ARTICLE

Do it MY Way! Midwifery Students' Perceptions of Negative Clinical Experiences and Negative Characteristics and Practices of Clinical Preceptors

Fais ce que JE te dis! Perceptions des étudiants en sage-femmerie au sujet d'expériences cliniques négatives et de caractéristiques et pratiques négatives des précepteurs cliniques

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ABSTRACT
The purpose of this paper was to describe the perceptions of midwifery students' concerning negative clinical experiences and ineffective role modeling received from clinical preceptors. Students (N=145) from accredited midwifery schools in the United States and Puerto Rico voluntarily completed a qualitative descriptive survey from a URL website. Descriptive statistics identified demographics and clinical setting characteristics. Open-ended questions gathered qualitative data about preceptor behaviours that were detrimental to student learning in the clinical setting. Content analysis of the narrative responses provided major themes that identified negative clinical preceptor characteristics and behaviours and negative clinical experiences from the student perspective.

Six areas contributed to negative experiences with preceptors from the students' perspective. These included the number of assigned preceptors; the teaching style of the preceptor; the life stress of the preceptor; lack of

preceptor knowledge; and a harsh clinical environment. The most difficult aspect of negative preceptors was the insistence for the students to "do it MY way".

Without effective preceptors much of midwifery's accumulated knowledge will be lost. By identifying negative clinical preceptor practices, improvements can be made to assist the preceptor and student in the process of learning. The negative practices represent areas where more research and interventions are needed.

KEY WORDS
clinical preceptor, midwifery students, negative characteristics, horizontal violence, bullying, education

This article has been peer-reviewed.

RÉSUMÉ

Cet article a pour but de décrire les perceptions des étudiants en sage-femmerie au sujet d'expériences cliniques négatives et de modelages de rôles inefficaces de la part des précepteurs cliniques. Des étudiants (Nbre =145) d'écoles d'obstétriques accréditées des États-Unis et de Puerto Rico ont accepté de participer à une étude descriptive qualitative à partir d'une adresse URL. Les données démographiques et caractéristiques du milieu clinique ont été établies sous forme de statistique descriptive. Les données qualitatives obtenues grâce aux questions ouvertes ont permis de cerner les comportements des précepteurs qui pouvaient être préjudiciables à l'apprentissage de l'étudiant en milieu clinique. L'analyse du contenu des réponses narratives a fourni les principaux thèmes identifiant les caractéristiques et comportements cliniques négatifs des précepteurs et les expériences cliniques négatives du point de vue de l'étudiant.

Six domaines ont contribué à l'expérience négative des étudiants avec les précepteurs. Ceux-ci sont : le nombre de précepteurs affectés; le style d'enseignement du précepteur; le stress quotidien du précepteur; le manque de connaissances du précepteur; et l'environnement clinique difficile. L'aspect le plus négatif exprimé par les étudiants était l'insistance du précepteur : « fais ce que JE te dis ».

La contribution efficace des précepteurs permet de transférer le bagage de connaissances des sages-femmes serait perdu à jamais. L'identification des pratiques négatives des précepteurs permet d'apporter des améliorations afin d'aider le précepteur et l'étudiant dans le processus d'acquisition. Les pratiques négatives permettent de signaler les domaines où plus de recherche et d'interventions sont nécessaires.

MOTS CLÉS :
Précepteur clinique, étudiants en sage-femmerie, caractéristiques négatives, violence horizontale, intimidation, éducation

Cet article fut révisé par ses pairs.

Editor's Note: This article may be perceived by some as strongly focused on the negative aspects of clinical preceptorship. Publication of the article was felt to be important in light of achieving balance with other previously-published articles which have focused on positive feedback.

Introduction

Clinical excellence is a hallmark of midwifery. The role of the clinical preceptor is critical for students' acquisition of clinical skills. At the American College of Nurse-Midwives (ACNM) Annual Student Meeting in 2003, concerns about the quality and behaviour of clinical preceptors were discussed. The discussion included the topic of "hazing" by clinical preceptors and negative behaviours that undermined student learning and self-esteem.[1] The Directors of Nurse-Midwifery Education (DOME) initiated a survey to seek more information about the student's concerns. This paper constitutes the first report from a larger study that examined both positive and

negative student perceptions of clinical midwifery preceptors' characteristics and students' reported experiences. This paper describes only the findings from the negatively worded responses to questions that asked students to describe negative clinical experiences and negative clinical preceptor behaviours and characteristics.

