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# The Journey from Bedside to Classroom: Making the Transition from Nurse to Nurse Educator

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THE JOURNEY FROM BEDSIDE TO CLASSROOM:  
MAKING THE TRANSITION FROM  
NURSE TO NURSE EDUCATOR

By

Anne M. Schoening

A DISSERTATION

Presented to the Faculty of  
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In Partial Fulfillment of Requirements  
For the Degree of Doctor of Philosophy

Major: Educational Studies

(Educational Leadership and Higher Education)

Under the Supervision of Professor Marilyn L. Grady

Lincoln, Nebraska

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THE JOURNEY FROM BEDSIDE TO CLASSROOM:  
MAKING THE TRANSITION FROM NURSE TO NURSE EDUCATOR

Anne M. Schoening, Ph.D.

University of Nebraska, 2009

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In spite of a national nursing shortage, American schools are turning away students in record numbers. This is due in large part to a critical shortage of nursing faculty. Recruitment and retention of qualified nurse educators is essential in order to remedy the current staff nurse and faculty shortage, yet nursing schools face many challenges in this area. New nurse educators are often recognized as expert clinicians at the bedside, and most have advanced degrees in nursing; however, few have formal preparation for teaching, and faculty orientation programs vary widely between institutions. Thus, new nurse educators often begin their academic careers with little preparation or guidance.

The purpose of this qualitative, grounded theory study was to generate a theory that describes the process of how nurses make the transition to the role of nurse educator. Purposive, theoretical sampling was used to identify 20 nurse educators who were teaching in four baccalaureate nursing programs in the Midwest. Using open, axial, and selective coding, a theoretical paradigm was created which symbolized this role transition as being on a journey with “no roadmap” and “no guide.” Participants described the

academic work environment as unfamiliar and struggled with a fear of failure, professional identity issues, student boundary issues, and time constraints. They utilized strategies such as self-directed information seeking, peer mentoring, and gradual acceptance of responsibility in order to adapt to their new roles. Consequences of a successful role transition included feeling like a teacher and thinking like a teacher.

From this data, The Nurse Educator Transition Theory (NETT) model was created. This model identifies four phases in the role transition from nurse to nurse educator: (a) The Anticipatory/Expectation Phase, (b) The Disorientation Phase, (c) The Information Seeking Phase, and (d) The Identity Formation Phase. Recommendations for practice include integrating formal pedagogical education into nursing graduate programs and creating evidence-based orientation and mentoring programs for novice nursing faculty.

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## Acknowledgement

To quote my study participants, “it’s been a journey.” When I began nursing school 20 years ago, I never imagined that I would come this far in my educational career. Even though I didn’t start out with this destination in mind, here I am. I would never have found my way on this journey without the help and support of so many:

- My parents, who worked long hours at back-breaking jobs so that I could have an education. You loved me even when I was hard to love, and I thank you. This especially is for you, Dad. I know that you are with me everyday.
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## CHAPTER 1

### INTRODUCTION

*“What am I doing here?” The brand-new nursing instructor asked herself as she stared at the sea of faces before her. They sat with pens poised as she cleared her throat and clicked the mouse to advance her carefully-prepared slide show. The students shifted in their seats, sizing her up; sensing her inexperience. “What am I doing here?” She asked herself again... “I am a nurse...and a good nurse...but not a teacher. How did I end up at this podium in this lecture hall?”*

#### Statement of the Problem

American schools of nursing are struggling with rapidly increasing enrollment in response to a national nursing shortage. By the year 2020, it is estimated that the United States will experience a shortage of more than one million nurses; however, the current educational system has been unable to keep pace with this increased demand (U.S Health Resources and Services Administration, 2004). Enrollment in entry-level baccalaureate nursing programs has risen steadily during the past seven years; yet in 2007 more than 30,000 qualified applicants were denied entry into these programs (American Association of Colleges of Nursing [AACN], 2007). This is due in large part to a shortage of nursing faculty.

Recruitment and retention of qualified nurse educators is critical in order to address the current faculty and staff nurse shortage in the United States, yet nursing schools face many challenges in this area. New nurse educators are often recognized as expert clinicians, and most have advanced degrees in nursing. However, few have formal preparation for teaching (Genrich & Pappas, 1997; Zungolo, 2004), and orientation

programs vary widely between organizations (Morin & Ashton, 2004). Thus, novice educators may feel ill-prepared for their new role, and job dissatisfaction may result (Siler & Kleiner, 2001). The research problem this study addressed is the difficulty that new nurse educators experience when they enter the world of academia, often with little formal preparation or orientation.

### Background/Significance

In 2009, novice nurse educators enter the academic setting with far less formal preparation than their colleagues did a generation ago. Prior to 1970, most master's degree programs in nursing were centered on traditional "role preparation," either in administration or nursing education (McKevitt, 1986). However, in 1969, the American Nurses Association (ANA) issued a position paper calling for graduate programs to shift their focus toward clinical specialization and advanced nursing practice, rather than these more "traditional" courses of study (Davis, Dearman, Schwab, & Kitchens, 1992; Fitzpatrick & Heller, 1980; Krisman-Scott, Kershbaumer, & Thompson, 1998; McKevitt). The result was a rapid educational paradigm shift.

A study by McKevitt (1986) revealed that between 1979 and 1984, there was a significant decline in the number of graduate nursing programs offering education as a primary area of study. Oermann and Jamison (1989) surveyed 92 nursing graduate programs and found that by 1989, only 11% of these schools offered a major in nursing education at the master's level. During the 1990's, only 4% of nurses enrolled in master's programs were pursuing degrees that would prepare them for a faculty role (National League for Nursing [NLN], 2002).

Graduates from clinically-focused programs possess advanced clinical knowledge and skill, but they may lack the basic understanding of how to teach. Status as a clinical expert does not automatically translate into status as an educational expert. In fact, the advanced training received by clinical specialists and nurse practitioners may actually make teaching at the generalist level in a basic nursing program more difficult (Zungolo, 2004). A lack of pedagogical and curricular knowledge may lead to an over-emphasis on content and perpetually “teaching as we were taught” (Zungolo, p. 22). This ultimately threatens the quality of instruction in nursing education and can lead to feelings of inadequacy in the novice educator.

To date, the literature examining the preparedness of nurse educators has focused on recruitment and retention activities (Gazza & Shellenbarger, 2005; Horton, 2003), developing core competencies for the job (Choudry, 1992; Davis, et al., 1992; Davis, Stullenbarger, Dearman, & Kelley, 2005), and calling for the need to restructure graduate nursing education (Zungolo, 2004). Although this problem is not new, researchers have only recently attempted to gain insight into the process that occurs when an experienced nurse makes the transition to novice nurse educator (Anderson, 2006; Dempsey, 2007; McDonald, 2004; Ramage, 2004; Siler & Kleiner, 2001).

This qualitative study of 20 nurse educators describes the phases of the transition from “bedside to classroom” and may be useful to both nursing school administrators and novice nurse educators. It is my hope that the findings presented here will help schools plan more effective orientation programs for new nursing faculty. I also hope that the adaptive strategies described by the participants will be of use to novice nurse educators as they begin their own journeys.

### Purpose of the Study

The purpose of this study was to generate a theory that describes the process of how nurses make the transition to the role of nurse educator. The research was conducted at four baccalaureate nursing programs in the Midwest. A qualitative, grounded theory approach was used (Strauss & Corbin, 1998) in order to generate a theory that is “grounded” in data, rather than driven by “a priori assumptions” (Glaser & Strauss, 1967, p. 3).

### Research Questions

The central research question that guided this study was: What theory explains how nurses make the transition to the role of nurse educator?

Additional questions included:

- What is the process?
- In what context do nurse educators enter the field of nursing academia?
- What facilitates or inhibits the transition process?
- What are the identifiable stages in the transition?
- What model explains this process?

### Definitions

The following definitions were used during the course of this study:

Advanced Practice Nurse: Advanced practice nursing is an umbrella term that includes registered nurses who have completed advanced education and training beyond the basic level needed for initial licensure. This education usually occurs at the master’s or doctoral level. Nurse Practitioners, Clinical Nurse Specialists, Certified Nurse Midwives,

and Certified Registered Nurse Anesthetists are included under the advanced practice umbrella (ANA, 2007).

Baccalaureate Nursing Program: Basic education for entry into practice as a registered nurse (RN) may be accomplished by earning either an Associate Degree in Nursing (ADN) or a Bachelor of Science in Nursing (BSN). Three-year diploma programs also exist. This education may take place in community colleges, which award an associate's degree, or private colleges and state universities, which generally award a baccalaureate degree. Students who complete these degrees from state-approved schools are eligible to take the National Council Licensure Examination for Registered Nurses (NCLEX-RN). Passing this exam is necessary for licensure as an RN in the United States (ANA, 2007).

Clinical Instructor: A nurse educator who supervises students providing care to patients in the clinical area. A clinical instructor may or may not have classroom responsibilities.

Clinical Nurse Specialist (CNS): A Clinical Nurse Specialist is a registered nurse with a master's or doctoral degree in a nursing clinical specialty. Certification exams are available in some, but not all, specialty areas of nursing. The CNS is eligible for advanced practice licensure in several states. The CNS conducts and applies research in the clinical setting, educates patients, families, and staff, engages in systems management, and provides expert consultation on complex clinical cases (Nebraska Department of Health and Human Services, 2007; National Association of Clinical Nurse Specialists, n.d.).

Nurse Educator: Nurse educators are responsible for designing, implementing, evaluating and revising academic and continuing education programs for nurses (Nurses for a Healthier Tomorrow, n.d.). Nurse educators may be employed in the academic setting or as staff educators in clinical agencies. In Nebraska, the minimal degree requirement for teaching in a registered nursing program is a graduate degree in nursing, or documentation of annual progress toward this degree (Nebraska Health and Human Services Regulation and Licensure 97-007.03A, 2006). The focus or specialization of the graduate degree is unspecified, but the statute indicates that the individual should be “academically and clinically prepared” in their specialty if they are teaching students in a clinical area (p. 7). There is no requirement for graduate coursework in the field of nursing education. For purposes of this study, a nurse educator is defined as an individual who is employed as faculty in a school of nursing and is responsible for instruction and/or supervision of nursing students.

Nurse Practitioner (NP): A nurse who has obtained additional education and licensure to manage common health problems and chronic conditions. Nurse Practitioners may prescribe treatments and medications. Most have earned a master’s or doctoral degree in nursing. All must pass a national certification examination. There are several areas of certification and specialization (Nebraska Department of Health and Human Services, 2007).

## CHAPTER 2

### CONTEXT OF INQUIRY

“Broadly speaking, what distinguishes the man who knows from the ignorant man is an ability to teach.”

--Aristotle

#### Review of the Literature

Strauss and Corbin (1998) caution grounded theorists to delay an extensive literature review until after data collection and analysis is complete. In doing so, it is often argued that the validity of the project will be preserved because the researcher will not be “seeking out what the literature suggests” (Morse & Richards, 2002, p. 169). However, Charmaz (2006) acknowledges that a focused review of the literature can strengthen a newly developed grounded theory. She recommends beginning with a critique of relevant studies, and then returning to the literature to clarify ideas, and defend one’s positions. Thus, I begin here with a review of the literature that currently exists on the transition from nurse to nurse educator. In Chapters 5 and 6, I will compare my findings with those of other researchers and position my theory within the existing nursing education literature.

#### *The Transition Experience in Nursing Academia*

Since the movement toward clinical specialization in graduate nursing education began, researchers have written about the difficult role transition from nurse to nurse educator. Citing a lack of preparation for teaching, Esper (1995) described the struggles that nurse clinicians face when they find that the academic work setting values different skills and accomplishments than the clinical work setting. Locasto and Kochanek (1989) used Kramer’s theory of “reality shock” to describe this role transition. Their work

suggests that new nurse educators experience a “honeymoon phase,” a “shock and rejection phase,” and a “resolution phase” as they adapt to their new role.

More recent inquiries have focused on identifying the personal traits of those who have made a successful transition. Morris (1995) and Young and Diekelman (2002) sought to identify specific behaviors, values, strategies and practices of effective nurse educators. Using a feminist lens, Morris explored how caring, responsibility, and connectedness influenced the effectiveness of female faculty, while Young and Diekelmann researched how novice nurse educators “learn to lecture.” Both of these studies identified the use of interactive, student-focused teaching as a characteristic of effective nursing faculty. Young and Diekelmann concluded that novice faculty initially favor teacher-centered methods of instruction, but as they begin to feel more effective in their new roles, they utilize more learner-centered methodologies.

While these two reports focused on skills and behaviors, others have described the transition experience in broader terms. Congdon and French (1995) examined the adaptation of nurse educators in the United Kingdom as they transitioned into the university environment. They found that nurse educators tend to “nurture” their students and have difficulty fostering student independence. Overall, the five nurses in their qualitative study placed a high value on building nurturing teacher-student relationships and a low value on research and publication. They attributed these difficulties to their nursing background and a lack of preparation for their academic role.

In a phenomenological study, Siler and Kleiner (2001) contrasted the experiences of six novice and six experienced nursing faculty. Although four major themes were identified, their final report focused solely on the expectations of novice nurse educators.

Participants in this study described the academic environment as unfamiliar, with a lack of guidance and orientation. In reflecting on their expectations, they pointed out the striking incongruence between the unstructured environment in the academic setting and the structured orientation and preceptorship that they had received in the clinical setting.

This is consistent with McDonald's (2004) and Dempsey's (2007) findings.

McDonald followed eight novice nurse educators through their first semester of teaching in Canada. In order to successfully transition into their new work environment, McDonald discovered that her participants "framed" their teaching through their past experiences, their caring for students and the profession, and their clinical expertise. Expanding on these findings, the educators in this study reported that their transition was made difficult when they did not feel as though they were cared for, or if they felt their personal knowledge was inadequate to perform the role. An overall lack of orientation and guidance was perceived as a lack of caring, and an absence of formal pedagogical education was described as contributing to a lack of personal knowledge.

Reporting on the experiences of six novice nurse lecturers in Ireland, Dempsey (2007) also identified a lack of orientation and mentoring in the university-based setting. Overall, the participants in her study reported a positive transition from a clinical position to a teaching position; however, they noted that time constraints, workload, and a lack of guidance hindered their role transition. Participants in Dempsey's study also felt that their master's-level education was inadequate to prepare them for the practical duties of their new role, even if they had taken courses in nursing education theory.

Ramage (2004) and Anderson (2006) have generated theoretical descriptions of the transition from nurse clinician to nurse educator. In a grounded theory study, Ramage

focused on the identity changes that occur as nurses transition from practice to education in the United Kingdom. The central category of “negotiating multiple roles” was used to explain how novice teachers assume their new role as educators (p. 289). The transition was described as a process of “disassembling” the nursing identity (p. 289) and then “rediscovering” and “realizing” the new “self” (p. 292) as educator.

Anderson (2006) developed a theoretical model of the work-role transition after interviewing 18 nurse practitioners and clinical nurse specialists in their first or second year of employment as a nurse educator. Her model depicts the transition from clinical expert to novice educator as a six-phase process, beginning with a “pre-transition” phase and ending with a “late transition” phase. As the educators in her study made the transition, they moved from focusing on “self and survival” in the early phases to “developing vision” and “finding balance” in the final phase (p. 138). Anderson also identified factors which facilitated the transition, such as past work experience, support from family and colleagues, and the use of mentors. Hindering factors included unrealistic expectations, a lack of formal preparation, student issues, lack of orientation, and a heavy workload. Anderson (2008) has also presented her theory in the form of a metaphor, equating nursing academia with an ocean and the transition process as “treading water” (p. 82).

Although these researchers have approached their inquiries in different manners, they make several common conclusions and recommendations. These include: (a) the need for formal orientation to the academic work setting that extends beyond the first few weeks of employment (Anderson, 2006; Congdon & French, 1995; Dempsey, 2007; McDonald, 2004; Morris, 1995; Siler & Kleiner, 2001), (b) mentorship (Esper, 1995;

Locasto & Kochanek, 1989; McDonald; Morris; Siler & Kleiner), and (c) formal preparation for teaching (McDonald; Morris; Siler & Kleiner; Young & Diekelmann, 2002).

### *Skill Acquisition in Nursing and Nursing Education*

There is a strong parallel drawn in the literature between the transition of nurses to the academic setting and the transition of new graduate nurses to the clinical setting (Anderson, 2006; Dempsey, 2007; Siler & Kleiner, 2001; Young & Diekelmann, 2002). Benner (2001) has described the development of clinical practice expertise in nursing using the Dreyfus model of skill acquisition (Dreyfus & Dreyfus, 1986). This model suggests that individuals pass through five levels of proficiency as they acquire and develop a skill: novice, advanced beginner, competent, proficient, and expert (Dreyfus & Dreyfus). According to this theory, novices typically exhibit “rule-governed behavior,” (Benner, p. 21) relying heavily on policies and procedures since they lack practical experience to guide their decisions. Experts, however, rely less heavily on rules and often use intuition and experience to guide their behavior. See Appendix A for a detailed description of each skill level in the Dreyfus model.

Benner’s (2001) work has transformed the way that new graduate nurses are oriented and socialized into the clinical setting. Realizing that novices and advanced beginners need structure and guidance, hospitals have developed elaborate “preceptorship” programs for nurses who are new to a clinical area. Nurse “residency” or “transition” programs are also in place at many major institutions. These “residency” programs provide a transition period of employment for up to a year for new graduate nurses and are characterized by close preceptorship, classroom instruction, and support

network meetings. These intense programs have been linked to increased retention, decreased stress, and increased job satisfaction for new graduate nurses during the first year of employment (Krugman, et al., 2006).

Nursing's widespread knowledge of Benner's work and the rapid proliferation of nurse residency programs may account for the surprise expressed by the participants in the existing studies on the transition of novice nurse educators. Benner's (2001) application of the Dreyfus model to clinical practice in nursing has demonstrated that new graduate nurses emerge from their educational programs as advanced beginners, since they have at least had the opportunity to care for patients in their clinical rotations. If this same rationale is applied to the experience of most newly-hired nursing faculty it becomes apparent that, "new graduate nurses are actually more prepared to function than the new teachers who have little or no experience in assuming the faculty role" (Siler & Kleiner, 2001 p. 402).

Berliner (1988), who has applied the Dreyfus model to the development of expertise in pedagogy, coined the term "postulant teacher" to describe an educator who possesses content knowledge, but lacks pedagogical knowledge and training. Berliner calls "postulant teachers" the "greenest of green, the rawest of raw recruits" (p. 7) and warns that such teachers will require extra training and support during their early teaching years in order to overcome their "perceptual and conceptual deficiencies" in teaching (p. 21). Although he was not specifically describing teachers in the higher education setting, his label of "postulant" would certainly be an appropriate descriptor for new nursing faculty who are educated only in their discipline.

### *Formal Educational Preparation*

According to Shulman (1986), it is not enough to know one's discipline. Effective teaching is dependent on the possession of both content knowledge and *pedagogical* content knowledge. Shulman defines pedagogical content knowledge as the knowledge of how to most effectively teach a subject and an "understanding of what makes the learning of specific topics easy or difficult" (p. 9). Without formal preparation for teaching and practical experience, clinical experts most likely do not possess pedagogical content knowledge when they begin their teaching careers.

A strong case is made in the transition literature for the requirement of some sort of formal preparation in nursing education, either through graduate study or faculty development opportunities (McDonald, 2004; Morris, 1995; Siler & Kleiner, 2001; Young & Diekelmann, 2002). A survey of 427 new nurse educators by Davis, et al. (1992), revealed that novices feel comfortable in the clinical area, but they lack confidence in the classroom. One-third of the respondents reported having no formal graduate coursework to prepare them for their faculty role. Similar findings were reported by Bachman, Kitchens, Halley and Ellison (1992), who found that novices do not feel confident performing duties related to instruction and evaluation of students when they begin their careers as educators.

Studies by Herrmann (1997) and Nugent, Bradshaw, and Kito (1999) suggest that nurses who participate in nursing education courses report higher levels of confidence and self-efficacy in the faculty role. The NLN has recognized the value of formal preparation for teaching and issued a statement in 2002 which urged master's degree

institutions to develop or re-instate programs designed to prepare nurse educators. They specifically targeted the needs of advanced clinicians in their statement (NLN, 2002).

### *Mentoring and Orientation in Nursing Academia*

In the absence of formal preparation for the role, the use of assigned mentors and the development of orientation programs has been suggested as a method of decreasing stress and burnout in new nursing faculty (Shirey, 2006) and increasing retention rates (Gazza & Shellenbarger, 2005). Mentoring relationships may also strengthen organizational commitment to a university (Garbee & Killacky, 2008). Although the use of mentoring has been shown to enhance scholarly productivity in other academic fields (Boice, 2000), there are very few evidenced-based reports on the outcomes of mentoring for nursing educators (Morin & Ashton, 2004).

