they were required to account for their evaluation of students' clinical competence, particularly, if the opinions of the clinical lecturer and the preceptor differed.

Although preceptors passed on practice wisdom and brought into nearness the practices of nursing for students, the timing of teaching/learning experiences varied. In this way, working together as one was bound to time and space. For Heidegger 'Being' is time. Time is "lived" time and "space" is related to nearness or remoteness (Heidegger, 1962/27, p. 82). Both time and space were context dependent upon the intensity of the preceptors' patient assignments. The challenge for preceptors was how to find both time and space for them to 'live' their precepting practice. Although educators recognise that the teachable moment occurs when the student shows interest or asks questions, the preceptors tended to separate theoretical discussions from practice learning experiences and consign theoretical discussions to moments when they had time to think about them. This was usually outside the immediate patient/nurse encounter. Such an attitude by preceptors is most probably related to a belief that teaching takes time and in the immediacy of the situation, working with very sick patients, they were not prepared to 'teach' on their feet. The preceptor's preparedness to address growing students' knowledge from practice was left up to when they had time for thinking. This attitude would suggest that on the face of it, most preceptors themselves separate theory from practice as was most probably their own experience of teaching and learning as a student themselves. It is also part of being a novice educator. As such, it could therefore perpetuate a theory/practice gap (Rolfe, 1993; Speedy, 1989). Nevertheless, as they worked with students, preceptors did encourage students to link their theoretical knowledge with their patients' experience.

Another significant finding emerging in student interaction was the role preceptors took as they taught students the meaning of 'accountability' in professional practice.

All nurses are responsible as members of the profession for their quality of nursing practice. However, it was evident that the preceptor believed they were also accountable for the student's actions in relation to the preceptors' patient care. If this idea is extended, long term, the preceptor is accountable for undergraduate clinical learning in the reality of clinical practice. Yet, preceptors did not perceive this latter responsibility. The preceptors in this study safeguarded patients and students by working together as one with the students. Additionally, students were learning the meaning of accountability in practice and how it worked out in practice in patient care. Although preceptors appropriated the dual mantle of responsibility and accountability for patient care and students' practice, they were mindful of its weight.

Preceptors also disclosed that 'working together' was an important learning experience both for the preceptor and the student. 'Working together' included encircling the patient into the learning context. Preceptors would create a context where the student became an integral part of their practice when working with patients. Preceptors engineered learning encounters and 'hooked' the patient into the learning situation in order to help the student to learn in a meaningful relationship with the patient. Patients themselves coached the students. Patients are the bystanders of received nursing services and see and hear a great deal. It was the preceptor orchestrating the learning situation, knowing the student, knowing the patient, recognising the students' capabilities, and trusting the student, that allowed for the full and rich learning sequences for students to occur.

The Preceptor as Builder of Nursing Practice: Teaching Reality Nursing

In Chapter Nine, the final data chapter, the relational theme of *The Preceptor as Builder of Nursing Practice: Teaching Reality Nursing* is the final contributor to the constitutive pattern *'Safeguarding the Practices of Nursing'*. Teaching the reality of nursing discloses how preceptors revealed their practices as preceptors. Practices included anticipating, listening, showing, role modelling, noticing, telling, teaching, responding to questions and observing students in their practice. In this way, 'safeguarding' included the passing on of practice in order to ensure the continuation of the rich practices of nursing. Heidegger has shown this in his famous example of the "ready-to-hand" (Heidegger, 1962/27, p. 191) mode of being in the world. The "ready-to-hand" mode is always understood in its "totality of involvements" (Heidegger, 1962/27, p. 191). In his famous example of the hammer, Heidegger

states that the hammer exists for the sake of hammering. It is only in 'hammering' that the hammer comes to life and becomes meaningful in its use. It is in the practice of hammering that knowledge about the hammer is learned. So too, it is in the practice of precepting that 'nursing' comes to life. Preceptors in their 'totality of involvement' in the world of nursing practice taught student nurses how to be a nurse. It is in the practice of precepting that the ready-to-hand mode of being-as-preceptor in its 'totality of involvements' comes to life. Heidegger (1962/27, p. 99) claims that practical behaviour is not atheoretical. Knowledge exists for a purpose that is usually embedded in its associated practical action, and in this study, knowledge was built through teaching reality nursing.

Chapter Nine reveals that preceptors incorporated their preceptees into their practice world as they delegated aspects of their own nursing practice to their entrusted preceptee. However, the preceptor was always mindful and watchful of their preceptee as they practised. As both preceptor/preceptee were situated in the fast moving, challenging and varied nursing context that confronts the registered nurse in the day to day practice world, the preceptor dealt with the immediacy of practice demands as they arose. Preceptors taught reality nursing by offering trusted students, the opportunity to meet challenging nursing situations. It was the student's ability to maintain dialogue that developed trust between preceptor and preceptee. Preceptors needed to be assured that students would not "leap in" (Heidegger, 1962/27, p. 122) beyond their ability to manage patient care safely. In situations of risk and extension of the student's practice, the preceptor maintained a constant vigil to ensure that the patient and the student were safe. As students took up their preceptors' challenges, preceptors built students' confidence and kept them safe as students constructed nursing knowledge from their practice.

An interesting finding was that in teaching reality nursing, preceptors concede aspects of their practice to their preceptees but do not relinquish their over-riding responsibility for their patients. Dialogue revealed students' readiness and willingness to manage complex modern health care including 'hi-tech' interventions for very sick patients. During these episodes, preceptors would assess, teach, observe, guide and support their preceptee's efforts as they built and strengthened their nursing practice in the real practice world of nursing. Preceptors talked through unpractised nursing interventions with students to ease comfort levels when entering the patient situation. As part of this process, preceptors made a way for students to learn particular nursing skills by requesting patients' permission for students to

undertake specific aspects of their nursing care.

Another significant aspect of teaching reality nursing emerged as preceptors linked the students' theoretical understanding of ethical knowledge to reality situations. Preceptors used the situated context to point out to their preceptees, how the ethic of care related to the day to day practice of nursing. In this, the Health and Disability Commissioner's Bill (1994) and its associated Patient Code of Rights (1996) guided preceptors' ethical nursing practice. Preceptors, by incorporating the code of ethics into their own practice, built a practical working knowledge for students of how a code guides practice. As such, preceptees working closely with the preceptor, were witness to the difficult decisions for patients and health professionals alike, such as 'Not For Resuscitation', (NFR) orders. Examples came through the data to show how preceptors advocated for their patients with the medical team. In this way, preceptors provided the real-life context that would transform students' theoretical understanding of ethics to a practice based ethics informed by the reality of the everyday world of practice.

Likewise, preceptors used practice situations to build meaningful legal knowledge that preceptees must learn to practice safely and legally. By using everyday practice situations, preceptors engaged students in dialogue which helped students make the link between what they knew and how it related to a particular clinical situation. In this way, preceptors helped students make sense of the many aspects of nursing practice that would otherwise lack emphasis. Strengthening reality practice facilitated a gradual maturing of the student readying them for eventual graduation. All the while, the preceptor prepared the student to move toward the threshold of the reality of a graduate world of practice.