Review of the Literature

Precepting was initially implemented for nurse-midwifery education in the United States by the first midwifery education program in 1929.[2] The importance of being an effective clinical preceptor has been emphasized by the American College of Nurse-Midwives (ACNM)[3] Division of Accreditation (DOA). Evidence of formal preceptor training has been required since 1998. This has resulted in several recent publications concerning effective clinical precepting in midwifery education.[1,4-6]

Research examining effective clinical preceptor characteristics, preceptor assessment tools and preceptor training are found in nursing, medical, and midwifery literature. One hundred and fourteen articles were discovered through a Pub Med/CINAHL search for the years of 2004 and 2005 using the keywords: preceptor, precepting, characteristics, programs and research. The same search, without a date restriction, but with the inclusion of the words midwifery and nurse-midwifery, produced only thirty-five non research-based citations. Only four articles from all searches concentrated on identification or examination of negative preceptor behaviours and characteristics, negative student experiences, or negative settings.[7-10]

Mazor, Stone, Carlin, & Alper[10] examined relative strengths and weaknesses of preceptors using clinical teaching skill items rated by 263 internal medicine medical students over three years of preceptorship. A skill item was ranked as a weakness if it was consistently ranked among the three lowest choices. Four main weaknesses of preceptors were identified. Preceptors did not help students to improve physical examination skills, or learn interviewing skills. Preceptors did not provide constructive feedback and were deficient in addressing the specific learning needs of students. The investigators reported that preceptors in outpatient settings had fewer weaknesses than those in inpatient settings.

Manyon et al.[9] interviewed a sample of medical student preceptors in ambulatory care settings to distinguish differences in instructional approaches between preceptors that received high ratings and those who received low ratings from their students. Students reported that lower scoring preceptors demanded more student observation and allowed less early, active participation. Preceptors questioned students rather than listening to them and believed that the burden of learning belonged to the student. Low scoring preceptors did not see learning as a complex social process but utilized an autocratic apprenticeship model and Socratic questioning.

Pierce[8] explored student nurses' perceptions of preceptors and clinical experiences using a qualitative design. Content analysis was conducted on responses to open-ended questions given to 44 first and second year students. Questions focusing on negativity were: "What made a bad clinical day?", "What was detrimental to your learning?", and "What did you least like about your preceptorship program?". The students reported a bad clinical day if they were only allowed to watch, were unable to perform the skills they had achieved, or felt a lack of structure or a lack of direction to the experience. They preferred preceptor interaction and reported a "bad day" if they perceived that the preceptor seemed unsure of the role or did not provide adequate feedback. Detrimental learning was perceived when the preceptor was not available to spend time with the student, appeared inattentive or aloof, or made the student feel alone and unimportant.

Craig's[7] descriptive study utilized a survey and open-ended questions to interview students. Students were asked to identify common positive and negative interpersonal characteristics of clinical instructors on a 23-item survey. One hundred and seventy-nine junior and senior nursing students from three schools participated. Thirteen follow-up interviews were conducted for clarification and verification of the initial analysis. The most negative clinical instructor characteristics were: exhibiting behaviour that increased student anxiety, avoiding admission of one's own

limitations and mistakes, and student intimidation. The midwifery literature review revealed a lack of research concerning clinical preceptors, despite the fact that clinical preceptors are the foundation of midwifery education. The lack of pertinent literature supported the need for this study, which was an important initial step in midwifery research designed to learn more about clinical preceptor characteristics.

Methods

This research was conducted using a qualitative descriptive design and content analysis of open-ended questions. Institutional review board approval was obtained from two universities. The design was chosen so that an emic perspective "an insiders view"[11] could be obtained from students concerning thoughts and perceptions about clinical preceptors and their experiences with clinical preceptors. Retrospective self-report data collection via open-ended questions complemented the emic view and was considered an excellent way to capture information about "feelings, values, opinions and psychological characteristics".[11] Open-ended questions were used so that the "richness, depth, and complexity of the respondent's" own words about their experiences written in a narrative fashion could be obtained.[11] The use of the Internet for data collection was economical and provided easier access to the geographically dispersed sample. Content analysis was the method of choice for the study design and for grouping of narrative data into themes.