Genrich and Pappas (1997) reported on the outcomes of an orientation program for three new nurse educators. Use of a formal or informal mentor was identified as the most valuable resource to the new educators during their first year of employment. Blauvelt and Spath (2008) reported a new faculty retention rate of 80% after implementing a year-long structured mentoring program which required weekly mentor/protégé meetings for one semester. Availability, listening to concerns, and providing feedback on teaching performance were specific behaviors that protégés reported as beneficial during their transition to nursing academia (Brown, 1999).

### Conclusion

In conclusion, there has been investigation into the transition from nurse to nurse educator; however, gaps in the literature still exist. Esper's (1995) and Locasto and Kochanek's (1989) work imposed an existing theoretical framework on the process and is

based on literature reviews and expert experience, rather than grounded data collected from multiple participants. Morris (1995) and Young and Diekelmann (2002) focused on specific behaviors, skills, and practices, rather than the transition experience as a whole.

Congdon and French (1995), McDonald (2004), Ramage (2004), and Dempsey (2007) all conducted studies in countries other than the United States. Congdon and French, Ramage, and Dempsey's studies were primarily aimed at investigating role transition brought about by a major systems change, which moved nursing education into a university-based setting and resulted in the creation of new roles for nursing faculty. This limits transferability of the findings, due to the inherent structural and organizational differences in both education and practice in other countries.

McDonald's (2004) and Anderson's work (2006) had similar aims to the study presented here; however they were conducted with a slightly different participant pool. McDonald's study focused on part-time nursing faculty in university and community college settings in Canada. Participants in her study were all in their first year of teaching. Anderson's study included only nurse practitioners and clinical nurse specialists who were in their first or second year of teaching in a baccalaureate setting. Using Benner's model as a contextual backdrop, these participants were chosen based on Benner's contention that the novice and advanced beginner periods of skill acquisition in nursing usually last a total of 1-2 years (Anderson, 2006; Benner, 2001). Anderson's study was not published until after data collection for my study began.

Siler and Kleiner (2001) have described the essence of the lived experience through phenomenological inquiry. Although their participants consisted of both novice and experienced nursing faculty, their final report focused only on the perspective of true

novices, much like McDonald (2004) and Anderson (2006). Although Benner (2001) proposes that it takes approximately three years of repeated exposure to similar situations in order to reach the competent level of performance in nursing, skill acquisition in the Dreyfus model may develop at different rates for different people. Thus, an individual at one stage may demonstrate traits of higher or lower stages in a particular situation, depending upon his or her experience (Berliner, 1988).

I believe that the role transition most likely overlaps more than one level of the Dreyfus model. I chose to seek a wide range of perspectives in order to generate a theory which might provide an understanding of the context, causal and intervening conditions, strategies, and consequences (Strauss & Corbin, 1998) that exist as a nurse makes the transition to the role of nurse educator.

## CHAPTER 3

### APPROACH TO THE STUDY

“When you theorize, you reach down to fundamentals, up to abstractions, and probe into experience.”  
--Charmaz (2006)

#### Methodology

##### *Rationale for Qualitative Design*

A qualitative, grounded theory approach was used for this study. According to Merriam (1998), qualitative research has five key characteristics: (a) the goal is to understand the meaning that people construct in response to a phenomenon, (b) the researcher is the primary data collection and analysis instrument, (c) qualitative research usually involves extensive time in the field, (d) qualitative research is inductive, rather than deductive in nature, and (e) qualitative research results in thick, rich descriptions to convey what the researcher has discovered about a phenomenon.

Qualitative methods enable the researcher to gain information about participant perspectives in a natural setting (Hatch, 2002), and allow for a complex understanding of the meaning of a phenomenon as the participants themselves have experienced it (Merriam, 1998). This *emic*, or insider’s perspective, is the result of the participants’ construction of reality, rather than the researcher’s (Merriam). Qualitative inquiry also provides for the collection of data that may assist the researcher to discover new theories and theoretical frameworks (Morse & Richards, 2002).

##### *Rationale for Grounded Theory Approach*

The grounded theory approach was methodologically congruent with the research questions presented in Chapter 1. Because these research questions examined processes

and stages completed during a period of time, such as the process of “becoming” someone or something new, they were appropriately addressed using the grounded theory method (Morse & Richards, 2002, p. 30). Grounded theory methodology is useful for gaining insight into how individuals react or behave in response to a phenomenon (Glaser & Strauss, 1967). According to Glaser and Strauss, this method yields a theoretical description of social process that is “grounded” in data, rather than based on preconceived assumptions. Thus, a “grounded” theory is more apt to represent reality than a theory based on speculations (Strauss & Corbin, 1998).

Grounded theories are generated by the researcher collecting interview data, making multiple visits to the field, and developing categories of information. By inter-relating these categories, the researcher is then able to either construct written theoretical propositions or a visual diagram of the theory (Creswell, 2007). Rigorous coding procedures assist the researcher in identifying categories and making connections between concepts within the data (Strauss & Corbin, 1998).

#### Role of the Researcher

According to Strauss and Corbin (1998), it is important to maintain an objective stance during the research process. However, they acknowledge that complete objectivity is “impossible” and that all research contains some elements of subjectivity (p. 41). They encourage qualitative researchers to begin their projects by recognizing and acknowledging their own biases in hopes that they will be able to work through them during data analysis. This will help the researcher to strike a balance between objectivity and sensitivity in order to be open to subtle meanings within the data and “give voice” to the participants (Strauss & Corbin, p. 43).

### *Assumptions and Biases*

As a nurse educator myself, I possessed certain assumptions and potential biases that I knew might interfere with data collection and interpretation. The first of these was my own experience. I have been a nurse for fifteen years. I spent the first ten years of my career working in the hospital setting, primarily as a bedside staff nurse. During my last two years of employment in the hospital setting, I worked as a clinical staff educator. Although I had a great deal of administrative responsibility in this role, I still worked very closely with the nursing staff and managed to maintain a clinical focus. It was during this time that I was earning my Master of Science in Nursing (MSN) degree.

My master's education prepared me as a Clinical Nurse Specialist (CNS) in the field of women's health. The program was entirely clinical in nature, even though one of the core functions of the CNS is patient and staff education. The courses that I took were the same as those that prepare Nurse Practitioners; however, I completed approximately 500 clinical hours in an inpatient setting, implementing evidence-based practice projects and assisting with policy development.

During the last year of my graduate education, I left the hospital and began teaching in a baccalaureate nursing program. I had expressed an interest in teaching to the faculty of my master's program and asked if I could spend some of my clinical hours working with a nurse educator. I was told that this was not an option at the time. I also hoped to take an elective in nursing education theory that my university offered, but learned that it would be an "add on" to my program, thus costing me extra time and money that I did not have. Therefore, I began my own teaching experience without any

sort of formal preparation, other than my previous experience working as a clinical educator with patients and the nursing staff.

Although I felt that I was in an extremely supportive environment, my transition was difficult at times. I began teaching in the clinical area and, because I was comfortable there, I experienced a “honeymoon phase” during my first year as an educator. There were some orientation sessions offered for new faculty at my university, however, my school and clinical schedule prevented me from being able to attend all of them. This schedule also kept me off campus on most days, so I did not get to meet many faculty outside the course I was teaching. During my second year, I accepted a full time faculty position and it was then that “reality shock” set in when I began lecturing, writing exams, and grading papers. I soon began to realize all that I did not know and I became aware of how handicapped I was without a strong pedagogical foundation. As I began this study, I had to acknowledge that my own experience might have led to certain assumptions and biases about the transition from nurse to nurse educator. I had to realize that everyone’s experience might not be like mine.

A second potential source of bias became apparent when I began to recruit participants. For convenience, I began recruiting participants who were geographically close to me. Because of my former nursing employment at a major medical center, my attendance in a graduate nursing program at a large university, and my employment as a nurse educator, I was familiar with the career paths of some of the first participants that were recruited. Thus, I may have had some preconceived ideas regarding their potential responses. There is also the possibility that our professional relationship may have

influenced their responses. In order to overcome this, I chose to seek participants outside of my own city and state as the project progressed.

A third source of potential bias arose from a prior project that I had conducted for a doctoral course. During the spring of 2006, I conducted a pilot study for a qualitative research course in which I interviewed two nurse educators following a protocol similar to the one used in the current study. This led to the development of a preliminary theory describing the transition of novice nurse educators. Although it was impossible for me to “erase” this early data collection and analysis from my mind, I took measures to remain objective yet sensitive throughout the course of the research.

### *Maintaining Objectivity*

In order to maintain as much objectivity as possible, I followed the guidelines suggested by Strauss and Corbin (1998). These include comparing incidents carefully within the data and periodically searching the literature for similar examples. In grounded theory, data collection and analysis occur simultaneously. During analysis, I compared similar incidents between participants. I used successive interviews to check assumptions from earlier interviews, and I used theoretical sampling in order to obtain multiple views on events. Strauss and Corbin recommend these techniques in order for the researcher to examine a phenomenon from every angle possible. I also attempted to maintain an air of skepticism throughout the analysis. I accomplished this by frequently questioning the results and following verification procedures, which will be described later in this chapter. Finally, I returned to the literature four separate times during this study in order to assist in my examination of the categorical properties and dimensions that emerged during analysis.

## Procedures

### *Participant Criteria*

Participant criteria was limited to nurse educators teaching in baccalaureate nursing programs that were accredited by the Commission on Collegiate Nursing Education (CCNE) and had tenure requirements. The CCNE is the accrediting body of the American Association of Colleges of Nursing (AACN).

### *Ethical Considerations*

Prior to beginning this study, five university-based schools of nursing that met the criteria described above were chosen as data collection sites. Conditional, expedited approval was obtained to conduct research at each of these sites from the Institutional Review Board (IRB) at The University of Nebraska-Lincoln (UNL) in 2006 (see Appendix B). Each university was then approached for permission to recruit faculty from the nursing school on their respective campuses. This process proved to be complex, as each university had different requirements for conducting research on their campus:

- Two of the universities required the study to undergo the expedited approval process from their IRB.
- Two universities granted permission after their IRB reviewed UNL's conditional approval and the research protocol.
- One university simply required the endorsement of the Nursing Dean.

After receiving the necessary permissions from each university, final approval to collect data was granted from UNL on a site-by-site basis (see Appendix C). Data collection for this study consisted of interviews, which qualified for expedited review under UNL IRB category number 7. This review category was appropriate, as the

research posed a less than minimal risk to participants and was conducted with a non-vulnerable population (UNL IRB, 2006). This category also includes research that involves asking questions about participants' perceptions and identity. Participants were not asked about sensitive information, such as recreational drug use, sexual practices, or criminal behavior. Informed consent was obtained from each participant prior to data collection (see Appendix D).

#### *Purposive and Theoretical Sampling*

The participant criteria was limited to faculty teaching in baccalaureate nursing programs with tenure requirements because nursing education is conducted in a wide variety of settings, and the faculty experience and career expectations often differ among programs. For example, unlike their colleagues in the community and technical colleges, faculty in a university setting may be placed on a "tenure track," which requires additional scholarship and service commitments. Faculty in universities with an intensive research mission also may have a mandatory research component to their appointment. Faculty in graduate programs instruct professional nurses who are often pursuing advanced practice careers. This experience may differ markedly from the faculty in a basic nursing program. Thus, the participant criteria for this study was limited in the manner described above to ensure that participants were working in similar academic environments.

Purposive sampling was used to identify nurse educators with varied levels of experience. In this type of sampling, participants are chosen because they possess certain characteristics (Hatch, 2002). As the research progressed, additional participants were chosen in order to best develop and refine the categories of the emergent theory

(Charmaz, 2006; Glaser & Strauss, 1967; Strauss & Corbin, 1998). This need for theoretical sampling resulted in a protocol change half-way through data collection.

When the study began, the research protocol included only faculty who were in tenure-track positions or who had already achieved tenure. Additionally, the original purpose listed on recruitment documents stated that the aim of the study was to investigate how “bedside” nurses made the transition to the role of nurse educator. After ten interviews, however, it became apparent that limiting the criteria in this manner excluded several of the undergraduate, clinical, and newly-hired faculty at two of the institutions. It also became clear that the use of the word “bedside” in the original purpose statement was a source of confusion for potential participants who had held an administrative or nurse practitioner position prior to becoming nurse educators. It was not the original intent of the study to exclude these individuals and their perspective was needed in order to best develop the emerging theory at that point in data collection.

Because of these developments, a request was made to the IRB in March, 2008 to change the protocol to include non-tenured faculty and delete the use of the word “bedside” from the purpose statement in recruitment documents and the consent form. This allowed for the recruitment of additional faculty, which was necessary in order to generate a theory that would describe a range of “stages” or “phases” of the transition. (See Appendix E for evidence of this protocol change.) Sampling continued until theoretical saturation was reached. This occurred when no new data was found that added to the properties and dimensions of the emergent categories (Glaser & Strauss, 1967).

### *Participant Characteristics*

Twenty nurse educators participated in this study. These individuals were recruited from two public institutions and two private, religious institutions. Although recruitment was attempted at one additional public institution, I was unable to recruit participants from this site. The final sample consisted of eight educators from public institutions and 12 educators from private, religious institutions. Their nursing specialties varied, with backgrounds in medical-surgical, psychiatric-mental health, obstetric, and pediatric nursing. They were responsible for a wide range of instructional responsibilities, from clinical teaching in the hospital to classroom, administrative, and research activities.

Their years of both nursing and teaching experience also varied, as was the intent of the theoretical sampling process described earlier (see Table 1). There was also considerable variation in their educational preparation (see Tables 2, 3, and 4). Nineteen of the participants were female, and all but one of the participants was employed full time as a nurse educator.

Table 1. Participants: Years of Experience in Nursing Education and Nursing Practice

|                           | Two years or less | 3-10 years | 11-20 years | More than 20 years |
|---------------------------|-------------------|------------|-------------|--------------------|
| Years Teaching Experience | 5                 | 10         | 2           | 3                  |
| Years Nursing Experience  | 0                 | 4          | 2           | 14                 |

Table 2. Participants: Highest Degree Earned

| MSN | PhD/EdD |
|-----|---------|
| 11  | 9       |

Table 3. Graduate Degree in Nursing Education Prior to First Teaching Position

| Yes | No |
|-----|----|
| 3   | 17 |

Table 4. Nursing Education Electives in MSN Program

| Yes | No |
|-----|----|
| 4   | 13 |

Even though it is not the goal of purposive or theoretical sampling to yield a perfect representation of a population or group (Charmaz, 2006), the participants in this study had backgrounds similar to nursing educators teaching in baccalaureate programs in the United States. A mere 5.7% of faculty in AACN-member schools are male (AACN, 2008a), and less than half of all nurse educators in baccalaureate programs are educated at the doctoral level (Berlin & Sechrist, 2001). Thus, the participants in this study closely fit the profile of baccalaureate nursing faculty described in the literature.

#### *Participant Recruitment*

Once the final approval from the UNL IRB was received for each institution, a letter was sent to the Dean of the nursing school in order to identify potential participant names. After contacting Deans at the first two sites, I learned that the Deans were actually emailing their faculty and having them contact me directly if they were interested in participating. Because this procedure seemed to expedite the process and actually provided for increased participant confidentiality, this method was used to recruit faculty at the last two sites (after receiving IRB approval).

Deans were then emailed with information about the study and asked to forward the email to their faculty. The email invited all interested faculty to contact me directly via email or phone (see Appendix F). Once I was contacted by a potential participant, a letter that further explained the study and participant requirements was emailed to them (see Appendix G). As an additional method of recruitment, each participant was given a generic letter that explained the purpose of the research and invited anyone interested to

contact me (see Appendix H). This letter was given to participants after their interview. They were encouraged to distribute it to any colleagues who might meet the study criteria.

### *Data collection*

Data collection consisted of semi-structured, face-to-face interviews that were approximately one hour in length. The semi-structured interview is a formal interview in which the researcher begins with guiding questions, but follows the leads of the participants, probing into areas that surface during the discussion (Hatch, 2002). When conducting the interviews, I followed Charmaz's (2006) recommendations for "intensive interviewing," (p. 26) which uses broad open-ended questions, but also allows the researcher to focus on significant statements. In this type of interviewing, a semi-structured format can be followed, but the researcher may also restate the participant's points or come back to earlier points made by the participant in order to validate understanding and accuracy. Specific questions and probes for this study can be found in Appendix I.

### *Participant Confidentiality*

The interviews were recorded using two tape recorders in a quiet room at a location of the participant's choosing. All of the interviews except for one were conducted on the participant's home campus. Participants were asked to avoid stating their name or any institution names during the interview. Each participant was assigned a participant number, and each tape was marked with this number and the date of the interview. The interviews were transcribed by a professional transcriptionist who signed a confidentiality agreement (see Appendix J). All printed copies of transcripts, tapes, and

consent forms were stored in a locked cabinet in a locked office. Interview tapes will be erased after the successful defense of this project.

During data analysis, the transcripts were imported into an Atlas.ti software program on a computer in my home office. Participants were assigned a pseudonym, and all files were de-identified. Once the files were loaded into the Atlas.ti program, I listened to each tape and reviewed the transcription. All errors in transcription were corrected. If institutional names or names of individuals were unintentionally mentioned on the tapes, they were “blacked out” at this time on the final transcript.

### *Data Analysis*

The texts of the interviews provided the data for analysis. The Atlas.ti software program (Student Version 5.2) was used to manage a large amount of data and facilitate the coding process. Traditional analytic methods for the grounded theory approach as described by Strauss and Corbin (1998) were used for this study. These procedures include the use of open, axial, and selective coding. As I worked to develop the theory, I also integrated elements of Charmaz’s (2006) techniques for theoretical coding and the use of memos into my analytical process.

According to Strauss and Corbin (1998), open coding is the process of identifying concepts in the data which stand for phenomena and then grouping them into categories based on their properties and dimensions. Properties are characteristics of a category which help to define it, while dimensions represent the range of variation within a category. As the open coding process progressed in this study, I began to group the concepts that I identified into categories and subcategories. After analyzing 433 pages of data, I found that I had identified a total of 73 codes during open coding. By sorting

through research memos that I had written during the open coding process, I was able to determine that some of these codes were actually properties and dimensions of larger categories. I grouped these together in code “families” (Charmaz, 2006; Creswell, 2007) in an open coding matrix (see Appendix K). The categories in the matrix later became the “building blocks” of the theory (Strauss & Corbin, p. 101). Some of the original open codes were eliminated during this process if they were not found to be well developed.

Axial coding is defined by Strauss and Corbin (1998) as the process of “reassembling data that were fractured during open coding” (p. 124). During axial coding, categories are linked at the levels of their properties and dimensions to form a visual model that helps the researcher understand the “who, when, where, why, how, and with what consequences” of a phenomenon (Strauss & Corbin, 1998, p. 125). This model, which is typically referred to as the axial coding paradigm, helps to connect both structure and process in the emerging theory. The paradigm is typically created by linking categories together in order to identify the causal conditions, intervening conditions, and context surrounding the phenomenon of interest as well as the strategies and consequences that result from it (Strauss & Corbin). The axial coding paradigm created for this study is presented in the next chapter (see Figure 1).

After categories and their subcategories were identified and defined, selective coding procedures were used to link these categories into a “storyline.” During this process, a central category was identified that defined the purpose of the research and described the phenomenon of interest. According to Strauss and Corbin (1998), the central category is typically abstract, it appears frequently in the data, all categories relate

logically to it, and it represents “the main point made by the data” (p. 147). A discussion of the storyline and central category can be found in Chapter 4.

It should be noted that, although I have described my coding procedures as a series of “steps,” data analysis was really a fluid, rather than a static process (Strauss & Corbin, 1998). Data collection and analysis took place simultaneously, alternating visits to the field with coding in a “zigzag” fashion (Creswell, 2007, p. 64). This allowed me to choose each additional participant according to the developing theory and to use each new interview as an opportunity to “check hunches” and further develop emerging categories (Charmaz, 2006, p. 104).

Several versions of the open coding categories were created and refined during a two-year period. In order to compare incidents in the data between events and participants, I generated an axial coding paradigm for each participant. When I felt I was nearing category saturation, I then re-read all the transcripts, and re-examined the quotations which were assigned to each code. I also reviewed all of the memos that I had written during data analysis and began sorting them according to the open coding categories. I used this memo-sorting process and the 20 individual paradigms to create the final open coding categories and axial coding paradigm. I then wrote a “storyline,” which described the process and assisted in the identification of the central category.