Further, preceptors resonated an awareness of becoming a preceptor in highly stressful times. Precepting was an added burden to them in an already overloaded working day. They were aware that in safeguarding nursing practice existed the in-betweenness – they wanted to help students by teaching the reality practice of nursing but they were also mindful of the cost to their own being. That cost was overlaid at all times with the knowledge that they were accountable for their own practice to patients and wanted to ensure that patients got the very best treatment and quality care.

Summary

In summary, the thesis identifies issues that should “lie before us and be taken to heart” (Heidegger, 1968, p. 217) if the promise of contemporary nursing education for a graduate with a degree is to be realised. Part of this promise includes a graduate who is capable of utilising research based practice, reflective and critical thinking and can demonstrate independent competent practice at a beginning level. These findings reinforce the point that the rhetoric must mirror the reality. At present there is an “abyss” (Heidegger, 1962/27, p. 194) that separates the ideal and the real worlds of practice. It was evident in this study that preceptors and clinical lecturers did not work together closely.

In this thesis, preceptors did not feel appropriately prepared educationally or practically to precept students. Many reasons were given for this. One major reason was that in the immediate context of nursing education and nursing practice, serious upheaval due to severe government reforms was changing the nature of the organisations and the way that preceptors and clinical lecturers worked. A second reason was that preceptors implied there were new and extra expectations being placed upon them when they were already over-stretched in the practice setting. Also there seemed to be a distinct lack of communication between the educational settings and the practice environment which left the preceptors uncertain as to how to proceed with precepting undergraduate student nurses.

Preceptors expressed concern that increased expectations from the educational institute were impacting upon their practice. In particular, the added responsibility for assessment of student learning. They noted that, although they enjoyed precepting, they found it an exhausting experience on top of their busy patient assignments. Their exhaustion contributed to an element of unsettledness from being forced to precept students rather than having a choice whether to be involved in the process. Further, the changing context, which has continued to smoulder in the new millennium due to the political nature of health, was constantly eroding their sense of normality within their work place. Not only were preceptors coping with nursing service provision and precepting students, but also, constant organisational change.

Other areas of challenge included the changing nature of the student population that is coming into nursing. Preceptors noted that they needed to relate to a multicultural

and mature age student population that was different to the traditional school leaver who entered nursing in former years. Thus the skills required to facilitate learning in the diverse group of adult students challenged the preceptors.

The vigilance required of preceptors to keep the student and patients safe was undertaken by a constant mode of assessing where students were at in their practice. This assessment also gave preceptors an idea of the level of students' capabilities and their readiness for learning. Diekelmann (1989) reminds us that clinical knowledge must be developed personally by the practitioner and can only be acquired through experience. The preceptors were ever mindful of providing the clinical challenges to build preceptees into competent safe practitioners.

Preceptors involved students in their practice world to pass on reality based practices of nursing. Working together and working with patients, preceptors helped preceptees to work through complex clinical challenges to develop technical skills. In this way, preceptors prepared preceptees for the technological reality of contemporary health care. Preceptors patiently mentored students by passing on tips they had learned to make the transition from student to graduate nurse easier. Preceptors also discussed with students ethical issues that arose in practice. They were also able to identify legal aspects of practice that, for the student, seemed incomprehensible. In the 'together' work with students, the teaching, coaching, guiding and building work of the preceptor was disclosed. But more importantly, preceptors, through the sharing of their own practice through direct role-modeling and dialogue, provided students' with the possibility of developing clinical expertise at a beginning level. As they did so, however, preceptors noted that the constant vigilance required in precepting undergraduate students safely was exhausting. They felt doubly accountable. First, to their patients for the standards of their own practice and for the practice of students, and secondly, to students for their clinical education.

Converging conversations

The findings of the research and how they sit in the wider context of knowledge

Heidegger (1962/27) claimed that being 'as' something appropriates meaning to a certain way of being-in-the-world. Heidegger (1968, p. xiv), stated that:

"it is only when we are really immersed in what is to be thought can we reveal truly the nature of anything no matter how commonplace it may be, and only then can we avoid our habitual ways of grasping it as it is for us, i.e. subjectively".

It is through the circular, discursive and reflexive hermeneutic activity of reading, thinking, questioning and writing of the research that the disclosures of the participating preceptors help us to avoid "our habitual ways of grasping subjectively" (Heidegger, 1968, p. xiv) what we may have thought we knew about being-as a preceptor. I now turn to consider how the disclosures of the preceptors strike an accord or discord with conversations occurring in the wider context of knowledge. In so doing a discussion of 'safeguarding the practices of nursing' in relation to a central organising Heideggerian notion of 'authenticity and inauthenticity' follows. Three key related notions will synthesise my thinking. The first notion is authenticity and "mine-ness", the second, is inauthenticity and meaninglessness, recognising that these two ways of being in the world are not either/or positions but are held open in flux or play (Darbyshire, Diekelmann & Diekelmann, 1999). The third is *phrōnesis* (moral knowledge) to include possible futures.

Authenticity: Preceptors as 'Mine-ness'

From our understandings thus far, preceptors considered that they were not appropriately prepared educationally or practically to precept undergraduate student nurses. From this outcome, the question arises: "What will it take for preceptors to be authentically in the world of nursing practice and nursing education in order to safeguard the practices of nursing?"

When Heidegger (1962/27, p. 68) discusses 'authenticity and inauthenticity' he does not mean 'genuine' or 'false'. Rather, he refers to *Dasein* – that is a way of being-in-the-world. *Dasein's* possibility of being authentic or inauthentic is rooted in the fact that *Dasein* is 'always mine it must always be addressed by a personal

pronoun, I am or you are' (Heidegger, 1962/27, p. 68). Further, Heidegger continues by stating "Dasein has always made some sort of decision as to the way in which it is in each case 'mine'. ... Dasein is in each case essentially its own possibility". Preceptors therefore, in their search for 'mine-ness', according to Heidegger, have the choice to be in the world as preceptor. In a Heideggerian sense, they therefore should be given the choice whether to precept undergraduate students and not be 'thrown' into the experience as was shown in this research. Grant, Ives, Raybould and O'Shea (1996) identified that registered nurses who wished to precept students were different in their precepting from those who did not. If indeed preceptors wish to feel at home in the experience of being-as preceptor to undergraduate student nurses they then need to experience living in the hermeneutic 'as' of being-as preceptor in order to experience 'mine-ness'.

Moreover, Sartre (cited in May, 1997) claimed that the choice of authenticity is a moral choice. Underlying existential ethics, one is morally responsible for who one is. One can choose to be in the world in a certain way. That is one can make choices for attitudes, disposition and character as well as one's behaviour. Authenticity involves a deep feeling of accountability to one's self. The choice of being-as preceptor therefore brings with it moral responsibility. May (1997) claims that community membership - and preceptors are members of the nursing professional community - is a moral responsibility. Evidence would suggest therefore that preceptors should choose to be preceptors rather than have the role imposed upon them.

For preceptors to feel 'at home' in both worlds of nursing practice and nursing education would require change in the way preceptors work at present. That is, because preceptors are first and foremost registered nurses responsible for patient care, the possibility for them to be authentically in the world and claim 'mine-ness' as preceptors is denied.

