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American nursing programs have cited faculty shortages as the primary reason for turning away qualified applicants, with the greatest number of faculty vacancies noted in graduate programs. The shortage of qualified nursing faculty can be connected to nurse shortages in the clinical area, which may impact the quality of patient care. Furthermore, nationwide, Advanced Practice Nursing (APN) programs are transitioning from master's level preparation to the Doctor of Nursing Practice and require doctorally prepared faculty. This is of particular importance for Certified Registered Nurse Anesthesia (CRNA) programs that mandate qualified CRNAs teach all anesthesia content. The goal of this study was to explore the transition experience of CRNAs from clinical practice to academia to understand factors impacting this transition. Schlossberg's (1981) transition theory was used to guide this study.

Semi-structured interviews were used to collect data from seven participants across the United States via telephone interviews. The Interpretative Phenomenological Analysis method was used to guide the analysis of the data. One super-ordinate theme, identity amalgamation, and three nested themes, establishing credibility with students and peers, making a mark, and overcoming the organizational hump, emerged. The findings from this study show that the transition experience for CRNAs from clinical practice to academia is not drastically different from the transition experience of other nursing faculty. One unique finding was the importance of the role of professional involvement in the transition experience of CRNAs. Future research should aim to compare the

experience of new faculty in other APN specialties, as well as to evaluate the effectiveness of mentor and orientation programs to ease new faculty transition.

THE TRANSITION EXPERIENCE OF THE CERTIFIED REGISTERED NURSE
ANESTHETIST FROM CLINICAL EXPERT
TO NOVICE EDUCATOR

by

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Approved by

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To my daughter, Hazel,

If you every doubt what you can accomplish, let this work be a reminder to you. From wearing a glass slipper to shattering a glass ceiling, you have the right to be whatever you wish, and I will always support you.

APPROVAL PAGE

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CHAPTER I

INTRODUCTION

Faculty Shortage

American nursing schools are facing a shortage of faculty that is impacting the number of students schools can educate. In 2018, American nursing schools turned away more than 75,000 qualified applicants (Rosseter, 2019a). Reasons listed for turning away qualified applicants included faculty shortages, budget constraints, and insufficient resources; however, faculty shortages were listed as the primary reason in two-thirds of schools surveyed. Moreover, that same year greater than 1,700 faculty vacancies were noted in American nursing schools at the undergraduate and graduate levels. In addition to faculty vacancies, the creation of greater than 130 new positions would be needed in 2018 to meet the current demands of nursing education in America (Rosseter, 2019a). Therefore, between vacancies in existing positions and positions in need of creation, at least 1,800 nursing faculty were needed in 2018 to meet current student demands. Additionally, the U.S. Department of Labor Bureau of Labor Statistics predicts a 35% increase in nursing faculty demands by 2022 (National League for Nursing [NLN], 2018).

The aging of faculty is also contributing to the faculty shortage (NLN, 2018). The percentage of faculty aged 30 to 60 years dropped by 3% between 2006 and 2009, while the percentage of full-time faculty over 60 years of age increased by 7%. Furthermore,

57% of part-time faculty and 76% of full-time faculty were over the age of 45 in 2009 (NLN, 2018). The American Association of Colleges of Nursing (AACN) report that in 2015 and 2016, the average age of doctorally prepared faculty was between 51 and 62 years, while the average age for masters-prepared faculty was between 50 and 57 years. Moreover, the AACN reports that the average age for retirement of nursing faculty is 62.5 years, and the Bureau of Labor Statistics predicts that 10,200 current faculty members will retire by 2022 (NLN, 2018). Based on current faculty needs, projected needs, and projected retirement rates collectively, schools of nursing would need to recruit over 3,400 new faculty per year through 2022 to meet faculty needs (NLN, 2018).

The incongruence of supply and demand for nursing faculty has created a significant crisis in American nursing education. The shortage of faculty has far-reaching implications. Prelicensure programs cite the faculty shortage as the primary limiting factor in expanding their size. A strong correlation has been noted between the inability of prelicensure programs to meet clinical nursing demands for graduates and the current faculty shortage (NLN, 2018). At the graduate level, all programs have had an increase in the percentage of qualified students turned away due to the faculty shortage. The effects are mainly seen at the master's level, where the percentage of applicants denied admission has increased by 10% since 2009 (NLN, 2018). In 2016, the AACN reported that greater than 9,700 qualified applicants for master's programs and approximately 2,100 qualified applicants for doctoral programs were rejected due to faculty shortages and clinical site shortages. Moreover, potentially negative implications for patient care are arising from nurse shortages in the clinical area that can be related to the inability to

educate able individuals as nurses due to faculty shortages (McDermid, Peters, Jackson, & Daly, 2012).

The faculty shortage also impacts the quality of education, specifically as it relates to the diversity of culture in nursing education. A 2009 faculty census showed that the majority of nursing instructors were female, at approximately 95% (NLN, 2018). Additionally, racial and ethnic minorities were poorly represented among nursing faculty. Currently, nurses of racial and ethnic minorities with advanced degrees are more likely to choose a clinical versus academic appointment. This further limits the diversity of nursing faculty, which is currently predominantly white females. The lack of diversity noted in faculty may limit the ability of nursing schools to provide a culturally appropriate education in preparing nurses for a diverse patient population (NLN, 2018).

Factors Impacting Faculty Shortage

The literature has noted several factors as impacting the faculty shortage. Job stress and workload impact job satisfaction, thereby affecting intent to remain in academia. Financial compensation is also a common cause for dissatisfaction and may hinder the recruitment of new faculty.

Job stress and workload. A recent study by Ampadu (2015) found that close to one-half of nursing faculty report job stress despite high levels of job satisfaction, indicating job stress alone is not a reliable predictor of job satisfaction. However, correlations among job satisfaction and intent to remain in academia were noted (Ampadu, 2015). The NLN (2018) reported that 45% of nurse educators are dissatisfied with their workload in academia. Non-administrative nurse educators in pre-licensure

programs and graduate-level programs report having both teaching and administrative duties. On average, faculty report working 56 hours weekly. Additionally, more than 60% of nursing faculty work clinically, adding a 7- to 10-hour workday to their workweek. Twenty-five percent of faculty that were considering leaving academia cited workload as the inciting factor (NLN, 2018). Not only does workload contribute to dissatisfaction on the job, but it may be a barrier to the recruitment of faculty. A survey of Certified Registered Nurse Anesthetist (CRNA) practitioners working clinically with students shows that 26% of respondents would not transition to academia due to increased workloads (Merwin, Stern, & Jordan, 2008)

Compensation. In addition to increased stress and workload, decreased compensation for academic jobs is a barrier to recruitment and retention, contributing to the faculty shortage. Advanced practice nurses (APNs), such as Nurse Practitioners, make an average yearly salary of \$97,083. However, in academia, the average yearly salary for master's prepared faculty is only \$77,022. Decreased compensation for academic versus clinical work is also seen with other APNs, namely CRNAs. A 2008 survey of nurse anesthesia faculty shows that assistant program directors and anesthesia program faculty are consistently paid less than their clinical counterparts (Merwin et al., 2008). Additionally, faculty are more likely to work more hours weekly than nurses in clinical practice. After adjusting for the number of hours worked weekly, assistant nurse anesthesia program directors and CRNA faculty were paid \$18-20 less per hour than clinical faculty. Clinical faculty are CRNAs that work predominantly in the clinical area providing direct patient care. These CRNAs also work one-on-one precepting anesthesia

students from anesthesia programs affiliated with the hospital in which they work. CRNAs receive no additional compensation for precepting anesthesia students; instead, it is considered part of the job description in addition to the primary duties of patient care. Of the anesthesia faculty surveyed, 54% of respondents reported salary as the most important barrier to recruitment of anesthesia faculty, and 24% of respondents listed salary as the second most important barrier. Of the clinical faculty surveyed, 43% reported salary as the most important barrier to entering academia (Merwin et al., 2008).

Doctor of Nursing Practice Programs

With nationwide changes in healthcare delivery systems, the Institute of Medicine and Joint Commission have encouraged health care professionals to evaluate and reimagine current educational practices (AACN, 2014). Knowing that higher levels of nursing education have been linked to better patient outcomes, the AACN recommended the education of advanced practice nurses (APN) be improved. In 2004 the AACN released a Position Statement that called for the transition of all APN programs from the master's to doctoral level by 2015 through the advent of the Doctor of Nurse Practice (DNP). The DNP is a clinical doctorate that is on par with professionals in other healthcare fields, such as the Doctor of Pharmacy or Doctor of Physical Therapy. The DNP serves as a terminal degree by incorporating current educational standards seen in master's programs with the addition of evidence-based practice, leadership, quality improvement, and informatics to better meet the needs of complex patients and healthcare systems (AACN, 2014).

While the master's route remains the prevailing method for entrance to APN practice, the number of doctoral programs nationwide has grown (AACN, 2014). Currently, greater than 300 schools offer the DNP across all 50 states (Rosseter, 2019b). One hundred twenty-four DNP programs are in the planning stages (Rosseter, 2019b). However, it has been noted that the lack of faculty is an obstacle impeding the growth of DNP programs nationwide (AACN, 2014). With the current emphasis on increasing the educational preparation of APNs, more faculty are and will be needed to teach at the doctoral level, specifically in DNP programs, further contributing to the faculty shortage.

While many current faculty in APN programs are continuing to teach, the transition to DNP will require doctorally prepared faculty to assume faculty roles in APN programs (AACN, 2014). The DNP is not specifically designed to prepare nurses for a role in academia (AACN, 2014). However, with the unique body of knowledge associated with APN practice, an influx of new DNP-prepared faculty can be anticipated. These faculty may or may not possess formal education in pedagogy. Current literature indicates that lack of formal instruction in education may cause faculty feelings of confusion and angst that contribute to role ambiguity in new nursing faculty (Boyd & Lawley, 2009; Grassley & Lambe, 2015; Weidman, 2013). However, literature is sparse regarding the transition experience of APN faculty teaching in graduate programs, particularly CRNAs. Greater exploration of the transition experience can provide insight into the experience of APNs in graduate programs.

Anesthesia Education

The Council on Accreditation (COA) of Nurse Anesthesia Educational Programs dictates that all students admitted to nursing anesthesia programs after January 1, 2022 must graduate with a doctoral degree (Council on Accreditation of Nurse Anesthesia Educational Programs [COA], 2016). All program directors and assistant program directors of nurse anesthesia programs must be prepared at the doctoral level by 2018 to enable this transition. Additionally, the COA mandates that only an appropriately prepared CRNA or Anesthesiologist can teach the anesthesia curriculum. Nurse anesthesia faculty must be licensed as a Registered Nurse in one jurisdiction in the United States. They must be nationally certified by the Council on Certification/Recertification of Nurse Anesthetists. Furthermore, doctoral students must have appropriately credentialed faculty (COA, 2016). This creates an even greater demand to recruit and retain doctorally prepared CRNA faculty to meet the educational needs of future generations of CRNAs.

Significance

Faculty shortages have led to the recruitment of clinical experts to academia to fulfill faculty needs (Murray, Stanley, & Wright, 2014), including APNs. It is costly to recruit nursing faculty, with greater financial strain noted if faculty are not retained (McArthur-Rouse, 2008). Understanding the challenges related to the transition experience from expert clinician to novice nursing faculty can help nursing education program administration implement programs that promote adaptation to the new role and faculty retention.

Previous studies have qualitatively explored the transition experience of expert nursing clinicians to new nursing faculty, but the majority of American studies focus on nursing faculty teaching at the pre-licensure or baccalaureate level (Anderson, 2009; Cooley & De Gagne, 2016; Mann & De Gagne, 2017; Schoening, 2013). There is currently a scarcity of data regarding the transition of APNs from clinical practice to academia. While Anderson (2009), Bailey (2012), Weidman (2013), and Gardner (2014) all included APNs in their samples, not all APN specialties were represented individually or collectively between studies. Additionally, current studies focus on APNs teaching in undergraduate education. Faculty in CRNA programs are teaching in graduate programs. The current lack of literature focusing on APNs teaching in graduate programs should be explored to gain a full understanding of the transition experience.

Specifically, there is a paucity of literature on the transition experience of CRNAs from clinical practice to academia. Because COA requirements for nurse anesthesia programs mandate that an appropriately prepared CRNA or Anesthesiologist teach all anesthesia content, understanding the transition experience of CRNA faculty from a clinical to an academic position is imperative to recruitment and retention of anesthesia faculty. Further investigation into the transition of CRNAs to new faculty roles is necessary to ascertain if parallels exist with current literature. Current data, with the addition of new data on CRNA faculty, can assist in creating a global picture of the transition experience of clinical experts to academia.

Theoretical Framework

Schlossberg's (1981) transition theory is a developmental theory rooted in the idea that development continues throughout the lifespan. Origins of the theory are based on previous research regarding anticipated life transitions, such as marriage, birth, and retirement. Furthermore, unanticipated transitions of unknown duration, such as imprisonment in Nazi concentration camps, were explored to provide a holistic picture of transition and adaptation. Investigation of current developmental theories was also utilized to define theoretical concepts and establish relationships among them (Schlossberg, 1981).

Schlossberg (1981) defines transition as "an event or non-event [that] results in change in assumptions about oneself and the world and thus requires a corresponding change in one's behavior and relationships" (p. 5). Characteristics of transition include role change, source, timing, onset, and duration of the transition, as well as the degree of stress noted with the transition (Schlossberg, 1981). Adaptation to change is defined as the incorporation of a transition into one's life in such a way that it no longer is distressing or inconvenient to the individual.

Characteristics of Transition Theory

A transition triggers a role change, which is perceived as a role gain, role loss, or combination of the two. A role gain is often considered a beneficial opportunity, while a role loss is often perceived as unfavorable and potentially perceived as a threat. A role loss may hinder adaptation. Regardless, role gains and role losses can be associated with

low and high levels of stress, which impacts the perception of the transition and adaptation (Schlossberg, 1981).

Sources of change can be internal or external, which can impact how an individual considers the transition. Transitions arising from internal sources, or anticipated transitions, are easier to adapt to than those arising from external sources, or unanticipated transitions. Even when a transition is anticipated, the timing of the transition must also be taken into account. An expected transition that occurs earlier or later than anticipated can be viewed as unfavorable and associated with greater levels of stress (Schlossberg, 1981).

The degree of incongruence perceived in the pre-transition and post-transition environment is another determinant in stress levels that may impact adaptation to a transition (Schlossberg, 1981). The presence or absence of interpersonal and institutional supports further impacts the perception of the change in environment and associated stress levels. Schlossberg notes that interpersonal supports, such as family and community, and institutional supports, such as mentors, can have positive influences on adaptation. In addition to the presence or absence of resources, one's inclination or willingness to utilize said resources is another determinant in how successful an individual is in adapting. The greater the resources and willingness to utilize them, the greater the success (Schlossberg, 1981).

Schlossberg also recognizes previous experiences as influential in the ability to adapt to transitions. People that have encountered past transitions and have navigated them successfully are more likely to adapt to future transitions. Previous experience

managing transitions provides an individual with a model of how to prepare for and cope with change (Schlossberg, 1981).

Application to Current Study

Faculty shortages have encouraged the recruitment of clinical experts in academia in order to meet current faculty needs (Murray et al., 2014). Understanding the transition experience of clinical nurse experts to novice nurse educators is important in gaining perspective on faculty recruitment and retention. While current literature has identified some challenges such as economic compensation, job stress, and preparation, the paucity of information regarding CRNAs teaching in graduate programs calls for further inquiry to support current findings. Transition theory's broad view of transition may guide data analysis.

Weidman (2013) reported that while some clinical nurse experts intended to enter academia, the impetus presented itself sooner than anticipated, relating to Schlossberg's (1981) notion of source and timing. Transition theory also relates to role transition as it applies to the transition from expert to novice. New nursing faculty report sensing a change in their status from expert clinician to novice educator when transitioning to academia (Anderson, 2009; Boyd & Lawley, 2009; Cangelosi, Crocker, & Sorrell, 2009; Gardner, 2014; Weidman, 2013), relating to Schlossberg's (1981) idea of role gain or loss. New faculty are gaining the role of educator but losing the role of clinical expert. Boyd and Lawley (2009) note that their clinical practice strongly influences clinicians' professional identity. The incongruence of this loss of expert status, combined with the acceptance of novice status, may cause role strain (Anderson, 2009; McDonald, 2010;

Weidman, 2013) and impede role transition in some individuals (Boyd & Lawley, 2009). These relational statements from current literature support relationships depicted in transition theory.

Conclusion

America is experiencing a shortage of nursing faculty that will only worsen with impending rates of faculty retirement and increased faculty demands. Faculty shortages are having detrimental effects on nursing students, with thousands of qualified undergraduate and graduate nursing students being turned away due to lack of faculty. In efforts to combat the faculty shortage, the recruitment of clinical experts, including APNs, to academia to fulfill faculty needs has increased (Murray et al., 2014). Faculty recruitment is costly, and greater cost is noted with faculty attrition (McArthur-Rouse, 2008).

Furthermore, a nationwide effort to advance nursing education has been seen with increasing the preparation of APNs from the master's level to the clinical doctorate. With the advent of DNP programs, the need for graduate faculty is increasing (Rosseter, 2019b). However, faculty shortages are limiting the expansion of needed DNP programs (AANC, 2014). Understanding faculty experiences relating to transitioning to academia is needed to promote recruitment and retention of faculty, particularly graduate faculty.

Current studies detail the transition experience of clinical experts to novice nursing faculty but focus on faculty at the pre-licensure or baccalaureate level, leaving a gap in knowledge regarding the transition experience of nursing faculty in graduate programs. Furthermore, while some studies include APNs, they do not include CRNAs.

Overall, there is currently a paucity of literature regarding the transition experience of CRNAs from clinical expert to novice educator. Moreover, the COA requires that anesthesia-specific education be provided by a CRNA or Anesthesiologist; therefore, exploration of the transition experience of CRNA faculty is necessary.

CHAPTER II

REVIEW OF LITERATURE

This chapter will review the current literature related to the transition of nurses from clinical practice to academia. Studies from across the United States, as well as international studies, are included to provide a comprehensive picture of the current knowledge, allowing for gaps in knowledge to be identified. Both primary research and literature reviews are included. Additionally, a review of Schlossberg's (1981) transition theory and its use in nursing literature related to the transition from clinical practice to academia are included.

Reviews of Research

In 2004, Diekelmann reviewed the literature to gain insight into the experience of experienced practitioners as novice faculty, with most of the information cited in the review coming from one unpublished doctoral dissertation. Novice faculty reported uneasiness at their lack of pedagogical knowledge. Additionally, the novices reported feeling a lack of support from experienced colleagues because they were too busy to provide guidance and answer questions. Some experienced colleagues displayed annoyance at questions from novice faculty, which caused novice faculty to feel isolated and alone. Novice faculty found that previous clinical experiences were not enough to guide them in their new roles as faculty. Drawing on past experiences left some faculty feeling out of control in the classroom and hindered student learning. Furthermore,

participants reported difficulty in classroom time management. Specifically, participants reported difficulty in finding time to cover the assigned content while emphasizing important clinical content (Diekelmann, 2004).

McDonald (2010) searched the Cumulative Index to Nursing and Allied Health Literature (CINAHL) and PubMed to find articles regarding the transition of clinical experts to novice nursing faculty. Keywords included nursing faculty, new faculty, nurse faculty roles, novice nursing faculty, new faculty and culture, new faculty and success, faculty and challenges, and nursing faculty transition. The National League for Nursing's (NLN's) 2005 Core Competencies for Nurse Educators and Benner's Novice to Expert Theory were used to guide analysis of articles. McDonald found that novice educators enter academia with a knowledge deficit. Novice educators must learn to navigate the academic culture as well as the clinical culture of practicum sites used by Schools of Nursing. They must also learn to use educational technology that was not necessary for clinical practice. This places them at a knowledge deficit from the beginning (McDonald, 2010).