#### *Verification Procedures*

In order to verify the data collected and enhance the study’s internal validity, I used the tools of member checking, peer examination, and post-analysis literature review. Merriam (1998) describes the member checking process as, “taking data and tentative interpretations back to the people from whom they were derived and asking them if the

results are plausible,” (p. 204). Peer examination is accomplished when colleagues are consulted for feedback regarding the findings as they emerge (Merriam). In this study, all participants were asked to review their transcripts for accuracy, and they were given the opportunity to change or add to their final transcript. Each participant was asked to sign a document indicating receipt and review of the final transcript. Preliminary interpretations were presented to the first ten research participants, and were deemed to represent their experiences. The axial coding paradigm and theoretical model presented in Chapters 4 and 5 were also reviewed with participants from each research site at various stages of their development. Peer examination was provided by the advisor for this project.

As mentioned earlier in the chapter, I wrote approximately 85 interpretive memos during data analysis and sorted through these in order to develop and refine the theory. These memos captured my thoughts about the emergent theory and the codes that were identified throughout the research process. I also used memos to ask myself questions about what I was seeing in the data. Charmaz (2006) states that memo-writing is crucial in grounded theory research because it sparks new ideas and insight and forces the researcher to analyze data and codes in the early stages of a study. Finally, I returned to the literature as needed to further my knowledge on new categories and information that emerged during the research process (Strauss & Corbin, 1998).

## CHAPTER 4

### PRESENTATION OF THE FINDINGS

“New graduate nurses who have had student clinical experiences are actually more prepared to function than the new teachers who have little or no experience in assuming the faculty role.”

--Siler & Kleiner, (2001)

#### Using the Axial Coding Paradigm

During the process of axial and selective coding, a story began to emerge that described the participants' transition from nurse to nurse educator. Although the axial coding paradigm depicts this story in visual form (see Figure 1), it is the words of the participants that paint the real picture.

#### *The Storyline*

The core category and central phenomenon that emerged was the concept of being on a *journey down a new career path*. The participants found that they had to navigate this path on their own. They had *no roadmap* and *no guide* to help them find their way. They felt like a *stranger in a strange land* as they encountered a work world vastly different than the clinical setting, with titles they did not understand (i.e. Instructor, Assistant Professor) and ambiguous employment practices (i.e. tenure). Forced to *blaze their own trail*, they sought out *peer mentors* in order to acquire the knowledge necessary to do the new job on their own. They put together their own *self-directed orientation* programs and learned how to *make the role their own*. These strategies helped them to *reach their destination* and make the transition to the role of nurse educator.

This storyline describes the *causal conditions* that led the participants to choose nursing academia as a career, the *contextual* workplace conditions that existed in their new environments, *intervening conditions* that hindered their transition into their new

role, the *strategies* they used to successfully adapt to the situation, and the *consequences* of successful transition. This chapter will provide a description of each of these elements in the axial coding paradigm and a discussion of the theoretical findings. The axial coding paradigm is depicted in Figure 1.

#### Causal Conditions: The On Ramp

There were several causal conditions which led the participants to choose nursing academia as a career. They were: wanting to make a difference, lifestyle, and “the thing to do at the time.”

##### *Wanting to Make a Difference*

The participants repeatedly expressed how a career as a nurse educator provided them with an opportunity to influence the future of the profession. Many had encountered nursing students in the clinical setting and had positive first teaching experiences with them, often as mentors for new graduates or for nursing students during their clinical rotations. They had received positive feedback from both students and colleagues on their teaching abilities. They began to feel that nursing education was a way to make their mark on the profession by influencing the next generation and “making a difference.”

One relatively new nurse educator described her early experiences with students in the following manner:

Because I had worked closely with students as a staff nurse...during their clinical rotations...I enjoyed it; I felt I was good at it. I had gotten good responses from both students and their clinical instructors that they had good experiences when they were with me. And...I felt like it was

kind of my niche that I didn't anticipate when I started nursing. I didn't anticipate that I would enjoy teaching or instructing so much.

So...when I started graduate school too...that's kind of the direction I wanted to go in, although my graduate degree is not specifically in nursing education...but (I) knew that's kind of the route I wanted to go.

Through these early positive teaching experiences, the participants began to see teaching as a way to develop others, help them “grow” and “succeed.” They described developing the future of the profession by making a “contribution” to students and eventually the patients that they would “touch or affect.” A seasoned nurse educator described this feeling of “wanting to make a difference” by stating, “I thought teaching (was) maybe something that I could start from the grass roots of getting nursing students to start thinking beyond just a task...I could make a difference then...”

Part of “making a difference” meant fulfilling a desire to teach in a new way. There was a general consensus among the nurse educators that their own undergraduate education had been dissatisfying. The participants used such words as “force fed,” “regimented,” and “old school” when describing their own undergraduate experience. By becoming nurse educators themselves, they felt they could inspire students in a way that they had not been when they were in school. One participant stated that she wanted to:

Take that knowledge that I have and apply it and assist others to grow and develop. I remember my diploma program, I had...teachers that...it was like teaching me French...They were just talking through the text book;

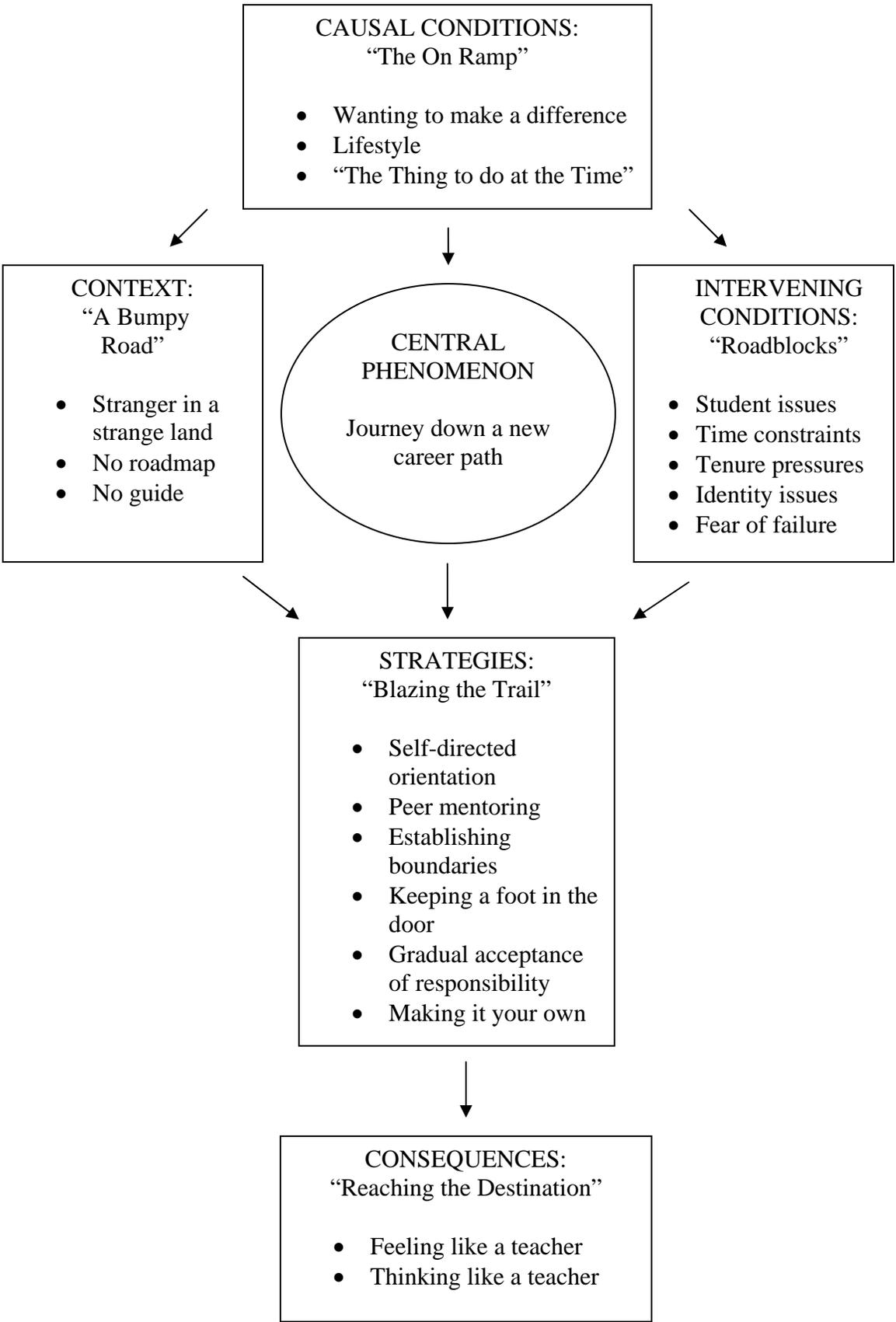


Figure 1. Axial Coding Paradigm

it's like I'm going to be a teacher that teaches with clinical knowledge.

Others recounted the punitive nature of their undergraduate clinical experiences:

I've had some instructors--we probably all have--that were really horrible. I mean they weren't around in the clinical or if they were, they were putting you on the spot or challenging you or telling you you were doing something wrong.

This desire to teach in a "new way" was echoed by a relatively new nursing faculty member as she described her rather optimistic teaching philosophy:

...like as an undergrad I remember my clinical instructors keeping notes on everything we did wrong, very punitive. And so for me it's more like, "Well how have they progressed?" ...They try their best, I know they do... I think that they all want to learn and do a good job... I'm assuming that they all want to do the best that they can...I'm thinking that my mindset...comes out in what I do and how I treat them...

### *Lifestyle*

A second causal condition was related to the somewhat grueling nature of a clinical or administrative position in healthcare. The unpredictable schedule of a hospital staff nurse became difficult to manage, particularly for those with children or other family commitments. For these participants, the academic calendar provided an escape route from weekends, evenings, and holidays spent away from family. One nurse educator described how the lure of a predictable schedule influenced her decision:

“I’ll be honest...working days rotating to nights, thinking about starting a family, that was a concern...you know there are holidays...I know that sounds petty but that’s a part of it too...” She went on to say:

And you start thinking about well, what else can I do? And you know, I could have done clinics, or those type of things but that didn’t interest me. But then I thought, well I could...facilitate change, I could make a difference, I could have the summers off with my kids; I could still do some practice during the summer, so I was wanting to have it all, I guess.

The autonomy enjoyed by university faculty allowed the participants greater flexibility in how they spent their time. This was a major change from the inflexible shifts spent in hospitals and clinics and proved empowering for some:

I like the flexibility that I can work at home sometimes if I don’t have meetings and have posted office hours or class, that I can spend the morning at home in my pajamas with a cup of coffee and revise, you know, a presentation or a syllabus or you know, develop the test and then maybe get dressed at noon and then go teach a class at five. So you know, I mean having that ability is nice.

In addition to a flexible schedule, life in the academic setting enabled the nurse educators to indulge in a shared passion for lifelong learning. They described how their work as teachers required them to keep current on new clinical developments and research in the discipline. One participant stated that she loved higher education so much that she would have been a “professional student” if she could. Another described this

love of learning and how it shaped her career choice by stating, “You know what? I like...going to school...there's a certain part of me that probably will always want to go to school and learn and stretch my imagination...”

A third participant articulated how being a teacher requires a commitment to lifelong learning by stating, “You will never stop learning because your students will never stop asking questions, and you really have to enjoy that. You have to enjoy that continual quest to know more, to know more, to know more.”

The participants also acknowledged that there were very few settings that could provide them with the opportunity to utilize their newly-acquired research skills. Nursing academia was really the only career setting in which they felt they could use their advanced degrees and have the support needed to produce quality scholarship and research:

A new nurse educator who had worked as an advanced practice clinician described this revelation in the following way:

The other piece that was important was as a full time nurse...I don't think I had any hope of ever moving my research interest or scholarly activities forward and what's been so fantastic about this year is that in addition to teaching--getting that access to students--I've been able to move my research and scholarship forward and I realize now that that's really important to me. And as a full time (advanced practice nurse), you're just so--you're not in an academic setting, so you don't have people around you talking about these things...I think it would have been impossible for me to move that forward in a meaningful way. So

now I feel like I have the best of both worlds. I can practice clinically, I can teach, and I am being paid to work on grants, to do lit reviews to explore topics that I want to explore. Like that is so ideal to me!

*“The Thing to Do at the Time”*

The final causal condition proved to be less idealistic. Six of the participants felt that nursing education, particularly in a university-based baccalaureate program, was a natural progression of their career after earning an advanced degree. After finding that opportunities outside of academia can be somewhat limited for nurses with doctoral degrees, the educators in this study felt that there was little else to do.

As one participant stated, “I think it’s the same answer that people say (when asked), ‘well, why did you get married?’ Well it just seemed to be the thing to do at the time.” She later added, “I don’t know. What else do you do with a Ph.D. degree?”

A seasoned nurse educator described how teaching was something that she felt she could fall back on, as sort of a “Plan B” in her life after she earned her doctoral degree:

It’s like OK, well let’s go to plan B, what should I do? ...it’s like what should I do? And I interviewed with some places and it just didn’t quite feel right or else they didn’t have the contract...that I wanted. But I thought, you know, I probably want to teach, but I’m not going to stay in the same place doing the same thing with this knowledge. There’s got to be something for me!

### Context: A Bumpy Road

After choosing to enter nursing academia, the educators in this study described feelings of stepping into an uncertain environment which was “very different from the hospital environment” they had left behind. Their former jobs had been characterized by structure, and policies and procedures for doing things the “right way.” The participants were surprised by the loose work structure and the lack of formal orientation and mentorship they received for their new role as educators. They were accustomed to lengthy orientation programs with a formally assigned “preceptor” for new employees. In their new work setting, the participants found themselves in the context of being a stranger in a strange land, who is on a journey with no roadmap and no guide.

#### *Stranger in a Strange Land*

The participants entered nursing academia to teach. They wanted to make a contribution to the profession. They wanted more flexibility in their day-to-day schedule. They had been encouraged by others. They liked working with students, and they liked being students themselves; however, they had little understanding of what working in a university setting really entailed. Five of the participants confessed that they did not understand the rank and tenure system or the scholarship and service requirements for a faculty member in a university setting. This was new and uncharted territory.

One participant who was nearing the end of her second academic year as a nurse educator described how:

...promotion and tenure...was...another animal that I hadn't even thought of. You know...the way that you see it...on television and the popular media, you know, you see everybody that teaches in college is a professor.

They call them professors and you know I really had no clue what really is involved in that. How do you achieve even an assistant or an associate or you know, what does that entail?

Another educator, who had an impressive résumé as a clinical educator prior to entering nursing academia, still did not fully understand the system at the end of her first year in a non tenure-track position:

...still to this day...I truly don't understand...this whole notion and all of the words and what they mean: tenure, non-tenure, associate professor, assistant professor, clinical instructor versus non-clinical instructor, faculty...all of the different rank and tenure things... sometimes you really feel stupid asking those questions especially since I've been here for a year and then it's like, "Well don't you know that by now?"

She went on to demonstrate how this lack of understanding made it difficult for her to make informed career decisions about her future in academia. In the following comment, she disclosed how she is unaware of the security that tenure can provide for faculty:

I think there are some benefits to being tenured, otherwise people wouldn't want to be tenured, but I'm not quite sure what those benefits are. I think they can get time off and I would assume they get more money. I mean these are all things I don't know that I am only guessing at; that they can take time to do research, that maybe they don't have a full teaching load...I'm really not sure, but it seems to be everybody wants to

be tenured. So there has to be some reason for that. But, that's one of the things I don't understand now.

The rank and tenure system was not the only contextual factor that contributed to feeling like a stranger in a strange land. The participants also described how initially out of place they felt with students in the clinical setting. When working with students here, their responsibilities were different than when they had their "own" patients as staff nurses. They described the experience of being a "guest" in an unfamiliar setting and having to provide care for patients in partnership with staff nurses who "did not treat you like you were necessarily a co-worker." This lack of collegiality in the clinical setting further contributed to the feeling of being a "stranger."

One instructor described this feeling of being a "guest" or "stranger" in the following way: "I don't actually work there; I don't always know the ins and outs of how they do things and I come in with eight students..." She went on to say, "...because I've never worked there, I don't know where all the equipment is and...I'm not as familiar with their charting."

This feeling was unfamiliar for the educators in this study because most of them had previously worked in jobs in which they were not only comfortable, but highly competent. In their new roles as educators, they were forced to move from this "expert" level of performance into the role of "novice." This occurred not only in the clinical setting, but in the classroom as well. Participants described this as a feeling of "starting over...almost like a new career."

“I considered myself an expert in what I was doing (before)...” one participant recounted. “I went from being an expert to an absolute novice, and I felt like it. I felt about this big, an inch big, because...I don’t know anything.”

After finding themselves in this uncomfortable position of being a “novice,” some of the participants expressed doubt in their ability or desire to do the work that needed to be done in order to develop expertise in the nurse educator role. One novice educator compared the two experiences:

Well if it’s similar to my role as a home health nurse, I’m an expert! And I know I do it well. And I’m comfortable with it and anything that comes my way I can take it on. So I could see that same thing. I can envision that in teaching as well...the thing is...am I willing to go through all the things that it takes to get through to become that expert?

#### *No roadmap*

All twenty of the participants in this study felt as though they had not been adequately oriented to their new role as a nurse educator. Their accounts of the orientation process varied greatly, even within the same institution. Formal orientation sessions were described as brief, usually lasting only a few hours. This suggests that providing a lengthy, structured orientation to new faculty is not an established practice at these institutions.

Although this fact was evident early in the data collection process, the *in vivo* code for “no roadmap” was identified when one participant described her lack of orientation to her teaching position in the following way: “It’s like who’s on first? It’s...not a very comfortable feeling when you are like drop-kicked with all of this

information...without knowing where you're going. No road map!" She went on to say, "...if we as teachers don't have a roadmap, how are we going to teach the students?"

Repeatedly, participants described similar situations: one-day orientations to the workplace, no supervision in the clinical setting, and little guidance for classroom responsibilities, such as lecturing and test construction. Participants described being "thrown in," "flying by the seat of my pants," and "winging it." "They just gave you an assignment and walked away," one educator recalled. Another described her first day by stating, "It's like sink or swim--here's your syllabus. If you need something, let me know."

This "sink or swim" experience was unsettling and unexpected. A first-year clinical instructor offered the following description of her orientation, which was similar to other participants' experiences:

I was barely oriented. There was a half day...it was about two weeks before the first clinical day and it was less than ideal...I think there were twenty-some of us, some with experience, some of us brand new, in a poor setting. And we were sitting in chairs... students are walking by...we did get a folder with some information, but it didn't answer a lot of questions...the course director...sort of went through what she was going to be doing for all of us clinical folks...communication was pretty poor... I didn't know anything... I wasn't really sure what the whole four-year program was for this university...I didn't feel well prepared, let me say.

One participant described her anxiety about not receiving any direction from colleagues. In an attempt to learn more about the course she would be teaching when she was first hired, she contacted a colleague over the summer, but was rebuked:

...the message I got was, "Look. Cool your jets. We'll talk in August."

That terrified me...I was basically braced for the fact that I could expect no more than a syllabus... The idea of starting with a blank slate seemed ridiculous...give me *something*. So over the summer I was anxious, to say the least, about the fact that I had nothing to go on.

Preparation for clinical teaching was not much better. In most cases, novice nurse educators were given no more than a contact name at their clinical agencies. They were expected to set up their own time to become oriented to their clinical units, and they did not report being observed by other faculty members once they began their clinical teaching duties. One first-year instructor did not realize the impact that this lack of orientation would have on her ability to work effectively with students until she began working with them hands on:

...my orientation was very minimal... I spent maybe four hours with someone...she helped me with things like getting PYXIS access, getting computer access, showing me around the unit, but nothing really hands on and then... I spent a shift with (another nurse)... I got to do some medication administration, I saw what kind of pumps they used but I don't think I really got a handle on how the floors function, how the nurses interact. So then (when) I actually started with students...again I really

feel like I was minimally prepared for that, but I don't think I realized it at the time, how much I didn't know about it.

The feeling that they were left to "sink or swim" in both the clinical setting and the classroom led the nurse educators to question why there was no structured orientation program in place for novice teachers. They contrasted this lack of guidance with the structured environment of the clinical setting. When asked what was least helpful to her during that first year of teaching, one seasoned instructor replied:

I think just not having a structured orientation. If I would have had that I would have been very, very pleased. Cause...it's going from a hospital environment; very, very rigid, to another place where you just show up when you show up and...how do I put all this stuff together? I think that...could probably have helped me a lot. Structure, a formal mentor...