Preceptor Accountability

Preceptors perceive 'double accountability', that is accountability for patient care and for student learning. In fact the accountabilities are three fold. Their accountability is first and foremost to their patients, secondly to students and third to the profession. Preceptors in this study perceived a moral obligation to the student for clinical education. Preceptors are aware that students pay for their education

and are also aware that money is transferred from vote education to vote health and goes 'somewhere' into the clinical agency (Coopers & Lybrand, 1994). Preceptors believe it should be used for nursing education. Conversely, in the light of the *Strategic Review of Undergraduate Nursing Education* (KPMG Report)²¹, (2001, p. 8, 7.260) a recommendation is made that the New Zealand government review the arrangements for funding service providers for clinical learning for students.

Competency

A key area in New Zealand nursing is the issue of competency. Competency rests upon nationally consistent standards that originate from Nursing Council. The definition of competence that Nursing Council has chosen is by Piercy (1995) and includes specific tasks and general characteristics of effective role performance to include values, ethics and reflective practice. All nurses must demonstrate eleven competencies to become a New Zealand registered nurse (Nursing Department/Schools Handbook, 1999a).

Educational institutes are held accountable under the Education Act (1989) to employ competent and appropriately qualified staff to teach on its programmes. The Nursing Council of New Zealand's requirements for nurse lecturers to hold a Master's qualification if teaching on a Bachelor's programme by the year 2000, is not carried over to the clinical setting where students undertake half of their nursing education programme. Clinical practice is essential to become a nurse. Further, Benner (1984) would have us believe that one must be practising within a particular environment to develop expertise. The proposed Competency Assurance Bill (2001) assumes that Registered Nurses' competence will be developed within specialised areas of practice. What about being-as preceptor? Surely this requires a specialist preparation?

The preceptor as a key facilitator of student learning in clinical education has been advocated widely internationally (Benner et al, 1996; Clayton, Broome & Ellis, 1989; Dyson, 1998; KPMG Report, 2001; Myrick, 1988; Nehls et al., 1997; Ohrling & Hallberg, 2001; Packer, 1994). That the practicing nurse is invaluable as the key person to pass on the practices of nursing is not in dispute. What is of concern is

²¹ The Strategic Review of Undergraduate Nursing Education (2001) was undertaken during the writing of this research report. All nurses were invited to make submissions to this report. Early findings of this research were included in submissions (p. 135).

the failure to address systems within nursing education and nursing service that would ensure a collaborative approach to nursing education that recognises the expertise of both sectors. That is the educational expertise of the clinical lecturer and the practice expertise of the preceptor. Central to this concern is the quality of nursing education that the student should receive. Preceptors are the clinical teachers. The question arises, how can preceptors be assisted to claim 'mine-ness' and take up their 'authentic' possibility in being-as preceptor?

A lack of understanding of the contemporary world of nursing education

Dasein or being-in-the-world includes an historical cultural orientation toward teaching and learning, for meaning is always grounded in temporality. A tension exists between the historical world of nursing education and the new world with new and different expectations. Preceptors feel the moral imperative (Watson, 1988) to act as a teacher to prepare competent practitioners but they are held back by anachronistic cultural practices that do not readily yield to change. The often claimed 'good old days' were not what they are portrayed as. Crookes (2000) makes the point that student nurses 'in the good old days' working as employees of hospitals were adept at 'fitting in' rather than being well prepared to cope with the situations that confronted them. What continues to occur is that new nurses simply model themselves on existing nursing practice. Although students' may have questions as to the appropriateness of their nursing education and note different values between theory and practice, they know they must conform to survive. It would appear, in spite of advancement, some things remain strangely unchanged. In contemporary nursing education, students as consumers of a professional education programme at a degree level for which they are paying, should focus upon educational goals as an individual and as a learner not as a generic worker able to carry out multiple tasks (Castledine, 1996).

Theory/practice separation

Additionally, there is no time to bring theory and practice together in an overt and meaningful way due to the exhausting nature of the many role demands that preceptors incur. Vaughan (1989) pointed out that the two roles, those of practitioner and preceptor, are superimposed upon one another without any discussion of which parts can be discarded. Vaughan claimed that to sustain both roles requires superhuman effort. This research goes further and suggests that there fails to be any recognition of the need to discard any part of the registered

nurse role or the preceptor role despite the fact that the preceptor simply cannot carry out a dual role concomitantly. In fact, it could be argued that preceptors are abundantly disadvantaged because they are expected to carry out multiple roles. It has become clear within this thesis, that preceptors actually get more work to do because an assumption is made that with a student in tow, there are 'two pairs of hands' instead of one.

Preceptor preparation and credibility

It could also be seen that there is a lack of commitment to the espoused value of clinical teaching (Mignor, 2000) by educational institutes which allows preceptors to operate without guidelines or support. Yet ironically, clinical practice is hailed as being at the heart of the discipline of nursing. It could also be said that the practice of nursing is 'picked up' once the student is constantly exposed as a graduate to clinical practice on a day to day basis (Edmond, 2001), rather than taught. However, Davis & Barnham, (1989) pointed out that the preceptor should have a Master's preparation. Advanced education skills encourages the person to think and question outside the square.

Meaninglessness and Inauthenticity

A sense of meaninglessness was experienced by preceptors who believed they were not valued for the effort they genuinely extend to student nurses to prepare them to enter the profession. For Heidegger, meaning is always grounded in temporality and is appropriated through our unique way of being-in-the-world with others in a shared world of involvement. That is, for preceptors, meaning is grounded in their every-day activity as nurses providing patient care. Temporality includes an historical, present and future orientation. A preceptor, as envisaged in the future world of nursing education and nursing practice, implies one who is both educationally and practically prepared for the role (Myrick, 1988, Greenwood, 2000, Strategic Review of Undergraduate Nursing Education, (KPMG Report, 2001).

Groundlessness is a lack of meaning. Heidegger refers to this as an "abyss" (Heidegger, 1962/27, p. 194). When there is a failure to grasp "mine-ness" (Heidegger, 1962/27, p. 68) by preceptors through either being forced to precept student nurses because there is no one else to do it, or being prevented from having enough time to devote to their precepting responsibilities, a groundlessness is experienced. The abyss, in this thesis, included a lack of preceptor/lecturer dialogue

that would have made the preceptor privy to meaningful information to assist them to help the student more effectively. As a minimum, preceptors require course documentation and explanation as to what the student is to learn and be guided in as they develop their practice. When dialogue is absent, the abyss commonly termed the 'gap' prevails.

When, as is common, clinical agencies give little recognition to or reward the work of preceptors then, regardless of appreciation expressed by students, they are prone to feel inauthentic and that their efforts lose meaning. Moreover, within the prevailing culture of recent and present times within the health and education sectors, the human resource becomes commodified and utilised as part of Heidegger, (1977, p. xxix), calls the "standing reserve". Preceptors are viewed as an economic unit or an EFT. Minimal provision is made for status or reward. Since these two go together they are, therefore, budgeted according to economic value. Corporately therefore for preceptors, their ontological being is diminished.

Phrōnesis

Thirdly, the concept of *phrōnesis* along with the notions of accountability, co-operacy and leadership will be discussed in relation to considering what could transform the experience of being-as preceptor. An ancient Greek conception of moral knowledge, *phrōnesis* brings a moral dimension to a situation that is under question, a mystery to be opened up, understood and result in appropriate action. Being-as preceptor brings with it far more than the passive acceptance of traditional ideas and opinions (Gallagher, 1992). It also compels a need for the preceptor to be engaged in the educational process. *Phrōnesis*, Gallagher points out, also requires a self- understanding. This understanding of the self leads to change in the learner therefore holds the potential to transform the preceptor/preceptee relationship.