Also, novice faculty often have dual roles as both clinical and didactic faculty, and they are expected to perform proficiently at both. This causes them to experience increased pressure to be good as both a clinical practitioner and an educator. Furthermore, changes in salary and workload may impair adaptation to the role of educator. Nurse educators usually receive lower salaries than their clinical counterparts. Workload varies based upon the courses an educator is assigned to teach. The workload may be large enough that it requires faculty to take work home with them, a major

variation from clinical practice. However, mentoring, both informal and formal, can promote socialization and support of novice nursing faculty. It may also help the novice educator in navigating the social norms and expectations of academic culture (McDonald, 2010).

Spencer (2013) reviewed the literature regarding the transition of clinical nurse experts to novice nursing faculty to develop guidelines to ease transition. Specific search engines and keywords searched were not provided. Four qualitative studies were reviewed, as well as other non-research articles with practical instruction for novice nurse educators. Spencer found that the transition to education can be difficult for novice educators because clinical expertise does not translate to educational expertise. Spencer recommends peer mentoring and faculty development to ease the transition of novice educators. Both provide the novice educator with resources to manage their new role better. Utilization of resources, particularly scholarly journals on nursing education, can also be used to improve pedagogical knowledge. Lastly, Spencer (2013) recommends that new educators create a unique style that promotes student engagement.

In 2015, Grassley and Lambe searched the ProQuest Central and CINAHL databases for peer-reviewed articles regarding the orientation and mentorship of novice nursing faculty who were previous clinical experts. Keywords included mentoring or orientation, nursing education, expert clinical, novice nurse educator and mentoring, faculty, and nursing education. They included 17 articles in their final review, and they highlighted components found to promote successful adaptation to the role of novice educator for clinical experts transitioning to academia. They recommend that novice

educators seek formal education in pedagogy. This can be accomplished through a formal academic program, an intensive, or a mentorship program. Specifically, novice educators need to learn how to plan and guide learning experiences for students, how to evaluate students, how to manage difficult students, how to incorporate simulation, and legal and ethical considerations unique to education. Novice educators also need guidance on academic culture, specifically, language, expectations, relationships, and policies and procedures. Incorporation of novice faculty into academic culture can improve work satisfaction and promote retention of new faculty. This can be accomplished via detailed orientation or ongoing mentorships (Grassley & Lambe, 2015).

Synthesis of Review of Research

Review articles show that clinical expertise does not translate into educational expertise. Novice educators often enter academia with unrealistic expectations regarding workload and scheduling. This leads novice faculty to feel overwhelmed when presented with the reality of academia. Additionally, clinical experts enter academia lacking the necessary skills in pedagogy. This increases the stress and frustration new nursing faculty experience. Moreover, novice faculty encounter high expectations to be proficient in both the clinical and academic arena. This further increases the stress experienced by new nursing faculty.

Clinical experts transitioning to education rely on their clinical knowledge to guide their educational style. However, clinical knowledge is not enough to successfully manage student learning. At times, relying on past experiences may hinder classroom management because educational methods for managing classrooms vary from methods

of managing continuing education for experienced nurses. Furthermore, physical classroom resources may vary from the clinical setting to the university. This further contributes to feelings of stress, frustration, and inadequacy experienced by novice faculty. Experienced practitioners transitioning to academia need guidance in the form of continuing education and mentorship from experienced faculty. Inclusion in faculty events, such as meetings, may promote feelings of acceptance, improving the morale of the novice educator, and encouraging retention.

Primary Research

In 2001, Siler and Kleiner explored the perceptions of novice nursing faculty entering academia. They purposefully sampled six participants experienced in nursing education and six participants who were novice nurse educators. Of the novice educators, none had previous experience in education. Participants were from five un-named states in the United States, and they represented 11 diverse American Association of Colleges of Nursing (AACN) member schools. Ten participants were interviewed in person and two were interviewed via phone. All interviews were transcribed, and follow-up inquiries were collected via email. Hermeneutic analysis was used to examine the data. Data showed that none of the novice faculty were prepared for their new role and the new culture of academia. Novice faculty had expectations of academic culture and workload that were incongruent with reality. All novice faculty reported full workloads despite their lack of experience. While new faculty did look to experienced faculty for guidance, assistance from experienced peer educators was inconsistent and, at times, unobtainable. Novice faculty reported difficulty learning basic academic culture and skills and were

unsure where to find resources to guide them. No formal evaluation or feedback was given during the first year in academia for any of the novice faculty. This left faculty relying upon student evaluations and student performance to judge their skills and amend their teaching styles (Siler & Kleiner, 2001).

P. Young and Diekelmann (2002) explored the experience of new educators learning to lecture. Seventeen educators with less than two years of experience in teaching were included in the study. Participants taught in associate, baccalaureate, and master's degree programs. Eight participants were master's-prepared, six were doctorally prepared, and three were currently enrolled in doctoral preparation. Unstructured interviews were audio-recorded and transcribed. Data were analyzed hermeneutically by a research team. Data showed novice educators report inadequate preparation for their new roles, including lecturing. Because each class is unique, novice educators should learn to read student reactions to material to ensure when a point of understanding is reached. Therefore, connections with students were integral to learning how to lecture effectively. New educators should be open to reflecting upon their experiences and learning from them. Mentors can help guide reflection. Novice teachers may find anxiety over their new role and lack of experience initially hampers their ability to manage lectures and respond to student needs (P. Young & Diekelmann, 2002).

Anderson (2009) used naturalistic inquiry to guide her descriptive, explanatory study of the work-role transition of expert clinicians to novice nurse educators teaching in baccalaureate programs. A purposive sample of 18 participants, all females and ranging in age from 40 to 62 years from 14 nursing programs in the midwestern United States

was used. Semi-structured interviews were conducted in person. Morse and Richards coding schema was utilized with descriptive, topic, and analytic codes. Anderson (2009) found the work-role transition phase to be dynamic and different for everyone. Phases of transition were identified, and a metaphor of a mermaid swimming through a sea of academia was used to describe each phase. The first phase identified was splashing through the shallows where novice educators are introduced to academia with reduced workloads and responsibilities. Participants in this phase reported decreased anxiety and blissful ignorance of problems in academia. The second phase was drowning. Participants report leaving their comfort zone, trying to establish relationships with academic and clinical peers and students, learning new skills and unlearning previous skills, facing the reality of academia, and questioning their decision to enter academia. In this phase, participants report anxiety, confusion, and self-doubt. The third phase is treading water. Participants begin to adjust to their workload and responsibilities, and request feedback to improve their performance. Participants report increased comfort and confidence in this phase. The last phase identified is throughout the waters, where participants begin to incorporate their personal expertise, adjust to academic culture, and learn to react to students (Anderson, 2009).

Cangelosi et al. (2009) explored the perspective of clinicians becoming clinical nurse educators by analyzing written narratives from 45 participants. Participants were preparing for roles as part-time or full-time clinical nurse educators by attending the Clinical Nurse Educator Academy, an independent 4-day intensive that prepared experienced clinicians for roles in education. Academy attendants could be employed in

education or could be clinicians considering transitioning to education. The sample included bachelors-prepared and masters-prepared nurses. The types of programs current educators were affiliated with was not provided. Whether participants were currently serving in education roles or considering transitioning to education was also not specified.

Researchers found novice educators were consistently excited to share their expertise and influence the next generation of nurses but were frustrated with the lack of guidance and mentoring they experienced during their transition. They reported feelings of anxiety and uncertainty during their transition. Novice educators also felt they lacked the pedagogical skills necessary to be successful in education. Additionally, participants felt dismayed at returning to the novice role after working hard to achieve expertise as clinicians but were willing to learn new skills to be successful in education. The frustration with being a novice educator was attributed to the lack of guidance and understanding of how to develop into an expert nurse educator (Cangelosi et al., 2009).

McArthur-Rouse (2008) performed a qualitative study of six nursing faculty with 2 or fewer years of experience at a university in Canterbury, Kent. The mean length of employment was 12.6 months, with a range of 3 weeks to 2 years. Semi-structured, individual interviews were audio-recorded, analyzed, and paraphrased by the researcher. Direct transcription of passages was used for important information. Three focus areas were explored: prior experience and reasons for applying for the new post, formal induction mechanism and the mentorship system, and main concerns on commencement of their new post. Participants reported their previous experience in clinical and

management was of little help in adjusting to their new role in academia. Some participants reported difficulty in adjusting to the lack of structure in scheduling, classroom management, and difficulty in navigating academia culture. This led to feelings of anxiety and the overpreparation for student encounters. Faculty members also report loss of their professional identity as clinicians, leading to feelings of confusion and conflict. Formal mentor programs and education programs did ease transition. Variations in the formality of mentor relationships were reported; however, all participants reported the mentorship was beneficial in easing transition. Major concerns for new faculty were lack of clarity in their responsibilities, lack of guidance on how to effectively manage their role, and lack of understanding of institutional functioning. New faculty members need structure, direction, and practical guidance to promote successful adaptation to their new role (McArthur-Rouse, 2008).

In 2009, Boyd and Lawley used a convenience sample of nine nurse lecturers for a qualitative study of the workplace learning of new lecturers in nursing education in the United Kingdom. All lecturer participants had between one and four years of appointment in higher education. Semi-structured interviews were used to gather data from participants. Three interviews with line managers (the person responsible for managing the new lecturers) were used to gather data on the context of the workplace. Finally, institutional documents regarding appointment, induction, and continuing professional development were analyzed. Lecturer participants report feeling unprepared for their new role due to lack of preparation in pedagogy and lack of understanding of academic culture. Despite feeling they needed their clinical expertise to establish

credibility with students, they felt faculty and administration did not value their previous clinical experience. Additionally, they reported difficulty in letting go of their professional identity as a clinician and accepting their new identity as an educator. This led to feelings of confusion and role ambiguity, making the transition to educator more difficult. Specific challenges to transitioning to education noted by lecturer participants were time management and pedagogical skills, such as test-writing, evaluation, and assessment. Participants reported that mentoring and professional support helped them adapt to their new role. However, informal support networks were unclear, making participants hesitant to reach out for needed support. Some participants stated that they were hesitant to ask for help for fear of being perceived as less credible in the academic community. Lastly, participants had trouble setting boundaries in their new role, both with academic peers and students (Boyd & Lawley, 2009).

Bailey (2012) obtained a sample of nine Advanced Practice Nurses (APN) via purposive sampling to conduct a phenomenological study of the transition experience of APNs from clinical practice to academia. All participants had to be masters-prepared APNs with a minimum of two years in education, no previous formal experience in academia, no formal education in pedagogy, no experience as a clinical instructor, and at least five years of experience in their APN specialty. Five participants were Certified Nurse Practitioners, two were Certified Nurse Midwives, one was a certified Clinical Nurse Leader, and one was a Clinical Nurse Specialist. No Certified Registered Nurse Anesthetists (CRNA) were included. Semi-structured interviews were conducted over the telephone or in person, audio-recorded and transcribed verbatim. Transcripts were

reviewed by participants to promote credibility. Researcher bias was bracketed during transcript review. Bailey (2012) used Colaizzi's method to analyze data. Significant statements were identified, categorized, and integrated to form a description of the phenomenon. This was then validated by participants. Participants reported that lack of preparation for an academic role, lack of peer support, and insufficient orientation hindered their transition experience. Additionally, participants reported difficulty balancing clinical demands with academic demands and reported they found their academic workload to be excessive. The use of mentors and formal training in pedagogy eased their transition. Participants recommended that future novice APN educators consider co-teaching and formal education in pedagogy to ease their transition (Bailey, 2012).

Schoening (2013) utilized purposive, theoretical sampling to obtain 20 nurse educators from baccalaureate programs in the midwestern United States to complete a grounded theory study and create the nurse educator transition model. Nineteen of 20 participants were female. Academic responsibilities varied among clinical teaching, didactic instruction, administration, and research. Fifteen participants had 10 or fewer years of experience, two had 11 to 20 years of experience, and three had more than 20 years of experience. Semi-structured face-to-face interviews were audio-recorded and transcribed for analysis. Schoening (2013) utilized Charmaz's techniques for theoretical coding. Four phases of transition were identified and included anticipation/expectation, disorientation, information seeking, and identity formation. In the anticipation/expectation phase, participants voiced expectations for a flexible lifestyle, career

progression, and positive impacts on students. The disorientation phase was characterized by role ambiguity, lack of guidance and structure, and negative experiences with students. The information-seeking phase was characterized by actively seeking resources, peer mentoring, overpreparing, and utilization of clinical knowledge. The identity formation phase was characterized by establishing boundaries, accepting responsibility, and creating a personal educator identity (Schoening, 2013).

Weidman (2013) used a phenomenological qualitative design to explore the lived experience of eight clinical nurse experts transitioning to academia. Participants had no experience in nursing education before their current role in academia. They had at least a Bachelor of Science in Nursing (BSN) with a minimum of 5 years of clinical experience, or a Master of Science in Nursing (MSN) without a degree in nursing education. Participants had less than 2 years of experience in their current role, and nurse practitioners were included in the study. Participants ranged in age from 27 to 60 years and consisted of six females and two males who taught in programs ranging from diploma to master's degree. The researcher conducted a semi-structured interview with each participant. Participants identified a desire to teach and influence the next generation of nurses as an impetus for transitioning to academia. Upon entering academia, participants reported feeling overwhelmed by job duties and lack of guidance. They also reported feelings of stress related to lack of guidance and difficulty in utilizing skills unique to academia. Additionally, feelings of frustration related to basic principles of pedagogy were reported by novice educators. Moreover, difficulty with student evaluation due to lack of information about student's baseline knowledge and lack of

objective guidelines for student evaluation was noted. Orientation, mentor networks, and faculty development were noted to ease transition by encouraging competency and increasing novice faculty comfort and confidence (Weidman, 2013).

In 2013, Chapman conducted an interpretive phenomenological study of the transition experience of four novice clinical faculty and interpreted results using Parse's systematic framework for thematic analysis. All participants were from a proprietary school in the Southwestern United States, had less than 2 years of experience in teaching, and were currently teaching a clinical component of a didactic course. Parse's systematic framework guided data collection and analysis. Semi-structured in-person interviews were audio-recorded and transcribed verbatim. Morse and Richards coding method was used to code data by grouping codes into categories, and then grouping categories into descriptive themes. Member checking and peer debriefing were used to promote trustworthiness. Participants reported that the transition to academia was internally motivated. However, lack of experience in academia, lack of time for preparation, and lack of institutional support led to feelings of stress and anxiety. Observing other instructors, continuing education, and informal mentor relationships eased the transition experience. Also, participants reported that a detailed orientation would have eased the transition (Chapman, 2013).

Australian researchers Murray et al. (2014) conducted a qualitative meta-analysis of the transition experience of clinicians to academia for nursing and allied health sciences professions, including physiotherapy, health care, and social care. Data were obtained from CINAHL, EMBASE, MEDLINE, SCOPUS, Education Research

Complete, and Academic Search Premier. Keywords included academ*, facult*, and transition, as well as clinic* or practit* or profession. Studies from nursing, physiotherapy, health, and social care were included. To be included in the analysis, study samples had to be comprised of at least 50% of nurses or allied health professionals. The central theme identified was an identity shift for the clinician transitioning to academia. This was characterized by four phases, feeling new and vulnerable, doing things differently, expecting the unexpected, and evolving into an academic.

In the first phase, feeling new and vulnerable, participants felt as if they were starting anew. Tasks took longer than anticipated to complete, and participants reported feeling disempowered, insecure, and stressed. In Phase 2, expecting the unexpected, participants were confronted with the reality of academia. In general, expectations were incongruent with reality because participants based their expectations on their experiences as students. Participants were unaware of the institutional and administrative duties the academic role comprised. Additionally, participants anticipated time for adjustment to their new role but felt they were expected to perform proficiently immediately. They reported that student evaluation was agonizing and difficult to learn. The increased autonomy of academia was overwhelming for some. Overall, participants reported feeling like the work was never-ending and hard to master. In the third phase, doing things differently, participants began to learn to organize their schedules and work. This process was self-motivated by the participant and not guided by experienced peers. Prioritization methods were explored by novice faculty to find an approach that worked

for each faculty member. In the last phase, evolving into an academic, participants were learning to stop using their title as a clinical practitioner and start accepting their role as an academic. For this to occur, participants had to feel confident in their ability as an educator. Participants reported a lack of feedback from experienced peers and administration regarding their performance and voiced desires for more feedback to guide their professional development. Completion of post-graduate degrees in education helped increase participants' confidence in their ability (Murray et al., 2014).

In contrast to other studies exploring the transition experience, Gardner (2014) explored factors related to educator efficacy. A purposive sample of effective educators, identified from peer nomination, was utilized. Eight master's-prepared nurse educators from a western state in the United States were included in the study. Seven women and one man participated. Participants were Caucasian and African American, ranged in age from 45 to 61 years, ranged in years of experience in nursing from 20 to 39 years, and years of experience in nursing education from 5 to 29 years. They taught in associate degree, prelicensure baccalaureate, and registered nurse to baccalaureate nurse programs. Half of the participants were Advanced Practice Nurses; specifically, two participants were nurse practitioners and two were clinical nurse specialists. All participants reported that support and encouragement through professional mentoring and the formation of relationships with colleagues, whether formal or informal, were integral to educator efficacy. Developing a dynamic teaching style was also identified as being influential in being an effective educator. Active teaching methods, including clinical experience, were reported as promoting student success. Planning and experience were noted to increase

the confidence and competence of the nurse educator. Taking time for professional development and utilizing constructive feedback also encouraged educator efficacy (Gardner, 2014).

Goodrich (2014) quantitatively explored the relationships among readiness, confidence, personal control, support, decision independence, general self-esteem, and work locus of control for nursing faculty teaching full-time in baccalaureate programs. A convenience sample of 541 registered nurses in the Eastern United States was used. The sample was not limited to novice educators. Most of the participants were female (92.1%) and between the ages of 50 and 59 years. Over half (55.3%) had children. Over half of the participants (59.3%) had baccalaureate degrees as their first nursing degree, and less than half (44%) had a master's degree. Over one-half of the participants (61.7%) were licensed as a registered nurse, over one-fourth (28.5%) were licensed as both a registered nurse and advanced practice nurse, and a small proportion (7.8%) had only advanced practice nursing licensure (Goodrich, 2014). Participants completed the Career Transitions Inventory (CTI), Work Locus of Control (WLoC), and Rosenberg Self-esteem Scale (SES) via an online survey. Overall, participants had high scores for confidence, personal control, self-esteem, and locus of control. This indicates that participants felt they had personal control over their transition and felt confident in their choice. Moderate scores were reported for readiness and independence, indicating participants had mixed feelings about making their career transition and felt the transition impacted individuals other than themselves, such as their family and friends. So, while participants felt confident and ready to make the transition, they still had some unsure

feelings and they were aware the transition could impact their personal relationships. Positive relationships among CTI subscales and the WLoC score were noted for all subscales except readiness and personal control. Additionally, nurses with less experience in education had higher scores of readiness, while those with more experience had higher scores in control. This indicates that novice educators are ready to do what is necessary to achieve career goals, while experienced educators feel greater levels of control in their career paths (Goodrich, 2014).