When pressed on what a structured orientation program or "roadmap" should include, participants discussed the need to learn the "nuts and bolts" and the "nitty gritty" details that were necessary for performing their work roles. These "nuts and bolts" consisted of technical details such as the availability of clerical support (i.e. things as simple as where to go to make copies) and basic information about the mission of the school. One participant confessed that during her first year of employment she "knew nothing about (the school of nursing)...nothing about the institution...I didn't really get a sense of what the mission was aside from making nurses."

Perhaps the most pressing need that the participants discussed during their early transitional period was the need for information about the school's curriculum and when specific skills and information are taught to the students. Participants described being

handed a piece of paper with the students' plan of study on it or being directed to a computer to learn about the curricular design of their institutions. Lack of curricular knowledge had a negative impact, particularly for those teaching in the clinical setting. Participants suggested that having these details might have alleviated some of the anxiety they felt as novice educators:

I didn't know what (the students) knew and what they didn't know...there still wasn't somebody that sat me down and said, "OK, this is what you need to do"... there was nobody that said, "OK, your first week is done, what did you find challenging? What didn't (you)?" There was none of that. There was no communication.

Another educator agreed with this perspective, recalling how she never really understood what the clinical expectations for the students were during the early months of her journey:

Expectations as far as my role...knowing what the students were learning about in class was kind of up in the air. And I felt like it was a real struggle to figure out...what have they learned before they got to me and what are they going to be responsible for after me? Because a lot of times in clinical I would be assuming that they already knew something when they didn't.

This confusion over their students' skill and knowledge acquisition was manifested in struggles with student evaluation. Again, this was quite apparent with those teaching in the clinical setting, in which instructors are often required to provide students with written weekly evaluations on their performance. A seasoned instructor

recalled that when she wrote her first evaluations, she “really didn’t have a clue” what she was doing, mainly because she “didn’t really have any context in which to place them” when she first started teaching.

She went on to say, “...I mean what is it that they should be able to do? ...if you read a...care plan...Was this senior level? Or was this beginning level? I didn’t have anything to put that into. I didn’t know.” She later added, “I just knew where I was. I didn’t know where they were supposed to be.”

In addition to information about the “nuts and bolts” of their institutions, the educators in this study expressed a pressing need for formal pedagogical training. Three of the participants had earned a master’s degree in Nursing Education prior to their first teaching experience. Four others had taken at least one elective in Nursing Education during their graduate program. The remaining thirteen who had no formal preparation for teaching were shocked that their employers would expect them to know how to teach without prior experience. As one instructor stated, “I’ve taken care of patients in the hospital for the last ten years, how do I know how to teach? I don’t.”

This same participant went on later to describe specific competencies that she felt she was not qualified to perform without some sort of formal education:

I struggled... How do I write a good objective? I mean, I’ve never been taught that. I’ve never been taught how to write a good test question...there’s a lot to that...I mean we have test banks we can look at; I can read a lot of test questions; I can see these test questions are good or these test questions are bad; I have been provided with a written recommendation for writing test questions...I wish there was some formal

education for new faculty members who really don't have a teaching background on how to do that.

A nurse educator who had just completed her first year pointed out how graduate nursing education does less to prepare its students for teaching than other disciplines. She stated, "...at the university where I teach...some students work by doing their TA...they get teaching experience. But in my case when I was in school I was working clinically." She went on to passionately describe her fear of how her own lack of formal training might negatively impact her students:

They (the students) deserve to have teachers who know how to interpret a (test) result correctly. If you don't know how to read those stats what the hell are you doing making decisions about which question to toss out and keep in? ...it's unethical. It's like letting someone operate on someone who doesn't know what they're doing...we would never accept that in the clinical setting, but we accept it in teaching sometimes...if you're going to give a quantitative exam, you damn well better know how to use the results. And I didn't have any training in that, and that was a little scary.

The feeling of being unprepared was not limited to those who lacked graduate preparation for teaching. Although the participants who had some kind of formal preparation generally described it to be beneficial, they acknowledged that it was not enough to fully prepare them for the nurse educator role. One participant described her master's program in Nursing Education:

Well when you look at how they prepared me on a scale of, say 0 to 10, with 0 being no preparation and 10 being very prepared, oh, maybe a

3...You know we talked about objectives, and we talked about the psychology of learning and evaluations. But as far as getting out there and teaching...I probably got more out of a seminar I went to for writing test questions...when you look at clinical...there was not anything focused towards clinical education in my master's program.

This may be related to the fact that there was usually no practical or contextual component within their graduate programs that gave them an opportunity to apply their knowledge. An educator with more than two decades of experience recalled how the two electives that she took in Nursing Education did not benefit her as much as she had hoped:

I know that in one (course) we...had to prepare a post conference and objectives and that. And that particular assignment was really helpful; I can remember that to this day. (For) the curriculum (course), we did a whole extensive thing related to accreditation...for whatever reason as applicable as that would seem...perhaps it was the role I was in then--It wasn't particularly helpful.

She went on to point out, "It was a long time before I had any reference point for any of the information we had in that class, and by then that was long lost."

Two of the participants completed a student teaching experience, or nursing education "practicum," in their master's program. For one of them, this experience was conducted in the classroom and consisted of lecturing, writing exams, and grading papers. He received close supervision during these activities from a seasoned nurse educator. This participant stated that the practicum experience "prepared me pretty well

for my teaching career.” He particularly emphasized the valuable lessons he learned “about how to approach students and boundaries.” The other participant’s practicum consisted of delivering one lecture and spending a semester as a clinical instructor with students in the hospital. For her, this experience was not as she’d hoped, mainly because she felt as though she was not given proper guidance. For example, she could not recall any sort of orientation to the clinical setting and noted that no one accompanied her to the hospital on her first day with students.

### *No Guide*

Just as the participants were on a journey with no roadmap, they also found that they had no guide to help them find their way. Sixteen of the participants stated that they did not have a formal preceptor or mentor to assist them in acclimating to their new work setting. The predominant arrangement was to meet with a “contact person” (usually a course director or a fellow faculty member teaching in the same clinical course) at the beginning of the semester to “learn the ropes.” None of the participants reported having regular observation or feedback from other faculty on their teaching in the classroom or clinical setting.

This relaxed arrangement was again very different than what they had experienced in the clinical workplace, where new employees are usually assigned a single preceptor for weeks or even months of training before they are expected to function independently. Participants reported feeling as though they had no real “direction.” As one educator reported, “I didn’t know up from down.” Some questioned their abilities as teachers, even after one or two years on the job:

...they didn't sit in with the class with me to make sure that I was doing everything right...And that's great in the sense that I didn't feel uncomfortable thinking that somebody would be overly critical of what I was doing but in a sense...I was questioning myself. You know, can I actually teach? Am I a good teacher? It might have been better for somebody to maybe even watch a video tape of my lecture and give me hints or tips or pointers to do things differently.

A lack of mentorship contributed to feelings of isolation, particularly among clinical instructors who were not on campus every day. These educators, who may spend one or two days off campus with students in the clinical area, reported "function(ing) like "islands...feeling very much alone..." This led one novice to feel as though she was not valued by the institution. Her loyalty to the school decreased as a result of this isolation:

...I was asking for more orientation... But there really wasn't any mentor. I'm not sure that anybody was vested in my success except me and probably the Dean...to some extent they just needed somebody and so I think I was just filling that role...but I think there was also part of me that didn't want to get real invested either...

Seven of the participants described blurred lines of communication in their universities. The educators talked about ambiguous reporting lines and a lack of "clear communication channels" within their schools. They confessed that they did not really understand who they should go to with questions or problems during their early days. One of them described how having an assigned mentor might help to remove some of that ambiguity:

...we need a mentor program...everybody needs to have that; you need to have one person that you can go to and ask. I have...three team leaders and two program chairs and a boss to go to...I need ONE person.

Four of the participants in this study reported that they had a formal mentor assigned to them in their first teaching role. All of them spoke positively about this experience and described an arrangement in which they met regularly with an experienced nurse educator to discuss student issues and pedagogical techniques. One educator who had taught in three different settings contrasted the positive experience she had with two formally assigned mentors in her second teaching position. This was a sharp contrast to her first experience, in which she had been forced to “sink or swim:”

...they mentored me through everything. I mean how to do tests, how to analyze my tests. My Dean was one of them and she had her Ph.D. in education, so she was very good at curriculum and building exams and you know her teaching style and those kinds of things. So I learned a lot from both of them. And...the other person who I taught with...she was wonderful with, "OK, now we're going to have to sit down with a student and tell them that they're not progressing." ...she basically, you know, mentored me through that whole process too...It was a very good experience...they didn't just like throw me in and say, “Here you go!”

#### Intervening conditions: Roadblocks

In the context described above, the nurse educators in this study also faced a host of intervening conditions which acted as potential “roadblocks” on their journey to a

successful career transition. These conditions were student issues, time constraints, tenure pressures, identity issues, and fear of failure.

### *Student Issues*

Very early in their journeys, the nurse educators recognized differences in the teacher/student relationship as compared to the nurse/patient relationship. As teachers, they were moving into a role that required them to set boundaries and limits with students. They were forced to evaluate students on their performance and dole out consequences for negative behaviors. They faced situations in which they had to issue failing grades to those not meeting established program standards. These role expectations were a sharp contrast to the helping and trusting partnerships that they had established in the past with patients.

One nurse educator described this contrast as “going from what I was doing with...patients, I went (from) having the most thankful job to the most thankless--working with students, student nurses.” Another educator, who was starting her second year of teaching, articulated the difference in the relationship in the following way:

...if you think about our jobs as nurses, that’s not something we have to worry about. I mean, with our patients, we always want to make them happy. Now again, there may be times when they're not compliant and they don’t do things that we would like them to do, but you aren’t responsible for giving them consequences. So it’s very different, what we do along those lines.

Although nine of the participants had reported positive experiences with students in the clinical area as staff nurses, the tone of these experiences often shifted when they

became formally responsible for teaching and evaluation. Six participants described their surprise at a perceived lack of respect that their students had for them. They recounted examples of students being “argumentative” and having a “sense of entitlement.” One nurse educator provided the following as an example of this “entitlement:”

There's probably lots of examples, everything from the tone that they use when they talk to you and the way they talk to patients... there was a group project and I graded the papers...and the students came in--not to discuss--they came in to fight their grades and they didn't like my feedback, my opinion, and of course their final grade...instead of coming in to discuss...they come in with their guards up and they're argumentative and students will argue with you until you give in, or until you have back up...

There was often a feeling that these behaviors were related to generational differences between the students and educators. Both novice and experienced educators described this generational divide. They spoke of how students today are part of a “consumer generation” who need a large amount of direction and do not always take full responsibility for their learning. Two educators (from different institutions) described how members of this “consumer generation” have little tolerance for experimentation in the classroom. “They had a really short fuse,” one educator stated...“We have paid the money; you provide the product.” Another educator described how students did not want any extra information beyond what would be on the exam. “They didn't really want me to go off there...it was interesting. And that's what I got on my evaluation. They were like, ‘Stick to the book. We don't want this other stuff.’”

Again, this sort of rejection differed greatly from what they had experienced in their nurse/patient relationships. The realization that the teacher/student relationship is not always a friendly one was often difficult for nurses who initially wanted to be liked by their students. Looking back on her first negative evaluations from students one participant declared, “We don’t at all prepare people for the fact that students just really may not like them very well sometimes. You know what I mean?”

Another participant described how personally she took her first negative student evaluations:

I was just so hurt, you know, if they didn’t like me and I think that probably is a sign of just...not learning to set my own limits, and knowing that that is a growing process they need to go through and not taking it personally...Better teachers are able to know this is just part of their development and not take it on as a weakness in themselves and I struggle with that.

#### *Time Constraints*

A second intervening condition that the participants in this study faced was that of time constraints. More than half of the participants described feeling as though they never had enough time. This feeling was attributed to increased student enrollments, faculty shortages, the burden of committee work and scholarly projects, and the need to keep current clinically. Although participants entered nursing education so that they could enjoy a more flexible schedule, they soon found that a successful career in this field required them to keep several “balls in the air.”

One participant described how keeping current clinically was important to establishing credibility with the students. She did recognize, however, how difficult it was as a full-time faculty member in a university setting:

I do feel that...you need to be able to show the students that you have the experience of which you teach...if you're teaching nursing theory, nursing research... roles, concepts, etc...maybe you don't need to have a clinical component but if you're trying to teach OB, Pediatrics, Med Surg, Critical Care, some of those things, you need to have been in the work place in the last five years. ..that is something that is very hard for nursing faculty to accomplish especially if you're full time faculty... The full-time faculty are spending their weekends and a lot of time on their own, trying to maintain their skills and obtain their clinical hours for credentialing.

In addition to teaching, scholarship, and service demands, remaining accessible to students and devoting time to student needs was a top priority for the educators in this study. An experienced nurse educator who had significant administrative responsibilities in addition to her teaching load described her time management conflicts:

Personally for me, the most difficult (thing) has been time to do scholarship. In order to be promoted, I need to do more scholarship. And so a couple weeks ago when I had my evaluation and visited with the Dean...I said, "You know, I feel like part of my role...is to be accessible to the students...I have a responsibility to be responsive to them...I don't feel like it's right that they should have to make an appointment to see me

for ten minutes... But if you try and work on an article and you're interrupted four times...

The accessibility of the computer and the ability to work at home created a work world without boundaries. This resulted in increased communication with students, but further encroached on the nurse educators' time. One experienced educator noted this change over the years:

I think the students in this electronic world very much believe that you know, they can send you an email at 2 a.m. on Saturday, and they can be highly incensed that you don't get back to them... Blackboard and all these electronic things....they are assets. But do we have to use them all the time? Can the students feel free to ask a question at 2 o'clock Saturday morning? Do we really have an obligation?

Another participant described how she struggled to not let "teaching take over my life." She stated:

I think it's kind of a compulsive thing. Whereas at the hospital you could like, let things go. My shift was over with; my twelve hour shift was done. Someone else has got it. With teaching, it never stops. And, you know, unfortunately the computer is just too accessible and so the work continues. I don't know how to put boundaries--I can put boundaries with my students, but that computer, how do I put boundaries with that?

This "work without boundaries" often spilled over into what would typically be considered the participants' off time, such as weekends and evenings. One novice educator described how lecturing on Monday created a high level of weekend anxiety:

...the load that I've been given this semester is more than full time... what am I doing, Friday through Saturday for this 7:30 in the morning, Monday lecture? I'm preparing for the lecture. Not only that but I have to do the grunt work, of making out the slides, really preparing and immersing myself and then Sunday evening I go to a coffee house and I really think it through.

### *Tenure Pressures*

Although they were not all on the tenure track, all of the participants in this study were employed in universities in which there were tenure systems. Because of this, participants disclosed that they were in environments in which their clinical knowledge was not valued as it had been previously. Instead, a high priority was placed on research and scholarship, rather than clinical expertise or even teaching ability. This contributed to a feeling of animosity for some. Looking back on her early days as a novice educator, one experienced participant described how she compared herself to her colleagues with doctorates:

We had a saying...we were...the "refrigerator nurses." You know we were married, we had children, we were working, we were going to school, and we were surviving...we were teaching the majority of the undergraduate students who would actually go out and be licensed...but we weren't getting the rank and tenure and the promotion...we were taking the most risks but we were treated like the "refrigerator nurses." Let them do the work and we'll just take the lot.

Eleven of the educators in this study were prepared at the master's level. These participants realized that if they ever wanted to advance in the university system they needed to complete their terminal degree, even if they were not on the tenure track. One participant, who was trying to make a decision about pursuing her doctor of philosophy (Ph.D.) degree, described her future at the university in this way:

...they'll say you don't ever have to get your Ph.D. That's fine. You can stay as a master's prepared faculty. The highest rank that you will achieve will be an assistant professor and that's fine. Everybody has to make that choice for themselves. And then on the flip side, it's seems like so many of the perks and things to do with the university are geared towards the Ph.D. people.

Five of the participants in this study chose to complete their Ph.D. or another clinical practice doctorate, even though it was not required of them. These participants felt that it would help to put them on an even playing field with their peers. When asked about her motivation to return to school, one non-tenure track participant stated, "The drive to do that is, that in order to be acknowledged within the university system you have to have a doctorate. To have a Ph.D. is what I have been mandated. It is not however, what I think I want."

Another educator added, "... if I'm going to give education a chance I need to try this... With the university in order to advance, you need to advance your education and that's where we come in as far as a Ph.D."

Whether by "mandate" or "choice," the decision to pursue a Ph.D. added to the time constraints already described earlier. One novice educator who was finishing her

first year as a full-time faculty member described how she thought that teaching would provide her with the flexible schedule needed to pursue her terminal degree; however, she was finding it more difficult than ever to work on her dissertation:

I finished my coursework last year...faculty (are) saying, "You need to finish your dissertation; you need to finish your PhD." I'm thinking, "Well that's great, but I didn't have the opportunity to even get at it this year." So it's been really like a year off...originally...some kind of like "win/win situation" was pitched to me. Well, that's not the case at all... I have to negotiate and figure out, you know, exactly what is my work load going to be next year because I know I've been feeling guilty about not working on my...research. *Really* guilty. Cause I mean, I don't want to stay in one place. I want to finish.

### *Identity Issues*

The third intervening condition that emerged from the data was that of identity issues. Participants described conflicting feelings between their former identity as a "nurse," and their new identity as a "nurse educator" or "teacher." One participant described a period of mourning that she went through after she left a clinical position which she "loved." Her use of the word "separation" below hints at the feeling of loss she experienced:

... I had a real decompression period coming out of that very heavy clinical job to this job...I think the worst of that separation is behind me, but I really did not know how much I liked my job until (I left).

A sense of struggling to find where one “fit” or “belonged” in this new role emerged during data analysis. The participants described no longer being able to completely identify with nurse clinicians, especially if they had earned a terminal degree and were not practicing clinically. One participant, who had earned her Ph.D. in another discipline, described how she no longer felt fully accepted by her peers or the students:

... I think any nurse informed by another discipline has a much broader perspective of things...but it did also create a really big identity crisis coming back into nursing, because I didn't fit anymore. I hadn't been clinically active for a long time and that is what's valued, especially by undergraduate students.

After the notion of identity issues began to emerge, participants were asked if they thought of themselves as a “nurse” or as a “teacher” first. The participants who were able to answer this question identified with the “nurse” role much more strongly. One participant who had four years of teaching experience had difficulty identifying with the “teacher” role:

I think of myself as a nurse. And that's an interesting question because (when) people who I just meet or don't know me (ask), “What do you do?” I say, “I'm a nurse.” They'll say, "Oh what hospital do you work at?" And I'll say, “Well actually I'm working at teaching right now,” but I don't say, "I'm a teacher," or "I'm a nurse educator," or, "I teach at a nursing school." I don't say that. I say I'm a nurse. So I think that's very interesting...I think first and foremost, whether you teach or not you

probably are a nurse...in my mind I'm a nurse...I think it's just interesting that I don't make that transition.

In contrast, an educator who had eight years of teaching experience stated that she had grown comfortable with her teaching identity. She often told people that she was a university teacher, particularly in the summer when she was off work. However, she still felt that nursing was at the heart of her professional identity. "I think I now think of myself more (as) a teacher," she said. "But I think nurse comes first. That's the foundation."

### *Fear of Failure*

The final intervening condition that the nurse educators encountered during their journey was their fear of failure. This fear was particularly striking when the participants described their early days of teaching and was present in both clinical and classroom situations. More than half of the participants described fear of failure in some way. For many of them, their biggest fear was being unable to answer a student's question. As one instructor put it, "They (the students) expect you to know everything."

Fear of not having all the answers turned one of the experienced participant's early years into a time of low self confidence. She stated, "I was so afraid that I wouldn't know and they would ask me something and I would look like a fool." Later in the interview, she added, "I wasn't comfortable with saying 'you know, I don't know. I'll find out,' or 'I don't know. Let's find out together.'"

Fear also arose from self-doubt in their teaching ability. Early in their transition, the participants tended to place blame squarely on themselves when teaching activities did not go well. They worried that their lack of ability and experience might harm the

students in some way. One instructor stated that during her first year of teaching she "...was always thinking, "Well, maybe I'm not teaching this well. Maybe they're really not learning as much as they need to learn, because my job is to create the learning environment so am I creating it?"

A lack of feedback on performance perhaps made the situation worse. When reviewing the coded quotations for "no roadmap" and "no guide," there was a distinct undertone of fear in several of those statements as well, suggesting some relationship between these concepts. For many of the novices, their only source of feedback on their teaching ability came from the students. One new instructor described how, although this was positive, it was not enough to alleviate her fears:

In the beginning, I would leave that classroom just feeling devastated, like what did I talk about for an hour and a half? Just thinking, "What did I do? They must hate me now." And despite the fact that I was actually getting some positive feedback from the students in my clinical group and also students that were not in my clinical group, I'm thinking, "Gosh I screwed that up." ...there was a huge amount of pressure.