Five recent midwifery graduates and three nurse-midwifery faculty members from two different education programs volunteered as content experts. They reviewed the survey questions developed by two midwifery program directors. The same volunteers pre-tested the web site survey to verify ease of access and use. A professional consultant was used to ensure that the instrument was physically attractive and professionally formatted.

The purpose of the study was defined in the introduction and anonymity was guaranteed for respondents. Informed consent was obtained from all subjects. Each applicant was screened for eligibility according to inclusion criteria, defined as at least one clinical experience rotation and current enrollment in a DOA accredited program. Before continuing with the survey, demographic and descriptive data was collected. The original survey included 12 open-ended questions providing an opportunity for respondents to give both positive and negative responses. This paper presents only the findings from the five negatively worded questions and one "catch all" question that generated negative responses about clinical preceptor behaviours or traits, negative student experiences, and negative clinical settings (see Table 1).

Table 1 - Study Questions for Analysis

1. If you had more than one clinical preceptor, do you feel this was a *disadvantage* or an advantage? Explain.
2. What characteristics in your clinical preceptors hindered your learning?
3. What do you feel is the most negative characteristic in a clinical preceptor?
4. What was your most traumatic and/or humiliating experience with a clinical preceptor? Was your clinical preceptor supportive or condemning?
5. In what practice setting have you found the worst clinical preceptor? Why do you think this was true?
6. Comments (Discuss any experiences that you have had that added to your learning that were not addressed in the survey.)

Content analysis was conducted to derive groupings and themes from the responses to the open-ended questions. Frequency counts of common phrases or themes were determined. The

themes were established by relating the grouped data to one another. "Quasi-statistics"[11] were generated to tabulate themes and insights from the data.

Space triangulation, defined as collecting data from multiple sites, clinical settings, and institutions, and person triangulation, defined as collecting data from different levels and types of students helped to establish credibility and validate the data from multiple perspectives. Investigator triangulation, defined as a minimum of two researchers for analysis decreased interpretation bias and brought divergent perspectives to the analysis. [11] Once the initial themes emerged from the data, "peer debriefing"[11] was conducted by two of the researchers in order to evaluate the themes for possible errors in interpretation, portrayal adequacy, and parsimony. An audit trail was kept for confirmability.

Results

The purposive convenience sample consisted of all male and female English-speaking students currently enrolled in an ACNM DOA accredited midwifery program. A query of the program directors established that there were 390 potential student participants that met the inclusion criteria. During a six month period program directors were prompted three times by group email to distribute the website access information (the URL) for the survey to their eligible students. Confidentiality was maintained because the program directors had no way of knowing whether any student either accessed the web-link or completed the survey.

Only 145 (76 %) of the 190 students who initially completed all or part of the web survey met or correctly filled out the inclusion criteria. The 145 eligible respondent answers were analyzed. Ninety-one percent of the respondents had begun their education within the last two years and 68% had completed three to six semesters/quarters of education with a range of one-16 semesters/quarters. The mean age of respondents was 33.46 years (SD=10.43). Table 2 summarizes the sample demographics and presents the varied clinical experiences of the respondents.

Table 2 - Sample Characteristics

Demographic Characteristics	N (%)
Female	144 (99.3)
Male	1 (0.7)
Type of Education Program	
Full time program	127 (87.6)
Part time program	18 (12.4)
Traditional masters	87 (60)
Post masters	3 (2.1)
Distance learning	19 (13.1)
Masters entry	28 (19.3)
Post baccalaureate	3 (2.1)
CM	1 (0.7)
Clinical Rotation Experiences at Time of Survey	
Family Planning	125 (86.2)
Gynecology	131 (90.3)
Postpartun	117 (80.7)
Intrapartum	110 (75.9)
Newborn	90 (62.1)
Prenatal	135 (93.1)
Primary Care	95 (65.5)
Year Student Started in Midwifery Program	
1999	1(.7)
2000	1 (.7)
2001	11 (7.6)
2002	34(23.4)
2003	75 (51.7)
2004	23 (15.9