Blaine's (2015) dissertation focused on barriers and benefits to transitioning from clinical practice to academia. Ten MSN-prepared participants ranging in age from 31 to 65 years were interviewed. Years in academia ranged from 1 to 12 years. No APNs were included in the study. Semi-structured interviews were audio-recorded and transcribed. The constant comparison method was used to code interviews, and themes were identified. Peer debriefing was used to promote validity and reliability. Participants reported that having previous experience as adjunct faculty or having completed coursework in nursing education eased the transition experience by clarifying expectations. Having a faculty mentor to guide the transition process was overwhelmingly reported as positive. Additionally, an organized and developed orientation to the role and institution was also reported as beneficial. Lastly, lack of the need to work night shifts, weekends, or holidays was reported as positively contributing to the transition to academia. Barriers reported included a decrease in salary compared to clinical practice and an increased workload. Additionally, one participant reported

negative attitudes and perceptions of clinical nurses towards nursing faculty as a barrier (Blaine, 2015).

Brown (2015) used purposive sampling to recruit seven novice nurses from one Associate Degree program in North Carolina to conduct a qualitative case study. Participants had to be an educator in the clinical and academic setting and could not have more than three years of teaching experience. The sample consisted of four women and three men, ranging from 28 to 57 years. Five participants had an MSN, and two participants had a BSN. Semi-structured interviews, a document completed by the college for the Board of Nursing detailing the functioning of the school of nursing, and demographic information provided data for analysis. Interviews were transcribed verbatim. Data were coded and themes identified. Member checking was used to encourage validity of findings. Participants reported moving to academia to give back to the nursing profession. Challenges faced included an increased workload, variable work hours, a decrease in pay, and lack of pedagogical preparation. Faculty peer support was present if requested, but participants report structured support would have eased their transition. Positive aspects of academia were reported as positive interactions with students (Brown, 2015).

Logan, Gallimore, and Jordan (2015) explored the transition experience of Registered Nurses from clinical to academia in Australia and the UK with a qualitative interview study. Semi-structured interviews were conducted with 14 nurse educators, with half being from Australia and half from the UK. Participants were university nurse academics with a 3- or 5-year contract in both rural and urban areas. Four major themes

of adapting to change or cultural identity in transition, external forces, teaching, and progress up the academic ladder, were identified. Adapting to change or cultural identity in transition was characterized by a change in the working environment. Participants reported less teamwork in the academic environment, with increased autonomy in their work. Participants also reported feeling the need to master multiple work roles, namely clinical practice, administration, teaching, research, and community involvement. This led to feelings of being overwhelmed with their new role. External forces are characterized by forces impacting the educators' academic practice. Student satisfaction, attrition rates, and funding were reported to be integral to faculty review, regardless of quality student performance. Participants report this limited their ability to find time to participate in research. Teaching was emphasized because class size was integral to university funding. Teachers felt distinct from researchers in the university structure. Participants expressed frustration that not all faculty taught in the classroom, and that those who did teach in the classroom were not allotted time for research. Lastly, progress up the academic ladder was characterized by the attainment of higher degrees and participation in research. While support was reported for doctoral education, participants reported a lack of support in further research activities, specifically at the postdoctoral level (Logan et al., 2015).

Cooley and De Gagne (2016) performed a hermeneutic phenomenological qualitative study to increase understanding of the transition experience of expert clinicians to novice faculty. Kolb's experiential learning theory provided the theoretical framework for the study. Novice educators were defined as masters-prepared expert

clinicians with less than three years of experience in education teaching prelicensure nursing students, specifically theory and clinical education. Participants were recruited from private, religious, 4-year colleges. Most participants were white females. Face-to-face interviews that were audio-recorded and transcribed verbatim and participant journals provided the study data (Cooley & De Gagne, 2016). Researchers found that novice educators identified insufficient time, knowledge, and support, and incongruent expectations as barriers to educator competency. Facilitators to competency were previous education in pedagogy, student evaluations, personal attributes, and transformative learning experiences. Transformative learning experiences were often related to the context in which these experiences occurred and were found to occur between individuals with strong relationships (such as between the novice educator and a close friend or peer), or between the novice educator and a student. Additionally, these learning experiences often occurred with major events, such as engagement in learning activities with students about critical nursing concepts (Cooley & De Gagne, 2016).

Tucker (2016) performed a qualitative phenomenological study to examine the experiences of nine novice nurse educators teaching in associate degree programs in community colleges in the Pacific Northwest region of the United States. Nine participants were purposively sampled with inclusion criteria of baccalaureate or master's educational preparation, lack of experience in academia before the current role, less than 5 years of clinical nursing experience, self or peer identification as an expert clinician, less than 3 years of experience in their current academic role, and full-time employment in academia. Eight participants were master's-prepared nurses, and clinical experience

ranged from 8 to 40 years (Tucker, 2016). A demographic questionnaire and semi-structured face-to-face interviews were used to gather data. Field notes and journaling supplemented interview data. Van Manen's method guided manual data analysis. Major themes identified included anticipating the transition, starting out, learning to teach, influencing factors, and getting there. Subthemes for anticipating the transition included having a desire or being recruited to teach and being dissatisfied with clinical roles. Subthemes for starting out included inadequate orientation and mentoring, lack of preparedness, and need for knowledge and information. Learning to teach subthemes were jumping in with both feet, early experiences, and wanting and receiving feedback. Facilitating factors, hindering factors, and knowledge, skills, and attitudes of new faculty were subthemes for influencing factors. Lastly, identifying growth and initiating change, finding rewards and satisfaction in the role, and choosing to continue were subthemes for getting there (Tucker, 2016).

McDermid, Peters, Daly, and Jackson (2016) explored resilience-developing strategies for novice nurse educators in the United Kingdom and Australia. A total of fourteen participants, 13 women and one man, between the ages of 33 and 55 years were included. None of the participants had doctoral degrees, but all had clinically relevant postgraduate degrees. Experience at their current academic institution ranged from six weeks to five years. Semi-structured, conversation-style interviews were audio-recorded and transcribed for analysis. Participants reported challenges such as difficulty understanding role expectations and career progression tracks. Additionally, participants lacked confidence in their ability as educators and did not fully understand workload

expectations and demands. Previous clinical experience did not prepare them for roles in academia because different skill sets were needed for success in academia and clinical. This, combined with a lack of feedback from experienced colleagues about performance, led to feelings of stress and anxiety. The use of personal and professional support systems gave participants a sense of belonging and provided resources for navigating their transition (McDermid et al., 2016).

Another study focusing on clinical nurse educators explored the perception of nine novice adjunct clinical nursing faculty who directly supervised prelicensure nursing students in Texas (Mann & De Gagne, 2017). All participants were clinical faculty for associate nursing programs except one who served as clinical faculty for a baccalaureate program and had three or fewer years of experience in education. All participants were classified as expert clinicians, as defined by Benner's Novice to Expert Theory. Participants ranged in age from 25 to 75 years of age, ranged in educational preparation from associate's to master's degree, and three of the participants had previous experience in academia. Demographic data, critical incident prompts, and narrative timelines were completed via web-based, field-tested questionnaires. Interviews were also completed, and audio-taped and transcribed verbatim for analysis. Conventional content analysis was used to code the data and organize information into concepts and categories (Mann & De Gagne, 2017). Four themes were identified: unpreparedness, facilitators and barriers in the transition, new learning needs and processes, and salient recommendations to pass on.

Initially, participants reported feeling unprepared for their new role. They relied heavily upon previous clinical experiences and university orientation to guide them.

Participants reported graduate education, previous clinical experience, previous experience precepting students, formal and informal professional and personal mentor networks, continuing education, and familiarity with the clinical institution all facilitated their transition. Increases in their workload, unfamiliar clinical sites, unfamiliar faculty and staff, lower than anticipated economic compensation, and fear of adverse student outcomes and evaluations all hindered their transition. Participants reported the need for new learning experiences, such as learning to work with students, learning to prepare for clinical education, learning to work with new coworkers, and continuing education on clinical and educational principles as being necessary for success as clinical educators. Salient recommendations for new educators include that not everyone is successful in education; bridging theoretical knowledge and clinical knowledge takes time and considerable effort; flexibility and growth are necessary for success; and relationship formation among students, faculty, and staff are integral to success (Mann & De Gagne, 2017).

Anderson-Miner (2017) interviewed eight BSN faculty from schools in the northeastern United States to describe the positive factors contributing to the successful transition from clinical practice to academia. Purposive sampling was used to find masters-prepared participants teaching full-time in baccalaureate programs with less than 3 years of experience in academia. Participants ranged from 26 to 60 years of age. Semi-structured interviews were conducted via telephone and in person, then transcribed verbatim from audio-recordings. A reflexivity journal was used to record observations and personal feelings during the interview process. Thematic analysis and constant

comparison were used to analyze data. Four themes were identified: mentoring, collaboration, camaraderie, and positive attributes of the faculty role. Mentoring and support from faculty and administration mitigated difficult aspects of the transition from clinical to academia and was reported to decrease stress. Detailed orientation was included under the mentoring theme. Collaborating with fellow faculty showed novice faculty they were appreciated by experienced faculty and lessened stressful experiences in times of uncertainty in their new role. Collaboration also allowed less experienced faculty to learn from more experienced faculty, easing their transition. Camaraderie encompassed inclusion in professional and personal activities, welcoming and supporting novice faculty. Lastly, positive aspects of the job, such as increased flexibility in scheduling and autonomy, led to positive feelings surrounding the transition (Anderson-Miner, 2017).

Wagner (2019) explored the impact of mentors on the retention of novice faculty. Eleven novice faculty from baccalaureate programs in the Midwest with less than 3 years of full-time experience were sampled. All underwent at least a one-year formal mentorship program. The success of the mentor program depended largely on the relationship formed between the mentor and mentee. Participants reported feeling overwhelmed and confused at times despite the mentor program. Furthermore, some participants reported having unclear expectations of their roles upon entering academia. While some found the culture of academia welcoming, others reported a hierarchy with newer faculty being lower than experienced faculty (Wagner, 2019).

Bice, Griggs, and Arms (2019) used narratives of tenure-track faculty to examine experiences of new tenure-track faculty with varying terminal degrees, namely Doctor of Nursing Practice (DNP) and Doctor of Philosophy. They found that tenure-track faculty appreciate collaboration and partnership regardless of their terminal degree. Additionally, regardless of terminal degree, new tenure-track faculty found it difficult to balance multiple professional responsibilities, such as sometimes having didactic and clinical responsibilities in addition to writing and publication, with personal ones. Lastly, destructive criticism, namely degree shaming, was found to be a problem for DNP faculty (Bice et al., 2019).

Calvert (2018) sampled 12 participants with equal or greater than 5 years of clinical experience but less than 5 years of full-time experience in education and nursing. Participants taught in Associate and Bachelor's degree programs. Two participants had received their doctoral degrees; the remainder had their master's degree. Findings show a desire for increased flexibility and a passion for teaching encouraged experienced clinicians to transition to academia. Upon entering academia, participants reported confusion and a lack of guidance in their new role. Learning how to apply clinical knowledge and experience to didactic instruction was important for learning to function in academia. Formal education, professional resources, namely mentors, and administrative guidance eased the transition, while lack of support and guidance from experienced colleagues and administration hindered the transition. Additionally, challenges to transition such as financial disincentive and incivility can slow successful adaptation to the new role (Calvert, 2018).

Synthesis of Primary Research

A review of current studies does show improvement in the transition experience for novice nurse educators. Initially, Siler and Kleiner's (2001) study showed that novice nurse educators were not given reduced workloads, and this contributed to anxiety, frustration, and stress in their new role. However, in Anderson's (2009) study of novice educators, many reported initially being given decreased workloads to promote transition. Despite this improvement, novice educators continue to report feelings of anxiety and frustration related to incongruent expectations and reality and lack of mentoring and resources to facilitate transition.

A review of current studies shows that novice educators consistently report incongruent expectations and reality for academic scheduling and workload. Furthermore, they lack a full understanding of academic culture and structure. A lack of peer guidance, resources, clear expectations, and feedback hinder attempts to adjust to these new realities. This causes novice faculty to report feelings of being overwhelmed and frustrated in their new role. Many studies report these feelings lead novice faculty to question their decision to enter academia.

Skillsets needed for clinical and academic success were found to vary, supporting that clinical expertise is not equivalent to educational expertise. Additionally, lack of preparation in pedagogy increased stress for the novice nurse educators. Role ambiguity led practitioners to hold onto their identity as clinicians until they achieved confidence in their role as an educator. In the face of role ambiguity, lack of professional feedback

hindered transition, while supportive professional relationships served as resources and increased feelings of belonging.

Consistently, novice faculty report a lack of feedback from experienced peers. Studies show that novice faculty are self-reliant in finding resources to aid in their development as educators. When evaluating their performance, novice faculty report relying upon student performance and feedback to measure their progress rather than formal evaluation from experienced peers and supervisors. This leads to feelings of isolation and frustration in the new educator.

Current studies support that positive transitional factors include mentoring, peer support, increased scheduling flexibility, and increased autonomy. Peer support and mentoring include the use of detailed orientations to clarify institutional expectations and job roles. However, organized and consistent peer support and mentoring were not consistently present across studies. Studies show that often mentoring and support networks are informal and only available upon request. Novice faculty reported feeling hesitant to request support for fear of being too needy. It should be noted that while some studies report that increased autonomy is a benefit, increased autonomy without sufficient support was reported to increase anxiety for novice faculty. Particularly, the combination of increased autonomy and increased workloads led to feelings of apprehension and being overwhelmed.

The majority of current studies focus on faculty teaching in prelicensure baccalaureate programs. Currently, there is a paucity of literature focusing on novice educators teaching in graduate programs. Furthermore, few studies include Advanced

Practice Registered Nurses and those that do only include Nurse Practitioners and Clinical Nurse Specialists, with very few Certified Nurse Midwives. Of the studies reviewed, none include Certified Registered Nurse Anesthetists (CRNAs). American nurse anesthesia programs are all graduate programs and are primarily staffed by CRNAs. One cannot assume based on current literature that the experiences of CRNAs or those teaching in graduate education will match those of faculty teaching in prelicensure baccalaureate programs. More research is needed to explore the transition experience of CRNAs in academia.

Use of Transition Theory

Transition Theory

Schlossberg's (1981) transition theory was published in 1981 and aimed to explore the experience of transition and development throughout life. Schlossberg defines transition as an occurrence that brings about change in one's self and world view. Adaptation to a transition occurs when the individual experiencing the transition accepts the changes in their self and world view and incorporates these changes into their personal paradigm. Six characteristics of transition affect adaptation: role change viewed as a gain or loss, change resulting from internal or external forces, timing of change, onset of change, duration of change, and degree of stress associated with the change. Adaptation is dynamic and dependent upon how individuals view their circumstances, change in situation, and the utilization or deficit of supportive resources (Schlossberg, 1981).

Schlossberg's (1981) transition theory has been used extensively in psychological research. Initially, it was used as a model to guide the exploration of transition in men with unanticipated loss of employment. From a different but related perspective, it has been used to guide the development of a program aimed to ease transition and promote the adaptation of novice employees entering their first job. Another related use was the development of seminars used to guide the anticipated transition and promote successful adaptation among workers preparing to retire (Schlossberg, 1981). More recently, Schlossberg's transition theory can be seen used across disciplines, such as nursing. Poronsky (2011) used transition theory as the framework for her study on the impact of online nursing faculty as mentors for nurses transitioning to the role of family nurse practitioners. In 2013, Schmitt used Schlossberg's (1981) transition theory to guide data analysis in a secondary analysis of working nurses with less than one year of experience to gain insight into their needs and resources. It has also been used in studies specific to the experience of nurse clinicians transitioning to academia.

Use of Transition Theory in Nursing Education

Esper (1995) used transition theory to describe the transition of nurse clinicians to novice nurse educators in three phases of assimilation. In Phase 1, novice educators enter academia with an idealized idea of education and unrealistic expectations. Novice educators view education as a prestigious role with a flexible schedule. However, in entering Phase 2, novice educators begin to experience conflict between their expectation and reality. They begin to experience feelings of inadequacy secondary to insufficient preparation for the academic role. Additionally, novice educators find that increased

workload demands limit schedule flexibility. Moreover, due to a lack of confidence in their ability as an educator, novice faculty often spend more time preparing for student interactions than do more experienced educators. Novice educators can use experienced faculty as resources in this phase, but some faculty lack access to experienced peers. In Phase 3, the novice educators begin to accept their new role. Failure to do so may result in the novice faculty member leaving academia to rejoin clinical practice. Novice faculty that feel included in the faculty team are more likely to remain in education. This can be accomplished by including new faculty in meetings and events with existing faculty, as well as providing informal and formal mentor networks. Additionally, faculty development programs focusing on pedagogical principles may ease the transition of novice faculty (Esper, 1995).

Another use of transition theory was in Anderson's (2009) study of the transition experience of baccalaureate program faculty. Anderson aimed to create a holistic picture of the transition experience by identifying psychological, social, and cognitive factors involved in transition. Anderson used Schlossberg's (1981) transition theory to inform the psychological perspective of transition, with a focus on adapting to a new professional identity. Upon completion of the study, factors from each aspect of transition were identified. The psychological aspects of transition noted in participants included having expectations, facing discomfort in a new role, questioning, accepting, and building confidence in a new identity. The findings from Anderson's (2009) studies supported previous findings, namely Schlossberg's (1981) transition theory.

Conclusion

This review of current studies shows common themes among nurses transitioning from clinical expert to novice academic. Clinical experience and expertise do not equate to educational expertise. Many expert clinicians transitioning to academia who lack formal training in pedagogy report difficulty in adapting to their new role. Training, either formal education, co-teaching, or formal mentorship, can aid in pedagogical development. Additionally, many expert clinicians enter academia with expectations that are incongruent with the reality of academia. Studies show that while novice faculty report increased autonomy in scheduling, the increased workload and reduced salary are greater than anticipated. These findings were consistent across national and international studies

Professional support in the form of detailed orientation and formal mentor networks are consistently reported in national and international literature to ease transition. However, studies show that mentor networks are often informal and lack structure, making utilization difficult for many novice faculty and hindering adaptation. Moreover, the lack of formal feedback from experienced peers and administration further contributes to difficulty adjusting to the new role. When new faculty are unable to understand the expectations of academia, this contributes to feelings of inadequacy, stress, and confusion.

Moving from expert clinician to novice academic was also reported as difficult across studies. New faculty report a loss of identity as a clinical expert. Lack of expertise in academia, combined with loss of expertise in clinical practice, leads to role ambiguity,

which hinders adaptation. This finding was predominantly reported in international studies, yet similar findings are seen in American studies. Formal training in pedagogy, formal mentor networks, and formal orientation were reported as beneficial in helping novice faculty establish their academic identity.

Current studies consistently focus on faculty in undergraduate programs. However, while some APNs are included in studies, none of the studies reviewed included CRNAs. Due to their specialized body of knowledge, CRNAs are necessary for anesthesia education. The Council on Accreditation for Nurse Anesthesia programs mandates that a CRNA or Anesthesiologist teach anesthesia information (Council on Accreditation of Nurse Anesthesia Educational Programs [COA], 2016). Therefore, understanding the transition experience of CRNAs from clinical practice to academia is important for recruitment and retention of anesthesia faculty. The experience of CRNAs transitioning to academia is unknown, and further exploration is warranted.

Key components from transition theory can be seen in current literature, including nursing education literature. Because current studies support a shift in identity, role loss and gain, and the value of professional support systems, Schlossberg's (1981) transition theory may be useful in guiding data analysis.

CHAPTER III

METHODS

This chapter focuses on the plan used for conducting a research study into the experiences of Certified Registered Nurse Anesthetists (CRNAs) transitioning from clinical practice to academia. The research question and methodology will be explained, including the current use of the analysis method in the literature. Recruitment and sampling, protection of human subjects, data collection, and data analysis are also described.

Research Question

What are the lived experiences of CRNAs as they transition from clinical expert to novice nurse educator?