A new era required

The increase in nursing knowledge and research over the last ten years has made profound changes to the profession of nursing at all levels. Therefore a new organisation is required which will create an effective learning environment where students can thrive. The transition, in this researcher's view, must be made both in the clinical agencies and educational institutes to take up the responsibility for the preparation of nursing graduates. It is the work environment of nurses that must

move to accommodate nurses rather than the opposite (Crookes, 2000; Greenwood, 2000). Preceptors and clinical lecturers as key people with the potentiality to be harbingers of a new era, able to transform the health and education sectors, must work together to realise that goal. What is shown in this thesis is that there was no consistent approach made from clinical lecturers to preceptors to assist in the augmentation of contemporary nursing values. Preceptors made minimal reference to research related to their practice. Time to reflect on practice was not highlighted, yet students were encouraged to go home to read up on specific conditions and create patients' care plans. Some preceptors assisted students with situated decision making (Benner et al, 1996) and critical thinking. A recommendation from the KPMG Report (2001, p. 72, 7.3) is that nursing curricula should integrate the aforementioned skills as part of nursing assessment skills in order to prepare competent nurses.

Leadership

Strong leadership is required to establish the core values of nursing couched in contemporary terms which will move the profession forward into the 21st century. Wheatley (1994) stated that leadership is always contextual and the context is established by valued relationships. The preceptor who works closely with the student to merge theory with practice is central to this accomplishment. We have lived through an age that has been determined by one dominant view of the world, that of positivistic science. Ideology, geography, structures, policies and processes have bound institutions. They have, as it were, had invisible walls that have bounded the worlds within them. Wheatley (1994, p. 78) drawing on the ideas embedded in quantum physics wrote of this era;

“in the past, systems analysts and scientists studied open systems primarily focusing on the overall structure of the system. This route led away from observing or understanding the processes of change and growth that make a system viable over time”

Further, Wheatley (1994) claimed partnerships, participation and relationships are only part of the scenario. The rhetoric would have us believe that information is overwhelming modern society. Wheatley however, claimed that information is critical for our survival. Information, “freely generated and freely exchanged is our only hope for organisation” (1994, p.145). For systems to change, autonomy and the ability to change must exist at local levels in order for the total system to absorb

change and continually move to higher levels of functioning. In Wheatley's view, autonomy must refer to self-reference. To do so is to have a system remain in internal motion kept in harmony by the capacity for self reference (p.146). As each part changes, its capacity for self- reference ensures that it remains consistent with itself and with other parts of the system. An alliance is forged between the individual aspect and the whole. The ideas that are proposed by Wheatley (1994) challenges us to consider that what we have always understood may no longer be sufficient in a fast and changing world. The structures of yesterday may have become so rigid that they stifle new and innovative ways of thinking about nursing education and nursing practice in the preparation of new nurses. With the many issues facing nursing as a profession, the uncertainty of the future requires us to consider new options.

Co-operacy

The transition process involves co-operacy (Hunter, Bayley and Taylor, 1998). The term "co-operacy", describes the "technology of collective or consensus decision-making as distinct from democracy and autocracy" (p.7). Co-operacy begins with the person and their way of being. Co-operacy recognises that the way we think about work and the way we relate to each other has changed and is still changing in a context where information and information systems are not only altering the way we communicate but how we relate to one another. Co-operacy includes the idea of co-operative organisations, networks, teams and collective decision making based upon a set of values that recognises that all people are of equal worth, that difference is celebrated, that it is possible to work co-operatively together and that the best decisions are made by those people who will be affected by them.

Another aspect of co-operacy is that of relationships. A relationship age assumes that the world is made up of connected parts, all of which co-operate with each other. A critical aspect of co-operacy is that it views co-operative organisations as peer partnerships where the old systems of hierarchical organisations are replaced by peer partnerships which value each other as equals and worthy of respect.

Collaborative Partnerships

Collaborative partnerships where education and service work together more co-operatively with nursing education is a key recommendation of the KPMG Report

(2001). McCallin (1999), in a grounded theory study identified how health professionals work together in interdisciplinary teams. McCallin (1999) identified that teams were able to work together across disciplines by engaging in a dialogic culture. The informal discussion, *pluralistic dialogue* over-rode professional differences as long as the focus was on the client. In education, the focus is on the student. It is suggested that engaging in a dialogic culture using *pluralistic dialogue* McCallin (1999) could be seen as a way forward to enhance nursing education and nursing service relationships. Central to this dialogue would be consumers both in practice and education. That is, the patient in practice, and the student, in education.

In McCallin's study, pluralistic dialogue requires professionals to rethink professional responsibilities and reframe team responsibilities. Rethinking professional responsibilities in nursing would require clinical lecturers and preceptors to share a team perspective on nursing education that would include a constant dialogue between preceptors, practice settings, schools of nursing and students. A new way of managing nursing education would require sophisticated information systems at all levels and a shared responsibility through risk taking, negotiation and compromise. McCallin claimed that pluralistic dialogue has the potential to transform the way people function as a team.

Dialogue comes from the Greek roots "*dia* (through) and *logos* (meaning)" (Ellinor and Gerard (1998, p. 19). Dialogue is conversation with an open ear and mind, respectfully listening to others, willing to learn and to change. Dialogue encourages the exploration of meaning between people helping us to understand diverse points of view acting as a bridge to understanding between people. Dialogue differs from discussion. Ellinor and Gerard (1998, p. 21) claimed that dialogue encourages an holistic view of a problem, seeing both the whole and the connections between the parts, rather than breaking issues down into parts. It also assists us to enquire into assumptions rather than to justify or defend those assumptions that we hold that lock us into seeing problem areas from narrow perspectives. Dialogue also sparks thoughtfulness, inquiry and disclosure rather than our trying to persuade or tell others what they should do. It can create shared meaning among many and holds the potential for openness and willingness to work together to find solutions to common problems.

Good preceptors

Preceptors are part of the new world of nursing education. Good preceptors are a valuable resource to develop the practice of nursing and to advance the vision of nursing as a profession underpinned with advanced education qualifications to meet the increasing demands of today's complex world. The KPMG report (2001, p. 87, 7.27) recommend that "the use of a preceptorship model during student clinical experience be strongly encouraged". The report points out the need for effective partnerships between education and service providers to facilitate appropriate student learning experiences. There is a need for effective communication between the partners to facilitate student learning needs and goals and for clinical agencies to recognise the benefit students bring. Additionally, sharing the responsibility in partnership for the preparation of competent registered nurses. A variety of models to facilitate effective partnerships are identified in the report. Central to most effective models is the concept that preceptors and clinical lecturers share a partnership approach with dedicated preceptors who are funded by the service agency to work with students and clinical lecturers while students are on their clinical practicum.

Such a partnership idea would reduce the in-betweenness that preceptors felt in this study. Preceptors should feel safe and secure in the world of education and should feel a member of the educational team. There should be a sense of shared governance for new students of nursing, and a shared teaching and learning responsibility, with both preceptors and clinical lecturers being able to contribute not only to the students' education but also to their own professional growth. In this way they would gain a sense of belonging within the world of nursing education. Such a partnership would transform nursing education and nursing practice by engendering informed collaborative and collegial relationships.