Multiple Preceptor Assignments

The number of preceptors per student ranged from one (8%) to sixteen (1%). The most frequent numbers of preceptors were two (21%) and six (18%). When respondents were asked if multiple preceptors were an advantage or disadvantage, 69% of the respondents felt that the practice of multiple preceptors was an advantage, "up to a point", offering exposure to a variety of clinical management approaches. There was consensus that a lower ratio of preceptors to students was more conducive to learning. Students with indicated that this factor multiple preceptors negatively affected continuity in evaluations and documentation of progress. Multiple preceptors were perceived to result in inconsistencies in management and practice approaches. Seven respondents answered that exposure to multiple preceptors was a disadvantage and cited lack of continuity and clinical preceptor rigidity in behaviour as problematic.

The Worst Settings for Students

One question asked, "In what practice setting have you found the worst clinical preceptor?" Students identified tertiary, inner city hospital-based services, solo practices with time constraints for productivity, and those with very little communication as the most negative work environments. The most common phrase used by the students in their narrative responses was a setting that was "too busy to learn". They also described environments that restricted the autonomy of the midwife and lacked the support and respect of the physicians and staff as negative.

Students reported a decrease in the quality of teaching and level of support as the stress level of the preceptor increased. The most stressful place to learn was reported to be in Labour and Birthing Suites where actions and decisions were immediate and affected outcomes. There the midwife was seen as more scrutinized and closely supervised by the physicians. Birth was considered a stressful event that required rapid critical thinking by students and the hardest area for the midwife to "give up" control to the student. One student wrote, "It is an important moment and they don't want a student screwing up."

Thematic Analysis

Three questions specifically sought information on negative preceptor characteristics, behaviours that hindered learning, and perceived humiliating/traumatic experiences. A fourth question asked students to identify the practice settings (sites) in which where they encountered the worst preceptors. Comments about negative preceptors appeared

Table 3 - Negative Clinical Preceptor Themes

Theme 1: Negative Teaching Styles and Behaviours

"condescending"
"being walked away from"
"condemning"
"eating their young"
"traumatic"
"pay your dues"
"embarrassing"
"non-supportive preceptor"
"belittling"
"yelled at"
"harsh"
"demeaned me in front of a patient"
"intimidating"
"hip-bumped out of the way"
"undermining"
"made me feel dumb in public"
"humiliating"
"put on the spot"
"drilled with questions"

Theme 2: The Preceptor's Personal Issues

"talking about [me] behind [my] back
"Gossiping"
"Talking about the student to other employees"
"rolling [her] eyes, and acting negative when the student arrives"
"thinking they are more superior to you"
"the difference between crying yourself to sleep and wanting to give up"
"A CNM should NEVER have a student if she did not willingly choose to be involved in teaching"
"moodiness"
"apathy"
"meanness"
"prejudice"
"cynicism"
"sarcasm"
"bitterness"
"rudeness"
"tactlessness"
"emotional lability"
"chips on their shoulder"
"an abrupt manner"
"forced to teach"
"really unwanted"

Theme 3: Lack of Clinical Preceptor Skills or Evidence-based Practice

"out of touch with hospital care as it is now"
"someone that is not experienced, and not knowledgeable"
"been there forever"
"poor communication techniques"
"being unaware of different learning styles"
"being an inexperienced teacher"
"insecurity"
"unsure of her own skills and knowledge base"
"poor or inappropriate feedback"

Theme 4: Negative Practice Environments

"dissatisfaction/burnout"
"use of the medical model
"preceptors with heavy workloads"
"preceptor fatigue"
"apathy"
"complaining about too many students"
"not having enough time to teach"
"get their [preceptor's] work done"
"She didn't really have time to teach me much"
"I felt I was a burden"
"Unsupportive"
"M.D.'s and staff do not respect midwives"
"allowed unnecessary intervention by the physician"
"The worst ones are doctor wanna-bees."
"being left alone"
"preceptor unavailable"

Theme 5: The "Do it MY Way Syndrome"

"territorial, rigid, inflexible, critical"
"made it very clear she was worried I would harm her patient"
"jumping in and taking over from the student"
"rigid about student charting"
"impossible to please"
"let the student go"

in 50 % or more of all responses to the fourth question. Negative responses from this question and negative responses from another question that asked for further comments were also included in the thematic analysis. Supportive data from the five common themes that were generated are presented in Table 3.