Methodology

Due to the paucity of literature regarding the experience of CRNAs transitioning from clinical experts to novice nursing faculty, a qualitative study was indicated. Phenomenological inquiry provides a holistic picture of a phenomenon and is well suited to explore lived experiences, particularly for the study of nursing practice, education, and administration (Streubert & Carpenter, 2011). Since the focus of the research question was the lived experience, the study followed phenomenological principles. Understanding of the lived experience is crucial because the lived experience is comprised of acts that clarify an individual's perception of the phenomenon. Due to this,

the individual's subjective interpretation of the phenomenon is composed of truths about the reality of the experience. Therefore, the purpose of phenomenological inquiry is to understand, via description or interpretation, the lived experience of a phenomenon to understand the reality of the phenomenon (Streubert & Carpenter, 2011).

There are two major assumptions of phenomenology. The first major assumption is that an individual's perception of a phenomenon is evidence of reality (Richards & Morse, 2013). The second major assumption is that human consciousness makes experiences meaningful. Because individual consciousness is what makes an experience meaningful, experiences can only be understood in the specific context in which they occur. These assumptions again reiterate the importance of the individual's lived experience and how it contributes to the reality of the phenomenon. The researcher must consider the individual circumstances regarding the lived experience among individuals to find commonalities of the reality (Richards & Morse, 2013).

Phenomenology can be Husserlian (descriptive) or Heideggerian (interpretative). For both Husserlian and Heideggerian phenomenology, the lived experience is essential, meaning the phenomenon will be viewed from the perspective of the individual experiencing it (Richards & Morse, 2013). The major point of consideration in deciding which phenomenological approach to use is if one seeks to describe or interpret the experience (Reiners, 2012). For this study, a combination of Husserlian (descriptive) and Heideggerian (interpretative) phenomenology was utilized, and the data were analyzed using Interpretative Phenomenological Analysis (IPA) (Smith & Osborn, 2007).

Rationale

The goal of descriptive phenomenology is to describe the experience of the subject without bias. This requires that researchers recognize and exclude their preconceived notions about the phenomenon in question, a process called bracketing. The intention of bracketing is to make the researcher aware of the symbolism they have assigned to phenomena. Becoming aware of preconceived notions and meanings allows the researcher the opportunity to take an objective stance (Reiners, 2012). The researcher maintains him or herself as separate from the subject(s) and does not become enmeshed in the experience. Descriptive phenomenology describes the phenomenon from the perspective of the participant but does not interpret or assign meaning to the experienced phenomenon (Reiners, 2012).

Interpretative phenomenology rejects the idea of objectivity and accepts the involvement of the researcher in the phenomenon. Interpretative phenomenology recognizes that knowledge and understanding are gained through experience and that personal experience must be considered when interpreting phenomenon because it impacts the phenomenon (Reiners, 2012). The goal is to make sense of the lived experience in question through the interpretative activity of the researcher (Braun & Clark, 2013). Even though these two types of phenomenology seem mutually exclusive, IPA combines them to allow for the description of a phenomenon while accounting for researcher influence.

This researcher has personal experience as a CRNA transitioning from clinical expert to novice academic. Because of this experience, complete bracketing is not

possible, and the impact of personal experience may impact the interpretation of data and discovery of findings. This personal experience can be accounted for by the use of IPA, a method that combines descriptive and interpretative phenomenology.

Interpretative Phenomenological Analysis

Interpretative phenomenological analysis is a form of hermeneutic phenomenology. Hermeneutic phenomenology seeks to discover and interpret meaning, and, therefore, contains descriptive and interpretative elements combining Heideggerian and Husserlian approaches (Van der Zalm & Bergum, 1999). The double hermeneutic process seen in IPA is an example of this (Smith & Osborn, 2007). The double hermeneutic process recognizes that the participant will have assigned meaning to their experience. Therefore, the researcher will interpret the meaning of the participant's interpretation of their experience, making IPA a process of double interpretation. However, IPA moves further to formulate critical questions that help discover underlying currents that may not be apparent to the participant, such as questioning implicit biases, motivations, and goals (Smith & Osborn, 2007).

Specific to Husserlian phenomenology, the notion of bracketing may be used in IPA to identify the researcher's prior experience and knowledge (Pringle, Drummond, McLafferty, & Hendry, 2011). However, bracketing is not done for the purpose of setting aside these preconceived notions, but rather to recognize how they shape the interpretation of data (Pringle et al., 2011). Like Heideggerian phenomenology, IPA recognizes the active role of the researcher will impact access to participant data and influence interpretation (Smith & Osborn, 2007). For this study, the researcher explored

personal preconceptions as much as possible to provide an audit trail of how these preconceptions may have impacted the interpretation of the phenomenon.

History and use of interpretative phenomenological analysis. Jonathan Smith, Professor of Psychology at The Birkbeck University of London, developed IPA in 1996 to permit the rigorous study of subjective experiences and their impact on social cognition specifically related to health psychology (Interpretative Phenomenological Analysis, n.d.; Smith, 1996). Theoretically, IPA is rooted in phenomenology, hermeneutics, and symbolic interactionism; this combines the philosophy of consciousness with the theory of interpretation through an interpretative process that allows for the understanding of meanings one attributes to events (Biggerstaff & Thompson, 2008). Therefore, IPA recognizes the impact of researcher engagement with data accounting for the interpretative element, while maintaining an epistemological approach that provides insight into an individual's inner cognition (Biggerstaff & Thompson, 2008).

While originally used in psychology, IPA has grown in popularity over the last 10 to 15 years and has been used in disciplines outside of psychology, including nursing (Pringle et al., 2011). IPA has not been used extensively in the United States in nursing literature; however, publications of nursing studies using IPA can be seen from the United Kingdom, Europe, Australia, and New Zealand. Examples include the exploration of prescribing practices of district nurses and health visitors in Wales (D. Young, Jenkins, & Mebbett, 2009), the evaluation of an established model as a professional development model for wound care for advanced practice nurses in Australia (Upton, Alexander,

Upton, Upton, & Dunk, 2015), and the exploration of facilitators and barriers to hemodialysis treatment for middle-aged adults (Sciberras & Scerri, 2017). These examples show that IPA has been used in nursing to explore the experiences of both practitioners and patients.

IPA aims to generate evidence for practice based upon the life experiences of participants (Pringle et al., 2011). Therefore, the knowledge generated from IPA reflects actual life experience, thus informing practical knowledge for nursing. IPA is appropriate for nursing research owing to its holistic nature in approaching phenomena (Pringle et al., 2011), and its ability to generate knowledge that contributes to ethical, aesthetic, personal, and socio-political ways of knowing (Van der Zalm & Bergum, 1999).

Recruitment and Sampling

Because the purpose of the study was to interpret the lived experience of CRNAs transitioning to academia, purposive sampling was used to allow for the selection of participants with knowledge of the phenomenon of interest (Streubert & Carpenter, 2011). For this study, this includes the selection of CRNA educators who meet eligibility criteria. Additionally, snowball sampling was used. Snowball sampling is a purposive method that uses current participants to recommend additional participants for inclusion in the study (Richards & Morse, 2013; Streubert & Carpenter, 2011).

Inclusion criteria for this study were as follows: participants must be a CRNA with national certification in anesthesia and licensure in nursing with a full-time academic appointment; have a minimum of 1 year of full-time experience in academia; have less than 5 consecutive years of experience in academia; and be English speaking.

Exclusion criteria were lack of certification and licensure as a CRNA; less than 1 year of full-time experience in academia; greater than 5 consecutive years of experience in academia; and non-English speaking.

Greater than one year of full-time experience in academia is needed to allow the participant to have completed an entire academic year, which accounts for differences in workload and experiences that may occur between semesters. Initially, no greater than three years of consecutive experience in academia was chosen as a sample limiter based on Benner's (1982) novice to expert theory. According to the levels defined in Benner's theory, novice, advanced beginner, competent, proficient, and expert, many nurses develop competency after 2 or 3 years of experience. Although Benner's work was done using clinical nurses, it is likely that competence in academia might follow a similar trajectory. Interviewing educators with less than 3 years of experience was more likely to capture educators in the transition phase. However, saturation could not be achieved with the limits imposed by excluding educators with greater than three consecutive full-time years in academia. The inclusion criteria were amended to reflect the inclusion of educators with up to 5 consecutive years of education experience, which added two participants and allowed saturation to be reached.

Participants were recruited by email invitation sent to contact emails of various nurse anesthesia programs, including MSN, post-baccalaureate and post-master's DNP programs in the United States. A list of accredited anesthesia schools was obtained from the Council on Accreditation of Nurse Anesthesia Programs (COA). The list contained the contact email for each program. Additionally, the program director for each program

is provided on the list. If applicable, when the contact email for a program was a general mailbox and not the program director, an email invitation was sent to the listed program director as well. All emails included a description of the study purpose and structure, inclusion and exclusion criteria, and an email contact for interested participants. A follow-up email was sent after 2 weeks to both program and director addresses.

After utilizing the COA list, personal contacts were used to identify potential participants. Emails were sent directly to potential participants after accessing email address lists from anesthesia program websites. Interviewed participants were invited to share contacts for snowball sampling. When participants did share potential candidates, email addresses were located using university websites. For participants who were contacted via email directly secondary to snowball sampling, the same method as used for general recruitment was utilized.

Regarding qualitative research, it has been said that “predetermination of the number of participants for a given study is impossible” (Streubert & Carpenter, 2011, p. 91). The number of participants in the study was determined by the data generated and was, therefore, dynamic and variable. Interpretative phenomenological analysis recommends a small sample size (Smith & Osborn, 2007), usually six or fewer participants (Smith, Flowers, & Larkin, 2012); however, sample sizes ranging from one to fifteen have been seen in the literature (Pietkiewicz & Smith, 2012). Recruitment of participants for this study was continued until the data collected reached saturation. Saturation is said to be reached when thick, rich data have been collected, a repetition of themes is seen, and no new themes are identified (Richards & Morse, 2013; Streubert &

Carpenter, 2011). For this study, recruitment was continued until seven participants were recruited, interviewed, and data analyzed.

Protection of Human Subjects

The core of research ethics can be centered on the four principles of respect, competence, responsibility, and integrity (Braun & Clark, 2013). These themes are reflected again in the Belmont Report's three ethical principles of respect for persons, beneficence, and justice. These principles ensure the autonomy of participants, protection for participants with decreased autonomy, respect for independent decision making, protection from harm, voluntariness, and equal distribution of the benefits and risks of research (U.S. Department of Health, Education, and Welfare, 1978). The study was reviewed by the University of North Carolina at Greensboro's Institutional Review Board prior to the start of the study and deemed exempt.

Informed Consent

To obtain informed consent, all interested participants were emailed a consent letter explaining the purpose of the study, the inclusion criteria, and the details of participation. The letter detailed the potential risks and benefits of study participation, reiterated voluntariness of participation, and discussed maintenance of confidentiality (Waltz, Strickland, & Lenz, 2010). Furthermore, the consent included the acceptance or refusal of additional contact by the researcher after completion of the interview in case clarification of data was needed. An email address was provided where participants could submit questions regarding informed consent as necessary. The emails came directly to

the researcher. Participants were asked to read the consent letter and were provided with a digital copy of the consent for their records prior to initiating data collection.

Additional to the emailed letter, at the start of data collection the researcher provided participants the opportunity to ask questions and/or clarify concerns. Verbal consent for audio-recording was obtained at the start of the interview before initiating recording. Lastly, at the conclusion of the interview, consent for the researcher to contact the participant to clarify information as needed was again discussed and audio recorded.

Protection of Confidentiality

When considering qualitative research specifically, one must recognize the delicacy of the maintenance of beneficence and justice. These both relate to the idea of anonymity and the prevention of harm. Because qualitative research is contextually rich, information gathered is specific to the participants and may allow for identification of the participant by the reader. Caution must be used when including quotes and descriptive data to ensure that the participant's confidentiality is maintained (Streubert & Carpenter, 2011). To protect participants, important characteristics (e.g., age, gender) are provided as percentages (Richards & Morse, 2013). Additionally, participants were not referred to by name, but rather by assigned pseudonyms (e.g., Anna, Bob, etc.). To further protect anonymity, quotes were amended to protect identifying characteristics. Examples of amendments include removing geographic information or gender. Amended quotes were noted by the use of brackets to replace identifying language, or the use of ellipses to remove identifying information.

A master list of interview audio-recordings was stored in the UNCG Box in an individualized location. Transcripts with pseudonyms were also stored on UNCG Box, but in a different location than the recordings. Only the researcher and dissertation committee had access to the stored information.

Data Collection

Demographic Information

Demographic data were verbally collected at the beginning of the interview and included in the audio-recording. Demographic information included identified gender, age range, race/ethnicity, state of employment, highest level of education attained, current enrollment in an educational program, employment in what type of school (public versus private university), training specific to pedagogy, years in nursing education, years of clinical experience as a CRNA (outside of nursing education), and job duties in the educational employment (i.e., didactic, clinical, and/or administrative). Age range versus age in years was used secondary to feedback from a pilot study of clinical nurse experts transitioning to academia (Kress, 2017). Participants in the pilot study reported greater comfort in providing a range versus a specific age. A demographic questionnaire was generated that the researcher used to guide demographic questioning. The demographic data questionnaire can be seen in Appendix A.

Interview Data

When using IPA, it is recommended that semi-structured in-person interviews be used for data collection to promote flexibility, allowing participant experiences to guide data collection (Smith & Osborn, 2007). Therefore, interviews were semi-structured, and

all attempts were made for interviews to be conducted via video conferencing. However, all participants either preferred a telephone interview or were unable to conduct a video conference. Therefore, all interviews were conducted via telephone.

When using IPA, it is recommended to construct questions that encourage the participant to detail their experience without interruption from the researcher (Smith & Osborn, 2007). Broad, open-ended questions are encouraged. However, to promote free speaking from the participant without over-guidance from the researcher, questions may be so broad they require the use of prompts to clarify questions (Smith & Osborn, 2007). Interviews began by asking participants to describe their experience transitioning from clinical practice to academia. The researcher asked for clarification of data from the participant as needed. If not addressed, the researcher prompted the participant to describe the impetus for transition, support during their transition, positive and negative experiences related to the transition, and/or previous experience in nursing education. Additionally, data driven prompts, prompts which were added to the interview template based on data collected in previous interviews, were utilized.

Interviews were audio-recorded and transcribed verbatim, with any references to names blinded. Audio-recording encourages an objective record of data for analysis. Audio-recording is encouraged in IPA to allow the researcher to make notes on non-verbal cues, such as word choice and cadence (Smith & Osborn, 2007). The interview guide can be seen in Appendix B.

Data Analysis

IPA consists of a series of steps that are flexible in their use to meet the needs of the researcher and data generated (Pietkiewicz & Smith, 2012). However, common steps include: listening, reading, and rereading the data; making notes, akin to coding; identifying potential themes or patterns across cases; finding relationships among themes; abstraction; and writing up the study. The use of participant quotes to explain interpretations and represent participant experiences was used (Pietkiewicz & Smith, 2012). An audit trail describing analysis was utilized to track analytic decision-making.

Data analysis began immediately during the first interview as the researcher made notes about tone and inflection. Following transcription of interview data, data analysis was done as outlined below. Data analysis was concurrent with data collection; therefore, preceding interviews and their analysis were used to inform subsequent interviews. For example, data collected during interviews drove the researcher to utilize additional interview prompts during subsequent interviews. Each interview transcript was analyzed directly after researcher transcription, and identification of themes among data were explored between each interview. Consultation with the researcher's dissertation chair and committee was used during data analysis to guide the analysis further.

Initial Data Interpretation

Qualitative analysis begins during the interview as the researcher observes non-verbal cues and listens to participant accounts (Streubert & Carpenter, 2011). The researcher begins to form an impression during the interview, and this impression may impact data analysis. The researcher used member checking to inform data interpretation,

to enhance credibility. During interviews at the conclusion of a subject the researcher would pause and summarize her interpretation of what the participant had said for clarification. After data collection, IPA recommends listening to audio recordings, reading and rereading transcripts, and reviewing interview notes to begin analysis (Pietkiewicz & Smith, 2012). This encourages the researcher to think of the data in the context in which it was collected, accounting for the influence of the atmosphere and setting. Additionally, the review of non-verbal data, such as cadence and voice inflection, provides the researcher with deeper insight into the verbal data collected. An in-depth review immerses the researcher in the data, helping the researcher understand the meaning of the data (Pietkiewicz & Smith, 2012). The researcher reviewed interview notes while transcribing interviews. This allowed the researcher to read and listen to data simultaneously. After transcription, the researcher re-read data before beginning exploratory noting.

The aim of IPA is to reveal an individual's beliefs and constructs through their words and actions. Therefore, the focus of the next step of analysis is on the content and language used by the participant to promote understanding of the data from the view of the participant (Pietkiewicz & Smith, 2012; Smith & Osborn, 2007). During this phase, the researcher utilized exploratory noting in the margins of the interview transcripts. This allowed the researcher to begin to look for themes within the data set. It also allowed the researcher to note undiscovered ideas that may inform future interviews. This step in the analysis is like free textual analysis. The researcher read the entire transcript, making

notes in the left margin, saving the right margin for themes (Smith & Osborn, 2007).

These steps were repeated for each interview.

Identification of Emergent Themes

Once initial interpretation was complete, the researcher reread the transcripts and recorded emerging themes from the notes and data (Pietkiewicz & Smith, 2012; Smith & Osborn, 2007). The comparison of themes was achieved by placing them in a table and reviewing the descriptive comments in each transcript to find interrelationships, patterns, and/or connections. The use of quotes from the participants to illustrate the themes and to ensure the relation of the themes generated to the raw data is recommended (Smith & Osborn, 2007). Therefore, further analysis of emergent themes through the use of linguistic and conceptual commenting to support descriptive comments was used. Linguistic commenting includes utilization of participant quotes, word choice, and cadence. Conceptual commenting contemplates how the researcher's experience may impact the interpretation of data. This was done for each interview until the chart of potential themes was completed.

After identifying potential themes for each interview, a master list of themes was constructed (Smith & Osborn, 2007). The researcher focused on analytical ordering of themes, connecting related themes. Abstraction was used to cluster themes together based on their relationships and to identify a superordinate theme. Once clustered, the researcher examined the cluster and related it back to the raw data from interviews to ensure appropriate clustering by creating a free text document that included participant quotes exemplifying themes and exploratory and analytic comments that related nested

themes to the superordinate theme. Again, use of the participants' actual words, as well as conceptual commenting, are encouraged in IPA to ensure the support of nested and super-ordinate themes (Smith et al., 2012).

Narrative Report

Lastly, themes were translated into a narrative account. The formation of the narrative account is technically another step in data analysis, as the narrative account represents the data and its overall interpretation (Smith & Osborn, 2007). The narrative account includes identified themes and researcher analysis exemplified by participant quotes (Pietkiewicz & Smith, 2012; Smith & Osborn, 2007). Caution was used to ensure that analytic statements were distinguished as such, ensuring the reader can differentiate between raw data and interpreted data. The relation of study findings to current literature and the theoretical framework was explored and discussed.

While published studies have explored the transition experience of nurses from clinical practice to academia, there is a paucity of literature focusing on CRNAs and those teaching in graduate programs. The assumption that the experience of CRNAs teaching in graduate programs is the same as nurses of varying specialties teaching in prelicensure programs cannot be inferred from the current literature. This study of CRNAs teaching in master's and doctoral level programs addresses this current gap.

CHAPTER IV

RESULTS

This chapter focuses on researcher preconceptions, sample description, a review of data analysis, and discussion of results. A preconceptions section discusses the researcher's personal experience and how that impacted interpretation of the data. A description of the sample provides an overview of participant characteristics. A review of data analysis summarizes the steps used by the researcher in the analysis process. Lastly, the results discuss the super-ordinate theme and nested themes identified in the analysis.