The KPMG Report (2001, p. 63) quotes from Bechtel, Davidhizar and Bradshaw (1999) in the United States context, that global trends in accelerated change in health care delivery, along with diminishing resources within nursing education, require a re-think and re-design to teaching and learning in nursing education. The report states that these trends and issues are similarly likely to be present in the New Zealand context.

A phenomenological study

At the conclusion of writing this thesis, a publication by Ohrling & Hallberg (2001) reported the findings of a larger study on similar themes. It discussed the meaning of being a preceptor, of being precepted and of teaching and learning in a preceptor-preceptee relationship during student nurses' clinical education on hospital wards. In Finland, this study produced many similar understandings to this present work. Two main themes were disclosed: *Sheltering the students when learning and Facilitating the students learning*. The theme of *sheltering the students when learning* is similar to *safeguarding* students as they learn as discussed in this thesis. Students must be cherished and protected and preserved from harm or danger so that they can learn. This thesis attests to the fact that, as preceptors and preceptees enjoy continuity in their relationship, preceptors build a 'home' in order for student nurses to build, cultivate and grow their practice.

In many ways, Ohrling and Hallberg, (2001) showed remarkable similarities between the current research. Similarities between the two studies include how preceptors feel the responsibility to role model good care of patients. How preceptors assessed students to see their learning, asking students questions in order to ensure that the student knew what they were doing, and listening to students as they interacted with patients to ensure that they were communicating and performing nursing actions effectively. In Ohrling and Hallberg's study, preceptors took responsibility for extending student learning, and through the preceptors' insight, choice of action and accurate assessment of students' competence, their students' fear of failing was diminished.

An additional point in Ohrling and Hallberg's (2001) study which mirrors this current research is that preceptors also complained of feelings of loneliness especially when students did not appear to be achieving, or if there were problems with a student or with evaluation of the students' learning. Similarly, in this research too, preceptors gave voice to their feelings of uncertainty as to whether they were teaching the students' the 'right' knowledge and skill. Ohrling and Hallberg suggest that educational institutes and the clinical staff could create networks and become reflective partners. This could be a way of aligning the preceptors' contextual knowledge and competence with the clinical lecturers' research-based theoretical knowledge. Both could be interwoven and promote each other to enhance student

learning. But also, reflective partnership could serve to grow the preceptors' practice as a preceptor.

Patton and Cook (1994) claimed what is required is creative alliances between education and service sectors. What needs to be taken to heart is that alliances require collaboration, commitment, communication and co-operation. Vaughan (1989) was one of the first authors to address the need for a closer relationship between nursing practice and nursing education by introducing the idea of joint appointments. A joint appointee has been defined by Lantz, Reed and Lewkowitz (1994, p. 38) as a formalised agreement between two institutions where an individual holds a position in each institution and carries out specific and defined responsibilities". In the United Kingdom, there has been further refinement of joint-appointee position in the form of lecturer-practitioners (Castledine, 1991; Elcock, 1998; Gibbon & Kendrick, 1996; Gould & Crooks, 1996; Salvoni, 2001; Vaughan 1989; Wright, 1991).

There have been varying degrees of success with joint-appointee positions. McKenna and Roberts, (1999, p. 14), identified that "success depends upon the personal attributes of the appointees, realistic expectations, flexibility to allow the concept to evolve, and support from colleagues and management". The authors also point out that joint appointments can be problematic in so far as there can be ambiguity in role clarity and expectations.

Summary

Preceptors cannot feel authentic when they are not 'at home' in their world which spans both the world of nursing practice and the world of nursing education. Preceptors find it difficult to claim mine-ness and authenticity because they hold dual accountability, firstly to their patients and secondly to their students. In meeting their primary obligations, preceptors are, first and foremost employees of a clinical agency and are required to fulfil their responsibilities to their patients as part of the organised service delivery of nursing care.

Secondarily, their accountability for preparing new nurses to be competent as registered nurses is less clear. The fact that this responsibility is added on to an already overfull practice day coupled with the lack of status within the organisation's

formal structure leaves an 'abyss'. A part of preceptors' daily practice is 'ungrounded'; in Heideggerian terms, it is in-authentic.

A collaborative approach to nursing education is required involving both the education sector and the clinical agencies to work together 'to grant ground' to a place where preceptors can feel at home. Only when preceptors are at home in a world that recognises the valuable contribution they give to the profession of nursing can they dwell, build, cultivate and grow new practitioners.

An ancient Greek concept of moral knowledge *phrōnesis* gives a moral dimension to a situation that is under question. But rather than seeking a solution through the usual linear steps of problem solving, the situation should be left open as a source of wonderment or mystery. Being open can then allow possibilities to eventuate.

The preceptors' place in nursing practice and nursing education is acknowledged as being very valuable. Several ways of creating a grounded preceptor practice have been cited in literature, with the lecturer-practitioner being perhaps the most promising. From the Strategic Review of Nursing Education (KPMG Report, 2001), the recommendation has been made to both clinical agencies and educational institutes to collaborate on nursing education. What is required is leadership, co-operation and above all, commitment to honour a shared place in a community where each can celebrate their place.

Implications of this Research for Education

This thesis demonstrates a lack of preparedness of the preceptors to precept undergraduate student nurses. As a minimum, preceptors should hold a Bachelor's degree, but a Master's should be a requirement to be aspired to within a nationally achievable time-frame.

This study highlights the difficulty in preceptors of having the dual responsibilities of patient care and precepting student nurses. Preceptors require a reduced patient assignment from their employing agencies in order to focus some of their energies on precepting.

A joint working arrangement should be worked out between clinical agencies and educational institutes that will facilitate student nurses' learning. Preceptors should

be conversant with degree programme outcomes and the outcomes expected of undergraduate student nurses at the conclusion of their nursing education programme.

Education and service sectors should collaborate to understand the curriculum requirements of the Bachelor degree programme. The two sectors should dialogue effectively with each other, listening to each other's concerns and developing a will to work through difficulty to reach mutual satisfactory outcomes for both.

A close proximation geographically between educational institutes and clinical agencies would facilitate easy exchange of expertise but should not preclude sectarian exchange. That is between region and region and country and country. The ultimate goal is to provide quality teaching and learning encounters between preceptors and students in order to develop competent new nurses. Such exchanges must be worked out at the highest level but be interpreted at the preceptor/student interface. Therefore dialogue must take place between all levels of an organisation but most importantly, decision making at the level of curriculum implementation should involve preceptors, lecturers and students.

Preceptors should also undertake an adult learning instruction course so they can teach adult students in an educationally sound manner. The current student population is diverse, with many very mature adults entering the profession as prospective nurses. This requires preceptors to possess a range of principles and adult learning strategies to facilitate preceptor-student communications and supportive learning encounters.

As part of preceptor preparation, preceptors should undertake an assessment course. Preceptors need to be taught how to assess learning in a manner that is educationally sound. Additionally, preceptors should take up the assessment responsibility for students only if they are thoroughly conversant with the standards required by the Nursing Council of New Zealand at all levels of the undergraduate curriculum. If the Nursing Council Competencies are to be measured in practice and the changing role of the clinical lecturer is one of liaising or linking between the education sector and the clinical setting, (Orchard, 1999), then the question is asked, how can preceptors undertake this important role without possessing the clinical teaching preparation currently required of clinical lecturers, and without

familiarity with the curriculum learning outcomes that the student's competencies are measured against.