Negative Teaching Styles and Behaviours

The first major theme identified was that of negative teaching styles and behaviours. This was defined as behaviour that included negative descriptors such as "condescending", "condemning", "traumatic", "embarrassing", "belittling", "harsh", "intimidating", "undermining", and "humiliating. Students described instances of "being put on the spot", "drilled with questions" and "being walked away from". Descriptive responses regarding negative teaching styles and behaviours included "eating their young", and "a person [the preceptor] that wants you to pay your dues", in reference to preceptors.

Sixty-seven percent of students described at least one "non-supported experience with a preceptor" while 41.5% stated they had a "non-supportive preceptor". Three students described non-supportive preceptors that "left them alone" in the hospital while the preceptor stayed at home. The two most common descriptors of non-supportive experiences were "humiliation" and a "condemning" or "condescending" attitude.

Negative verbal feedback in the presence of other people was perceived as the most undesirable preceptor behaviour. Examples included "being yelled at", "demeaned me in front of a patient", "hip-bumped me out of the way", and "comments that made me feel dumb in public". Students indicated that these responses were at times the result of personal preceptor issues.

The Preceptor's Personal Issues

A personal preceptor issue was the second most prevalent theme and was directly correlated with a negative teaching style. Personal preceptor issues were defined as personality traits, attitudes, and personal preceptor problems that fostered negativity toward the student or had a negative impact on the learning environment. Students often described both a perceived negative teaching style and personal issues in the same preceptor. One student stated the preceptor was "talking about the student [me] behind her [my] back to the nurses [which] set up a really negative atmosphere." This same preceptor also "told me I was her best student and that she planned to hire me". Gossiping about students' behaviour or about subjects unrelated to midwifery was detrimental to student learning. "Talking about the student to other employees" was a common descriptor.

The personality of the preceptor affected the student. Students stated that depressing and egotistical personalities of the preceptor caused negative learning. One student described the preceptor "rolling [her] eyes, and acting negative when the student arrives". One clinical preceptor's personality was described as "a bad attitude, thinking they are more superior to you in a rude way". The preceptor's style contributed to the student's negative perception of her/his progress, knowledge and growth. Another student stated that having a preceptor with personality issues was "the difference between crying yourself to sleep and wanting to give up…" and "knowing that only time and attention to improvement will make you the midwife you want to be". Negative preceptor attributes described by respondents were moodiness, apathy, meanness, prejudice, cynicism, sarcasm, bitterness, rudeness, tactlessness, and emotional lability. If the preceptor appeared "anxious", this "made students feel insecure and unsure of what they were doing". Those with "chips on their shoulders" or "an abrupt manner" contributed to student insecurity.

Having preceptors that disliked or did not want to teach was an issue described by students. Students stated that they felt "really unwanted" when the managers required the preceptor to teach, or when the preceptor felt pressured to teach or when they taught only "for the money". The preceptors who were "forced to teach" contributed to negative experiences. One student replied with capitol letters, "A CNM should NEVER have a student if she did not willingly choose to be involved in teaching." Some preceptor's dislike for teaching was perceived

as stemming from their lack of clinical skills.

Lack of Clinical Preceptor Skills or Evidence-based Practice
Students expressed strong feeling about knowledge levels. They were emphatic that preceptors who did not have current knowledge and evidence-based practice hindered learning. The students' expected preceptors to be knowledgeable, current, and use evidence based practices. Statements about the lack of knowledge included preceptors that were "out of touch with hospital care as it is now" and preceptors that were "not skilled in primary care". Student described interactions with preceptors that were "not experienced, and not knowledgeable" and preceptors who had "been there forever" without updating their skills and knowledge.

A lack of teaching skills was also considered detrimental to the student's experience. Failures to review clients with the student and "poor communication techniques" were part of poor teaching. Inadequate teaching also included preceptors being unaware of didactic material being taught in the student's educational program, "being unaware of different learning styles", and being inexperienced. Inexperience with teaching was described as "insecurity". One student stated, "When a midwife is unsure of her own skills and knowledge base it translates into negative interactions with students."