Preconceptions

Interpretative Phenomenological Analysis (IPA) is a form of hermeneutic phenomenology that seeks to discover and interpret meaning. It contains descriptive and interpretative elements combining Heideggerian and Husserlian approaches (Van der Zalm & Bergum, 1999). The double hermeneutic process seen in IPA is an example of this combination (Smith & Osborn, 2007). The double hermeneutic process recognizes that the participant will have assigned meaning to their experience. It also recognizes that the researcher will have preconceptions that will influence the interpretation of the data (Smith et al., 2012). Therefore, the researcher will interpret the meaning of the participant's interpretation of their experience, while considering the influence of timing and personal experience, making IPA a process of double interpretation (Smith et al.,

2012). This section will describe the preconceptions of this researcher and how they have influenced the analysis.

The researcher is a Certified Registered Nurse Anesthetist (CRNA) with over 9 years of experience in anesthesia practice. Specifically, the researcher has experience as an anesthesia educator with over 6 years spent precepting anesthesia students in the clinical area and four additional years as a Clinical Assistant Professor in a graduate nurse anesthesia program. She noted her personal experience as an educator to be a mix of conflicting thoughts and emotions related to her competencies as an anesthesia provider and educator. Review of the literature supported that many nurses in transition from practice to education share feelings similar to the researcher as related to the transition experience; however, there was a lack of available literature regarding the unique experience of CRNAs. This prompted the researcher to explore further the experience of CRNAs transitioning from clinical practice to academia.

In order to explore her preconceptions based upon her experience, the researcher spent time in self-discussion of her personal experience, noting emotions that accompanied the experience and identifying why she may have felt a particular way. She noted these experiences and feelings in a journal. Specifically, the researcher identified that while she had achieved expert status clinically, she felt like a novice in education. Additionally, the researcher believed fellow faculty did not view new faculty as their equal and that to be perceived as an equal team member, new faculty must prove their ability as an educator and dedication to the program. Hours worked varied greatly between clinical practice and academia, with academia being marginally more flexible,

but requiring a greater time commitment. Additionally, the researcher did not receive a formal orientation to the program or a formal mentor. These preconceptions impacted the study by guiding her to include some prompts in the interview questionnaire to ascertain if these were unique experiences and emotions or shared among those with similar circumstances. Before collecting data, she trialed these prompts in a pilot study and discussed their usefulness with her committee chair.

With each interview the researcher used notetaking to identify when participant responses and/or emotion fit or conflicted with her preconceptions. She then used follow-up questions, when necessary, to further explore participant feelings regarding similar experiences. When transcribing, reading, re-reading, and performing exploratory noting on the data, the researcher further questioned her own preconceptions, made notations, and discussed them with her committee chair for further exploration. These preconceptions were noted in a journal so they could be easily referenced during analysis of the data to determine how these preconceptions may have influenced data interpretation.

Sample

A total of seven participants were interviewed for the study. Participants were from the contiguous United States and U.S. territories, except for the Northwest and Southwest United States. The sample consisted of four males and three females, and all participants ranged in age from 30 to 49 years. The predominant race was White (86%). Over one-half (57%) of participants taught in public universities, while the remainder taught in private institutions. All participants had their doctoral degrees, with the majority

(86%) having their clinical doctorate, defined as Doctor of Nurse Anesthesia Practice, Doctor of Nursing Practice, or Doctor of Management Practice in Nurse Anesthesia. Only 29% of participants had formal training in pedagogy. Over half of all participants (57%) had greater than 3 years of experience in anesthesia education, including part-time experience. Most participants (57%) had greater than 3 years of clinical experience in anesthesia practice before transitioning to academia. All participants had didactic, clinical, and administrative duties. See Table 4.1 for complete demographic data.

Table 4.1

Demographic Characteristics

Characteristic	<i>n</i> (%)
Sex	
Male	4 (57)
Female	3 (43)
Age Range	
30-39	3 (43)
40-49	4 (57)
Race	
White	6 (86)
Hispanic/Non-white	1 (14)
School	
Public	4 (57)
Private	3 (43)
Current Enrollment in Education Program	1 (14)
Formal Coursework in Pedagogy	2 (29)
Education	
Clinical Doctorate	6 (86)
PhD	1 (14)

Table 4.1

Cont.

Characteristic	<i>n</i> (%)
Years of Experience in Education	
≤ 3 years	3 (43)
> 3 years	4 (57)
Years of Experience in Anesthesia Prior to Academia	
≤ 3 years	3 (43)
> 3 years	4 (57)

Results

Analysis Overview

The researcher began analysis before the interview process by discussing and noting preconceptions. Some preconceptions influenced interview prompts. Analysis continued during the interviews by noting participant emotion, cadence, and word choice. After completing individual interviews, the researcher transcribed the interviews verbatim. She then read and re-reading transcripts to ensure understanding of the data. Next, exploratory noting was used in the form of descriptive comments annotated in the margins of transcripts. Interview prompts and technique were adjusted after this step based upon the identification of participant-led data (i.e., exploratory noting led to the identification of data not originally included in prompts for the interview transcript, the transcript was then modified to reflect important concepts based upon participant response). These steps were repeated for each new data set until saturation was reached.

Next, the identification of emergent themes and patterns across cases was completed. Descriptive comments in each transcript were reviewed to find

interrelationships, patterns, and/or connections. A comparison of potential emergent themes between transcripts was made by creating a chart. The inclusion of supportive descriptive comments for each theme in the chart of emergent themes eased searching for connections across emergent themes. Further analysis of emergent themes through the use of linguistic commenting to support descriptive comments was utilized. For instance, for each emergent theme, a column was made with descriptive comments, similar to codes. Then the researcher referred back to the interview transcripts for linguistic commenting, either including meaningful quotes or noting participant word choice or cadence.

After the identification of like themes, the process of abstraction was employed. The clustering of the identified themes, otherwise known as nested themes, was used to identify a potential super-ordinate theme—identity amalgamation. There were three nested themes: establishing credibility, making a mark, and overcoming the organization hump. The super-ordinate theme and nested themes were explored and defined with linguistic, descriptive, and conceptual commenting. For instance, the researcher used a chart that included descriptive codes, as described above. She then used those codes to reference the interview transcripts for linguistic commenting, choosing quotes and noting specific word choice and cadence. The researcher then created a document that included the super-ordinate and nested themes. She referred back to the chart, as well as each transcript, to review the listed descriptive and linguistic comments and compare them to the data collected. These were then listed as they applied to each theme. Then the researcher again used linguistic commenting by selecting quotes from various

participants that exemplified the emerging themes. After compiling all the information, the researcher employed conceptual commenting by considering her personal experience to find how the data related to the overall transition experience.

Super-ordinate Theme

Identity amalgamation. The transition from clinician to educator is a difficult one. Gwen stated,

And then you're put in this new role and it's almost that transition back to novice from being an expert. And so, in that role where you go from being really good and knowing how to do everything by yourself to where you need to ask a lot of questions, that was hard.

Individuals feel a sense of identity loss as they lose the role of expert clinician and assume the role of novice educator. For this reason, CRNAs in transition find it important to maintain their professional identity as a clinician and merge it with that of an educator.

While experienced anesthesia educators may identify as an educator only, the CRNA in transition does not appear to abandon or retire their identity as a clinician; instead, they find it important to merge this identity with their new identity as an educator. This is not an instant or linear process, but one that is individual and variable. Furthermore, this may change as the CRNA in transition gains experience and confidence in their role as an educator. Alan stated,

I see my mentor, [they] definitely identifies now on the education side and [they don't] really have a desire to be in the clinic. [They] feels like [their] role is now in academia. I don't ever want to lose the hybrid of being able to teach but also still be very current and active clinically. But yeah I can see the struggle and with time it's going to be, may be harder, not maybe, it's going to be harder, so my identity has shifted some but I still, I'm still in the clinical area so much and they

still think of me that way, it's almost like they still see me as a clinician. So as long as I keep them fooled (giggle) and stay there enough that they see me I think that that's going to help.

The idea of being “very current and clinically active” shows that Alan equates clinical competence with current relevance in anesthesia, demonstrating the value he places on being a clinician. This implies that one must be clinically active to be currently relevant. Moreover, the idea of “keeping them fooled,” helping in the identity amalgamation, shows that Alan finds confidence in being seen as a clinician, a role in which he feels he is an expert. The view he has of himself as a clinician, as well the view his peers hold of him as a clinician, helps to ease his transition into a new role in which he does not yet feel confident as an expert by giving him a solid foundation. It seems that in a time of identity reformation, it is important for the CRNA in transition to be able to identify with a professional identity, in this case the clinician with whom they feel confident, to compensate for feeling like a novice in the role of educator.

The idea of clinical competence being central to faculty performance was also echoed by Frank, who stated, “. . . before I came along it really wasn't even encouraged for people to work clinically. I see too much value in staying clinically relevant.” This shows that there is a divide between the clinical CRNA and academic CRNA. Upon entering academia, CRNAs may not be encouraged to work clinically. However, clinical practice can support faculty credibility and help faculty stay “relevant.”

Additionally, there is intense pressure on being an educator because of the idea of an educator as equivalent to that of an expert. One participant stated,

I feel like now when I'm in clinic there's a different level of respect. I feel like, I think people by and large look at University faculty as experts and they often, whether it's true or not, they think you're one of the smartest people in the room. And I think because I had a strong clinical background and performance and had that respect I think that it, I think that helped. But it is different now.

It is accepted that CRNAs in academia are experts. However, the clinical practice of anesthesia and the practice of academia are very different. Competence in one does not immediately translate to competence in the other. Here the participant shows that by having a strong clinical foundation they were able to adapt to their new role as an educator more easily. The strong clinical foundation provided a knowledge base that allowed the CRNA in transition to feel self-respect and garner the respect of their clinical peers.

Overall, the importance of a shift in professional identity is paramount. This shift can be difficult, as the CRNA is transitioning back to the role of novice. This can be further understood by exploring how CRNAs in transition establish credibility with their peers and students, how they make their mark, and how they adapt to the organizational hump.

Nested Themes

Establishing credibility. Upon entering academia, the CRNA feels the need to establish credibility as an educator. This is a two-fold process as the CRNA seeks to establish credibility with students as well as with peers. However, no participant explicitly stated what the student's actual expectations of the faculty really were. Instead, they discussed their perceptions of student expectations based on the expectations of their faculty when they were students.

Establishing credibility with students. Charlie stated,

You know, you have students, and they're adults, and they have expectations, and you have expectations of them, so it's kind of a two-way bridge. See you expect something from the students and they expect something from you. It's like the saying, you receive what you give, so to get a good result from students you have to give yourself. And you know, being in a profession like nurse anesthesia where we want our students, we demand a lot of them and we want them to be high-level, so we have to meet that high level of education.

Another participant, Frank, said, "the students get out what you put in and if you are really wanting to excel you do have to do some extra above and beyond stuff if you want to be successful and do well." Despite not being able to state directly what students' expectations of their faculty are, this demonstrated that these participants understand that adult learners have expectations of their instructors. This immediately places a high level of expectation upon new faculty. Additionally, the participants feel a responsibility to their students to be good teachers.

Because participants felt confident in their role as clinical practitioners, that confidence translated to precepting students, which was seen as not that much different than working clinically. Alan stated,

As a clinical preceptor you're, you have credibility because they see you immediately interacting with patients and doing things. So you dress the part, you interact with surgeons and anesthesiologists, and they see you working so there's not that building of anything, I mean it's just there. In the classroom, I definitely felt like I had to perform and meet these expectations that, he says he's a CRNA, he says he's very experienced, and then I just had to jump in and start teaching and proving myself . . . Really clinical teaching in my mind is easy because I can just teach doing what I like to do. In the classroom it's definitely different because it has to be so broad and deep at the same time and they are really like sponges wanting to learn everything. And there's a lot to cover, you know when you are in

one case you are focused on one system, one surgery. It's a little overwhelming when you take in the whole picture of what can happen during a didactic class.

This shows that one's clinical performance, here talking to patients and interacting with clinical peers, is sufficient to establish credibility, making clinical instruction and precepting "easy" as compared to didactic instruction. Additionally, in the clinical area instruction is "focused"; therefore, more limited to the case one is performing. If questions are asked outside of the realm of the case, preceptors can advise students to focus on the case instead of being expected to know it all. In the classroom there is no "doing" that conveys immediate credibility, making the novice educator feel like they are "performing." This shows the novice educator may feel like an imposter as an educator. Also, there is no limit to the discussion in a classroom. This can cause the new educator to have an "overwhelming" feeling at the possibilities of inquiries from students.

Alan also stated,

So I had had some experience with teaching, but I had no idea how overwhelming it would be to enter the graduate level and teach on that level and be able to understand information well enough to be able to field questions from the smartest group of people I had ever taught. So that was a transition. Just really having to immerse myself in in the, whatever course I was teaching, so that I knew well enough to teach it, but also to field those questions. But I didn't really didn't realize it was going to be as much work as it was . . . compared to clinical practice it was definitely a much bigger hour commitment.

Here again, one can see the expectation Alan placed upon himself. For Alan, the definition of a good teacher is someone who knows it all, again creating an "overwhelming" feeling that is different from the experience in clinical practice.

Similarly, teaching “on that level” and fielding questions from the “smartest group of people” he had ever taught invoke the same overwhelming feelings. This again reiterates the feeling of being an imposter—am I really good enough and smart enough to teach these students? This question registers even deeper as CRNAs are clinical experts. To transition from a clinical expert that is expected to be able to do and know it all, and then enter a situation in which you cannot do it all and do not know it all can shake the core of your professional identity.

Establishing credibility with peers. Another aspect of entering academia that can be challenging is navigating interactions with peers. Frank stated,

Yeah, that was challenging. Some of the faculty members, um, one in particular definitely oh, there was a lot of resentment that I came in with new ideas. They liked the status quo, so I had to fight with that a little bit. So that was challenging, actually discouraging. Several things I would say, this would be a great idea and the answer was we’ve tried that, it didn’t work, so it definitely caused a little bit of contention between me and this faculty member.

Feeling discouraged and feelings of contention are related to being seen as less than equal. This speaks to the dichotomy of having to establish oneself as a peer among a group of fellow CRNAs as faculty despite having already established one’s role as a peer among them clinically.

Edward said,

In the office sometimes you come in as a new faculty member, you’re bright-eyed, bushy-tailed if you will, to use the cliché, and you’re full of ideas. What if? What if? What if? We could. We could. We could. And everyone’s not always 100% receptive to that, you know? Sometimes you need to just sit and listen for a little while I’ve learned, and sort of take in what is happening before you start making suggestions about what could be happening. Because sometimes there are

reasons that it's done that way. Now sometimes those norms and the dogma need to be challenged, but not every time. So that's been, definitely a challenge.

This shows that peers have an expectation of new faculty to conform to their created norms. New faculty are expected to “just sit and listen” until they have proven themselves to peers. At this time, they can begin to make suggestions about ways to improve the system. This speaks to an unspoken hierarchy where experienced faculty have more power. It also speaks to the idea of new faculty as novices. New faculty do not yet understand the “reasons” a program is run a specific way and are expected to learn and understand these before challenging them. This may contribute to the new faculty's feelings of being an imposter and not belonging in an academic role. They are not yet seen as peer in academia despite being among CRNAs, whereas in the clinical area they enter as a peer and teamwork is immediately encouraged.

Alan said,

Oh well, I think that because I had been in politics and state government for about 10 years of my career . . . I was really out in the front during all that in a leadership role, I think they started looking at me more as a colleague because they saw my name on everything, they saw that I was getting things done, and motivating change, so that was helpful. But even all that, I still, on day one, I think they still thought of me as a student and I really had to prove myself . . . It's been a little bit challenging , but I think just being positive, and respecting them and giving them, not thinking I can do it without their help, or that I have better ideas, being a team player, and walking a delicate line of not trying to come in and take over with all kinds of new ideas knowing that they're ingrained.

Alan began teaching in the program he attended years earlier. Despite having leadership roles outside of clinical, Alan still felt the need to “prove” himself to existing faculty. Not only did Alan have to display ability, he had to display respect to the existing faculty by

showing them he was “not thinking he could do it without their help.” This speaks to the “delicate line” new faculty face. They must be competent yet humbled by the simple fact they are new. While they are expected to perform independently, they are also expected to understand that they have not established themselves as equal among faculty peers.

When discussing sensitive topics such as relations among experienced and novice faculty, nonverbal cues gave insight into participants’ feelings. During these discussions, participants often slowed the speed with which they spoke, taking breaks and often pausing to ponder word choice. Additionally, they often offered quick clarification in the form of a compliment for experienced faculty each time a critique was voiced. The change in cadence and carefulness with which they spoke was very different than at other times during the interview, leading the researcher to note their change in attitude. The researcher interpreted this as participant discomfort in voicing comments that were other than positive about faculty peers.

Mentors. Establishing credibility with peers was made easier by forming mentor relationships with peers. Asking for help in academia can be difficult due to being physically separated in separate offices and separate classes. In the clinical setting, CRNAs are taught teamwork immediately and it is an expectation. In academia, one often functions independently and is expected to establish oneself before being accepted fully into the team. There may be the fear that ‘if I can’t do it alone or I have to ask for help, I have to admit I’m not good enough, I’m an imposter.’ Denise said, “I hate to bother other faculty members with teaching me how to do stuff like this, they’re overwhelmed and worked as well.” One way to establish credibility among peers without the added stress

of being viewed as an imposter or bother was to utilize mentors, both formal and informal, as resources while learning the new faculty role. Having a mentor allows for a resource contact that one can feel comfortable to ask for help when needed. Furthermore, acceptance by the mentor as their peer can model that acceptance for other faculty.

Only 14% of participants were given a formal orientation to their new faculty role and university. Furthermore, only 29% of participants were assigned a mentor; the remaining 71% established informal mentor relationships with colleagues on their own. The fact that participants who were not assigned a mentor still felt it beneficial to develop a mentor relationship with existing faculty speaks to the importance of a mentor in easing the transition from clinical to academia. Charlie held,

[Mentors] can make a huge difference because they can give you good advice, can guide you through processes, because sometimes the University can be so big and if you work in a university system like the one I work, there's a lot of processes and a lot of stuff that you don't even know where they're even meeting, but there's something waiting for you, and there's a way you're supposed to do it. And sometimes knowing how to do it, it's much better if you have somebody who says, no you do it this way, than having to look for all the manuals and regulations and blah, blah, blah, to see how it is done. Having somebody there that will give you advice on how to proceed and what you should do, it makes a huge difference.

Becky stated, "On the academic side I had two outstanding mentors that really helped ease my transition and teach me the administration role, teach me the nuances of the curriculum and connect me with educational resources for nurse anesthesia education." For Becky, she received very little support from clinical colleagues, which made her question her decision. The support of her academic colleagues helped her in feeling

confident she had made the correct career move for her. It should be noted that lack of support from clinical colleagues was not a common finding among these participants.

Gwen said,

I have felt very well supported by the University, oh, they have a couple things in place to help new faculty transition, so I . . . they had us go to, about once a month they had a session they do for first-year and second-year faculty on different, you know sometimes it's pedagogy, sometimes it's university process, things like that, but things to help you get rolling and learn how things go at the University. And then were assigned a one-on-one mentor, and so our program director who is a CRNA was my mentor and she was kind of my go-to person for all of my questions . . . She had taught before and I had not. So, she was a good resource person for all of my many questions, but I felt like I was barely staying afloat for a long time.

Despite the formal orientation and assigned faculty mentor, Gwen felt she was “barely staying afloat for a long time.” This speaks to how different the faculty role in anesthesia is compared to the clinical one. The lack of formal training in pedagogy seen in the sample can further explain this feeling. New faculty need mentors because they are entering academia with no training in education.

