

MEANING OF BOUNDARIES TO RURAL PRECEPTORS

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ABSTRACT

Preceptorship is widely used as a cost-effective clinical non-traditional teaching method. However, insufficient research has been done in this area, particularly as to how a successful student-preceptor relationship is formed. The rural setting poses additional challenges as the nursing instructor is not physically present to monitor the course of the student-preceptor relationship or to resolve arising boundary issues. This is part one of a grounded theory project whereby eleven rural preceptors were asked ‘what kinds of professional boundaries do you create in the rural preceptorship experience’ and ‘how they created and maintained professional boundaries while precepting nursing students’. The research project consisted of two parts: each examining the perspectives of preceptors and students. However, this study will focus on the perceptions of preceptors and is the first to examine perceptions of preceptors in the area of teaching and boundaries in rural settings. The resulting core variable was: trusting the student to be safe and the psychosocial process was the relationship they developed with the student.

INTRODUCTION

The preceptorship experience is widely used by a number of professional faculties, including nursing, as a cost-effective method of providing quality field experience. Students are individually assigned to preceptors in a formal, one to one teaching/learning relationship which allows them to experience the reality of the nursing staff role with the support of a role model and a resource person immediately available to them (Kaviani & Stillwell, 2000; Öhrling & Hallberg, 2000). Preceptorship is comprised of a triad - the student, preceptor and faculty member - that work together to achieve a student’s transition to the role of graduate nurse. Preceptorship has come to represent the process of “pairing new graduates with an experienced nurse to facilitate role transition to that of a staff nurse” (McCarty & Higgins, 2003, p. 91). As part of the socialization process, students come to develop professional relationships and implicit in this, begin to recognize and resolve boundary issues. An effective preceptorship experience is dependent on the development and maintenance of this kind of professional relationship and so an important question that needs asking is: how are these professional boundaries created and maintained?

A setting that is particularly vulnerable to professional boundary challenges is the rural setting due to the existence of dual and multiple role relationships that nurses have within small communities. The rural setting is also vulnerable due to nursing shortages which have had devastating effects. Research has shown that preceptorship is an important tool for recruitment of new graduates to rural areas (Neill & Taylor, 2002) thus challenges for rural preceptorships such as boundary issues need to be identified and resolved. The focus of this article is how rural preceptors address boundaries within the preceptorship relationship.

SIGNIFICANCE OF THE RESEARCH

Despite the widespread use of the preceptorship program as a method of clinical teaching, the challenges of such a program for students, preceptors and faculty are not well understood. This is especially true for rural placements where the physical presence of a faculty instructor is an impossibility and thus an understanding of the effectiveness of rural placements is entirely dependent on the effectiveness of communication channels between the faculty and the preceptorship site. A negative experience with a student can influence the willingness of a staff nurse and their colleagues to preceptor at later points in time. Faculty, students and preceptors need to understand boundary issues in the student-teaching relationship, avoiding harsh consequences should boundaries be crossed inadvertently. Since positive preceptorship experiences can serve as recruitment of students, preceptors need to be diligent about professional relationships with students.

REVIEW OF THE LITERATURE

Long and Weinert (1989) define rural nursing as the provision of health care by professional nurses to persons living in sparsely populated areas. Bushey (2000) stipulates the issues of defining rural nursing are significant because it affects nursing care, preparation of nurses, and nursing work-life issues. Bushey (2000) notes the ability to function autonomously and the ability to adapt nursing interventions to a low-tech environment is historically characteristic of rural nursing practice in Canada and rural nurses need to be expert generalists (2001). Paradoxically, this setting is a rich learning opportunity for student clinical placements as they are faced with a wide variety of experiences and are forced to act at a greater level of independence and competence (Van Hofwegen, Kirkham, & Harwood, 2005).

Beatty (2001) declares that little has been done to investigate the rural nurses' learning needs or the context of their practice setting. In addition, she notes professional isolation prevents these providers from networking with colleagues to discuss new treatments and evaluate effectiveness (Beatty, 2001). Weinert and Long (1991) surveyed rural nurses and found they had to travel between thirty and sixty miles to reach a college or university. However, in the medical literature, a review of the impact of students on rural practitioners found reduced professional isolation, increased identification with precepting peers and increased interaction with the medical school to be positive impacts of rural preceptorships on preceptors (Walters, Worley, Prideaux, Rolfe & Keaney, 2005).