Inappropriate feedback, not receiving feedback, or receiving critical feedback without the inclusion of any positive comments, was a common complaint. Students referred to poor verbal and written communication techniques, stating that written evaluations were often not congruent with verbal feedback.

Negative Practice Environments
The students' perspective of negative practice environments included job dissatisfaction/burnout, heavy workloads, use of the medical model, and working with uncooperative staff that did not help or respect midwives. Burnout and a heavy workload included perceptions of preceptor fatigue, apathy, complaining about having too many students, and not having enough time. Lack of time for teaching included limited student interactions, insufficient time for processing interactions, and not enough exposure to learning experiences. Preceptors that were perceived as overworked tended to use students to "get their work done" even if the student was unprepared for the task. Practice settings that were busy and where midwives were overwhelmed produced perceptions of the worst preceptors. One student wrote, "She didn't really have time to teach me much and I felt I was a burden."

Settings that were perceived as restrictive or were unsupportive of the practice of midwives were described as negative. One student's description was "Unsupportive, restrictive environment where M.D.'s and staff do not respect midwives and are watching the monitors and supervising the midwives (sic) every move." Another student stated there was negativity when the preceptor "allowed unnecessary intervention by the physician." Fifteen students actually described encounters with medical staff where the preceptor offered no defense or support for the student. Many participants addressed the lack of preceptor support as part of a negative practice environment. Adoption of the medical model of care by midwives was seen as a factor contributing to a negative learning environment. One student stated, "The worst ones are doctor wanna-bees. They are very medical."

The "Do it MY Way Syndrome"
Students frequently commented that a preceptor's use of and belief in the medical model was perceived to increase rigidity in teaching or as one student stated "the do it their way or the highway." The "My Way Syndrome" was described as "territorial, rigid, inflexible, critical" behaviour that led to lack of respect for the students' knowledge base and unclear student expectations. This in turn prevented students from making autonomous management decisions. One student captured this resistance in the following response "I had a preceptor who made it very clear she was worried I would harm her patient."

Respondents frequently described incidents where preceptors did not allow the student to make decisions and preceptors who were not flexible or open to alternative management plans offered by the student. Examples described preceptors

"jumping in and taking over from the student", being "rigid about student charting", "forcing the student to learn in a style that doesn't fit the student", and being "impossible to please".

Territoriality and being protective of clients was seen as part of the "My Way Syndrome". This included refusal to "let the student go" and "She wants/needs all of her patients to like her best."

Limitations of the Study

One limitation of this study was the number of students who responded to the survey, only 37.2 % of potential 390 participants. Polit & Beck [11] stated however, that a less than 50% response rate is common in web-surveys. It is possible that the response rate was higher than reported; because it was not known with certainty that all qualified students had access to the web-link URL. In addition, for various reasons, some of the "potential" respondents may have become inactive during the six month survey period.

It is assumed, however it is not known whether or not the respondents were representative of the entire convenience sample. The low response rate may have provided a biased view concerning the negative nature of the questions. No mechanism was in place to prevent a respondent from accessing the survey more than once. However, the investigators doubt that a respondent would have reentered the survey for a second or third time and provided yet another lengthy narrative to the open-ended questions. The homogenous volunteer population consisted primarily of female, full time traditional students. This and the qualitative nature of the study limit generalization.

Discussion:

Optimal Preceptor/Student Ratios

It certainly appeared, based on student responses, that the number of preceptors per student should be limited. More than one preceptor is necessary to provide students with an exposure to different role model styles. Varied clinical skills, and styles of midwifery care were learned from multiple preceptors. A new student might benefit initially from a preceptor that specialized in beginning students, and later from a preceptor who assists students with increasing autonomy.[5]

Multiple preceptors however, may be detrimental to role transition. Corcoran-Ulrich[12] compared baccalaureate nursing students' role conception for those randomly assigned to a single preceptor or to multiple preceptors. The students with multiple preceptors displayed a significantly greater role attainment discrepancy. Students with multiple preceptors did not progress as well because preceptors were unable or unwilling to track the student's progress. Clinical time was wasted when students were frequently asked to repeat demonstrations of competencies for multiple preceptors. Kavianai & Stillwell[13] studied focus groups with preceptors, preceptees in nursing, and nurse managers, and reported that a consistent preceptor provided the opportunity for more individualized learning and better role modeling in baccalaureate nursing students.