Others stated that their fear of failure was related to having to teach outside of their comfort zone. Although fourteen of the participants had backgrounds in a specific clinical specialty, they were often called on to teach content outside of this specialty. This experience fueled their fear that they would not effectively teach the students or that they would not be viewed as an expert by the students. One instructor described teaching students how to insert a nasogastric (NG) tube, a skill that she herself had rarely performed:

...you know you had your little textbook by you so you all could walk and talk through it...I'm not the expert in putting these things in but...I'm sure if I was exposed to it, I could probably get that NG in...

Another participant described how she often was learning the material right along with the students when she prepared her lectures:

I don't know every area really well. So some areas I just spend time getting up to date on... some of the topics, I was very comfortable with... But some of it I definitely was, literally on some days, hours ahead of them in terms of getting it in my head so I could talk about it.

#### Central Phenomenon

In the context of struggling to find where they “fit” without a “roadmap” or “guide,” the central phenomenon of being on a journey down a new career path emerged. There was an underlying tone in the dialogue of “searching” for something or trying to “find” where they belonged that further supported this imagery. In addition to the “roadmap” and “direction” references mentioned earlier, some participants described their transition with phrases such as “I've traveled a road,” or “it's been a journey.” These comments further supported this emerging image and fit with the contextual and intervening conditions already described.

#### Strategies: Blazing the Trail

Several strategies were identified that helped the nurse educators find their way on their journey. These strategies were developed in order to cope with the contextual and intervening conditions described earlier. They included self-directed orientation,

peer mentoring, establishing boundaries, keeping a foot in the door, gradual acceptance of responsibility, and making it your own.

### *Self-Directed Orientation*

Because they lacked a roadmap for their journey, the participants took it upon themselves to create their own orientation program. An essential component in this self-directed orientation was acquiring the knowledge that they needed of both the “nuts and bolts” of the organization and the “formal” pedagogical training that most of them lacked. This was accomplished through a blend of formal and informal processes.

In order to learn the “nuts and bolts” they sought out information wherever they could find it. The participants described this informal quest for information as “individually driven.” As one participant stated, “When it comes down to it there are just certain things you have to jump in and do yourself. And so I really had to go out there on my own and network on my own.” Another participant likened this information search to an archeological expedition:

...I dug! You know, I can't just sit and say, "Gosh, I wish I knew that." It was like me saying, “OK, I'm going to talk to the other people that are involved with those courses; I'm going to get together with people that teach level one and say, ‘Tell me.’”

This determination to learn more led half of the participants to seek pedagogical knowledge through formal channels. Four of the educators took part in faculty development programs at their universities; one enrolled in an online nursing education course; one audited a course in nursing education on her campus; one began reading nursing education journals; two of them sought a master's degree in nursing education;

and one began a doctoral program in education. They were all careful to point out, however, that these efforts were entirely on their own. They had not been required, or often even encouraged, to pursue these developmental opportunities by their employers. After discussing her participation in a faculty development program, one educator explained, "...those were things that I sought out...they weren't offered to me. I sought those experiences out in order to learn."

Two of the participants began teaching with a bachelor's degree and returned to earn a master's degree in Nursing Education. One participant decided to pursue a doctorate in education. She offered her rationale for this choice:

...Where I work at you hear they want you to get...nursing doctoral degrees. And I see the benefit of that, but...I know how to be a good nurse; I don't know how to be a good teacher. So my goal for my doctorate is to have it be in education. I think it will just make me feel better as a nurse educator.

Perhaps because they had to find their way on their own, participants stated that they "over-prepared" for their first teaching experiences. This need to "over-prepare" was also fueled by the participants' fear of failure. Six of them described "over-prepared" as repeatedly reviewing the course content, even if that content was basic. For some, this need became compulsive. One educator, who was an expert in her clinical field, recognized that this "over-preparing" probably was not necessary; however she could not stop herself from doing it. It was difficult for her to trust in her knowledge and experience. Even after five years of teaching she was asking herself:

Why do I have to go back through my lectures and rewrite them? Why do I have to do that the night before and spend three or four hours on that? I know this stuff off the top of my head. I know what the test questions are going to be.

Another participant reported staying up “till two in the morning” researching medications and procedures before clinical so that she could “know everything about...every patient that they (the students) were going to care for.” This again stemmed from a need to have all of the answers for the students. One educator with nearly a decade of experience described how she over-prepared to help alleviate this fear during her first year of teaching:

I was over-prepared but I was sort of scared. I mean this was, you know, standing up in front of the class and having them all look at you and think you're the authority...and you're just thinking, “OK, I want to know everything!”

In addition to seeking teaching knowledge on their own and over-preparing, the participants applied their previous experience as nurses to situations that they encountered in academia. They offered several examples of how the work that they had done as a nurse had prepared them in an unexpected way for their work as educators. One faculty member described how her experience working with patients had prepared her to communicate with students:

I think everything that I did before coming into education...for example, that patient teaching...the things that I thought about...how ill they were, what level of education that they were, how I had to break it down; those

types of things all can be carried forward over to the student...the other thing that really comes to mind...is listening...really listening to the student as well as looking (at) what's behind the behavior...we do know a lot that we can apply to teaching and I think sometimes we think it's so new, and it's not. It's stuff that we are very good at.

The nurse educators also were able to draw on the organizational skills that they had developed when working in the clinical setting. One participant offered a checklist of the skills that helped her transition into her new workplace: "I think organization, setting priorities, setting goals, time management; all of those things come into play."

#### *Peer Mentoring*

Because they lacked a guide to show them the way, the nurse educators in this study sought out their own mentors among peers. Usually, this "peer mentor" was a course group leader or another faculty member with similar clinical or research interests. Rarely, it was an administrator. The levels of experience that these peer mentors had varied; however, all the participants described this relationship in a positive way. When asked what was most helpful to her during her first year of teaching, one of the first participants interviewed described her peer mentor:

I would say having a person that I could go to and talking with them about the issues. The good things and bad...she gave me some tips on how to handle it better than I was taught...by using examples...basically role modeling.

Sixteen of the participants described building a relationship with a peer mentor or "go to person." This "go to person" was someone that they perceived as being

“knowledgeable” and “approachable.” This individual was also someone that they could “go to” in a crisis. This was evident in the following remark from a first-year educator: “...my ‘go to’ person...she has been phenomenal...I didn’t have the feeling that I was going to crash and burn. If I crashed, I could call her and she would help me figure out how to get out of it.”

One novice educator selected her peer mentor based on the level of “respect” that she had from both colleagues and students. She described her peer mentor in the following manner:

...there's another woman here...who I just respect tremendously... not only do I respect her a lot, I hear students respect her and...that’s a good sign, I think, when faculty and students have an appreciation for the same person.

The support these “go to” mentors provided to the participants was described as “informal.” As one educator stated, “They didn’t even know they were mentoring me!” The informal nature of the relationship did not diminish the effectiveness of the interaction. In fact, the four participants who had been assigned a formal mentor reported still seeking out a “go to” person on their own. While they appreciated having a formally assigned resource person, they described their peer mentor as being a better “fit” in many ways.

One experienced participant offered this explanation: “I think mentoring's a hard thing because I think...to some extent, an assigned mentor doesn't work as well as being able to have a mentor that...has something that you need that you could benefit from...” She later added, “You just click better with some people

than others and so...I know that's in the literature and that's a big thing...I'm not sure that I'm in agreement that assigning that works all that well."

### *Establishing Boundaries*

By far the most universally utilized strategy among the participants in this study was establishing boundaries. This strategy was developed in response to the intervening conditions related to student issues and differences in the nurse/patient and teacher/student relationship described earlier. Nearly every participant discussed learning how to "draw the line," "set limits" or "establish boundaries" in their relationships with students. This strategy often surfaced when the educators were questioned about how their practice had changed over time.

Establishing boundaries became possible when the educators acknowledged the need to create a different relationship with students than they had with their patients. In essence they began to realize that, as a teacher, "not everybody is going to love me." As one seasoned educator stated, "I think I *can* be liked (by students), but I don't *need* to be liked anymore." A participant with five years of experience offered this description of how her teacher/student relationships have changed over time:

The first year...I was really green and timid...I wanted to work with the students but it was almost like a friendship. I'll guide you and you guide me! Now it is, 'I'm the teacher and these are the rules, and we are going to play by the rules.' ...So, I'm flexible but not as flexible as I was when I first started.

Eight participants attributed the difficulty that they had in establishing boundaries to their nursing background. One experienced educator described her struggle to hold all

students to the same standard, even if they were experiencing personal problems. This conflicted with her instincts as a nurse: “Sometimes if you know that a student's maybe having personal problems... It can be hard to balance your knowledge that they're having those personal issues...” She went on to clarify her statement, “...I think it (the nursing background) makes nurses in general not as good at that. I think we take too much into consideration sometimes.” She later added, “We're nurturers. That's why we chose to do what we do...But we're really here to nurture patients, not students...it's a balancing act.”

Acknowledging this same viewpoint, another educator described how she performed this “balancing act” between her feelings as a nurse and her feelings as a teacher:

...students will come in...to talk or they're not feeling well and I think...no, we're not here to take care of them, but with our profession we can't turn them away. We need to listen to them, advocate for them if and when appropriate...(but) we need to set those boundaries...we're not here to take care of them but we can be decent about what we do...

In spite of the difficulties that the participants had with establishing boundaries, they felt that this strategy was necessary in order to make a successful transition into their new role as a nurse educator. In fact, they felt that they were doing the students a disservice if they were too “wishy washy.” One participant described how she has raised her standards for her clinical students over the years. She explained, “I...think that students will work to the level of your expectations.” When probed to expand on this idea, she stated:

I think that if you challenge them, you're fair, but you make them work, I think the majority of students will rise to that level. And if you don't challenge them and you don't make them work they're going to go to that level too, because why wouldn't you? ...I think if you expect a lot out of students, you can get a lot from them.

### *Keeping a Foot in the Door*

In spite of the fact that time constraints made it difficult to keep current clinically, the majority of participants found some way to “keep a foot in the door” of the nursing world. This helped them to hold on to their nursing identity and increased their confidence in working with students. Eleven of the participants either “moonlighted” at local hospitals during the weekends and summers or had clinical practice contracts as advanced practice nurses. Although one of the institutions required its faculty members to engage in clinical practice, the other three did not.

One educator described the necessity to keep current clinically in the rapidly changing healthcare environment, and how that differed from other disciplines. She stated, “I don't know what it's like to be an English Professor, or a Math Professor, but I don't think a lot of those things are always changing like things are always changing in healthcare.”

Those who did not practice nursing outside of their faculty role occasionally expressed feelings of regret. One participant who was working on her Ph.D. simply did not have the time to practice, but hoped to someday. She worried that the time away from the bedside would cause her to lose skills:

...I wish that I did have the time for clinical practice, but...I'm still a student myself; I guess I'm hoping that when I'm done with my Ph.D. I can look at having a clinical practice in the summertime when I'm not teaching...I almost wish that it was part of this job to still have that clinical piece...I do fear that if I stay out of the clinical area for too long...what kind of things would I lose and what would that mean?... I remember having professors that hadn't really practiced nursing in twenty years and just thinking that they didn't really know what was going on and I don't want to be that teacher. I don't want to be that faculty member.

Those who were able to keep a foot in the door described how their practice benefited their teaching. They felt that it also improved their credibility with both the nursing staff in their affiliated hospitals and the students:

I think clinical practice has benefited my teaching by reviewing some of that basic information again...they (the students) also see you as...a little more legitimate. Like when I come to the lecture and (say), "Yeah on Saturday I had this woman and this is what happened." It's not like, "Oh ten years ago I had this patient and...now they're not even doing that procedure anymore."

#### *Gradual Acceptance of Responsibility*

Six of the participants described how their employers allowed them to begin their new positions with lighter obligations than they anticipated. This allowed them to focus solely on teaching during their first semester. They were then expected to gradually take on new responsibilities each year, such as committee work and advising. Others began

their careers with reduced teaching loads, or co-teaching a course with an experienced instructor. This strategy was useful in terms of decreasing time constraints and was the only strategy identified that was not under the participants' control. It was praised by all six of these educators. One explained how this process worked for her during her first year of teaching:

They just said, "Which lectures do you want?" And they took some other ones. So I didn't have the whole burden, and then we just gradually--each semester I took on more and more... But it wasn't like immediately the first year you were there, you were doing (all of) them.

Another novice educator gratefully recalled how reduced her load had been during her first year. This allowed her more time to seek the knowledge that she needed to do her job without having had formal preparation for her role:

...the emphasis this year very graciously has been on, "Just teach and get your other things going." ...I felt like I was allowed time to learn to teach and I was not overwhelmed with responsibility, like I sort of feared that I might be. As I'd heard I would be.

### *Making it Your Own*

The final strategy that participants used to successfully transition into their new role was "making it your own." The participants described this strategy as a way of taking ownership of their new role. This was a process that allowed them to find their own teaching "style" and "philosophy" and was accomplished by individualizing their classroom and clinical activities to fit that style. This

category emerged from the in vivo use of the words “make it your own” by three of the participants.

One of these participants described how this strategy helped her improve her teaching. After teaching for one semester, she began to ask herself, “How can I make this better and take more ownership of the structure and of the content and not be afraid of really making it my own?”

Another educator described how trusting in herself helped her to take ownership of the classroom. For her, “making it her own” was about getting “in the flow” in the classroom and being herself. She learned that she did not have to teach exactly like her colleagues. She could develop her own style: “...when I am in the flow...it feels very natural, because I’m not reading from notes... I just have to trust in myself that I know this stuff...”

Part of “making it your own” also meant just “getting through it.” This meant that they needed to teach a course or clinical rotation at least once before they could determine how to “make it their own.” The first time through was a way to get “some of the bugs worked out.” After that, they could focus on improving it and individualizing it. “There's no one else (that) can do this for you; you just have to jump in there....” One participant stated. “...you just get it over. You just get it done with.”

#### Consequences: Reaching the Destination

The educators interviewed had varied levels of teaching experience, ranging from as little as eight months to as much as 29 years. As data analysis progressed, it became evident that a participant’s ability to describe all facets of the transitional experience included in the axial coding paradigm was not necessarily dependent upon years of

teaching experience. Some experienced participants had difficulty describing a level of “comfort” in their role as educators, while newer faculty occasionally were very articulate about the consequences of their role transition. No explicit time frame was found for this process in the data. This suggests that successful transition to the role happens at different times for different individuals. It also supports the methodological choice to interview participants with varied levels of teaching experience.

For those who were beginning to find “comfort” in their new role, reaching their destination was characterized by feeling like a teacher and thinking like a teacher. These concepts served as “markers” for role transition.

#### *Feeling like a Teacher*

As was described earlier, identity issues were one of the intervening conditions for the participants in this study. Though not all of the experienced educators interviewed were completely comfortable in their new role, they described reaching a place where they felt “comfortable” or “effective” in their new role. Embracing this new identity meant feeling like a teacher, but not forgetting that they were a nurse.

For one participant, this feeling began to take hold after two years: “After the second year, I became more comfortable... Teaching fit with me...I felt validated. I wasn’t so unsure...” She went on to clarify that she now saw her new identity as a blend of the two professions: “...internally, I think of myself as a nurse educator...I identify the *nurse* though, because that's my foundation and I have to add the teaching knowledge on top of it to be an educator.”

Another participant described feeling more comfortable at the end of her third academic year. For her, this feeling of comfort came when she realized that teaching was

now part of her identity. Comparing her reasons for choosing the two professions, she stated, "...I was drawn to (my nursing specialty) for certain reasons, because of who I am and what I value...the same goes with being an instructor...it's just who I am and it feels natural to me."

Understanding the responsibilities of their new role and learning to value the impact they had on students helped others embrace their new identity. At the end of her second year, one participant described how she was beginning to take pride in her new identity as a nurse educator:

I think coming into academia I had no idea how involved it is and everything that you are responsible for. There's so much more than just going to a classroom and teaching and there's so much more than just giving a test and there's so much more than even just going to the hospital and being in clinical...you run across staff nurses who say, "Oh, yeah...you're teaching," kind of with that look like, "well I guess you gotta do something." You know, they just kind of demean you in a way...for me that was hard at first too, getting past that reality. But the people that I know and respect...that were kind of on my same level...when they turned to me and said, "You know, I'm thinking about doing that someday too," or you know when they would give some respect to the role it helped me to kind of process that a little bit more. You know I think it was easier for me to try to wrap my mind around that.

*Thinking like a Teacher*

More than half of the participants described how their teaching had become less content-driven over time. As they became more comfortable in their new role, they began to think that being a teacher is less about being an omnipotent authority and more about helping their students learn to think for themselves. A big part of making this transition was letting go of the need to have all the answers. An educator who had nearly a decade of experience described how she gradually became more comfortable with ambiguity in the classroom:

I find that if I wanted to be *the* expert on everything I would be frustrated because I know I'm not the expert on everything. I think there are things that I can impart but I don't think I'm expert on everything and is any teacher...? ...I think the dialogue is important as anything...

Letting go of the need to have all the answers led the participants to experiment with new pedagogical methods that were more learner-centered and interactive. Becoming more comfortable in their role as an educator allowed them to focus on improving their teaching, rather than simply trying to survive day to day. Several of them described utilizing case-studies in class and making attempts to better engage the students. A relatively new educator described how her teaching had evolved over time:

...I think just finding ways...to you know, jolt them, change things up, get them away from the slides, get them discussing in groups...How do you get away from the Power Point, one-directional teaching and get them thinking and talking and learning from each other and still cover content? So it's the content-driven thing versus learning to think. Give them a

couple bones to chew on and if you taught them how to think, they can chew on any bone! ...I was, especially the first semester, really super focused on content and very panicked that we hadn't covered X, Y and Z. But you just simply can't cover it all...you really just can't cover it all.

Helping the students to think for themselves meant learning how to "hold back" in both the classroom and clinical settings. Nine of the participants described how they became more comfortable letting their students problem solve on their own. "...I will hold back a little bit and let them explore things a little bit more," one participant noted. "(It) teaches them a little more critical thinking skills and a little bit more reliance on themselves..."

In the clinical setting, "holding back" meant becoming more "hands off" than "hands on." A novice clinical instructor described how she was currently struggling to make this transition herself:

...one thing that I keep, I guess playing around with is the difference between being almost overbearing or being too "hands on" versus "hands off." I think trying to figure out how much do I need to directly supervise my students...when is it that I need to try to back off and let them become a little autonomous... I don't want to take away their learning experience. I don't want to do too much for them, but I don't want to do too little.

At the core of these attempts to engage the students was a fundamental shift in teaching philosophy. The emphasis became the *process* of learning, rather than simply the *product*. The focus shifted from their behavior as a *teacher*, to the students' experience as a *learner*. There seemed to be a giving over of control; a realization that

they as teachers could not passively transfer knowledge to their students. "...we facilitate the learning," one educator stated. "...you can't just give the knowledge. You create the environment to facilitate the learning."

An experienced educator described how profound this realization had been for her:

I think the specific turning point for me was when I finally realized that it isn't the facts I give them, but it's...getting them to make the connection and to see the bigger picture...when I finally realized that I don't have to give them all the facts... It was a good ten to twelve years before I realized that.

### Summary

It is important to understand the experience of new nurse educators and the strategies they use to successfully complete their journey from bedside to classroom. The descriptions provided in this chapter represent the perspectives of 20 nurse educators with varied levels of experience in both public and private baccalaureate institutions. They serve as building blocks for a substantive level theory that describes the transition from nurse to nurse educator.

### Theoretical Propositions

Based on the data presented in this chapter, the following theoretical propositions emerged:

1. Nurses are generally unprepared for their new role as nurse educators. Orientation and socialization to this role is inadequate when compared with the process generally utilized in clinical settings.

2. New nurse educators struggle with an inherent fear of failure, identity issues, uncertain role expectations, job stress, and unanticipated difficulties with students. The loosely-structured academic environment is a sharp contrast to the tightly structured clinical environment of their past.
3. In order to overcome these contextual and intervening obstacles, novice nurse educators seek out mentors among their peers based on shared interests, perceived knowledge, and experience. They seek the knowledge necessary to perform their job through formal and informal, *self-directed* processes.
4. Nurse educators may experience difficulties establishing boundaries with students, due to inherent role differences between nurses and educators.
5. Gradual acceptance of responsibility allows the novice educator time to take ownership of the new role and cultivate a personal teaching style and philosophy. This strategy also allows time for the “over-preparing” that novice educators often do to alleviate the anxiety of early student encounters.
6. Successful transition into the role is marked by embracing the new identity of nurse educator. Identifying one’s self as a nurse educator is characterized by increased comfort with ambiguity in both the clinical and classroom setting and a learner-centered teaching philosophy.