Co-operation is required between the sectors and a will to move the commitment to the proper preparation of undergraduate student nurses forward to realise the aspirations of the profession to move nursing into the twenty-first century.

Commitment must be made to undergraduate student nursing education in its entirety. Students must be provided with learning context where they are welcomed and gathered into a supportive and nurturing professional community enabling learning from real life practice to encompass theoretical and practice outcomes.

Communication must be effective between the sectors. They must develop a willingness to be open and genuine and to listen effectively to concerns about nursing practice and education. The sectors need the will to work through difficulties in order to mutually satisfy those involved.

Implications from the Research for Practice

The historical way students have been absorbed into the practice setting requires review. A changed and changing socio-political and cultural health and education context demands a different preparation for students if they are to fit the world of the future.

A commitment is required from clinical agencies to identify and prepare preceptors educationally and practically. This can be seen as a joint investment between education and service settings and a way of budgeting for this must be worked out at leadership levels.

An ability to promote a team environment where student nurses are seen as integral supernumerary team members will prepare students to enter a world of nursing practice which encompasses interdisciplinary teams. As McCallin (1999, p. 277) stated, "interdisciplinary socialisation begins in the educational setting".

An environment that fosters 'thinking out loud' where students feel confident to share their thinking and where preceptors support their efforts within a interdisciplinary dialogue will foster co-operation between disciplines. Shared

decision-making will promote a moral community where all professionals value each other's contribution to the patients' health outcomes.

If there was time given to the dialogue that emerged from both preceptors' and students' shared experiences, students of nursing would learn that reflection on practice is a way of developing the professional person and their practice. Such reflective behaviours should be valued in practice and fostered as part of practice. A conscious decision to include this in the preceptors' workload would need to be negotiated between the clinical agency and the educational institute.

Reflections would inform both students' and preceptors' shared practice and develop both. Further, reflection naturally raises questions and questions create dialogue. Questions and curiosity are part of research behaviours which initiate inquiry and knowledge development. As we learn to engage in dialogue, deeper and new ways of thinking will be a natural outgrowth.

A commitment to develop the competent graduate nurse would necessitate time being given in the clinical placement to realise Benner, Tanner and Chesla's (1996) claim that competent performance requires deliberative and conscious decision-making and is the way that competence is acquired. Therefore practice would be seen as theory generating rather than practice being solely a field where one applies what one has learned. Time for discussion and integration of knowledge as students work with clients must be an integral part of their learning day in their clinical setting.

The lecturer-practitioner role should be established in a pilot scheme as identified by Vaughan (1990). It is important that the role be established as a new joint venture rather than a joint-appointment under a new name. The establishment of a joint taskforce to address how preceptors and clinical lecturers can form effective joint partnerships in nursing education supported by their respective institutions is a feasible way to move forward. This statement is made in the light of the recognition that each institution will be required to work out arrangements at a local level as to how a collaborative partnership will work between the sectors.

Implications for Further Research

There are many other methodologies that could have been used for this research. I could have used social critical theory that would have focused upon the socio-political context within which the research took place and the actors within it. Informed by Habermas's (1984) technical, personal and emancipatory interests, I could have explored the effect of rapid social change on precepting and preceptee relationships and how these impacted upon the teaching and learning process.

There is a need for action research to explore and develop a way of working together for both the sectors of education and practice, to explore the implications arising from this research. That is to find a working relationship between education and service that will address the manner in which preceptors can be prepared educationally for their role in precepting undergraduate student nurses. I believe that for the profession of nursing to realise their potential to be a major player in the health reforms world-wide, preceptors are key people as the teachers of clinical practice in the acute care setting. But preceptors require to assist the student to see 'the big picture'. That is there is an increasing need to promote health rather than focus intensely on the care of the sick. People suffer episodes of illness but return to their communities to convalesce. Nurses can and are poised to extend their scope of practice to take on new roles (Nursing Council of New Zealand, 1999b). There will always be the sick among us who will require nursing but nurses can make a significant contribution in the primary health area to promote wellness. They can also be involved in initiating social change.

An important adjunct to this research is that nursing education and nursing practice are in a constant spiral of change. Co-operacy is required. Nurse leaders must 'seize the moment' *carpe diem* to enact a collaborative partnership between the sectors to ensure nurses can provide quality care to patients both in acute care settings and in the community. The profession of nursing is facing a crisis in recruitment and retention of nurses world-wide in the face of increased choice of careers for women and men.

Future hermeneutic research could explore the experience of consumers when involved in the teaching/learning context for undergraduate student nurses. It could be useful to hear consumers' voices in relation to being part of the instructional context. Additionally, it would be helpful to explore how consumers experience the registered nurse (as preceptor) instructing the novice who is the deliverer of patient care under supervision.

Future hermeneutic research within the New Zealand context could explore the preceptor/preceptee dual relationship with the voices of both being heard in a common learning experience. It would be useful to hear how the preceptor learns from the practice of teaching and how the preceptee learns from the instruction of the preceptor. The teaching/learning encounter seeking shared understanding of their experience of baccalaureate education for both key players and how a transformative view of education is accomplished.

Future hermeneutic research within the New Zealand context should be undertaken in the community to explore the experience of being-as preceptors to undergraduate student nurses in the variety of community placements that students attend during their nursing education programmes. These include outpatients clinics, public health settings, nursing partnerships between educators and nurses in the school context and providing nursing services in private homes. The phenomenon of being a professional 'guest' within a person's home while delivering a professional service would be of interest as to how the consumer experiences the invasions of their private home by a professional who is delivering nursing services.

Preceptorship as a clinical teaching strategy needs to be explored further than in this research. What needs to be ascertained is how best to select, prepare and support clinical nurse teachers to enhance the delivery of quality clinical teaching that which acknowledges the implications of changing trends in health care on the future needs of student nurses.

There are few studies that examine the effect on preceptors' practice once they are engaged or have been engaged in the preceptor role. The impact on experienced registered nurses' lives of being-as preceptors to undergraduate student nurses should be investigated in order to understand what influences their satisfaction with and performance in the role. A better understanding of what clinical teaching means for registered nurses would assist nursing education and nursing service to more fully meet the needs of registered nurses employed as clinical teachers.

Limitations of the Research

The first limitation of the study is the method chosen. Phenomenology seeks not to create propositions, or to test hypotheses or to extend existing theory but rather to

bring to speech the things themselves in order to understand the meaning of the phenomenon of interest - in this research, the meaning of the experience of being-as preceptors to undergraduate student nurses.

The second limitation is to the scope of the study. The research contains the voices of the fifteen participating preceptors and their experiences of being-as a preceptor to undergraduate student nurses form the substance of this thesis report. Because of the nature of phenomenology and an examination of being-as preceptors, the report is responsive to the fifteen participating preceptors who participated in the research. Theirs are the only voices that one hears through this research report. There are many other voices which are not represented in this research but it is likely that the experiences of the participating preceptors also speak for some of them, for there is a certain common voice that resonates with clinical lecturers and preceptors alike as to what it is like to be a preceptor to undergraduate student nurses.