Bullying and Horizontal Violence in Midwifery Education

The nursing profession has begun to address the issue of bullying by studying the high incidence of horizontal violence. Bullying inflicted by nurses upon other nurses, particularly new graduates is not new. Horizontal violence and bullying was defined as interpersonal conflict between nurses.[14] It has been described as a type of psychological harassment that consisted of actions such as excess criticism, verbal abuse, humiliation, denial of access to opportunities, intimidation, yelling, "the silent treatment", and belittlement. This behaviour is often initiated by a person in authority or with a higher status, and contributes to a sense of interpersonal role conflict, decreased self esteem, decreased confidence, psychological stress, and silent suffering for the person being bullied.[14-19] It is well recognized that not all nurses make good clinical preceptors.[20, 21] The descriptors for bullying were similar, if not identical, to the words used by the students in this study to describe negative teaching styles, preceptor personal issues, and the "Do it My Way Syndrome". Mckenna et al.[14] studied distressing incidents involving student nurses and reported that the most common incidents included rude, abusive, or humiliating comments by

preceptors and nursing staff.

Several research findings and theoretical models may provide an understanding of the causes of negative preceptor behaviour. Oppression[22], female aggression[23], or invitational theory[24] could provide an understanding of the causes of negative preceptor behaviours and provide insight on how to manage the issues. It has been suggested that bullying occurs because both midwifery and nursing have in the past and, to some point the present, been an oppressed and subservient profession.[25-27] Both disciplines are predominantly female. The effects of female to female aggression, such as gossiping and shunning, have not yet been studied.[23] Friere's[22] oppression theory states that oppressed groups seek to follow the norms and values of the dominant group and reject themselves. The implications are that students will discard their normal practice behaviours and become less caring, nurturing and empathetic if oppressed.

Finger and Pape[20] examined the behaviours of perioperative nurse clinical preceptors using Purley & Schmidt's[24] invitational theory which examines the helping learning relationship between preceptors and learner. The invitational theory states that people might either be intentionally or unintentionally, personally and professionally, inviting or disinviting. Intentionally disinviting behaviour was considered a level of lethal functioning in a relationship that was the most destructive level of behaviour. At this level, a preceptor would consider herself and others irresponsible and worthless. The preceptor's disinviting actions towards others were intended to be purposefully insulting and demeaning. When a preceptor displayed negative actions or made statements that were perceived by the preceptee as uncaring and thoughtless, it was considered unintentionally disinviting behaviour. Disinviting behaviour of any type sent messages of worthlessness, lack of esteem and pessimism to the preceptee.[24]

"Good clinical skills do not necessarily equate to good teaching skills."

Students should not be placed with preceptors that are known to have inadequate inter-personal skills. Bullying should be actively discouraged and there should be policies and procedures in place to protect students who complain of being bullied. Intentional disinviting behaviour is a more serious situation, and must be dealt with appropriately. Midwives that truly dislike teaching or cannot teach, despite formal clinical preceptor preparation programs, should not be required to do so. Other activities may be more suitable for the individual's specific skills and abilities.

Creating Competent Clinical Preceptors

Clinical teaching requires a tremendous amount of energy and time. Preceptors must receive regular positive feedback and they should be "rewarded" and "rested from teaching" on an as need or regular basis. Teaching assignments should be adjusted to prevent or avoid overload or fatigue.

New or novice preceptors may benefit from more experience or a mentoring program with an experienced clinical preceptor. Until the midwife feels comfortable, in both a clinical and teaching role she/he should not be assigned as a clinical preceptor. Often, new preceptors benefit from manuals, handbooks, websites and conference offerings on effective clinical teaching and adult learning theories.[5]

New, more interactive and stimulating methods of teaching effective clinical precepting must also be developed. Meng and Morris[28] found preceptors benefited from filmed modeling situations and case study analysis. Hunter[29] found that clinical preceptors responded well when asked to describe their responses to clinical preceptor stories written by students. There was also evidence that suggested that more formalized educational preparation time was needed for clinical preceptor skill acquisition.[13,30] Altman[31] found that the average preceptor received only two and one half hours of training.

Availability, ease of selection, and clinical experience should not be the basis of preceptor selection. Good clinical skills do not necessarily equate to good teaching skills.