## CHAPTER 5

### THEORY INTEGRATION

“Education is not the filling of a pail, but the lighting of a fire.”  
--William Butler Yeats

The results of this study have implications for both novice nurse educators and administrators in schools of nursing. In order to put the theoretical propositions presented in the previous chapter into a meaningful context, I returned to my original research questions and the literature. This chapter offers suggestions for practical use of these findings.

#### Return to the Research Questions

##### *Central Research Question*

What theory explains how nurses make the transition to the role of nurse educator?

The theoretical propositions put forth in this study form the basis for the Nurse Educator Transition Theory (NETT). This is a substantive level theory that applies to the experiences of nurse educators in baccalaureate institutions. It describes the causal conditions that lead nurses to choose careers in academia, the context of that work environment, and the intervening conditions that they face within it. More importantly, it offers insight into the strategies that nurse educators use to adapt to their new role and the consequences or “markers” that transition has occurred. Each of these elements is further discussed in the answers to the remaining research questions below.

##### *Research Question 1*

What is the process?

The process can best be described by referring to the NETT Axial Coding Paradigm (see Figure 1). Using the procedures outlined by Strauss and Corbin (1998),

this paradigm was created to depict relevant relationships between the categories and sub-categories identified during open coding. The storyline presented in the previous chapter describes the process in terms of the abstract central category, “journey down a new career path.” Using the abstract concept of a “journey,” the broad categories of the paradigm were given names that reflected this theme, such as “the on ramp,” “a bumpy road,” “roadblocks,” “blazing the trail,” and “reaching the destination” to describe the transition process. Abstraction in the central research category is consistent with the recommendations of Strauss and Corbin, who contend that using abstract concepts allows for the theory to be used in other substantive areas. This may lead to the creation of a more general theory in the future.

### *Research Question 2*

In what context do nurse educators enter the field of nursing academia?

The context of the academic environment was described by the participants in this study as unfamiliar. They did not really understand their role expectations or the structure of their new work environments, and very little was done to successfully orient them to their new positions. These unprepared and unfamiliar feelings are consistent with the qualitative inquiries of Anderson (2006), Dempsey (2007), McDonald (2004), Siler and Kleiner (2001), and Young and Diekelman (2002). The imagery of being a “stranger” on a journey with “no roadmap” and “no guide” was especially significant in this study, as it describes how the participants lacked clear direction during the early period of their role transition.

*No roadmap*

The description of not having a “roadmap” is consistent with the concept of role ambiguity, which has been described in the social science literature. According to Kahn et al., (Kahn, 1964/1999; Kahn, Wolfe, Quinn, & Snoek, 1964), role ambiguity results when a person lacks adequate information in order to effectively perform his or her job. This may occur when a worker does not understand his or her scope of responsibility on the job, how supervisors evaluate job performance, acceptable behavior in the workplace, or opportunities for promotion. The nurse educators in this study reported that they were not provided with a basic “roadmap” of the curricular structure, student evaluation standards, and the “nuts and bolts” necessary to effectively perform their daily work. They also expressed confusion about their university’s organizational reporting structure, the rank and tenure system, and job performance standards.

Role ambiguity has been correlated with decreased levels of job satisfaction in nursing educators (Acorn, 1991; Fain, 1987; Gormley, 2003). According to Fain, role ambiguity is negatively correlated with academic rank, level of education, and years of teaching experience. In Fain’s study, role ambiguity was greatest for those teaching at the introductory rank of instructor and with less than five years of experience.

Participants working in the clinical setting with students reported feelings consistent with role ambiguity. They described learning how to function in a new capacity in an unfamiliar environment. Instead of functioning as a staff nurse on the unit, they learned to function as “guests,” who often have a limited ability to influence clinical practice. The notion of being a “guest” in the clinical setting has been identified in the literature by Esper (1995). This awkward position can interfere with the development of

collegial relationships with the regular nursing staff, and may result in feelings of marginality and decreased clinical competence (Ramage, 2004). Assuming the role of “guest” may be particularly distressing for educators who consider themselves to be expert clinicians.

In addition to adjusting to a new and ambiguous work setting, the participants in this study lacked preparation for their new role. For decades, nursing education scholars have been writing about the “reality shock” experienced by novice educators as they move into a role for which they are largely unprepared (Esper, 1995; Infante, 1986; Locasto & Kochanek, 1989). Less than half of the nurse educators in this study had any sort of formal pedagogical training. The breadth and depth of this training varied greatly. Three of the participants earned graduate degrees in nursing education prior to accepting their first teaching position, and four others took electives in nursing education during their master’s program. The rest either earned clinically-focused degrees or enrolled in a graduate program with an educational major after they began teaching. Thus, they had no experience with teaching prior to their first educational appointment.

The participants who did have formal training were generally pleased with the preparation that it provided them, although there was a feeling that such courses should perhaps place more emphasis on practical applications. This is consistent with Herrmann’s (1997) findings that participation in a graduate teaching practicum increases feelings of preparedness in clinical instructors more than courses in curriculum and theories of learning. The data presented here also supports the work of Nugent et al. (1999), which suggests that formal nursing education courses combined with teaching experience can increase self-efficacy in new nursing faculty.

None of the participants in this study took part in structured orientation programs that could offer them an adequate “roadmap” for their journey. They specifically expressed a clear need for information about the “nuts and bolts” of their day-to-day work and information related to the school’s curriculum and course sequencing. Gazza and Shellenbarger (2005) have suggested that having such basic information may decrease the amount of time new faculty spend seeking information and may allow them to be more productive.

*No guide*

Only four of the participants in this study were formally assigned a mentor or “guide” to help them navigate their first teaching position. The literature suggests that novice educators can benefit from structured guidance from a qualified mentor (Boice, 2000; Genrich & Pappas, 1997; NLN, 2006). As was mentioned in Chapter 2, the use of formally assigned mentors has been suggested as a way to decrease the stress felt by new nursing faculty (Shirey, 2006) and may decrease faculty turnover (Gazza & Shellenbarger, 2005). Based on the evidence presented here, the need for such guidance may be particularly important to nurse educators who have been exposed to tightly-structured mentorship models in the clinical setting. This contrast was identified by several participants.

*Stranger in a strange land*

In addition to a lack of guidance, the participants described the contextual experience of “starting over” as “complete novices.” The Dreyfus model (1986) contends that expertise in any skill can only be developed through experience. A lack of formal education (with a practical component) and a lack of orientation meant that most

of the participants in this study were “postulant” teaching novices by Dreyfus’ (1986) and Berliner’s (1988) definitions. The majority of them had gained advanced knowledge and at least proficient, if not expert, status in either clinical or administrative fields prior to entering nursing academia. Thus, they found it disconcerting to return to the role of “novice,” moving “backward” on the Dreyfus continuum as a new teacher in the unfamiliar setting of the classroom or laboratory. Their early desire to understand the “nuts and bolts” of their new careers as well as basic information about the curriculum and student learning objectives is consistent with the novice’s intolerance for ambiguity (Benner, 2001; Dreyfus & Dreyfus, 1986).

Overall, the contextual factors presented here are consistent with the findings of Anderson (2006), Dempsey (2007), McDonald (2004) and Siler and Kleiner (2001). The phenomenon of moving from “expert” clinician to “novice” educator (based on Benner’s model) was used as a context for Anderson’s study. Siler and Kleiner also identified strong parallels between the behavior of the novice teachers in their study and the novice nurses in Benner’s. In this study, the concept of moving from “expert to novice” also emerged from the data, thus validating the work of both Anderson and Siler and Kleiner.

It should be noted that the participants used several of the same words as Anderson’s (2006) participants to describe their experience, such as “sink or swim,” “flying by the seat of my pants,” and needing the “nuts and bolts” (Anderson, p. 118). Anderson also used the concept of feeling like a “stranger in a foreign culture” (p. 118) to describe the unfamiliar feeling that her participants experienced during what she labeled the “early transition period.” I had not reviewed Anderson’s findings prior to this study’s

data collection and analysis, as they were not yet published when this process began. This strengthens and validates the findings of my work as well as Anderson's.

### *Research Question 3*

What inhibits or facilitates the transition process?

The contextual and intervening conditions described in the axial coding paradigm were inhibitory factors on the participants' journey. Theoretically, these were abstractly depicted as "bumps in the road" and "roadblocks" that led to the development of specific strategies to facilitate the transition process. Because these strategies were generally self-directed, the label of "blazing the trail" was chosen to suggest that the participants had to find their own way on their journey.

#### *No roadmap, no guide, self-directed orientation, peer mentoring*

Because the participants were not given a "roadmap" or a "guide" when they embarked on their journey, they blazed their own trail by determining what they needed to learn and connecting themselves with peers who had the information they needed. This self-directed orientation involved "digging" for the facts themselves, "over-preparing," and selecting peer mentors.

The participants described this "self-directed" process as time-consuming and frustrating. As novices, they often were not sure what questions they even needed to ask, as they lacked experience and context to guide their fact-finding missions. McDonald (2004) noted that being a "self-directed learner" (p. 161) was essential in the academic setting, while Anderson (2006) described a process of "looking for resources" (p. 128) as a vital part of the novice's work-role transition. Siler and Kleiner (2001) also identified

this pattern, pointing out that when the novice's questions finally were answered, they usually did not receive the level of detail that they desired in the response.

Many of the participants sought a "peer mentor" or a "go to person" for assistance. This strategy was so widely utilized that even the four participants who reported being assigned to a formal mentor found it helpful. One of them confessed to feeling more connected with her self-selected peer mentor than her formal mentor. Another participant confided that, although her assigned mentor had a wealth of teaching experience and was very helpful, she felt as though she needed a second mentor that could offer her more practical information about her particular clinical specialty.

Peer mentoring has appeared in the nursing education literature as a potential strategy to increase research productivity and networking for those new to academia, and has been suggested as an effective supplement to formal mentoring arrangements (Jacelon et al., 2003). The participants who sought this guidance stated that their peer mentor helped them obtain practical information and emotional support. Emotional support may be of particular importance to novice nurse educators who trade the teamwork of the clinical setting for the "isolated" world of nursing academia (Esper, 1995).

According to Thorpe and Kalischuk (2003) traditional, hierarchical models of mentoring are outdated because they do not focus on the personal and professional development of the individuals. They have proposed a new mentoring model for nurse educators, The Collegial Mentoring Model, which is based on friendship, collegiality and honest communication over extended periods of time. This model focuses on developing both the mentor and protégé through making time for togetherness, caring, connecting,

and communicating. They contend that relationships built through the use of their model offer an antidote to the isolation felt by nurse educators and have the potential to increase faculty retention. The benefit of peer mentoring in this study supports the implementation of such a mentoring model.

*Identity issues, student issues, establishing boundaries, keeping a foot in the door*

Identity issues served as an inhibitory force in making the transition. The nurse educators described conflicting feelings between their “nurse” identities and their “educator” identities. They found it difficult to fulfill the ideals of both roles simultaneously, especially when dealing with students and trying to maintain their clinical competency in an environment that placed a high value on scholarship and research.

These feelings are consistent with *role conflict* (Kahn, 1964/1999; Kahn, Wolfe, Quinn, & Snoek, 1964), which occurs when an individual experiences conflicting expectations from the people around them. Role conflict is the psychological stress that results when complying with one set of expectations means not meeting others (Kahn, et al.). Like role ambiguity, role conflict has been associated with decreased levels of job satisfaction in nurse educators (Acorn, 1991; Fain, 1987; Gormley, 2003). A study by Oermann (1998) reported greater role conflict for clinical faculty teaching in baccalaureate programs when compared to those teaching at the associate degree level. She suggested that the large amount of time spent teaching in the clinical area left little time for the research and teaching demands of the baccalaureate setting.

Internal role conflict arose for the participants as they adjusted to the expectations of their new role and the differences between the nurse/patient and teacher/student

relationship. According to Infante (1986), such role conflict is unavoidable for the nurse educator because, “a nurse who has been deeply socialized into the role of caregiver...now must behave as an educator” (p. 94). Infante suggests that acclimating successfully to this new role requires the nurse educator to change deeply ingrained behaviors. Anderson (2006) proposes that novice nurse educators tend to think of the students as patients during the early phases of their work-role transition. She attributes this behavior to the habit of “thinking as a clinician” (p. 122).

Congdon and French (1995) state that when nurses become educators their “disposition towards caring for people and looking after ‘patients’ has not been left at the bedside” (p. 752). They identified this concept as “nursing the students.” Their participants defined “nursing the students” as a tendency to place students in a “sick role” and the need to “make things better” by “spoon feeding” them knowledge and being overly caring and nurturing in student relationships.

Morris (1995) suggests that effective nurse educators are able to be “friendly without being familiar” with their students (p. 295). The participants recreated new identities for themselves by learning how to perform a “balancing act” between their “nurse” and “teacher” identities. This was accomplished when they learned how to “draw the line” and establish appropriate boundaries with their students. By establishing boundaries, the nurse educators acknowledged that the teacher/student relationship is not always a friendly one and that consistent, but reasonable, standards need to be applied to all students.

In addition to effectively establishing boundaries with their students, several of the participants learned how to successfully blend the roles of “nurse” and “educator” by

“keeping a foot in the door” of the clinical world, either by “moonlighting” or establishing advanced practice contracts. This strategy fortified the “nurse” portion of their identity. They also worked to strengthen their skills as an “educator” by seeking the teaching knowledge that they lacked through formal and informal educational pursuits. By utilizing these strategies, participants were able to successfully blend the two roles, thus facilitating their transition to “nurse educator.”

Maintaining clinical competence as a strategy to decrease both role conflict and role ambiguity has been suggested by Acorn (1991). She reported that faculty with joint academic-clinical appointments actually experienced lower role conflict and role ambiguity than “traditional” faculty who did not engage in clinical practice. Although the differences were not significant, Acorn’s findings suggest that maintaining clinical proficiency may be an effective strategy for integrating the two identities of “nurse” and “teacher.” It is possible that remaining clinically competent could decrease the fear of losing one’s “nursing” identity in the role transition.

*Fear of failure and over-preparing*

Fear of failure in the eyes of the students was an additional inhibitory factor during the transition process for more than half of the participants. This fear manifested itself in a need to cover as much content as possible in class and a need to be prepared to answer any possible student question. Participants also expressed self-doubt in their ability to teach, which often resulted in a fear of somehow harming the students and/or patients. McDonald (2004) identified a similar fear in her participants, who worried that they were not providing students with the skills and knowledge they would need to enter into practice.

This fear is consistent with the behavior of novice nurses described by Benner (2001). She noted that novices tend to view critical situations and emergencies through the “screen” of their own “anxiety” (p. 20). After a “critical incident” they often question their performance and wonder if an error on their part somehow contributed to the unforeseen event. Thus, their focus is usually more on their own performance, rather than the event as a whole. Unlike the expert, they are unable to see the “big picture.”

In order to combat this fear, the participants tended to “over-prepare” for student encounters. This strategy was utilized by both novice and experienced educators, especially when they were presenting new content. This is consistent with Benner’s (2001) contentions that proficient or expert individuals may revert to the thinking patterns of those with lower levels of expertise when presented with new and unfamiliar situations. “Over-preparing” and “re-reviewing” content may allow the educator to return to the safety of the “rules” that novices crave.

Anderson (2006) also described a fear of not having all the answers in her novice participants. She suggests that those who have previously been experts in the clinical area are faced with the task of “relearning” content outside of their nursing specialty area so that they can successfully teach it to others (p. 126). They also grapple with the task of “unlearning” and “deconstructing” information and skills that they had previously performed intuitively (p. 127). This is necessary in order for the expert to break the knowledge down into basic elements that are understandable to the student. McDonald (2004) identified a similar fear in her participants.

*Time constraints and gradual acceptance of responsibility*

Time constraints were identified as an inhibiting factor by thirteen of the participants. This was not limited to the early period of the participants' careers; however, as novices, they were able to successfully adapt to these time constraints with the help of their employers. Gradual acceptance of responsibility in the form of a reduced teaching load or reduced committee work during their freshman year of teaching allowed the participants time to acclimate to their new role. The use of this strategy supports the recommendations from Siler and Kleiner (2001) and Morin and Ashton (2004) and may decrease anxiety for new nurse educators by allowing them to "ease into transition" (Anderson, p. 115). It also allows them the time they need to "over-prepare" for their encounters with students.

Moreover, by adding on responsibilities gradually, they were able to learn the role in stages. One of the experienced educators in this study noted how she became effective in "different parts of the role at different times." In her early years, she focused on mastering clinical and classroom instruction. As she grew more comfortable in her role as an educator, she moved on to mastering the service and then finally the scholarship requirements of the role. She noted that, even after more than twenty years, she was still developing her skills as a scholar and did not quite have the "total package" yet.

*Making it your own*

New teachers often focus on teaching, rather than learning (Young & Diekelmann, 2002). Again, this may be related to the novice's anxiety and tendency to focus on his or her own performance, rather than the "big picture" (Hogan, Rabinowitz, & Craven, 2003). Allowing new teachers to focus on teaching during their first year may

facilitate the process of “making it your own” by giving novices the time to personalize the course content and develop their own individual teaching style. The phenomenon of “making it their own” was also identified by Anderson (2006, p. 136) with the same label and similar properties and dimensions.

In order to make the role their “own,” participants described “just getting through it.” This meant “surviving” their first teaching experiences so that they could get a feel for what teaching was really like. Gaining confidence through experience allowed them to focus less on themselves as teachers and more on the students as learners. Once the participants began to build confidence through experience, they felt challenged to implement new teaching strategies acquired through faculty development activities. They began to feel that it was acceptable and necessary to incorporate their own personalities and style into the course content. They also began to realize the value of their past nursing experience and how nursing knowledge and skill could be applied in the educational setting. These findings are consistent with those of Young and Dikelemann (2002), who suggest that increased comfort may lead to experimentation with new pedagogical techniques.

#### *Research Question 4*

What are the identifiable stages in the transition?

In order to identify a sequence of “stages” in the transition from nurse to nurse educator, I returned to the storyline developed during the coding process. Charmaz (2006) rejects the use of the axial coding model in grounded theory research and cautions against imposing such an explicit frame on theoretical analysis. With the goal of creating a more robust theoretical model, I analyzed the data again to see if indeed there

were identifiable stages in the transition. Four stages were identified and are depicted in the NETT Model (see Figure 2). Characteristics of each stage are described below.

*Stage 1: Anticipation*

The “anticipation/expectation” stage of the transition begins when the nurse makes the decision to become a nurse educator. The variety of causal conditions described in Chapter 4 characterize this stage as a positive time in which the nurse enters the field with the anticipation of making a difference in the profession by influencing the next generation of nurses and pursuing meaningful scholarship. The nurse enters this phase with expectations of positive student encounters, a more flexible work schedule and career progression.

*Stage 2: Disorientation*

The second stage of the transition is a period of “disorientation” that starts when the nurse begins work as a nurse educator. This stage is characterized by an absence of structure and mentorship. There is generally inadequate orientation and socialization to the role. (Thus this is a period of “disorientation,” rather than “orientation.”) This results in role ambiguity, as the educator lacks both the basic knowledge necessary to perform the work, and an understanding of the organizational structure. “Disorientation” also results from “backward” movement on the “Novice to Expert” Dreyfus continuum.

*Stage 3: Information Seeking*

Because of the absence of structure and guidance in stage two, the novice educator must seek out the information to perform the work on his or her own. This stage is characterized by *self-directed* informal and formal activities. These consist of fact-finding, seeking out peer mentors, taking advantage of faculty development activities,

and taking an active role in learning how to teach. Those who are assigned to formal mentors during this stage consult them as needed, but may also seek out a peer mentor for supplemental information. During this period, novice educators tend to over-prepare for student encounters, as they are uncertain of the students' current level of knowledge and skill. They are also fearful of "failing" as a teacher by not having all the answers. Because they lack experience as teachers, they draw on their past experiences as nurses. They apply past nursing knowledge and experience to teaching situations.

#### *Stage 4: Identity Formation*

During this stage, nurse educators recognize the differences in the nurse/patient and teacher/student relationship. They discover the need for establishing boundaries with students. They integrate their "nursing" and "educator" identities by keeping their nursing knowledge and skills sharp ("a foot in the door") while continuing to develop their "teacher" knowledge base. They individualize classroom and clinical content and learning experiences to find their personal teaching style and voice ("making it their own"). These strategies are facilitated if their employer allows gradual acceptance of responsibility during the first year of teaching.