Another limitation of the study is that fifteen participating preceptors conversed with me for only two hours of their time. In that period, data is cumulative. Of necessity, it is not possible to place all of the narratives into the research report. Rather, excerpts from each transcript are provided in an as exhaustive as possible account of the experience of being-as preceptor to undergraduate student nurses. There could have been other stories embedded in the data that may have taken us on a different path. For example, many of the participating preceptors expressed a desire to know what had happened to the students they had precepted and wondered how their careers were progressing. They expressed a feeling of providing 'input' into students' careers without the satisfaction of seeing the whole come to fruition. A further study could be undertaken that explored the ongoing development of students who have been precepted and follow through the effectiveness of the precepting process in the students' ongoing career development.

As a researcher, I selected the most significant themes from the data that for me, answered the research question. But in that process, I selected excerpts from every one of the fifteen participating preceptors transcripts. I believed this to be an ethical obligation as part of the research process in order to include all the participating voices in the final report.

As stated in Chapter Four, the research report is my interpretation of the phenomenon of interest. I recognise that there are other interpretations and each reader will bring to the research their own interpretations, informed by their own temporal life histories and experiences.

Temporally, this research took place at a particularly poignant time in the history of New Zealand government reforms involving all governmental institutions. During the data gathering process, both health and education institutions were facing catastrophic changes that affected the day to day working life experiences of all institutional employees. It was not unusual for a preceptor to come to work on a Monday to find that their ward had been closed down over the weekend, pending further notice of re-opening. Such events were stressful for preceptors as were the many changes that they had to work through in their day to day affairs. The effect of this rapid social change, of necessity, impacts upon the context and the people who are implicated in this research.

The writing of a phenomenological report takes time. As van Manen (1990) stated it is in the writing and the re-writing that things return to themselves and illumination of the phenomenon comes to appearance.

Recommendations

Research skills

Nurses graduate with research skills and are taught that their practice should be supported by research and evidence based practice. Yet nowhere in this study is it shown that students are encouraged to seek evidence for their practice. However, new prominence given to evidence based health care and new approaches to funding are creating a demand within provider trusts for nurses with research skills.

Higher education requires the teacher to have research based practice. Therefore emphasis should be upon teachers (be they preceptors or clinical lecturers) to demonstrate the use of research as a basis of their practice in order to model research based practice to students. The KPMG report (2001) claims that research skills are one of the key skills nurses should graduate with if they are to be fitted to practice in the new millennium.

Reflective Practice

Time in the working day should be allocated for students to write critical down critical incidents as they occur in practice in order to develop reflective practice. Preceptors can assist students in this process by encouraging students to share with them insights gained from their shared practice. This would enrich the preceptors' practice as well as students. Further, it would give credence to the competence (Benner, 1984) for reflective practice expected at the conclusion of the baccalaureate degree and see its worth as part of developing the reflective practitioner (Schon, 1987, Teekman, 1997). Reflection on common experiences shared between the preceptor and the student encourages dialogue.

Commitment

Nursing lacks a joint commitment from both education and service to the bedrock importance of quality education in both the learning and practice contexts. The production of sound, safe and able qualified nurses depends on a learning environment in both sectors in which the students are supported by teaching and practice staff acknowledging a joint ownership of student nurses. Quality of health and nursing care for the consumers of health and nursing services is dependent on that being so. Deficiency in this regard has its genesis in nursing education. Based on experience, supported by the findings of this study, there is a clear requirement for preceptors, clinical lecturers, students and their institutions to be brought together to work to redress this deficiency. Such an action needs to be complemented by the decision makers in relation to the 'how' of managing nursing education. Beyond that, we require the gathering together of Chief Executives in both the education and health sectors. Their task should include consulting with relevant individuals in professional and general communities. Education and Service partnerships require to be built to facilitate the joint ownership of the developing nurse. I strongly recommend the formulation of a Memorandum of Understanding between relevant education and service institutions. Leaders of both service and education professional communities need to draw up policy and procedures to regulate the relationship. Preceptors involved in nursing education therefore would be actively involved in all facets of the nursing education process, from recruitment, teaching and assessing, to curriculum development. Subsequently, preceptors will also take pride in the successful graduates. There must be a shift away from the traditional and anachronistic systems of nursing

education (Greenwood, 2000) that have reflected mistrust between education and the service sector. Each sector has blamed the other for the new graduate's inability to 'perform' satisfactorily or to 'hit the ground running' (Greenwood, 2000).

Concluding Statement

Commitment of the education and service sectors to work together for the betterment of nurse students' learning experiences in the practice context is imperative. It is essential, also, for easing tension between the requirements of service providers and the more long term aspirations of a professional group.

The preceptors in this study believed that they were insufficiently prepared to be preceptors. This feeling came in the light of uncertainty that they were teaching students the correct knowledge because of a lack of familiarity with contemporary degree education for nurses entering the profession. Preceptors are in the best position to teach reality nursing to student nurses. Students value registered nurses' reality-oriented practice. But the emphasis in New Zealand remains on the technical aspects of nursing rather than on an integrated academic and practice approach in developing the new nurse.

Preceptors in this study were caught in the in-betweenness of being both registered nurse and preceptor. That is, preceptors as teachers, guides and supporters of student nurses became secondary to their primary function of being as-nurse and providing nursing services to patients. Their experience of in-betweenness restricted feelings of 'authenticity' as 'mine-ness' in a shared world of nursing practice and nursing education as they felt they did not belong wholly in either. The experience of being a preceptor in clinical practice to undergraduate student nurses is one that preceptors enjoy but found exhausting. Preceptors are the bridge between the worlds of nursing practice and nursing education, and require appropriate support to walk strongly in both worlds.

We began the thesis with the question: "What is the experience of being a preceptor to undergraduate student nurses in acute care settings?" The phenomenological question seeks to bring to speech that which is taken for granted, that which is hidden, that which is assumed and not given in language. This report reveals what was discovered on the hermeneutic journey undertaken to answer that question. At a time when increasing emphasis is upon the demands for skilled beginning nurses

entering practice in an increasingly complex health care environment, the contribution that registered nurses as preceptors make to nursing education cannot be over emphasised.

The profession of nursing is well aware of the challenges the twenty-first century brings. Advancing science and technology, as well as global information that is available to all who wish to access the world wide information network, provides the consumer of health care with instantaneous information about any health condition they wish to pursue. Accompanying this information explosion, is an increased consumer of health care sophistication that demands a well educated nurse to keep up. In its effort to meet the challenges, the profession internationally, has reviewed its educational preparation of new nurses to meet the challenges of the future of health care delivery. There has however, been little change in the way that new nurses enrolled in a Bachelor's degree experience their clinical learning when compared with earlier decades of nursing education. Preceptors who are registered nurses primarily employed to care for patients take a greater role in nursing education than they used to in earlier decades of nursing education. Conversely, clinical lecturers close contact and support of preceptors as they precept students has decreased. A change is needed in the way nursing education is managed within the profession to incorporate co-operation, and collaboration between the sectors. This will require addressing how preceptors are in their world of nursing practice and nursing education, and how clinical lecturers are in their world of nursing practice and nursing education. Each partner must have the freedom to choose to 'be', in Heideggerian terms, their 'authentic' self, and own their place in both worlds. In-between stands the new nurse of tomorrow. The reader is left with this end point. 'Each one hath a world and is a world' (Donne, 1998). The world of nursing education and practice fields fulfil the potentiality of the purpose of their 'world' together as well as separately. Preceptors and those who learn the practices of nursing with them, depend on that requirement being fulfilled. It is not an either/or position but rather as Ross (1991) claims, an integration of both-and. Visionary leadership is required to make the change happen.