Other participants used professional connections to establish a faculty mentor. More than one participant referenced professional advocacy in their state organization and government as a way to establish credibility and form professional relationships. For Frank,

. . . one of my fellow faculty members, we've just been friends since I graduated and have worked a lot together politically, so she really kind of took me under her wing and showed me the way the university system worked as far as the online, and the Blackboard that we use for lectures. So yeah, everybody was very supportive, but she was just somebody that went above and beyond to make sure I had a friend I could talk to.

Frank found the “first year was pretty, pretty overwhelming” and reported feeling “discouraged” and experiencing feelings of “resentment” among fellow faculty. Beyond being someone that was a professional resource, Frank’s informal mentor was a “friend he could talk to” implying they could discuss his experience transitioning to academia.

Alan said,

Well I had, I did a lot of state government, umm, with my state association and had leadership training, public speaking, media training, so I think a lot of that helped equip me with all those type of skill sets that also, you know I’ve networked with so many people. If a topic comes up I am not real familiar with I have a large bank of resources. So if it’s a business issue I talk to one of my CRNA friends that’s good in business. So, ah, I think having a good clinical background and good network of CRNAs makes it easier and is helpful to have that. I think when you do state government and you’re involved on a national level, a lot of the people that you’re associated with are in Academia. A lot of program directors that are able to, do, run for office, so it seemed like most of my buddies at national meetings were in education in some way. So it’s easy for me to just email, text, or call someone and say, what do you think about this? I’ve ran syllabi by people and that definitely is helpful.

Alan uses his network of professional contacts via his involvement in state and national organizations to create a support system of informal mentors. He also developed an informal mentor relationship with a colleague at the university where he teaches. This, too, was facilitated by his involvement in his state association. Having these relationships allows him to have “expert” contacts for a variety of topics, allowing him to establish credibility as knowledgeable and able among peers.

Making a mark. Another important aspect of transitioning to a faculty role was making a mark. The idea of making a mark on students and the profession of anesthesia was apparent in the data. Edward said,

The idea of influencing practice, perhaps one day even on a national scale, but definitely right now on a bigger scale than one patient at the time, although I think the work that I did in the operating room was very fulfilling, something is very attractive to me about the opportunity to use my other skills like communication skills and people skills . . .

Charlie said,

Well I think there's a satisfaction in, whenever you're in the academia there's a satisfaction that you get with teaching. And you'll see students that come and have dreams of being a CRNA and you help them achieve those dreams, plus it also helps you grow as a person because I've grown a lot being an administrator and an educator.

Here both participants discuss the impact being an educator can have. Edward references "influencing practice" and making an impact "on a bigger scale than one patient at a time" showing that academia allows him to make a bigger mark than clinical practice alone. Charlie discusses helping students achieve their dreams, speaking to the opportunity academia provides to make a mark on students.

Furthermore, academia in and of itself makes a mark on faculty. Edward notes that being an educator allows him to "use my other skills like communication skills and people skills," while Charlie said, "it also helps you grow as a person." He goes on further to say,

Professionally you grow a lot. That's why I don't ever regret choosing the path that I chose because I think that there's many aspects to oneself that grow by being in the academia. Not just that you learn how to administrate a program, or that you learn how to teach a class. Many things that apply to life, yeah, you see things differently when you're in the academia. You know you get to meet important people, you get to learn from them, you get to network. I've gone to meetings, I've met people, I've interacted with people that I've never interacted with if I were still in the clinical setting. So that opens the door differently. Like

you see change, and it's something that you can create change, you can move yourself and influence in certain directions whenever you go to academia. So let's say that I just decided to quit my job and do something else totally different, I think I would have more skills now to do whatever I want in life by having this experience.

This shows that both Edward and Charlie feel they have been able to utilize more skills in academia than were necessary in the clinical area. This led to greater professional development and the transition making a mark on them as individuals.

In more general terms, participants often discussed making a mark in their instructional style by making it their own. Alan said, "Well initially I was so busy. I re-did every course, so, I re-did every PowerPoint, every test, everything." Frank stated,

I had to transition everything to PowerPoint. It took me basically a year to redo all of my courses and there were times I was finishing a lecture preparation and then giving it the next day. So that first year was pretty, pretty overwhelming.

while Gwen said,

But that first time teaching all these courses oh, it's just there's not enough time to build in oh, well I feel like there's not enough time to build in the creative piece. So, like, it has to come the second time around . . .

This demonstrates that participants looked at their courses and instructional style as a way to make their mark.

Overcoming the organizational hump. Edward described the transition to academia as

Very, uh, I would say challenging and rewarding, if I picked two words. You know, that may sound cliché, but it's very true. In clinical you know I would

show up at 0630 or whatever time, 0600 depending on the day. And you're sort of given an assignment, you're given a schedule, and you just carry that out. You know as you transition into the faculty role, it's very different. You're sort of given an end goal that may not be completed for you know, one week, one month, one semester, or a year later. And then you're sort of navigating the scheduling and the organizing and putting those pieces together on your own. So, for me, that was a big difference right, in the difference in having a schedule or having a preset assignment versus having sort of an end goal and open window in which to sort of design, organize and complete that goal.

Edward found the lack of clear focus to be drastically different from clinical practice. He went on further to say,

I would say coming up with the workflow was challenging for me because again the idea of coming in and let's say I have lectures to prepare for, I have a course next semester that I'm organizing the objectives for and gathering lectures for, I have a CE conference coming up, maybe I'm going to teach in a lab at the AANA and I have a talk coming up. So, you could imagine you start to get these stacks of assignments on your desk and you're used to coming into clinical where, okay today I'm taking care of Ms. Jones, Ms. Smith, and Mr. Thomas. You know and instead . . . wow, there's months of work here in front of me, where do I start and how do I take this one bite at a time? So that was very challenging. Developing a workflow to approach those things . . . there was a lot of trial and error on my part.

This sentiment was echoed by Frank, who coined the term "organizational hump."

He stated,

The organizational hump that I, being able to get, know that you have all this content to cover and being able to give everything the amount of time it needs and still get through the semester without rushing or leaving anything left to misinterpretation. Also, to get research projects, and meet with students, and make sure you're not missing anything, that is definitely (laughs). I almost needed assistance with that I think.

Both participants found the independence of academia to be a challenge. In clinical, an assignment is given and carried out. In academia, there is freedom in deciding how to achieve an end goal. There is a new level of time management and planning that had not yet been encountered. This includes not only planning professional time but planning personal time.

When discussing the organizational hump, Charlie said,

It's been a bit traumatic (laughs), it's been a bit traumatic because, umm, as I told you at first when you get all this and you take it home then you start learning to manage situations and to forget about them and to think of them when you have to think of them, taking less and less of your work home. It's an ability that you have to develop when you're in the academia and are an administrative person.

Furthermore, Charlie felt that "Being an educator is always feeling like you're connected to your job." Frank said,

When I was in clinical practice I could go to my day and when I left, I was done. With this I am never done, there is always something to be done, and I initially would bring a lot of work home, and I realized I've got to have time off, so part of my organization is making sure I am doing work when I am at work and I am living when I am at home.

Gwen found that while the workday is more flexible in academia, allowing her to work from home when needed, it seems she was taking work home, working more hours, and she felt like there were "not enough hours in the day to get everything done." This shows that overcoming the organizational hump was challenging on a professional and personal level. For the first time in their anesthesia careers, novice educators constantly felt connected to their job and pressure to continue working even when at home. Because

their professional duties now regularly encroached on their personal time, new anesthesia educators found it necessary to plan for personal time when managing professional time. Without the inclusion of planning for time for personal activities, novice anesthesia educators felt their role in academia infringed upon their personal lives.

For some participants, the amount of work extended into other areas of their professional life as well, such as in clinical practice, research, or professional involvement. For Alan,

I was so busy that when I did work it was in the evening or a shift on the weekend to pick up extra time. But now I really feel that I am in a place where I can get in clinic once a week, so now I am able, as part of my 40-hour salary, I'm working a day in clinic.

Denise stated,

So, I think I had some perspective because I had been teaching part-time for a few years, so I knew what was going to be involved in academics. I didn't have any illusions about it being any easier of a job or any less of a time commitment. Um, one of the hardest transitions for me, and I'm sure for a lot of people is you're never away from this job. There is always emails, there is always things to respond to, there is always something else I can be working on, so that can be very draining. With clinical practice you punch out at the end of the day and you're pretty much done, at least until your next shift, and you can turn your brain off of anesthesia for a while. And you don't get that in academics.

She felt that one of the biggest challenges to her transition to academia was the change in time management and time commitment. She felt that her academic workload did not allow time for her personal research and that her evenings were not free anymore due to needing to work.

I definitely find that in the evenings I'm working on a piece of simulation material or fixing an exam or responding to faculty related emails, so, I don't know, I just feel like my evenings are not 100% free like they used to be, and that's definitely been something that we've had to adjust to at my household.

This again speaks to the idea of being constantly connected to your job. Here, however, we see that academic responsibilities can limit the novice educator's ability to practice clinically or contribute to their profession and/or professional organization.

Additionally, while participants reported greater flexibility in their working hours, they reported working more hours in a day or week than in clinical practice. Edward said,

We don't clock in at 0700, we don't clock out at 0300, we all contribute to get the job done. And so sometimes that means you know, not a 40-hour work week, sometimes that means a 60-hour work week, sometimes I'm here late in the evenings, sometimes because our department also runs a continuing education program out of the department. Um, and so that's in addition to your administrative and academic responsibilities uh, and so sometimes those conferences are on the weekend, or sometimes those conferences are held in a different state and so you may be traveling uh, you may be, you know, away from your family for 4 or 5 days, uh, consecutively when you're working on those types of projects. So that's where it sorts of extends beyond the classic 40-hour work week or clock-in-clock-out mentality for sure. And then I totally get what they're talking about like even if I'm on the road at one of these continuing education conferences, I'm still connected to my classes, I'm still emailing my students, I'm still posting assignments to Blackboard uh, things like this and so if you're let's say at a conference for 8 hours that day, you may in the hotel room that evening be working on stuff for school. So, there's flexibility of the hours but it's definitely not a like clock-in-clock-out kind of job, that's for sure.

Denise stated,

Now I have the flexibility to attend lobbying events, and I would not have had that flexibility to attend before. But I definitely, I've probably had more time for the extraneous activities before academics. It's like you're saying, your time is your time now when you're in clinical practice so I could write more, journal

more, engage with others in my evenings ‘cause they were free. Now my evenings aren’t even free.

Frank felt “the time commitment for my didactic job might be 40 hours on paperwork but it’s 60 or 70 . . .” Again, this reiterates that an academic job varies from a clinical one in that the work is continuous, flexible, and individualized. While this provides the novice anesthesia educator with benefits, such as being able to work from home, it also can lead to feeling overwhelmed and confused. The flexibility of an academic job often led participants to report that while they worked more hours than in clinical, they overall felt more satisfied with their career.

Conclusion

The superordinate theme of identity amalgamation shows that the transition from clinical practice to academia triggers an identity change in the CRNA. This change does not negate their identity as a clinician. Instead, through establishing credibility with students and peers, making a mark, and overcoming the organizational hump, the CRNA begins to create an identity as an educator. This creation of this identity is aided by the confidence and experience an individual brings from their clinical practice. Since their identity as a clinician is central to the development of their identity as an educator, the two professional identities merge to create a new professional identity.

CHAPTER V

DISCUSSION

This chapter focuses on how the findings of this study relate and differ from existing literature on the transition from nursing practice to education. To provide context for the findings, the education process for becoming a Certified Registered Nurse Anesthetist (CRNA) and how this may impact the transition experience of CRNAs moving from clinical practice to academia are discussed. Future implications for research and nurse anesthetist education and study limitations are also discussed.

Comparison to Existing Literature

Nested Themes

Establishing credibility. Establishing credibility with students and peers was integral to forming a new identity as a clinician and educator. Participants discussed how “overwhelming” coming into a graduate classroom was due to student expectations of their faculty. While students did not explicitly state their expectations, they were interpreted through the lens of the new faculty. New CRNA faculty felt they were teaching “the smartest group of people [they] had ever taught,” and that information was “so broad and deep at the same time.” This meant that to be successful, “you have to give of yourself.” They feared being unable to answer student questions. Lacking pedagogical training, many new CRNA faculty leaned on their years of clinical experience to establish credibility. While in the clinical setting, participants felt they had inherent credibility

because students were observing them practicing as a CRNA, implying that the way to be a credible CRNA faculty member is to practice clinically. While in the classroom, participants reported they used clinical experiences and connections to show students they were experts.

Additionally, participants reported the need to establish credibility and “prove” themselves with their academic peers. More senior faculty seemed resistant to ideas and suggestions from new faculty, lending to the idea that while new faculty were experts clinically, they were novices academically. This also suggests a hierarchy among faculty, with more senior faculty being higher. Mentors eased this process by giving the new faculty a point of contact for advice and guidance. Analysis of the data suggests that new faculty may feel like imposters upon entering academia due to the lack of pedagogical skills necessary to be successful in academia. Additionally, analysis shows that academia is more isolated than the atmosphere in clinical practice, with faculty teaching individual classes, having individual offices, and making individual schedules. The utilization of a mentor eases this singularity for new faculty.

The idea of the need to establish credibility was seen strongly in Anderson’s (2009) study of master’s-prepared clinical experts transitioning to academia. New faculty reported needing the establish credibility with colleagues, students, and agencies. Establishing credibility was vital to not appear as a “wannabe” in academia (Anderson, 2009, p. 205), supporting the idea of feeling like an imposter, as seen in the data from the current study. Anderson’s participants also reported a fear of not knowing information when asked by students, again supporting data seen here. To establish credibility,

Anderson's participants reported using expertise, namely, clinical expertise. This speaks to the super-ordinate theme of identity amalgamation, where CRNAs find it vital to merge their new identity as an educator with that of a clinical expert. However, Anderson did not speak to a merging of professional identities; instead, using clinical expertise as an adjunct to teaching. Anderson also found that mentors were a positive influence in transition. They were necessary for feedback that allowed new educators to develop and become more independent (Anderson, 2009).

Mentoring as being necessary for a successful transition to academia was strongly supported in the existing literature. Socialization and professional support in the form of mentors was found to ease the transition experience for nurse clinicians entering academia (Blaine, 2015; Brown, 2015; Chapman, 2013; Grassley & Lambe, 2015; Mann & De Gagne, 2017; McArthur-Rouse, 2008; McDonald, 2010; Schoening, 2013; Spencer, 2013; Tucker, 2016; Weidman, 2013; P. Young & Diekelmann, 2002). Furthermore, collaboration with fellow faculty made novice faculty feel appreciated and accepted, helping them to feel confident in their choice to make a career transition (Anderson-Miner, 2017). Gardner (2014) explored factors related to educator efficiency and sampled peer-nominated effective educators and found that mentors were integral to educator efficacy. Additionally, the feedback was found to improve educator efficacy (Gardner, 2014), and mentors provide feedback to improve performance (Anderson, 2009).

One unique finding from these data was the use of professional involvement to establish credibility and form mentor relationships. Current literature does not discuss involvement in state and national professional organizations and political advocacy as a

way for nurse educators to establish credibility with peers and form informal mentor relationships. These data show that CRNAs are extensively involved with their professional organizations and involved with political advocacy. They utilize this affiliation to show professional commitment and contribution to their peers. This allows CRNAs to be seen as equal peers regardless of if they have a purely clinical or academic affiliation. Additionally, multiple participants referenced using professional contacts from their political and professional affiliations to form academic mentor relationships. When the institution lacks mentors, CRNAs can look to their professional organization to find a suitable mentor. It appears that while this finding is different from existing literature, it still supports the integral role mentors play in successfully transitioning to academia.

Making a mark. The CRNA in transition to academia was often motivated by the opportunity to make a mark on students and the profession as a whole. Participants viewed academia as a conduit through which they could influence practice on a larger scale by influencing multiple students who would, in turn, influence multiple patients and influencing anesthesia practice on a national scale.

Current literature supports the idea of nurses transitioning to academia to make a mark on the profession. Nurses transitioning from clinical practice to academia often cite the desire to influence the next generation of nurses and make a greater impact in nursing as an impetus for their career transition (Cangelosi et al., 2009; Chapman, 2013; Schoening, 2013; Weidman, 2013). Nurses also reported feeling that education was a way to give back to the profession of nursing (Brown, 2015; Tucker, 2016).

New CRNA faculty also aimed to make a mark in the classroom by individualizing lectures and content. They sought to impart their personal style of instruction to students. This idea is not new and can be seen in existing literature. Schoening (2013) sampled nurses of varied experience teaching in baccalaureate programs and found that as novice educators became more experienced in their role, they began to incorporate their own style into teaching. Anderson (2009) spoke to master's-prepared clinical experts transitioning to academia and found educators developing vision, noting how experience increases comfort in the role and allows educators to look ahead to plan and individualize versus surviving daily tasks. The desire to individualize instruction to reflect personal style and knowledge also contributed to the organizational hump experienced by new educators.

Overcoming the organizational hump. Participants reported great difficulty in initially managing their new academia workload. One participant coined the term “organizational hump,” referring to the need to learn to be autonomous in organizing professional time. Multiple participants discussed how academia scheduling differed from clinical in that it was unstructured, and the educator decides how to manage their time to meet assigned tasks. This autonomy was challenging and overwhelming for new CRNA faculty.

Furthermore, new CRNA faculty reported increases in workload that often required they bring work home. The majority of participants felt that while their work schedule was more flexible than when in clinical practice, they now worked more than 40 hours per week. Additionally, they had difficulty finding a balance between professional

and personal time. Participants often had to plan for personal time within their professional schedule to ensure that professional duties did not encroach on needed personal time. The challenge of time management is not unique to CRNAs transitioning to academia and can be seen throughout the nursing faculty.

Dieklemann (2004) found that experienced clinicians who were new to academia reported difficulty with classroom time management. McDonald (2010) performed a literature review of the transition experience of new nurse educators and found that faculty reported greater workloads than that seen in clinical practice, requiring they work more hours to complete necessary tasks, at times taking work home. This finding was supported by Bailey (2012), who interviewed Advanced Practice Nurses transitioning to academia, and Mann and De Gagne (2017), who interviewed novice clinical faculty in nursing programs; both reported that new nursing faculty encountered increased workloads and difficulty in time management. Increases in workload were also noted by Siler and Kleiner (2001) when interviewing new nursing faculty in their first year of teaching. They reported that a lack of resources on how to effectively function as a new educator increased the time needed to complete assigned work. Anderson (2009) found that participants felt like they were *drowning* and that decreased workloads helped ease the transition. Boyd and Lawley (2009) and Logan et al. (2015) explored the experience of clinical experts transitioning to academia in the UK and Australia. They found increased autonomy in education and noted that this autonomy could be overwhelming for new faculty. The increased autonomy, combined with workload expectations and

demands, led to feelings of stress and anxiety in novice educators (McDermid et al., 2016).

Super-ordinate Theme

Identity amalgamation. The super-ordinate theme that originated from the data in this study was that of identity amalgamation. Nurse anesthetists in transition from clinical practice to academia find it important to maintain their identity as clinicians. This eases the transition to academia because upon transitioning to academia CRNAs feel they are making a “transition back to novice from being an expert.” Moreover, 71% of CRNAs sampled lacked training in pedagogy. This made the transition more difficult because new faculty felt they did not have the skills necessary to manage a classroom, prepare lectures and simulation, and develop and analyze examinations. The retention of their clinical identity allows the CRNA to identify with a professional identity in which they have earned expert status, lessening the impact of returning to a novice role as an educator.