#### *Consequences: Feeling and Thinking like a Teacher*

By utilizing various combinations of these strategies, nurse educators are able to facilitate their role transition from nurse to nurse educator. The result is an ability to fully embrace the role by internally identifying one's self as teacher (feeling like a teacher) and focusing on the learning process, rather than the product (thinking like a teacher). The "nursing" identity is not lost in this process, as it remains at the core of newly-formed professional persona.

Ramage (2004) found that clinical nursing instructors engage in a process of “disassembling” and then “rediscovering and realizing the self” by gradually suppressing their old nursing identities (pp. 291-292). This is consistent with Bridges’ transitional theory (2004), which states that all transitions in life start with an ending or “letting go” (p. 82). Making a successful transition depends upon being able to disengage, dismantle, and disenchant one’s self from a former way of life. In the NETT model, these tasks are completed during the identity formation phase and “feeling like a teacher” and “thinking like a teacher” serve as “markers” of successful role transition.

#### *Research question 5*

What model explains this process?

The NETT axial coding model (see Figure 1) describes the causal conditions, context, intervening conditions, strategies and consequences of the transition from nurse clinician to nurse educator.

The NETT stages of transition are depicted in the NETT model (see Figure 2). In order to further develop the central category of being on a journey, these stages are depicted as travel on a road. The anticipation/expectation phase begins at the top of a “hill” on the model, as this is generally a positive time. The “disorientation” phase is characterized by a downhill “slide,” as this is generally a period of confusion and unmet expectations. Information seeking and identity formation are shown as bringing the educator uphill again. These activities are empowering and move the nurse closer to the goal of successfully transitioning into the role of nurse educator. The circular arrows between information seeking and identity formation symbolize overlapping and concurrent activities, suggesting that information seeking may continue well into the

stage of identity formation, especially if new roles and responsibilities are added to the nurse educator's work load.

The contrast of the clinical and academic work environment, the difference in the nurse/patient and teacher/student relationship, and the change in teaching philosophy are depicted at opposite ends of the diagram. These represent the beginning and the end of the journey. Reaching the end of the journey in this model does not imply reaching a specific level of expertise. It simply implies that the role transition has been made. Successful transition is symbolized in this model as reaching the destination by integrating the two identities of "nurse" and "educator." Nursing remains at the core, but there is now comfort with the new, combined role of "nurse educator." This individual has not lost their nursing identity, but is now beginning to feel and think like a teacher.

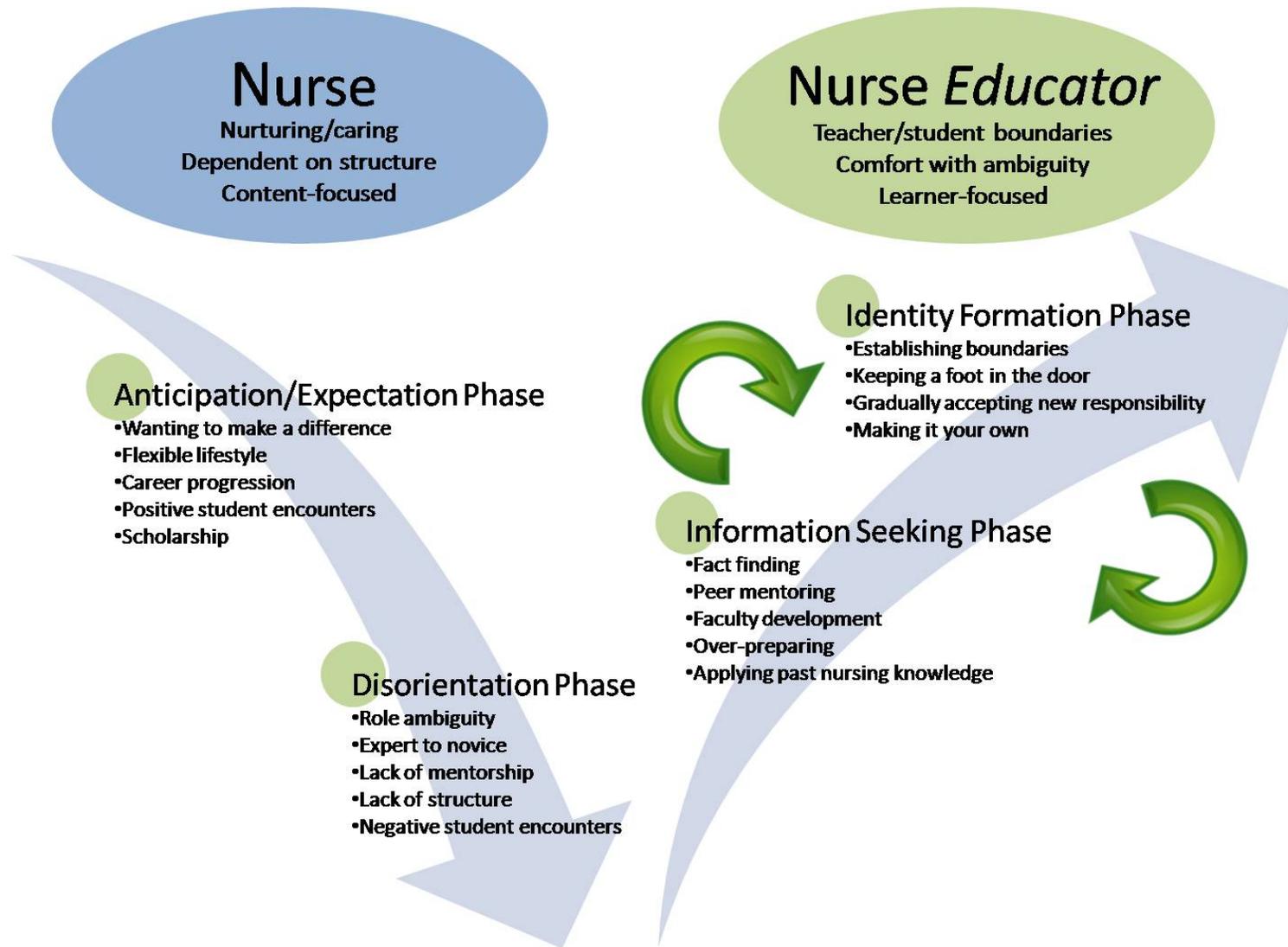


Figure 2: Nurse Educator Transition Theory (NETT) Model

## CHAPTER 6

### RECOMMENDATIONS AND FUTURE RESEARCH

#### Limitations

The results of this study strengthen and validate the findings of other, similar inquiries; however, there are limitations to its usefulness. This sample was a convenience sample of nursing educators in baccalaureate programs in the Midwest. These schools are CCNE accredited and have tenure requirements. As with any qualitative study, the findings are not generalizable outside of this group (Lincoln & Guba, 1985).

The theory presented here is a substantive level theory. Therefore, it may not explain the transition experience of novice nurse clinicians teaching in small baccalaureate programs or associate degree programs in community college settings. The theory emerged from data collected from nurse educators with varied backgrounds and levels of experience. Further inquiry is needed to determine if the theory is transferable to specific groups within nursing academia, such as part-time faculty or nurses within a particular clinical specialty.

#### Recommendations

In spite of these limitations, the results of this study have implications for practice and future research in nursing education.

#### *Formal Preparation for Teaching*

Perhaps the first recommendation is to require education related to instructional methods in all graduate nursing programs. These courses should be directed toward teaching individuals in the clinical setting, as well as the classroom. The focus should be less on theoretical models and more on practical application of knowledge. This can be

accomplished through the use of teaching practicums or student teaching experiences. This type of experiential learning is congruent with the Dreyfus model (1986), which contends that progression to a higher level of expertise in any skill is dependent upon practical experience. Incorporating pragmatic educational experiences into graduate nursing curricula is reasonable because most nurses educated at the advanced level may likely find themselves teaching in some capacity (i.e. serving as a preceptor for nurse practitioner students or participating in staff education as a clinical nurse specialist). Those who express an interest in teaching in the academic setting should be encouraged to choose electives in curricular design and other advanced concepts.

For those who enter the field without this preparation, schools of nursing should be willing to invest faculty development dollars in courses which may assist novice nurse educators to perform instruction, assessment, and evaluation functions. Abundant opportunities are available both online and face-to-face from nursing education's professional organizations. For example, AACN's *Education Scholar* is a comprehensive online program that covers traditional classroom teaching methods, active learning strategies, problem-based learning techniques, assessment methods, and even distance learning principles (AACN, 2008b). The NLN offers a certificate program in web-based learning for faculty learning to teach online (NLN, 2007). Both the AACN and NLN offer yearly faculty development conferences with sessions specifically targeted toward the needs of new nurse educators. A small number of conferences are also available through other agencies, such as *Nurse Educator Boot Camp* (DI Associates Inc., New Mexico). Post-master's certificates in nursing education are another viable option for clinicians.

### *Structured Orientation and Mentoring*

The NLN lists the existence of a structured, in-depth orientation to the faculty role as one of its “hallmarks of excellence” in nursing education (NLN Task Group on Nursing Education Standards, 2004). Orientation programs should be modeled after the work of Benner (2001) and Dreyfus and Dreyfus (1986), and should be of sufficient length to provide gradual acclimation to the full responsibilities of the faculty role (Siler & Kleiner, 2001). Morin & Ashton (2004) suggest that an orientation program should last at least one year in order for faculty to effectively make the transition to the academic work setting. These recommendations are consistent with the findings presented here, as the participants in the present study reported needing at least one full academic cycle before they could begin the identity formation phase (i.e. they needed to “get through it”).

Nursing education could benefit from emulating new graduate nurse “residency” or “transition” programs in the clinical setting, as these programs have demonstrated their ability to decrease turnover rates of new graduate nurses (Krugman et al., 2006). Successful programs will likely require the appointment of an administrator, such as an associate dean for faculty development, who would be responsible for overseeing the program and monitoring outcomes.

It is possible that a “tiered” program could be constructed that would allow for intense orientation during the first year of employment with a formal mentor. During this first year, the emphasis would be on teaching. A second, less structured year would follow during which the novice faculty member would continue meeting with a peer mentor of his or her own choosing. During this second year, the emphasis would be on developing the service and scholarship aspects of the faculty role. This may have

implications for those on a timeline for achieving tenure, and these should be addressed at the University level by Nursing Deans and Department Chairs. A solution would be to consider the first year of teaching a “residency” or “transition” year in which the novice educator would function in a capacity similar to a teaching assistant. The faculty appointment would be made during the second year of employment. This “tiered” approach would allow the educator time to adjust to the role of “teacher” before beginning an intense effort to build a scholarship and service record for tenure.

Mentoring should be an integral part of any orientation program for new faculty. Based on the results presented here, a combination of short-term and long-term mentoring assignments (Cangelosi, 2004) that utilize both formal and informal “peer mentors” would best fit the informational and social needs of novice educators. Berliner (1988) suggests that the best mentors may actually come from the ranks of competent or proficient educators (rather than experts) as they are still analytical in their approach and may be able to better communicate the rationale for their actions. Experts, however, can still be used as “models” of good teaching for the novice to emulate (Berliner).

Following the recommendations of the NLN (2006), comprehensive mentoring programs should be developed which provide formal requirements for both mentors and protégés. Regular meeting schedules, structured developmental activities, and exercises that encourage reflection on practice, such as journaling, are examples of formal requirements. Brown (1999) suggests meeting weekly for one month, and then at least once a month for one year. In order to best promote the professional development of new nurse educators, faculty mentors should receive training related to the elements of

effective mentorship and course release or reduced workload should be considered for both mentors and protégés.

Orientation programs should include institution-specific information related to rank, promotion, tenure, curricula, and the legal responsibilities of the nursing instructor in the clinical setting, as these may be foreign concepts to a person new to academia. There should also be considerable time spent on familiarizing novices with the school's program and curricular structure, as well mission, philosophy, and student assessment outcomes (Brown, 1999; Gazza & Shallenbarger, 2005). Additionally, special sessions should be planned which address the intervening conditions described in this study related to student issues, role conflict, fear, and time management.

Information should be presented related to the “nuts and bolts” of the instructor's day to day work. Lists of available resources for supplies, information technology, and support should be provided (Brown, 1999) along with written policies and procedures in the form of an orientation handbook (Blauvelt & Spath, 2008; Pierangeli, 2006). Basic skill and knowledge “checklists” should be developed in order to provide the novices with concrete evidence of orientation progress. These “checklists” may also be kept on file for future evidence of faculty competence at accreditation visits.

In order to reduce anxiety in the clinical setting, sufficient time should be allowed to orient to a clinical setting if the faculty member has not been previously employed there. “Release time” should be granted for the clinical instructor to spend time working with staff on the unit and to participate in formalized training within the organization (for example learning charting systems and equipment operation). There should also be a concerted effort on the part of administrators to consistently place clinical instructors

within a single setting, particularly during the first few years of employment. Rotating clinical sites should be avoided whenever possible, in order for the faculty member to establish a collegial relationship with the nursing staff on a clinical unit.

Finally, novice faculty should receive some form of feedback related to their performance at regular intervals during their first year of teaching. This could be accomplished through the use of peer teaching evaluation in both the classroom and clinical settings. The novice's clinical evaluation of students and exam questions should also be peer reviewed, as these were specific areas identified as deficits by the participants in this study.

Structured orientation sessions can be implemented using a traditional face to face format or in the form of online modules (Peters & Boylston, 2006). While the temptation to place all new faculty orientation modules online may be the most convenient in terms of time and scheduling, a mix of these two approaches might be best. Meeting with other new faculty may help to alleviate some of the social isolation identified by clinical instructors in this study.

#### *Clear Role Expectations*

New nurse educators need to be provided with clear job descriptions in both the classroom and clinical setting in order to reduce role ambiguity (Acorn, 1991; Fain, 1987; Oermann, 1998; Piscopo, 1994). Identifying specific nurse educator competencies may assist schools in developing clear faculty job descriptions and criteria for promotion and tenure. While several researchers have sought to identify essential competencies (Choudry, 1992; Davis, et al., 2005), the NLN's *Core Competencies of Nurse Educators*

(NLN Task Group on Nurse Educator Competencies, 2005) contains task statements which can provide novices with the detailed role expectations that they desire.

#### Future Research

In order to recruit and retain the best and brightest faculty within nursing, future research should focus on evaluating the strategies described here. Additional qualitative research should seek to examine the process of how nurses make the transition from “bedside to classroom” in other settings, such as associate degree programs and small private institutions. Results from these endeavors may provide a framework for designing evidence-based orientation, faculty development, and mentoring programs for new nursing faculty. Longitudinal studies could be designed which track the career progression and persistence of new nurse educators to determine the effectiveness of such orientation programs in decreasing faculty attrition rates. Data from qualitative studies could also be used to develop reliable and valid instruments to measure the role satisfaction of newly-hired nurse educators.

Quantitative research should focus on systematically measuring the outcomes of orientation and mentorship programs. Outcomes evaluation can be measured through the use of written evaluations (Brown, 1999), or instruments such as the Alleman Mentoring Scales Questionnaire (AMSQ) (as cited in Kavooosi, Elman, & Mauch, 1995). Role conflict and role ambiguity should also be monitored in novice educators, as they have been linked to job dissatisfaction (Gormley, 2003). Mobily’s Role Strain Scale (Mobily, 1991) has been used to measure these phenomena in nurse educators, and is an option for evaluating role strain in new faculty. Retention rates for orientation programs should be monitored and reported in the literature as well.

## Conclusion

The findings of this study provide insight into the process that occurs during the transition from nurse to nurse educator. It is my hope that the Nurse Educator Transition Theory (NETT) will assist novice nurse educators who are embarking on their own journey from “bedside to classroom.” The recommendations presented here may also provide guidance for nursing education administrators in planning orientation and mentoring programs for new nursing faculty. These recommendations are not without increased cost and effort on the part of an already strained nursing professoriate; however, if the result is an increase in recruitment and retention, the return on the investment is invaluable.

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APPENDIX A

The Dreyfus Model of Skill Acquisition

(Dreyfus & Dreyfus, 1986)

## Appendix A

### Five Stages of Skill Acquisition (Dreyfus & Dreyfus, 1986)

#### Characteristics of each stage

- 1.) Novice: Relies on “context-free” rules; Bases actions upon concrete facts and features relevant to a skill. No experience on which to base decisions.
- 2.) Advanced Beginner: Has some experience with real situations; Can recognize elements of past situations he or she has experienced before; Uses these along with “context-free” rules to guide behavior.
- 3.) Competent: Plans behavior with a goal in mind; Uses a hierarchical procedure to influence decision-making; Weighs alternatives and problem solves.
- 4.) Proficient: Bases behavior on past memories of situations; Plans actions based on those that have worked in the past; anticipates events based on past experiences; Possesses “intuition” or “know-how” which often cannot be articulated, but still thinks analytically.
- 5.) Expert: Does “what normally works;” Little formal problem solving or decision making; Responds without always reviewing rules in their heads; performance is fluid; Highly intuitive. Difficult to articulate.

Source: Dreyfus, H. & Dreyfus, S. (1986). *Mind Over Machine: The Power of Human Intuition and Expertise in the Era of the Computer*. The Free Press (Macmillan, Inc.): New York.

APPENDIX B  
Conditional Approval to  
Conduct Study

## Appendix B



HUMAN RESEARCH PROTECTIONS  
Institutional Review Board

September 26, 2006

Anne Schoening  
Dr. Marilyn Grady  
Educational Administration  
22676 Beverly Hills Lane  
Council Bluffs, IA 51503

TITLE OF PROJECT: **From Bedside to Classroom: The transition of Novice Nurse Educators**

Dear Anne:

This letter is to officially notify you of the conditional approval of your project by the Institutional Review Board (IRB) for the Protection of Human Subjects. It is the Board's opinion that you have provided adequate safeguards for the rights and welfare of the participants in this study. Your proposal seems to be in compliance with this institution's Federal Wide Assurance 00002258 and the DHHS Regulations for the Protection of Human Subjects (45 CFR 46).

Date of EP Review: **08/04/06.**

1. In order for final approval to be granted, the following condition must be met.

A. Please submit approval letters from the institutions you will be working with. These can be submitted on a site-by-site basis. You will need to submit 1 approval letter in order to be given final approval.

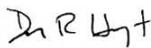
We wish to remind you that the principal investigator is responsible for reporting to this Board any of the following events within 48 hours of the event:

- Any serious event (including on-site and off-site adverse events, injuries, side effects, deaths, or other problems) which in the opinion of the local investigator was unanticipated, involved risk to subjects or others, and was possibly related to the research procedures;
- Any serious accidental or unintentional change to the IRB-approved protocol that involves risk or has the potential to recur;
- Any publication in the literature, safety monitoring report, interim result or other finding that indicates an unexpected change to the risk/benefit ratio of the research;
- Any breach in confidentiality or compromise in data privacy related to the subject or others; or
- Any complaint of a subject that indicates an unanticipated risk or that cannot be resolved by the research staff.

For projects which continue beyond one year from the starting date, the IRB will request continuing review and update of the research project. Your study will be due for continuing review as indicated above. The investigator must also advise the Board when this study is finished or discontinued by completing the enclosed Protocol Final Report form and returning it to the Institutional Review Board.

If you have any questions, please contact Shirley Horstman, IRB Administrator, at 472-9417 or email [shorstman1@unl.edu](mailto:shorstman1@unl.edu).

Sincerely,

  
Dan R. Hoyt, Chair  
for the IRB

  
Shirley Horstman  
IRB Administrator

cc: Faculty Advisor

## APPENDIX C

### IRB Approval

## Appendix C



October 26, 2006

HUMAN RESEARCH PROTECTIONS  
Institutional Review BoardAnne Schoening  
Dr. Marilyn Grady  
22686 Beverly Hills Lane  
Council Bluffs, IA 51503

IRB#2006-08-515 EP

TITLE OF PROJECT: **From Bedside to Classroom: The Transition of Novice Nurse Educators**

Dear Anne:

This letter is to officially notify you of the approval of your project by the Institutional Review Board (IRB) for the Protection of Human Subjects. It is the Board's opinion that you have provided adequate safeguards for the rights and welfare of the participants in this study. Your proposal seems to be in compliance with this institution's Federal Wide Assurance 00002258 and the DHHS Regulations for the Protection of Human Subjects (45 CFR 46).

Date of EP Review: **10/25/06**You are authorized to implement this study as of the Date of Final Approval: **10/25/06**This approval is Valid Until: **09/25/07**

1. Enclosed is the IRB approved Informed Consent form for this project. Please use this form when making copies to distribute to your participants. If it is necessary to create a new informed consent form, please send us your original so that we may approve and stamp it before it is distributed to participants.