Ullian, Shore & First (2001) stress the importance of two-way communication between medical preceptors and the faculty in dealing with problematic interactions between students and preceptors. However, in rural settings the physical presence of a faculty member is often an impossibility. Unprofessional behaviours such as inability to demonstrate knowledge and skills, attitude problems, dishonesty or poor work ethic, and poor communication skills may serve as red flags to unsafe practice (Luhanga, in press). Thus, unprofessional behaviour on part of either the student or preceptor must be even more diligently monitored.

As Hargrove (1986) stipulates, there are a number of critical ethical issues for rural mental health practitioners specific to the rural setting and challenging for the student-preceptor relationship including: the confidentiality of and within the professional relationship with a consumer of professional services; limits of practice; and multiple levels of relationships between persons who live and work in small communities. Roberts, Battaglia, Smithpeter, and

Epstein (1991) later affirm that ethical dilemmas encountered in small communities derive from several highly interwoven attributes of health care in these settings: overlapping relationships and conflicting roles among caregivers, patients, and families; challenges in preserving patient confidentiality; heightened cultural dimensions of health care; limited resources access to health care services and related issues of clinical competence; and exceptional stresses on caregivers in these settings. Thus, there is a greater possibility for boundary crossings in the form of confidentiality violations, unprofessional conduct, vague role definitions and interpersonal conflict in the rural setting. It is the preceptor who will be responsible for facilitating the student's learning experience and role socialization (Kaviani & Stillwell, 2000), including surmounting the added challenges facing the rural practitioner.

Thus the researchers set out to explore the questions: "What are the professional boundaries created during the preceptorship experience?" and "How do rural-based nursing preceptors create and maintain professional boundaries when teaching undergraduate nursing students?" in order to better support and facilitate rural preceptorships.

METHODS

Fourth year baccalaureate nursing students and their rural based preceptors were recruited for the study. The students had 340 hours of direct clinical preceptorship. Students were recruited through in-class visitation and were requested to sign a consent form before participating. Their preceptors were then contacted and recruited. No attempt was made to pair the students and preceptors to avoid coercion. The study received ethical approval by the host university review board. This article will only focus on the findings from the preceptors.

Data Collection

Data was collected through a series of semi-structured interviews, participant observation in the placement setting and review of course materials. The interviews were based on an interview guide consisting of open-ended questions. This helped to facilitate participants' freedom of response and allowed for the researcher to clarify responses.

Framework

To reveal "what is actually going on rather than what ought to be going on", the researcher chose a grounded theory method (Glaser, 1978, p. 14). Grounded theory was chosen as the framework for this study as there is a general lack of research in the area of preceptorship and boundary creation, and there is a need for more middle-range theories in nursing education that can be empirically tested (Streubert & Carpenter, 1999). Grounded theory recognizes that individual shape meaning through experience and although experience is unique to an individual, commonalities in experience occur with those sharing circumstances (McCann & Clark, 2003).

Data Analysis

Analysis of the data began almost as soon as collection using open codes (Glaser, 1978). Categories and dimensions emerged that were clustered together. These were compared among each other to determine how they connected. The researcher was guided by several questions

(Glaser, 1992). First, precisely what do these data reflect? While allowing for complete emergence of the data, this question reminded the researcher that what might have originally aimed to study might not be what emerges. Second, which category does an incident indicate? As the theory increasingly conceptualized, this question became easier to answer. Third, what were the basic social/psychological problems faced by the participants, and what was the basic social/psychological process or social structural process that made the preceptor-learner relationship workable? This process yielded a core variable.

To maintain rigor, four specific criteria were used: credibility, fittingness, auditability and confirmability (Guba & Lincoln, 1989). Preceptors reviewed transcripts, two independent external researchers reviewed the transcripts for themes, participant observation was used and field notes captured when saturation was achieved. The limitation for grounded theory is the inability to generalize to other settings. The data captures the experience of these nursing students at a particular moment in their program.