Existing literature does show that clinical experts transitioning to academia feel they are returning to novice status and that this is a frustrating experience (Cangelosi et al., 2009). New educators feel they lack the skills necessary, specifically training in pedagogy, to be successful in their new role (Bailey, 2012; Boyd & Lawley, 2009; Brown, 2015; Cangelosi et al., 2009; Diekelmann, 2004; Grassley & Lambe, 2015; McDonald, 2010; Siler & Kleiner, 2001; Tucker, 2016; Weidman, 2013; P. Young & Diekelmann, 2002). Additionally, studies show that continuing education, graduate education, and education in pedagogy ease the transition from clinical practice to

academia (Blaine, 2015; Chapman, 2013; Mann & De Gagne, 2017). Furthermore, studies support that clinical practice alone is insufficient to prepare nurses for a role in academia (Anderson, 2009; McArthur-Rouse, 2008; McDermid et al., 2016). This supports the findings that lack of pedagogical training in CRNAs makes the transition from clinical practice to academia more difficult.

Existing literature does show that nurses transitioning from clinical practice to academia form a new identity as an educator (Murray et al., 2014; Schoening, 2013). Schoening (2013) found that educators “integrate” their nursing and educator identities. On the contrary, Murray et al. (2014) found that nurses in transition undergo a role shift that culminates with their evolution into an academic. This is different from the findings of this study, as data show CRNAs find it important to maintain their identity as an expert clinician in order to combine that professional identity with that of an academic. The reason CRNAs may find the maintenance of their professional identity as a clinical expert as vital may be attributed partially to the return to novice status upon entering academia, and partially to how CRNAs are educated. The education process to become a CRNA is intense, rigorous, and consuming. It may be that CRNAs are reluctant to let go of the clinical practitioner aspect of their identity due to the pains endured to become a CRNA. This process is described below to provide context for the study findings.

Certified Registered Nurse Anesthesia Education

To be considered a qualified applicant for entry into a CRNA program one must possess a Bachelor's or graduate degree in nursing or a suitable major, an unrestricted professional nursing license or Advanced Practice Registered Nurse (APRN) license, and

a minimum of one year of full-time experience in a critical care setting (American Association of Nurse Anesthetists [AANA], 2019a). Licensure must be from the United States or its territories. At this time, a master's degree is the minimum entry into practice requirement for CRNAs. However, by January 1, 2022, all students admitted to graduate nurse anesthesia programs must graduate with a doctoral degree (Council on Accreditation of Nurse Anesthesia Educational Programs [COA], 2016). There are currently 121 anesthesia programs in the United States and its territories, with 91 of these programs awarding doctoral degrees (AANA, 2019a).

Nurse anesthesia programs are 24-51 months long and include didactic, simulation, and clinical instruction (AANA, 2019a). Students must complete 120 contact hours of advanced physiology/pathophysiology, 120 contact hours of basic and advanced principles in nurse anesthesia, 90 contact hours in advanced pharmacology, 75 contact hours in research, and 45 contact hours in advanced health assessment. Additionally, there is coursework in human anatomy, chemistry and biochemistry, physics, genetics, pain management, radiology and ultrasound, equipment, professional role development, wellness and substance use disorder, informatics, ethics and multicultural healthcare, leadership, management, business of anesthesia/practice management, health policy and finance, and clinical experience. On average, nurse anesthesia graduates have 9,369 hours of clinical training, including undergraduate clinical training and necessary critical care experience, upon completion of their graduate studies. The path to becoming a CRNA takes approximately 8 years (AANA, 2019a).

Upon completion of graduate school, one must pass the National Certifying Exam to be able to practice as a CRNA (AANA, 2019a). To remain certified, CRNAs must complete the Continued Professional Certification Program overseen by the National Board of Certification and Recertification of Nurse Anesthetists. It consists of two 4-year cycles, totaling an 8-year recertification cycle. The program requires CRNAs complete 60 Class A, or continuing education, credits, 40 Class B, or professional development activity, core modules in airway management, applied clinical pharmacology, and human physiology and pathophysiology, and pass a comprehensive examination every 8 years (AANA, 2019a). When one considers the time, effort, and money invested in becoming a CRNA it becomes clearer why CRNAs are hesitant to part with their identity as a clinical expert.

The requirements necessary to become a CRNA educator currently do not vary from those previously discussed. However, clinical experience is imperative to being considered for an educator position. Additionally, doctoral preparation is preferred. The AANA offers continuing education in the form of online modules and a yearly assembly specifically for anesthesia educators. However, formal coursework in pedagogy is not required.

Comparison to Researcher Experience

Similarities were noted between the researcher's previous experience and the participants' reported experience. Similar to the researcher, the majority of participants did not receive a formal orientation or mentor, but did benefit from informal mentor relationships. Additionally, while feeling like an expert clinically, majority of participants

felt like they had returned to a novice role as a new educator. Likewise, many expressed feeling the need to prove themselves to experienced faculty to be seen as peers in academia. Lastly, most found work hours in academia to be greater than in the clinical setting, but they did note a difference in flexibility, which compensated for the increased hours.

Theoretical Framework

Schlossberg's (1981) transition theory, a developmental theory grounded in the idea that development continues throughout the lifespan, served as the theoretical framework for this study. It posits that a transition triggers a role change that is perceived as a role gain, role loss, or combination of the two, and that this change is often associated with elevated stress levels. This role change can be helped or hindered by how an individual perceives the change (e.g., do they feel they control the change), the difference in the pretransition and post-transition environment, and the presence or absence of interpersonal and institutional supports.

The findings of this study support Schlossberg's (1981) transition theory. New CRNA faculty perceive their new role as having the potential of being a role loss in that without continued clinical practice they may lose their status as a clinical expert. However, with continued practice, transition to academia can be seen as a role gain whereby CRNAs maintain their current identity and merge it with their new identity of academia. Whether it is a role gain or loss, CRNAs in the transition from clinical practice to academia report increases in stress associated with the transition.

Furthermore, the difference in the pretransition and post-transition environment was a source of difficulty in adjusting to the transition. Participants reported difficulty in learning to overcome the “organizational hump” related to increased autonomy in organizing their workloads after having been assigned cases as a clinical CRNA. Additionally, the lack of institutional support in the form of a structured orientation was reported as hindering the transition for participants who lacked orientation and helping the transition for the individual participant who was given organized orientation. The presence of mentors, whether formal or informal, which can be seen as both institutional and interpersonal support, was also reported to ease the transition. Overall, study findings supported the use of Schlossberg’s (1981) transition theory as the framework for this study.

Limitations

While a smaller sample size is indicated for the use of Interpretative Phenomenological Analysis (IPA) (Smith et al., 2012), the small sample size of seven participants can be seen as a limitation of this study. One can argue that a larger sample size may have produced different results. However, data were collected until saturation was reached in an attempt to mitigate this limitation.

Sample characteristics are another limitation of this study. All participants except for one identified as White. All participants were between 30 and 50 years of age. One can say this may have impacted findings by collecting from a fairly homogenous population. However, Smith et al. (2012) recommend a homogenous sample for IPA. It is posited that if data are rich and thick, a homogenous sample will not be a limitation, and

the reader should be able to evaluate transferability. Another limitation related to the sample is that no participants were from the Western United States. While the study did include data from all other states and territories in the United States, a lack of data from the Western United States could impact findings.

Participants were interviewed via telephone and were audio-recorded. Lack of face-to-face contact with the participant during data collection limits the collection of non-verbal data. Furthermore, to promote dependability, triangulation of methods is encouraged in qualitative research (Streubert & Carpenter, 2011). Only individual interviews were utilized to collect data, and participants were only interviewed once.

Implications for Research, Education, and Practice

Research

Future research may be warranted to include CRNA participants from the Western United States to ensure the inclusion of all areas of the United States. Additionally, samples that include a broader range of age and race should be considered to ensure variations in experience are explored. Various methods of data collection, for instance, journals or focus groups, should also be considered to triangulate data and promote the dependability of findings.

Additional studies exploring the recruitment of CRNAs to academia are also warranted. Furthermore, retention of new CRNA faculty should also be explored, particularly methods to ease the transition experience (e.g., structured orientation and formal mentorship programs). Continued investigation into the experience of Advanced Practice Nurses (APN), namely Certified Nurse Midwives, Nurse Practitioners, and

Clinical Nurse Specialists, transitioning from clinical settings to academia should also be explored.

Education

Findings show that CRNAs are not regularly educated in pedagogy. When one considers the amount of education and training needed to become a CRNA, one can see that specifically creating coursework related to education may not be feasible or even warranted. However, more in-depth education in pedagogy should be given to CRNAs transitioning from clinical to academia. The AANA does offer continuing education in education, namely online modules on the principles and goals of writing curriculum, didactic and clinical instruction, and evaluation methods (AANA, 2019b). However, while not all participants reported completing the AANA modules, those who did found the courses to be less helpful than having the tutelage of a mentor or formal coursework. Furthermore, all CRNAs in this study found the use of a mentor, whether official or unofficial, to be beneficial in easing their transition to academia. Therefore, mentor programs should be organized for new CRNAs coming to academia, as well as orientation to the institution. In addition to these, universities should provide opportunities for formal training in pedagogy at the institution or through the use of continuing education programs.

Conclusion

Current literature shows that expert clinicians transitioning to new nursing faculty undergo a transition experience upon entering academia. This includes difficulty dealing with increased autonomy, new organizational structure, and new skillset. However, there

is a paucity of literature on the transition experience of CRNAs transitioning to academia. This is the first study to focus solely on CRNA educators, and one of few studies to focus on faculty in graduate programs. Findings support that CRNAs experience similar issues when transitioning to academia as their counterparts in prelicensure and baccalaureate programs. More APN faculty are needed to meet the increasing demand of APNs in the clinical area, including CRNAs. This study provides insight into how to ease the transition experience of CRNA faculty to help program administrators promote retention of new faculty.

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APPENDIX A

IRB EXEMPTION

6/15/2018 UNCG Mail - IRB Notice - 18-0263

Lynne Lewallen <lplewall@uncg.edu>

IRB Notice - 18-0263

To: Christine Kress School of Nursing Adult Health Nursing, Union Square, University of NC at Greensboro, Greensboro, NC 27402-6170

From: UNCG IRB

Date: 6/15/2018

RE: Notice of IRB Exemption **Exemption Category:** 2. Survey, interview, public observation **Study #:** 18-0263 **Study Title:** The Transition Experience of the Certified Registered Nurse Anesthetist from Clinical Expert to Novice Educator

This submission has been reviewed by the IRB and was determined to be exempt from further review according to the regulatory category cited above under 45 CFR 46.101(b).

Study Description:

Interviews will be conducted and audio-recorded with Certified Registered Nurse Anesthetists who have transitioned from clinical practice to academia to explore their experience becoming nursing faculty. Interviews will be in person, via video conferencing, or telephone. Transcripts of the interviews will be used as data to explore the transition experience. **Investigator's Responsibilities**

Please be aware that any changes to your protocol must be reviewed by the IRB prior to being implemented. Please utilize the most recent and approved version of your consent form/information sheet when enrolling participants. The IRB will maintain records for this study for three years from the date of the original determination of exempt status.

Signed letters, along with stamped copies of consent forms and other recruitment materials will be scanned to you in a separate email. **Stamped consent forms must be used unless the IRB has given you approval to waive this requirement.** Please notify the ORI office immediately if you have an issue with the stamped consents forms.

Please be aware that valid human subjects training and signed statements of confidentiality for all members of research team need to be kept on file with the lead investigator. Please note that you will also need to remain in compliance with the university "Access To and Retention of Research Data" Policy which can be found at http://policy.uncg.edu/university-policies/research_data/.

CC: Lynne Lewallen, Family and Community Nursing

APPENDIX B
RECRUITMENT EMAIL

Hello.

My name is Christine Kress and I am a PhD Candidate at the University of North Carolina at Greensboro. I am conducting a study to explore the transition experience of Certified Registered Nurse Anesthetists (CRNA) from clinical practice to academia. I am seeking CRNAs with national certification in anesthesia and licensure in nursing who currently hold a full-time academic appointment. A minimum of one year of full-time experience in academia, but less than or equal to five consecutive years of experience in academia, is required. Additionally, all participants must speak English.

The study will consist of a semi-structured interview with interested CRNAs in person, via video conferencing, or via telephone. This interview will be scheduled at a convenient time for the participant. Interviews are estimated to take 60 to 90 minutes. The interview will consist of asking the CRNAs to describe their experience transitioning from a clinical role to academia.

The goal of this study is to identify commonalities in the transition experience of CRNAs from clinical to academia in order to strengthen recruitment and retention of nurse anesthesia faculty and assist in developing orientation and mentoring programs for new faculty. I am kindly requesting this email be forwarded to all CRNA faculty within your organization. Interested individuals should use their personal email to contact me at cmbazik@uncg.edu.

Thank you for your consideration,

Christine Kress, MSN, CRNA

The University of North Carolina at Greensboro PhD Candidate

APPENDIX C

FOLLOW-UP RECRUITMENT EMAIL

Hello.

Thank you for your interest in participating in my study to explore the transition experience of Certified Registered Nurse Anesthetists (CRNA) from clinical to academia. At this time, I would like to confirm eligibility.

Study participants must hold national certification in anesthesia and licensure in nursing and currently hold a full-time academic appointment. A minimum of one year of full-time experience in academia, but less than or equal to five consecutive years of experience in academia is required. Additionally, all participants must be English speaking.

To clarify, participants must be employed full time in a faculty position to facilitate student learning. Participants may or may not hold clinical and didactic roles. Participants who are employed full time as a clinical CRNA who precept students as part of their clinical job duties but are not full-time nurse anesthesia faculty with the primary duty of educating and precepting students, are excluded from the study. Please do not hesitate to email me with questions regarding eligibility.

If you meet these criteria, please review the attached consent and email me at cmbazik@uncg.edu with your preferred contact for email and telephone. I encourage you to email me from your personal email rather than your professional email to enhance your confidentiality. Please include days and times for June, July, August, and/or September that would be conducive to your schedule for scheduling an interview. Additionally, please indicate if you prefer to schedule the interview via phone or video-conference (facilitated via Skype or FaceTime).

Thank you for your consideration,

Christine Kress, MSN, CRNA

The University of North Carolina at Greensboro PhD Candidate

APPENDIX D

DEMOGRAPHIC QUESTIONNAIRE

Demographic Questionnaire

- | | | | |
|-----------------------------------|-------|--------|--------------------|
| 1. What is your preferred gender? | Male | Female | Declined to answer |
| 2. What is your age range? | 30-39 | 40-49 | 50-59 |
| | 60-69 | 70-79 | |
3. What is your race/ethnicity?
 4. In what state are you employed?
 5. In what type of school are you employed (public vs. private)?
 6. What is the highest level of education you have obtained?
 7. Are you currently enrolled in an educational program? If yes, describe.
 8. Have you had training specific to pedagogy?
 9. How many years' experience in nursing education do you possess?
 10. How many years of clinical experience as a CRNA (outside of nursing education) do you possess?
 11. What are your job duties (didactic, clinical, and/or administrative)?

APPENDIX E
INTERVIEW GUIDE

1. Can you describe your experience transitioning from clinical practice to academia?
 - a. What made you want to go into academia?
 - b. Were there experiences that made your transition easier?
 - c. Were there experiences that made your transition harder?
 - d. Were there people who made your transition easier?
 - e. Were there people who made your transition harder?
 - f. Do you have any experience as an educator from your time as a Registered Nurse?
2. Is there anything we haven't discussed that you feel was important about your transition from clinical practice to academia that you would like to share?
3. May I contact you again, if necessary, to clarify anything we have discussed?

APPENDIX F

CODE CHART

Pseudonym	Previous experience	Mentor	Entering academia	Salary	Time	Professional Involvement/ Political Action	Student Interaction	Pedagogy
Alan	Rework existing material – no experience building a class; on the job learning, CEUs via AANA Clinical Coordinator	Informal peer mentor – previous positive relationship from joint political involvement	Concerns entering academia – lifestyle, salary, loss of clinical skills Enjoys teaching – positive feedback as a teacher (Sunday School Teacher)	Salary – less money outweighed by improved lifestyle	Greater time commitment than clinical job	Political involvement for 10 years (leadership role) How he established credibility and peer relationships How he created informal mentor relationship	Establishing credibility with students – clinical experience and practice, true to word (only tested on what he said he would), approachable, good resource Expectations – expects students to be prepared and has high expectation of self as instructor (feels like he can't say he doesn't know)	CEU's via AANA Learn modules

Pseudonym	Previous experience	Mentor	Entering academia	Salary	Time	Professional Involvement/ Political Action	Student Interaction	Pedagogy
Becky	Clinical coordinator before transitioning to education (responsibilities for orientation, clinical assignments – including remedial assignments, evaluation summary) Gradual transition – part-time teaching in anesthesia program before becoming FTE	Informal mentors, met outside of work, worked beside daily – daily face-to-face check ins, transparent about program (student issues, budget, committee work), clear lines of communication	After 3 years in clinical practice found best days were when working with students		More hours in academic work week “I would say there are probably more work hours, but they are more flexible in that I am in control of them . . . the schedule with an academic role is much more flexible and it’s one of the strengths of having a position in Academia.”	More time and money to attend national meetings – AANA Assembly of School Faculty		AANA CEU in education required
Charlie	No previous experience with	Informal mentor provided informal	Satisfaction in helping students achieve	Traditionally less than clinical counterparts	Didactic prep requires large time commitment	Professional Growth - Opportunity for	Document everything done correctly – unhappy	Curriculum, evaluation, and administration

Pseudonym	Previous experience	Mentor	Entering academia	Salary	Time	Professional Involvement/ Political Action	Student Interaction	Pedagogy
	education from time as RN	orientation – helped with accreditation paperwork and learning university	dreams, flexibility in scheduling, being in education keeps you current Challenge to enter academia – “it’s been a bit traumatic”		Work outside of office hours Have to balance responsibility Must make time for self and family “Being an educator is always feeling like you’re connected to your job” Plus side is flexibility in hours, more time for family Easier to go to work clinically and leave work behind At first constantly worried about	networking you don’t have in the clinical arena, development of new skillset, expanded influence, networking	students will sue program Administrator has to care for concerns of students	n courses via university coursework.