We wish to remind you that the principal investigator is responsible for reporting to this Board any of the following events within 48 hours of the event:

- Any serious event (including on-site and off-site adverse events, injuries, side effects, deaths, or other problems) which in the opinion of the local investigator was unanticipated, involved risk to subjects or others, and was possibly related to the research procedures;
- Any serious accidental or unintentional change to the IRB-approved protocol that involves risk or has the potential to recur;
- Any publication in the literature, safety monitoring report, interim result or other finding that indicates an unexpected change to the risk/benefit ratio of the research;
- Any breach in confidentiality or compromise in data privacy related to the subject or others; or
- Any complaint of a subject that indicates an unanticipated risk or that cannot be resolved by the research staff.

For projects which continue beyond one year from the starting date, the IRB will request continuing review and update of the research project. Your study will be due for continuing review as indicated above. The investigator must also advise the Board when this study is finished or discontinued by completing the enclosed Protocol Final Report form and returning it to the Institutional Review Board.

If you have any questions, please contact Shirley Horstman, IRB Administrator, at 472-9417 or email shorstman1@unl.edu.

Sincerely,

Dan R. Hoyt, Chair  
for the IRB

APPENDIX D  
Informed Consent Document

## Appendix D



UNIVERSITY OF  
**Nebraska**  
Lincoln

COLLEGE OF EDUCATION AND HUMAN SCIENCES  
Department of Educational Administration

INFORMED CONSENT FORM  
Page 1 of 2 Pages

**Identification of Project:**

From Bedside to Classroom: The Transition of Novice Nurse Educators

**Purpose of the Research:**

This research project will examine how nurses make the transition to the role of nurse educator. You must be 19 years of age or older to participate. You are invited to participate in this study because you are currently employed as a nurse educator.

**Procedures:**

Participation in this study will require approximately two hours of your time. You will participate in a 60-90 minute interview with the principal researcher regarding your career as a nurse educator. The interview will be audio taped with your permission, and conducted at a mutually agreed upon site. The researcher will contact you at a later date for a follow-up interview to verify the data after analysis.

**Risks and/or Discomforts:**

You will be asked questions regarding your career and difficulties you may have experienced in the past. This may trigger the memory of unpleasant events; however, the risk for participating in this study is not beyond the normal activities of everyday life.

**Benefits:**

There are no direct benefits to you for participating. This study may help identify how nurses successfully make the transition to educators. Understanding this process may lead to the development of better orientation programs in the future, thus enhancing recruitment and retention of qualified nursing faculty.

**Confidentiality:**

Any information obtained during this study which could identify you will be kept strictly confidential. The data will be stored in a locked cabinet in the investigator's office and will only be seen by the investigator during the study and for three years after the study is complete. The interview will be transcribed by a professional transcriptionist. Your name will not be used on the tape. During transcription and data analysis, you will be assigned a pseudonym. The information obtained in this study may be published in scientific journals or presented at scientific meetings, but the data will be reported in anonymous form. The audiotapes will be erased after review by an external auditor.

**Compensation:**

There will be no compensation for participating in this research.



UNIVERSITY OF  
**Nebraska**  
Lincoln

COLLEGE OF EDUCATION AND HUMAN SCIENCES  
Department of Educational Administration

Page 2 of 2 Pages

***Opportunity to Ask Questions:***

You may ask any questions concerning this research and have those questions answered before agreeing to participate in or during the study. You may call the investigator at any time: office phone, (402) 280-4777, or after hours (402) 660-3331. If you have questions concerning your rights as a research subject that have not been answered by the investigator or to report any concerns about the study, you may contact the University of Nebraska-Lincoln Institutional Review Board, telephone (402) 472-6965.

***Freedom to Withdraw:***

You are free to decide not to participate in this study or to withdraw at any time without adversely affecting your relationship with the investigator, the University of Nebraska, or your employer. Your decision will not result in any loss or benefits to which you are otherwise entitled.

***Consent, Right to Receive a Copy:***

You are voluntarily making a decision whether or not to participate in this research study. Your signature certifies that you have decided to participate having read and understood the information presented. You will be given a copy of this consent form to keep.

\_\_\_\_\_ Initial if you agree to be audio taped during the interview.

***Signature of Participant:***

\_\_\_\_\_  
*Signature of Research Participant*

\_\_\_\_\_  
*Date*

***Name and Phone number of investigator(s)***

Principal Investigator:  
Anne M. Schoening, MSN, RN  
(W) (402) 280-4777  
Cell (402) 660-3331

Secondary Investigator:  
Marilyn L. Grady, PhD  
(W) (402) 472-0974

APPENDIX E  
IRB Protocol Change

## Appendix E



HUMAN RESEARCH PROTECTIONS  
Institutional Review Board

March 7, 2008

Anne Schoening  
Dr. Marily Grady  
22676 Beverly Hills Ln  
Council Bluffs, IA 51503

IRB# 2006-08-515 EP

TITLE OF PROJECT: **From Bedside to Classroom: The Transition of Novice Nurse Educators**

Dear Anne:

The Institutional Review Board for the Protection of Human Subjects has completed its review of the Request for Change in Protocol submitted to the IRB.

1. Uploaded on NUgrant is the IRB approved Informed Consent form for this project. Please use this form when making copies to distribute to your participants. If it is necessary to create a new informed consent form, please send us your original so that we may approve and stamp it before it is distributed to participants.
2. It has been approved to remove the word "beside" from all recruitment documents and the informed consent form.
3. It has been approved to include all faculty; tenured track and non-tenured track.

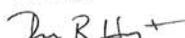
We wish to remind you that the principal investigator is responsible for reporting to this Board any of the following events within 48 hours of the event:

- Any serious event (including on-site and off-site adverse events, injuries, side effects, deaths, or other problems) which in the opinion of the local investigator was unanticipated, involved risk to subjects or others, and was possibly related to the research procedures;
- Any serious accidental or unintentional change to the IRB-approved protocol that involves risk or has the potential to recur;
- Any publication in the literature, safety monitoring report, interim result or other finding that indicates an unexpected change to the risk/benefit ratio of the research;
- Any breach in confidentiality or compromise in data privacy related to the subject or others; or
- Any complaint of a subject that indicates an unanticipated risk or that cannot be resolved by the research staff.

This letter constitutes official notification of the approval of the protocol change. You are therefore authorized to implement this change accordingly.

If you have any questions, please contact Shirley Horstman, IRB Administrator, at 472-9417 or email [shorstman1@unl.edu](mailto:shorstman1@unl.edu).

Sincerely,

  
Dan R. Hoyt, Chair  
for the IRB

APPENDIX F

Recruitment Email to Deans

## Appendix F

## Email to Dean to Identify Participants

(Salutation personalized with Dean's name here)

I am a doctoral student at the University of Nebraska-Lincoln pursuing a Ph.D. in Educational Studies. I am also a nurse educator at a private university in Omaha, Nebraska. The purpose of my dissertation research is to examine how nurses make the transition to the role of nurse educator. I believe that understanding this process may lead to the development of better orientation programs in the future, thus enhancing recruitment and retention of qualified nursing faculty.

This study is a qualitative grounded theory study. I wish to interview faculty who are currently teaching in baccalaureate nursing programs. Your school has been identified as a potential research site, and I have already obtained permission to interview nursing faculty at your school from the Institutional Review Board (IRB) or Dean of your university. I have attached a copy of this letter for your review.

I am asking for your help in identifying faculty that might be willing to participate. Assistance with this study is completely voluntary, and refusal to participate will not adversely affect the participants' relationship with the investigator, the University of Nebraska, or their employer. The interview will take approximately 60-90 minutes of their time, and will take place in a location of their choosing. After the interview, participants will receive a flyer that they can distribute to other colleagues inviting them to participate if they wish.

If you are able to assist with this research, please forward this message to your faculty and invite them to contact me either by email or phone. My contact information is listed below. If you wish to discuss the research or if you have any further questions, please feel free to call or email me. If I have not heard from you within two weeks of sending this letter, I may contact you by phone.

Thank you for your time and consideration.

Sincerely,

Anne M. Schoening, RN, MSN  
Primary Investigator  
(w) 402-280-4777  
(h) 712-366-5774  
[aschoening@creighton.edu](mailto:aschoening@creighton.edu)

APPENDIX G

Participant Recruitment Letter

## Appendix G



COLLEGE OF EDUCATION AND HUMAN SCIENCES  
Department of Educational Administration

Dear colleague:

I am a doctoral student at the University of Nebraska-Lincoln pursuing a Ph.D. in Educational Studies. I am also a nurse educator at a private university in Omaha Nebraska. The purpose of my dissertation research is to examine how nurses make the transition to the role of nurse educator. I believe that understanding this process may lead to the development of better orientation programs in the future, thus enhancing recruitment and retention of qualified nursing faculty.

This study is a qualitative grounded theory study. I wish to interview faculty who are currently teaching in baccalaureate nursing programs. You have been identified as a faculty member who meets the criteria for this study. If you are willing to participate, I would like schedule an interview with you. This process should take about 60-90 minutes of your time at a location of your choosing. An informed consent document will be provided to you, and your identity will be kept confidential.

Participation is completely voluntary. However, if you are willing to assist with this study, please email me at the address below or feel free to contact me by phone. If you wish to discuss the research or if you have any further questions, please feel free to contact me. If I have not heard from you within two weeks of sending this letter, I may contact you by phone in order to learn of your willingness to participate.

Thank you for your time and consideration.

Sincerely,

A handwritten signature in cursive script that reads "Anne M. Schoening".

Anne M. Schoening, RN, MSN  
Primary Investigator  
(w) 402-280-4777  
(h) 712-366-5774  
[aschoening@creighton.edu](mailto:aschoening@creighton.edu)

Marilyn Grady, Ph.D.  
Secondary Investigator  
(w) 402-472-0974

## APPENDIX H

### Invitation to Additional Participants

## Appendix H



COLLEGE OF EDUCATION AND HUMAN SCIENCES  
Department of Educational Administration

Dear colleague:

I am a doctoral student at the University of Nebraska-Lincoln pursuing a Ph.D. in Educational Studies. I am also a nurse educator at a private university in Omaha Nebraska. The purpose of my dissertation research is to examine how nurses make the transition to the role of nurse educator. I believe that understanding this process may lead to the development of better orientation programs in the future, thus enhancing recruitment and retention of qualified nursing faculty.

This study is a qualitative grounded theory study. I wish to interview faculty who are currently teaching in baccalaureate nursing programs. You have been identified as a faculty member who meets the criteria for this study. If you are willing to participate, I would like to schedule an interview with you. This process should take about 60-90 minutes of your time at a location of your choosing. An informed consent document will be provided to you, and your identity will be kept confidential.

Participation is completely voluntary. However, if you are willing to assist with this study, please email me at the address below or feel free to contact me by phone. If you wish to discuss the research or if you have any further questions, please feel free to contact me.

Thank you for your time and consideration.

Sincerely,

A handwritten signature in cursive script that reads "Anne M. Schoening".

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APPENDIX I  
Interview Guide

## Appendix I

### Interview Guide

#### From Bedside to Classroom: The Transition of Novice Nurse Educators

Date of Interview:

Time:

Introduction:

I'd like to thank you for agreeing to meet with me today. As we have discussed, I will be recording and transcribing our conversation today so that I can make sure that I have an accurate account of what we will be discussing. I will be asking you to review the transcriptions at a later date so that I can make sure that I have accurately captured your thoughts in regards to the topics we will be discussing today.

As you know, I am interested in examining how bedside nurses make the transition to the role of nurse educator. I would like to know what is helpful, and what is not. I am also interested in possibly identifying the stages that are essential for a successful transition. I am very interested in your experience and I encourage you to freely share with me anything that you feel will be important in helping me to understand this topic. I may ask some additional questions as we proceed in order to clarify information.

Do you have any questions before we begin?

Questions:

- 1.) Tell me a little bit about your present position as a nurse educator.

Probes: What is your current rank?

How many years have you been teaching?

Describe your current teaching responsibilities. Do you teach in the clinical setting, classroom or both?

Tell me about the courses you teach.

2.) Tell me about your nursing career prior to becoming a nurse educator.

Probes: Did you work primarily in the hospital or in a community or clinic setting?  
Tell me about your clinical expertise. Did you have a clinical specialty? If so, please tell me about that.  
Did you always work at the bedside? Did you ever serve as an administrator or manager? If so, please tell me about that experience.

3.) How did you get started in nursing education?

Probes:  
What appealed to you?

4.) Tell me about your orientation to the role of nurse educator.

Probes: Did your employer offer a formal orientation program? If so, please describe that. How did that prepare you for your current role as a faculty member?  
Did you have any formal preparation in your Master's program for your role as a nurse educator? Please describe.

5.) Tell me about your first year as an educator.

Probes:  
Was it what you expected?  
What went well?  
What did not?  
Looking back, what might have helped you?

6.) How is your practice now different than that first year?

Probe:

What lessons have you learned?

How is your teaching different now?

How are your interactions with students different?

7.) Think back to when you began to feel “comfortable” with your teaching ability.  
Tell me about that.

Probes: How many years do you think it took to feel “comfortable” in your role as nurse educator?

Was there a sort of “turning point” for you? Tell me about that.

8.) What has been the most difficult thing about making the transition from bedside nursing to the role of nurse educator?

9.) Tell about the pressure that you face in your daily work.

Probes:

Tell me about the tenure requirements that you face (or faced if tenured.)

How do feel these requirements have affected your transition into the world of academia?

Have they added stress? Have they helped you better understand your role?

Have you experienced any specific pressures regarding students? Tell me more.

Have you experienced pressures involving your clinical practice?

APPENDIX J  
Confidentiality Agreement

## Appendix J



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COLLEGE OF EDUCATION AND HUMAN SCIENCES  
Department of Educational Administration

**IRB  
Confidentiality Agreement**

**Transcriptionist or Auditor**

I, the undersigned, hereby acknowledge that I will in no way disclose the identities of subjects or convey known data from this \_\_\_\_\_ study. I will maintain participant confidentiality in all matters to which I have been given access relative to this study.

**Signed:**

**Date:**

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APPENDIX K  
Open Coding Matrix

Appendix K  
Open Coding Matrix

| Open Coding Category         | Properties/Dimensions   |
|------------------------------|---|
| Wanting to make a difference | Developing others <ul style="list-style-type: none"> <li>• Desire to teach in a new way</li> <li>• Influence the future of the profession</li> <li>• Non-regimented compassionate teaching</li> </ul> Positive first teaching experiences <ul style="list-style-type: none"> <li>• Positive feedback from students</li> <li>• Encouraged by colleagues</li> </ul> Dissatisfaction with the hospital routine <ul style="list-style-type: none"> <li>• Inability to make a difference in clinical position</li> </ul> |
| Lifestyle                    | Predictable schedule <ul style="list-style-type: none"> <li>• Time with family</li> </ul> Flexible schedule <ul style="list-style-type: none"> <li>• Autonomy</li> </ul> Lifelong learner <ul style="list-style-type: none"> <li>• Personal development</li> <li>• Academic environment</li> <li>• Research and scholarly interests</li> </ul>  |
| The thing to do at the time  | Natural career progression <ul style="list-style-type: none"> <li>• Limited opportunities with advanced degree</li> <li>• Not wanting to stay in one place</li> </ul> Plan B <ul style="list-style-type: none"> <li>• Something to fall back on</li> <li>• Career stability</li> </ul>  |
| Stranger in a strange land   | Uncharted territory <ul style="list-style-type: none"> <li>• Ambiguous job description</li> <li>• Lack of clear expectations</li> <li>• Unfamiliarity with the clinical setting</li> </ul> Expert to Novice <ul style="list-style-type: none"> <li>• Starting over</li> <li>• Becoming aware of deficits</li> </ul>   |
| No roadmap                   | Sink or swim <ul style="list-style-type: none"> <li>• Lack of structured orientation</li> <li>• Being “thrown in”</li> <li>• No clear direction</li> </ul> Lack of information/communication <ul style="list-style-type: none"> <li>• Need for “nuts and bolts” (basic information)</li> <li>• Curriculum</li> </ul>  |

|                           |  |
|---------------------------|--|
|                           | <ul style="list-style-type: none"> <li>• Student learning objectives</li> <li>• Student evaluation</li> </ul> <p>Unprepared</p> <ul style="list-style-type: none"> <li>• Lack of formal training</li> <li>• Lack of pedagogical knowledge</li> <li>• Inadequate preparation in graduate school</li> </ul>  |
| No guide                  | <p>No mentor</p> <ul style="list-style-type: none"> <li>• Isolation</li> <li>• Lack of collegiality</li> <li>• Lack of emotional support</li> </ul> <p>Ambiguous organizational structure</p> <ul style="list-style-type: none"> <li>• Uncertain chain of command</li> </ul>   |
| Student Issues            | <p>Student/teacher vs. nurse/patient relationship</p> <ul style="list-style-type: none"> <li>• Consequences for negative behavior</li> <li>• Not always friendly</li> </ul> <p>Negative student behaviors</p> <ul style="list-style-type: none"> <li>• Lack of respect from students</li> <li>• Student “entitlement”</li> <li>• Generational differences</li> <li>• Negative student evaluations</li> </ul> |
| Time constraints          | <p>Too many balls in the air</p> <ul style="list-style-type: none"> <li>• Trying to keep current clinically</li> <li>• Scholarship and service demands</li> </ul> <p>Work world without boundaries</p> <ul style="list-style-type: none"> <li>• Remaining accessible to students</li> <li>• Increased access in electronic age</li> <li>• Work never stops</li> </ul>  |
| Tenure pressures          | <p>A new reward system</p> <ul style="list-style-type: none"> <li>• Research valued over clinical expertise</li> <li>• Research valued over teaching expertise</li> </ul> <p>PhD pressures</p> <ul style="list-style-type: none"> <li>• Tenure</li> <li>• Need for “even playing field”</li> <li>• Need for career advancement</li> </ul>  |
| Identity issues           | <p>Nurse vs. Teacher</p> <ul style="list-style-type: none"> <li>• Mourning the loss of clinical identity</li> <li>• Holding on to being a nurse</li> </ul>   |
| Fear of failure           | <p>“Looking like a fool”</p> <ul style="list-style-type: none"> <li>• Fear of not having all the answers</li> <li>• Teaching outside of comfort zone</li> </ul> <p>Self doubt</p> <ul style="list-style-type: none"> <li>• Doubting one’s ability to teach</li> <li>• Fear of harming students/patients</li> </ul>   |
| Self-directed orientation | Seeking teaching knowledge   |

|                                      |  |
|--------------------------------------|--|
|                                      | <ul style="list-style-type: none"> <li>• Digging for facts</li> <li>• Pursuing formal training</li> <li>• Faculty development</li> </ul> <p>Over-preparing</p> <ul style="list-style-type: none"> <li>• Reviewing and re-reviewing basic content</li> </ul> <p>Applying nursing knowledge to teaching</p> <ul style="list-style-type: none"> <li>• Past experiences with patients and colleagues</li> <li>• Organizational skills</li> </ul> |
| Peer mentoring                       | <p>“Go to” person</p> <ul style="list-style-type: none"> <li>• Informal mentor</li> <li>• Emotional support</li> <li>• Knowledgeable and approachable</li> </ul>   |
| Establishing boundaries              | <p>Balancing “nurse” and “teacher” identities</p> <ul style="list-style-type: none"> <li>• Drawing the line with students</li> <li>• Setting limits with students</li> <li>• Establishing high standards</li> <li>• Not fearing negative student feedback</li> </ul>   |
| Keeping a foot in the door           | <p>Keeping current clinically</p> <ul style="list-style-type: none"> <li>• Keeping up with changes</li> <li>• Keeping skills sharp</li> <li>• Establishing credibility with students and colleagues</li> </ul>   |
| Gradual acceptance of responsibility | <p>Reduced responsibilities for the novice</p> <ul style="list-style-type: none"> <li>• Focus on teaching</li> <li>• Learning the role in stages</li> </ul>  |
| Making it your own                   | <p>Taking ownership of the role</p> <ul style="list-style-type: none"> <li>• Finding personal teaching style and philosophy</li> <li>• Getting “in the flow”</li> <li>• Being yourself</li> </ul> <p>Getting through it</p> <ul style="list-style-type: none"> <li>• “Working the bugs out”</li> <li>• Always trying to improve</li> </ul>   |
| Feeling like a teacher               | <p>Embracing the identity</p> <ul style="list-style-type: none"> <li>• Nurse educator identity vs. nurse identity</li> <li>• Understanding the role and responsibilities</li> </ul>  |
| Thinking like a teacher              | <p>Process vs. product</p> <ul style="list-style-type: none"> <li>• Not having to have all the answers</li> <li>• Teaching students to think</li> <li>• Learner-centered instruction</li> <li>• Focus on process improvement</li> </ul> <p>Hands on vs. hands off</p> <ul style="list-style-type: none"> <li>• Holding back</li> <li>• Facilitating learning</li> </ul>  |