SAMPLE

Eleven rural nurse preceptors volunteered and were interviewed in the rural setting. Ten had a diploma level of education while one preceptor had completed a baccalaureate degree in nursing; the average number of total years of nursing education was 3.06 years. All but one preceptor had been engaged in some form of continuing nursing education. There was a wide range of the number of years as a preceptor ranging from two preceptors who had a student for the first time to a nurse preceptor that had had 23 years of experience. Slightly over half had previously precepted 4th year baccalaureate students, and had also precepting experience with Licensed Practical Nurses, two year nursing diploma students, and paramedic students. Five preceptors indicated that they had had no preparation for the preceptor role. Four nurses indicated that their experience was founded on the information packages provided by the university. One preceptor indicated that her years of precepting experience had prepared her for her role.

RESULTS

The core variable was: trusting the student to be safe. The preceptee was a student and needed the chance to learn, however patient safety was still the most critical issues for the preceptors. The preceptors skillfully outlined the process they used to ensure the student had the knowledge to practice. The psychosocial process was the relationship the preceptor developed with the student. Six dominant themes emerged from the data. The first three theme described directly refer to teaching and learning.

First, preceptors (n=6) viewed their role as furnishing their students with the skills needed for a successful transition from student to staff nurse. They felt it necessary to introduce students to the “reality of nursing” and facilitating this transition as a role-model, supervisor and friend. The capacity for independent work was the primary objective of the clinical experience. Three nurses viewed the clinical experience as complimentary to the university training and saw it as their role to reinforce their students’ classroom knowledge. One nurse expressed “[my role is] to make sure that the girls coming out into the nursing field are fully prepared for a work situation.” In terms of boundaries, their first concern was knowledge. Essentially they needed to trust that the student had the knowledge to be safe.

The second theme that emerged pertained to the process by which preceptors teach their students. The majority of preceptors outlined a process of three steps: the student observes the task performed by the preceptor, and then the student performs the task under the supervision of the preceptor, and then goes on to perform the task independently without the supervision of the preceptor. Preceptors saw their role in the final stages of this process transform from a more direct form of guidance to that of a resource person, available for questions and encouragement.

Linked to this process was the mechanism by which feedback was delivered. Preceptors demonstrated a respect for student reasoning and emotions and generally took great pains to deliver constructive encouragement in a private setting. Criticism was never delivered in front of patients and rarely in front of other staff. They stressed the need to be open and deliver criticism or correct a task in a timely manner, however, the approach generally left the evaluation and final decision up to the student. One preceptor stated “the only times I’ve corrected is normally to say that . . . ‘I was taught that you should always do this,’ or ‘you should do this in this manner; I don’t know if that’s good or not.’ But I leave it up to her.”

The third major theme was the nearly unanimous response to the interview question: “How long does it take to know whether the student-preceptor relationship is going to be a positive one?” Nine preceptors felt, “the first day...you kind of know by the end of the first shift with them”. Factors influencing this relationship were very much based on personality and attitude rather than skill levels, thus most preceptors felt within the first shift, or at most after a couple of days, they had a sense of the student’s willingness to learn and their enthusiasm for the experience.

The fourth theme reflected further on the student-preceptor relationship. Most preceptors felt honesty and respect are major factors promoting a positive student-preceptor relationship. When asked what promotes a good relationship one preceptor responded, “I felt that I could trust her to do her best effort as well, and not have to be totally stand over her shoulder.” A mutual respect for the wealth of experience of the preceptor and the post-secondary education of the student contributed to a positive relationship. A preceptor qualified this, saying, “I think respect from both. My respect for her, wanting to learn skills she knows, information she has”.

In contrast to these factors, the fifth theme detailed factors that were inhibitors for a positive student-preceptor relationship. The majority of preceptors felt a lack of motivation was the greatest inhibitor to a positive relationship. One preceptor explained, “I think with the student, if they don’t have the initiation to go and try to do things and want to do thing and want to be there. I find it’s sometimes hard to get them motivated to jump in.” Some preceptors explained that an unmotivated student contributed to their workload rather than lightening it as was the case with eager and motivated students.

Lastly, when exploring the boundaries of the student-preceptor relationship, the question of the degree of personal disclosure was posed in the interview. Preceptors had mixed feelings when it came to sharing confidences with students. About half didn’t have a problem sharing personal information, although it had seldom occurred in their experience. The other half maintained a strictly professional relationship saying, “I don’t think I’ve been that close with a student. I won’t talk about personal or intimate things. Certain things aren’t up for discussion.” Many preceptors set professional boundaries with a student along the same lines as they would with other nurses or health care colleagues. They recognized the need to ‘take a break’ from constantly discussing work while on a break, however the boundaries remained clear with disclosure limited to “anything extra curricular, like sports or gym that sort of thing, but nothing personal”.