Instead, specific criteria for clinical preceptors must be developed and must be based on clinical competence, teaching ability and interpersonal skills. Additionally, the performance of clinical preceptors must be thoroughly, objectively and frequently evaluated. Education program personnel and or service directors must evaluate clinical preceptors with objective assessment tools similar to those developed for nursing by Hilligweg[32] and Finger & Pape.[20] The reliability and consistency of these tools discriminate between a nurse capable of participating in the preceptor role and one that is not.

Changing the Practice Environment

The self-esteem and confidence of a student placed with a preceptor who has a different philosophy or is in a practice environment that is not supportive, is easily damaged. Lessing-Turner[33] and Myrick[34] noted that the nursing and midwifery students' success or failure in a clinical preceptorship was predicated upon the feeling of the staff about a student. The preceptor was the single most influential factor in determining whether the student would be supported in the learning environment. Myrick[34] found that the preceptor and the preceptor's relationship with other staff set the tone for the student's learning environment. A change in the midwifery staff, nursing staff or the collaborative physician(s) could change the learning environment of a clinical site. It is paramount that students are placed in clinical sites that support the midwifery student and midwifery model of care. Kaviani & Stillwell's[13] reported that a lack of institutional and peer support and insufficient time to spend with preceptees had a negative impact on preceptors. Student comments from the negative practice environment theme support these conclusions.

Conclusions

Because of the scarcity of current research, more must be learned about the clinical preceptor-student relationship in midwifery. Frameworks such as invitational theory, female-female aggression theory, or oppression theory could be used to examine horizontal violence. Tools that assess the suitability for precepting midwifery students must be developed and adopted. Further work is needed to determine the actual amount of time needed to acquire clinical preceptor skills, and to determine how to best teach precepting skills. The effect of bullying on students in terms of stress related illnesses, absenteeism, retention, and recruitment must be examined. Future research based upon this exploratory qualitative study may further elucidate and refine the initial themes and may lead to more general and applicable conclusions.

Emphasis must be placed upon improved methods of preceptor orientation programs and preceptor evaluation. Clinical preceptors must be prepared to meet the educational goals and learning styles of the students. The responsibility for safe effective educational preparation of midwives lies with the profession, the educational system, the preceptor, and the student. Practicing midwives must make a commitment to growing our profession and taking the time and energy to teach students. If we do not nurture our future, who will?

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The individuals that shape the profile for midwives and their work at the Society of Obstetricians and Gynecologists of Canada (SOGC) come from across Canada and a variety of practice backgrounds. Kim Campbell is a Canadian midwife with a very long history of contributing to this profile at the SOGC. Ms. Campbell is an advocate for evidence-based maternity care and has experience throughout Canada in many practice settings as both a registered midwife and registered nurse.

Ms. Campbell's career as a health professional began in 1980 with nursing in both primary and tertiary institutions across Canada until 1996. The period from 1996 to 1998 was a pivotal point in her life. She began working on her Master's Degree in Nursing with a certificate in midwifery from the University of Alberta which included an internship in Vancouver at British Columbia Women's Hospital with the Midwifery Program and the Department of Family Medicine.

In 1998 midwifery was regulated in British Columbia so with full integration and funding of midwifery Ms. Campbell began a solo practice and founded the Valley Midwifery Group in Abbotsford. While continuing with active practice Ms. Campbell sat on the Board and various committees for the Midwives Association of British Columbia (MABC) from 1997 through to 2000. She began a term on the governing Board of the College of Midwives of British Columbia (CMBC) from 2000 and 2001 when she resigned to assume a leadership role for Canada's national midwifery professional body.

The Canadian Association of Midwives (CAM) Board welcomed her membership and ongoing leadership from 2000 to 2005. As the President of CAM from 2001 to 2004 and then past president from 2004 2005 Ms. Campbell represented Canadian midwifery both nationally and abroad as well as acting as the organizations chief executive officer including representing CAM as a delegate at the International Confederation of Midwives (ICM) councils in Vienna (2002) and Brisbane (2005). Ms. Campbell also organized and orchestrated the CAM Annual Clinical Conference for four years including the two years of a collaborative effort with the American College of Nurse Midwives.

Ms. Campbell believes in continuous improvement and is

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