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APPENDIX ONE

ARE YOU A PRECEPTOR ?

My name is Louise Rummel and I am seeking voluntary participation in a research study as part of my PhD Thesis through Massey University. The purpose of the research is to investigate the experience of being a preceptor to undergraduate baccalaureate nursing students in their clinical practicum.

The intent of the research is to show others (management, colleagues, educators and students) the valuable work you do and the contribution you make to nursing as you work with student nurses as preceptors.

If you would like to participate, your involvement would be twofold. First, keeping a diary of your experience of being a preceptor to a student nurse in his or her practicum for a 9 day period. This 9 day diary does not need to be continuous or be focused upon any one student with whom you are working. Rather, it is of your experience as a preceptor that the research is focused and it is this experience that you will record in your diary. Second, taking part in a minimum of two, one hour taped interviews to record stories from your practice that capture for you the meaning of being a preceptor to undergraduate baccalaureate students as they learn to nurse.

To protect your privacy, your name will not be used on any written documents but instead you will choose a pseudonym (false name). Only you and I will know your true identity throughout the research and in any subsequent publications.

I appreciate the time you have given to read this letter. If you are interested, I would be grateful if you would phone me at (09) 479-4905 (evenings) or at my work number during the day so that I can provide you with more information about the study and answer any questions you may have.

Yours sincerely,

Louise Rummel, RGON, MA (Nursing)
PhD Candidate, Massey University.

Home phone (09) 479-4905
Work (09) 274-6009 Ex. 8306



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**FACULTY OF
SOCIAL SCIENCES**

**DEPARTMENT OF
NURSING AND
MIDWIFERY**

APPENDIX TWO

THE LIVED EXPERIENCE OF BEING A PRECEPTOR IN UNDERGRADUATE NURSING EDUCATION

INFORMATION SHEET

My name is Louise Rummel and I am a PhD candidate at Massey University, Palmerston North. I am also a nurse educator interested in your experience of being a preceptor to student nurses in undergraduate nursing education.

I would like to invite you to participate in a research study as part of my PhD Thesis. The purpose of my research is to investigate your experience of being a preceptor to undergraduate nursing students in their clinical practicum.

If you choose to do so, your involvement will be twofold. First, keeping a diary of your experience of being a preceptor to an undergraduate student nurse in his or her practicum for a 9 day period. This 9 day diary does not need to be continuous or be focused upon any one student with whom you are working. Rather, it is of your experience as a preceptor that the research is focused upon and it is this experience that you will record in your diary. Second, taking part in a minimum of two, one hour taped interviews to record stories from your practice that capture for you the meaning of being a preceptor to undergraduate students as they learn to nurse.

The interview will be conducted at a mutually agreed upon venue and will be audio-taped.

The tapes that arise from the interview will be transcribed by a typist who will sign a confidentiality agreement.

Confidentiality will be maintained by ensuring that your name will not be used on any written documents but instead you will choose a pseudonym (false name). Only you and I will know your true identity throughout the research.

Your 9 day diary of your experiences of being a preceptor will be photocopied by me and the original given back to you. The photocopy of your diary will be kept by me in confidence in a metal filing cabinet in my home during the research and for 10 years following the completion of the research.

Likewise, transcribed interviews will be photocopied and the originals given back to you. Copies of your transcripts will also be held in confidence in a metal filing cabinet at my home during the research and for 10 years after the completion of the research.

My two supervisors, Professor Julie Boddy, Massey University Palmerston North, and Professor Nancy Diekelmann, University of Wisconsin, Madison, United States of America will also have access to your information during their supervisory role. Both professors will know you only by your pseudonym.

In qualitative research, there is usually data transcribed which is surplus to the purpose of the current study but may hold potential for a new study. At the outset of this study, I would like to seek your permission for the potential to use any surplus data that may arise from this research for secondary analysis. However, I would like to reassure you that I will again approach you for consent to the secondary use of your data before any further research is undertaken. Any new study that may arise from secondary use of your data will also require further ethical approval through Human Ethics Committees.

Reading this information sheet does not commit you in any way to the research. If you do decide to participate, you also have the right to withdraw including your data, at any time without consequence.

You have the right to refuse to answer any particular questions and to request the tape to be turned off during an interview. You have also the right to ask any questions at any time during your participation in the study.

Although unlikely, there is potential to harm another person during this research, through the description in an interview of an unsafe nursing act either by the preceptor or a student nurse whom he or she is precepting during the preceptor experience. It is assumed that you as the registered nurse preceptor, will have taken all the necessary steps to ensure the patient's safety.

The final study will be submitted as a research report for thesis requirements and may be used at research or education seminars or as the basis for papers published in journals.

Please contact me at my work at (09) 274 6009 Ex. 8306 between 0830 and 4.40 p.m. Monday to Friday, or (09) 4795341 (weekends or evenings) if you would like to proceed to be a participant in the research or if you wish to clarify or have any further information. Alternatively, contact Professor Julie Boddy, Department of Nursing and Midwifery, Massey University, Palmerston North (06) 356 9099 who can be accessed through the Massey University, Albany Campus switchboard, (09) 443 9700, Extension 4333.

Thank you for giving up your time to read this information sheet. I will contact you by telephone within a week to ask whether you would be willing to participate in this research.



Louise Rummel RGON, MA (Nursing)
Massey University.
PhD Candidate

1997

HEALTH ADVOCATES TRUST
PO Box 9983,
Newmarket, Auckland.

If you have any queries or concerns regarding your rights as a participant in this research you may contact the Health Advocates Trust, phone 623 5799.



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APPENDIX THREE

THE LIVED EXPERIENCE OF BEING A PRECEPTOR IN UNDERGRADUATE NURSING EDUCATION

CONSENT FORM

I have read the Information Sheet and have had the details of the study explained to me. My questions have been answered to my satisfaction, and I understand that I may ask further questions at any time.

I understand I have the right to withdraw from the study at any time and to decline to answer any particular questions.

I agree to provide information to the researcher on the understanding that my name will not be used without my permission.

This information will be used only for this research and publications arising from this research project.

I agree/do not agree to the interview being audio taped.

I also understand that I have the right to ask for the audio tape to be turned off at any time during the interview.

Signed:

Name:

Date:

Witness:.....

Name:..... Date:.....

APPENDIX FOUR

DECLARATION OF CONFIDENTIALITY

I understand the purpose of the research and the necessity for observing strict confidentiality of all the information I will come in contact with during the transcribing of tapes.

I _____ therefore declare that I will Not disclose any details of the identity of the research participants, nor of the content of the tapes I receive to transcribe.

The tapes that I receive to transcribe and the transcripts will be kept in a secure place while they are in my possession.

I understand that any disclosure of information pertaining to this research by me will be in breach of the Privacy Act (1993).

Signature: _____

Date: _____