Other boundary issues that were explored were gift-giving, touching, and keeping in touch with the student after the placement has finished. Nearly all preceptors with whom the question was raised (n=6) stated that gifts were by no means expected; however, that a little something or even a thank-you card or verbal appreciation provided the feedback and closure that was needed. Many found a sense of closure in a special last-shift coffee, sharing baking or having a 'reminiscent time'.

Pertaining to the question of touching, many said that friendly or encouraging 'pats on the back' did occur, and were often positively perceived. This occurred with preceptors who perceived themselves as 'touchy' people and who interacted with patients in a similar manner. However, whether they themselves were comfortable with touching or not, most preceptors had an awareness of whether another individual was comfortable with touching or not.

Lastly, the majority of preceptors (n=6) had kept in touch with students or wished to following the placement. They expressed interest in the students' future endeavours and working experiences. This was often facilitated by the rural environment with students returning to work in the rural area or having relatives that also worked and lived in the area.

The nurse preceptors reflected on the experience as specifically rural and the implications of this for both preceptors and students. The majority of nurses had not considered the goal of recruitment to rural areas when they had agreed to take on students and for many this possibility had not yet crossed their minds. One preceptor encouraged each of her students "to work in a rural hospital for 2 years before working elsewhere, so that you can learn a little bit of everything."

Secondly, they felt that a rural experience was particularly beneficial to students due to the generalist nature of a nurses' workload at a rural hospital. One nurse depicted the rural experience as compared to the urban as, "in the big city hospital they got it easy, because they don't have to know everything and they've got doctors right there. In the small hospital you have to use your brain a little; you have to think things out. Although in the city, they think everybody in the country is born with a potato in their head". They felt students received a broader experience rather than being restricted to a single specialist facility or area. They had the opportunity to work with patients of all ages and were able to prioritize their experiences according to where "the action was" on a particular shift. Challenges of this environment included having to be exceptionally organized and requiring the ability to prioritize under pressure.

DISCUSSION

When directly confronted with the question of how a professional relationship was established with a student, many preceptors could not articulate the elements of this process. However, when questioned about aspects of the student-preceptor relationship such as gift-giving, touching, self-disclosure, closure and factors contributing to a positive experience, these preceptors maintained professionalism, keeping objectives and boundaries at the forefront. This was demonstrated through behaviour such as keeping personal matters outside of the working relationship, restricting gift-giving to small tokens of appreciation and touching to what would be appropriate with patients or colleagues. Though faced with ethical challenges unique to the rural setting (students as children of friends and colleagues, heightened visibility in the community, confidentiality issues etc.) these preceptors set clear professional boundaries (Hargrove, 1986; Roberts et al., 1991).

The delivery of criticism in a constructive and respectful manner also contributes to the development of professional boundaries. Preceptors recognized students were not to be reprimanded as children, but as adults with their own learning, experience and decision-making processes. Criticism was always delivered in a private space and never in front of patients or colleagues. They found that students responded very well to encouragement alongside criticism and were forced to develop critical thinking in evaluating their own skills. The development of mutual respect and learning was fostered through this method of feedback.

The nurses were aware of the uniqueness of a rural placement in comparison to the urban clinical placement experience. They seemed to value the challenges of being a 'generalist' in such a setting (Hegney et al., 2002). Preceptors felt the role of a rural nurse gave students an opportunity to put into practice a wide range of skills, forced them to function more autonomously and exposed them to a variety of challenges (Bushey, 2000). Although they did not have recruitment goals in mind, they recognized the potential of rural placements as a recruitment strategy.

CONCLUSION

Rural nurse preceptors seem to have an implicit understanding of professional boundaries necessary for life and work in a rural community. However, with the introduction of students with urban backgrounds into these settings it may become more important to articulate these boundaries more clearly and definitely. It was noteworthy that a central conception of boundaries was trust in the area of the student's knowledge development. Additionally, as rural placements have been recognized as a successful recruitment strategy for health care professionals to rural areas, a greater number of students may enter these placements without having had previous experience in a rural area. If recruitment potentials are to be maximized it is important that a proper introduction to rural health care challenges and benefits be developed for these students and preceptors.

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