Pseudonym	Previous experience	Mentor	Entering academia	Salary	Time	Professional Involvement/ Political Action	Student Interaction	Pedagogy
					the job – connected to job			
Denise	<p>Previous experience in MSN – didn't have illusions it would be less work</p> <p>Spent 5 years working part-time in anesthesia education</p>	<p>Good friends with existing faculty – (informal) Mentor year (technology mentoring, student interactions, university process)</p> <p>"I hate to bother other faculty members with teaching me how to do stuff like this, they're overwhelmed and worked as well."</p>	Entered academia because best way to use PhD		<p>Greater flexibility (can work from home, leave in middle of day if needed)</p> <p>Greater time commitment than clinical practice</p> <p>Doesn't have time for personal research, evenings are not free anymore due to needing to work ("I definitely find that in the evenings I'm working on a piece of simulation material or fixing an exam</p>	<p>Greater time flexibility (family, engagement in professional organization, PAC involvement) – however feels like she was more involved (as below) when in clinical practice</p> <p>Always been very engaged with state association</p> <p>Editor for our Journal</p> <p>Participates in government relations and public relations</p>	<p>Dealing with students "extremely challenging" – need more resources to help faculty deal with students; students have hard time expressing themselves and being respectful, very competitive, question everything, "not a lot of boundaries in terms of emails and texting"</p>	No training specific to pedagogy

Pseudonym	Previous experience	Mentor	Entering academia	Salary	Time	Professional Involvement/ Political Action	Student Interaction	Pedagogy
					or responding to faculty related emails, so, I don't know, I just feel like my evenings are not 100% free like they used to be, and that's definitely been something that we've had to adjust to at my household")			
					“Greater time flexibility (family, engagement in professional organization, PAC involvement)			
					I think I had some perspective because I had been teaching part-time for a			

Pseudonym	Previous experience	Mentor	Entering academia	Salary	Time	Professional Involvement/ Political Action	Student Interaction	Pedagogy
					few years so I knew what was going to be involved in academics. I didn't have any illusions about it being any easier of a job or any less of a time commitment."			
Edward	Affiliate faculty – guest lecture, lab assistance, volunteer; gradually assumed more lectures each year Organized new grad support program as RN One day monthly	Assigned faculty mentor during first week (informal, fluid relationship, use as needed, used to bounce ideas off of, oriented him to department) – still maintaining mentor relationship	To serve something greater than self Influence practice Use different skills (communication skills) Enjoys presenting to groups Enjoys performing	Change in salary (lower financial incentive) worth if to be "serving something greater than myself"	Time management challenging – told assignment in clinical while faculty role you are "given an end goal that may not uh, be completed for you know, one week, one month, one semester, or a year later. Uh, and then you're sort of	Impact anesthesia practice across country Ease of and support from department for involvement at state and national level	Different learning styles than students 20 years ago – need student-centered approach Communicate via different mediums (students across state) including social zoom, email etc. but keep personal and professional	Formal coursework in pedagogy in anesthesia school – presentation styles, what is pedagogy, PP design, lecturing to engage; coursework gave him confidence; helpful to transition; gave opportunity to develop

Pseudonym	Previous experience	Mentor	Entering academia	Salary	Time	Professional Involvement/ Political Action	Student Interaction	Pedagogy
	teaching to new grads		and translating research		navigating uh the scheduling and the organizing and putting those pieces together on your own"		separate but be real and transparent with them	own style of teaching
	Preceptor		Passion		More time consuming than academia			
			Positive feedback from guest lecturing		Flexibility of hours for appointments but expected to be in office daily (hours were not the change, change was how to organize work hours)			
					May need to travel to do job			
					Overwhelming			
					Challenge managing large			

Pseudonym	Previous experience	Mentor	Entering academia	Salary	Time	Professional Involvement/ Political Action	Student Interaction	Pedagogy
					amount of emails			
					Time management was trial and error process			
					Compared and contrasted workflow of colleagues and mentors to devise own system; have more time as guest lecturer to prepare lectures than as FTE			
					Connected to classes regardless of location			
Gwen	Informal educational sessions for nurses	Informal but organized relationship	Interested in teaching	Same salary as clinical (but was working day shift and no call, would make more	Creating new courses time consuming and no time for creative piece, focus on covering all		Went to anesthesia program that was culture of fear	Webinars
	Preceptor	Monthly assigned outline of webinars	Enjoyed mentoring students; "I was interested,					Doesn't feel training in pedagogy would be helpful

Pseudonym	Previous experience	Mentor	Entering academia	Salary	Time	Professional Involvement/ Political Action	Student Interaction	Pedagogy
	PALS instructor	(AANA Learn education modules, simulation modules) and readings Relationship was helpful - covered pedagogy (syllabus creation and amendment, curriculum development, COA standards and accreditation)	and I felt that I wasn't sure if I was exactly ready to transition, but that the opportunity was there" Enjoys being a student	compared to academia if doing call), makes more when add in extra clinical practice Has heard other faculty say they make less	necessary material Taking work home, working more hours in the day, "not enough hours in the day to get everything done" Clinical job was set schedule approx. 45 hours weekly, academia flexible in hours and location (can work from home) but more hours in the week spent working (need 40 hours for academia and 8-hour clinical shift)		Creating open culture in current program Feels like current students complain, want shortcuts, and special treatment, decreased work ethic Set boundaries (only give cell phone to clinical students for emergency), use university email for professional communication , minimize texting	because was so overwhelmed starting with nothing (new program) DNP project focused on adult learning theory – does not consider this formal pedagogy but does feel knowledge of adult learning theory helpful to transition Educational technology – no formal training; IT support unhelpful; self-taught, ask colleagues questions

Pseudonym	Previous experience	Mentor	Entering academia	Salary	Time	Professional Involvement/ Political Action	Student Interaction	Pedagogy
					No change in schedule working in academia (was 5 days weekly in OR)			
					Able to work from home if needed – helps with childcare			
Frank	Clinical education for hospital for almost a decade - all of the critical care and OR related inservices AANA training for public speaking and leadership	Informal mentor – friend and professional colleague and previous instructor Shared office with informal mentor for short time and resources Open door policy Oriented to university	Always had desire to be a teacher but was off put by seeing struggles of teachers Good feedback from doing clinical education Enjoyed teaching	Paid well Can work OT clinically for more money Salary made up of pay from clinical and school	Organizational hump – difficulty in time management Clinical is structured and assigned, academia is overall goal with no specific way you have to reach goal Almost needed assistance with organizational hump	Previous experience serving on state board of directors Easier to be involved at state and local level, encouraged by program director, promoting profession helps school	Varies between clinical and classroom, peer type relationship in clinical (more relaxed) Open communication policy – must adapt to student’s way of communicating Encourages emails and texts and GroupMe discussion	No training specific to pedagogy Did AANA Learn modules but doesn’t remember them and can’t say if they were helpful

Pseudonym	Previous experience	Mentor	Entering academia	Salary	Time	Professional Involvement/ Political Action	Student Interaction	Pedagogy
		Went above and beyond to make sure he had a friend			Work is never finished		Older faculty resent new methods of communication and constant communication (subscribe to office hours), generational gap in communication among faculty	
		Relationship started before officially joining academia			40 hours on paper, 60-70 hours in reality			
					Hours more flexible, can work from home (benefit of education), can choose to work all hours at office or clinical (as long as university work is done)		Students can pit faculty against each other-open communication of individual expectations can prevent this	
					At first bringing a lot of work home			
					“The organizational hump that I, being able to get, know that you have all this content to cover and			

Pseudonym	Previous experience	Mentor	Entering academia	Salary	Time	Professional Involvement/ Political Action	Student Interaction	Pedagogy
					being able to give everything the amount of time it needs and still get through the semester without rushing or leaving anything left to misinterpretation. Also to get research projects, and meet with students, and make sure you're not missing anything, that is definitely (laughs) I almost needed assistance with that I think."			
					"When I was in clinical practice I could go to my day and when I left			

Pseudonym	Previous experience	Mentor	Entering academia	Salary	Time	Professional Involvement/ Political Action	Student Interaction	Pedagogy
					I was done. With this I am never done, there is always something to be done and I initially would bring a lot of work home and I realized I've got to have time off so part of my organization is making sure I am doing work when I am at work and I am living when I am at home."			

APPENDIX G

THEME DOCUMENT

Clinician to Faculty – Identity Amalgamation (superordinate)

There is not a clear definition of expert as an educator, but there is as a clinician.

(Alan) “I see my mentor, she definitely identifies now on the education side and she doesn’t really have a desire to be in the clinic. She feels like her role is now in Academia. I don’t ever want to lose the hybrid of being able to teach but also still be very current and active clinically. But yeah I can see the struggle and with time it’s going to be maybe harder, not maybe, it’s going to be harder, so my identity has shifted some but I still, I’m still in the clinical area so much and they still think of me that way, it’s almost like they still see me as a clinician. So as long as I keep them fooled (giggle), and stay there enough that they see me I think that that’s going to help.”

“I feel like now when I’m in clinic there’s a different level of respect. I feel like I think people by and large look at University faculty as experts and they often, whether it’s true or not, they think you’re one of the smartest people in the room. And I think because I had a strong clinical background and performance and had that respect I think that it, I think that helped. But it is different now.”

Establishing Credibility

Students: No one was able to state what student’s actual expectations of their faculty were, rather they described their interpretation of the student’s expectations and how they established credibility.

(Alan) Expectations – expects students to be prepared and has high expectation of self as instructor (feels like he can’t say he doesn’t know)

(Alan) Establishing credibility with students – clinical experience and practice, true to word (only tested on what he said he would), approachable, good resource

“as a clinical preceptor you’re you have credibility because they see you immediately interacting with patients and doing things. So you dress the part, you interact with surgeons and anesthesiologists, And they see you working so there’s not that building of anything, I mean it’s just there. In the classroom, I definitely felt like I had to perform and meet these expectations that, He says he’s a CRNA, he says he’s very experienced and then I just had to jump in and start teaching and proving myself.”

(Alan) “So I had had some experience with teaching, but I had no idea how overwhelming it would be to enter the graduate level and teach on that level and be able to understand information well enough to be able to field questions from the smartest group of people I had ever taught. So that was a transition. Just really having to immerse myself in in the, whatever course I was teaching, so that I knew well enough to teach it, but also to field those questions, But I didn’t really didn’t realize it was going to be as much work as it was but I love every minute of it. Since i do enjoy it I didn’t care to spend the time. But compared to clinical practice it was definitely a much bigger hour commitment.” IMPOSTER SYNDROME – expectation of yourself, for Alan the definition of a good teacher is someone who knows it all

(Charlie) “You know you have students, and they’re adults, and they have expectations, and you have expectations of them, so it’s kind of a two-way bridge. See you expect something from the students and they expect something from you. It’s like the saying you receive what you give, so to get a good results from students you have to give yourself. And you know, being in a profession like nurse anesthesia where we want our students, we demand a lot of them and we want them to be high-level, so we have to meet that high level of education.”

(Denise) “Just a virtue of having a long anesthesia practice. I bring a lot of varied experience to what I teach the students, and they really value that. I’ve definitely heard others complain about faculty who have not touched a patient in 10 to 20 years. I mean I’m an environment where there’s a couple different CRNA schools within a 20-mile radius. And I know those faculty haven’t been clinically practicing in a long time and that really makes a difference in terms of what you can relay to the students. So definitely my clinical experience has helped me transition into this role. Partnerships and relationships with nearby surgery centers, offices, hospitals, all of that. You know as students are transitioning and looking for jobs they know I am someone they can talk to for connections and networking and things like that. So that’s definitely helped as well.”

(Edward) Moving from teacher-centered approach (lecture) to student-centered approach (blogs, video chat, groupwork, problem solving), engaging students.

(Frank) “the students get out what you put in and if you are really wanting to excel you do have to do some extra above and beyond stuff if you want to be successful and do well.”

(Frank) “. . . before I came along it really wasn’t even encouraged for people to work clinically. I see too much value in staying clinically relevant.”

Overall, faculty felt their credibility as an instructor could be seen in their performance. Meeting student needs, whether it be in communication preferences or teaching styles was one way this was accomplished. Relying on clinical experience was another way to show credibility and knowledge in the field of anesthesia, helping to establish credibility with students. Continued clinical practice was necessary to stay relevant in education.

Peers: Asking for help in academia can be difficult due to being separated, separate offices, separate classes. In the clinical setting you're taught teamwork and it is an expectation. In academia you often function independently. There may be the fear that if I can't do it or I have to ask for help I have to admit I'm not good enough, I'm an imposter. One way to establish credibility among peers was to utilize mentors, both formal and informal, as resources while learning their new role.

Additionally, upon entering academia there are nuances that must be navigated in interacting with faculty peers.

(Edward) "In the office sometimes you come in as a new faculty member, you're bright-eyed, bushy-tailed if you will, to use the cliché and you're full of ideas. What if? What if? What if? We could. We could. We could. And everyone's not always 100% receptive to that you know? Sometimes you need to just sit and listen for a little while I've learned and sort of take in what is happening before you start making suggestions about what could be happening. Because sometimes there are reasons that it's done that way. Now sometimes those norms and the dogma need to be challenged but not every time. So that's been, definitely a challenge."

(Alan) "Oh well, I think that because I had been in politics and state government for about 10 years of my career . . . I was really out in the front during all that in a leadership role I think they started looking at me more as a colleague because they saw my name on everything, they saw that I was getting things done, and motivating change, so that was helpful. But even all that, I still, on day one I think they still thought of me as a student and I really had to prove myself by, they watched my interactions with other students, they heard me speak, I lead Journal Club so when in Journal Club they saw me leading. And then you know . . . I was teaching and . . . now I'm in an administrative role amongst former faculty. It's been a little bit challenging, but I think just being positive, and respecting them and giving them, not thinking I can do it without their help, or that I have better ideas, being a team player, and walking a delicate line of not trying to come in and take over with all kinds of new ideas knowing that they're ingrained."

Alan line 350-353?

(Frank) “Yeah that was challenging. Some of the faculty members, um, one in particular definitely oh, there was a lot of resentment that I came in with new ideas. They liked the status quo, so I had to fight with that a little bit. So that was challenging, actually discouraging. Several things I would say this would be a great idea and the answer was we’ve tried that, it didn’t work, so it definitely cause a little bit of contention between me and this faculty member. They have actually since left, and gone elsewhere, I don’t think it was because of me oh, but it’s all good. The work has to keep going.”

New faculty have to be able to find the appropriate level of independence to function successfully as faculty and meet expectations, while not upsetting the current status quo of the faculty team. Once faculty have proven themselves as competent, committed, team members peers are more receptive to their input.

Expectations of Peers

(Edward) “I don’t feel that I had a good understanding of expectations. So you know I had super high expectations of myself which I think led me often to, I don’t know, to feel like maybe I’m not meeting the expectations of the department. When in reality once I would sit and talk with them they are like, ‘No, at this point in your career there is no way you should be doing that, you’re on track, you’re doing a good job.’ So it was sort of, I would say there were unclear or expectations were not like defined for me . . . So therefore, I kind of defined my own so therefore, sometimes they were perhaps unrealistic.”

Presence of a mentor can serve to clarify expectations.

Mentor

(Alan) Informal peer mentor – previous positive relationship from joint political involvement.

(Alan) “Well I had, I did a lot of state government, umm, with my State Association and had leadership training, public speaking, media training, so I think a lot of that helped equip me with all those type of skill sets that also, you know I’ve networked with so many people. If a topic comes up I am not real familiar with I have a large bank of resources. So if it’s a business issue I talk to one of my CRNA friends that’s good in business. So, ah, I think having a good clinical background and good network of CRNAs makes it easier and is helpful to have that. I think when you do state government and you’re involved on a national level a lot of the people that you’re associated with are in Academia. A lot of program directors that are able to do, run for office, so it seemed like most

of my buddies at national meetings were in education in some way. So it's easy for me to just email, text, or call someone and say, what do you think about this? I've ran syllabi by people and that definitely is helpful."

(Becky) "Informal mentors, met outside of work, worked beside daily – daily face-to-face check ins, **transparent about program** (student issues, budget, committee work), clear lines of communication. Transparency allows competency to be achieved more easily."

(Charlie) "Informal mentor provided informal orientation – helped with accreditation paperwork and learning university."

"It's better if you have people that are backing you up. I did have some people that were the opposite, that were my mentors, and were the people that took me by the hand. And today I feel very grateful for those people that took me by the hand and told me, hey come with me they showed me processes and showed me stuff. that helped a lot, but I had people that were the opposite, that stood on the side, wanting to see me fail, they didn't help at all. So what did I do, I just distanced myself from people that have that type of attitude and came closer to the people that were willing to help me and mentor me to be successful."

"[Mentors] can make a huge difference because they can give you good advice, can guide you through processes, because sometimes the University can be so big and if you work in a university system like the one I work, there's a lot of processes and a lot of stuff that you don't even know where they're even meeting but there's something waiting for you, and there's a way you're supposed to do it. And sometimes knowing how to do it it's much better if you have somebody who says, no you do it this way than having to look for all the manuals and regulations and blah, blah, blah, to see how is it done. Having somebody there that will give you advice on how to proceed and what you should do it makes a huge difference."

(Denise) Good friends with existing faculty – (informal) Mentor year (technology mentoring, student interactions, university process).

"I hate to bother other faculty members with teaching me how to do stuff like this, they're overwhelmed and worked as well." Having a mentor allows for a resource person that you can ask for help when needed so you do not feel you are burdening other faculty peers.

(Edward) Assigned faculty mentor during first week (informal, fluid relationship, use as needed, used to bounce ideas off of, oriented him to department) – still maintaining mentor relationship.

(Gwen) Informal but organized relationship. Monthly assigned outline of webinars (AANA Learn education modules, simulation modules) and readings. Relationship was helpful - covered pedagogy (syllabus creation and amendment, curriculum development, COA standards and accreditation).

“But I have felt very well supported by the University oh, they have a couple things in place to help new faculty transition, so I . . . they had us go to, about once a month they had a session they do for first-year and second-year faculty on different, you know sometimes it’s pedagogy sometimes it’s university process, things like that, but things to help you get rolling and learn how things go at the University. And then were assigned a one-on-one mentor, and so our program director who is a CRNA was my mentor and she was kind of my go-to person for all of my questions oh, poor thing. She had taught before and I had not. So she was a good resource person for all of my many questions. but I felt like I was barely staying afloat for a long time.”

Mentor assigned modules and readings to ensure learning in pedagogy, organized but informal relationship. Provided guidance on syllabi construction, course construction, etc.

University orientation and monthly meetings related more to SON, so “promotion and tenure, stuff like that.”

(Frank) Informal mentor – friend, professional colleague and previous instructor who became mentor before officially joining academia. Shared office with informal mentor for short time and resources. Open door policy, helped orient to university, went above and beyond to make sure he had a friend. Began teaching where he was a student so had to establish self as peer and not student.

“But one of my fellow faculty members we’ve just been friends since I graduated and have worked a lot together politically, so she really kind of took me under her wing and showed me the way the university system worked as far as the online, and the Blackboard that we use for lectures. So yeah, everybody was very supportive but she was just somebody that went above and beyond to make sure I had a friend I could talk to.”

Another way to establish credibility with peers was through professional and political involvement. This shows leadership ability and professional engagement.

(Alan) Political involvement for 10 years provided him with a leadership role in the anesthesia community. It was how he felt he established credibility and peer relationships in academia, and also how he created informal mentor relationship with a fellow faculty member.

(Charlie) Professional involvement allows for professional growth and provides an opportunity for networking you don't have in the clinical arena, the development of new skillsets, expanded influence, and networking.

(Denise) Always been very engaged with state association. Editor for our Journal. Participates in government

(Frank) See above quote.

Making a Mark

(Add quotes for how they made a mark in the classes, redoing lectures, etc.)

(Alan) "I always have been a communicator and nurses in the operating room, it just, they would ask me questions and really enjoyed me teaching them just various things but I had actually preached at church for a while and had really positive feedback about how clearly I could express a thought, and people said you should teach. I was always interested in teaching and I love teaching students clinically so that really lent itself into an arena where there's no distractions as far as beeps and monitors, and to really get down into the books, it was very appealing to me, umm so I took the plunge."

"The person I succeeded . . . did not want to let go of [their] legacy and [their] courses. I think [they] really tried to influence what I was going to do, and wanted me to do things the way [they] had done. And I think [they were] almost aggravated when I first started taking initiative and doing things the way I wanted to . . . So [they were] a little bit challenging . . . [They] felt like it wasn't what [they were] expecting because [they] thought [they were] going to have to lead me by the hand. And because I took initiative and just did things it took [them] back a little bit. Because [they] definitely wanted to lead me by my [hand]. But we worked through it, and [they're] happy, and things are going well. But, [they were] definitely, it was intimidating."

(Becky) "I found after about 3 years in clinical practice as a CRNA that my best days were spent working with students."

(Charlie) "Well I think there's a satisfaction in, whenever you're in the academia there's a satisfaction that you get with teaching. And you'll see students that come and have dreams of being a CRNA and you help them achieve those dreams, plus it also helps you grow as a person because I've grown a lot being an administrator and an educator."

(Edward) “The idea of influencing practice, perhaps one day even on a national scale, but definitely right now on a bigger scale than one patient at the time although I think the work that I did in the operating room was very fulfilling , something is very attractive to me about the opportunity to use my other skills like communication skills and people skills . . .”

(Gwen) “I want to do my job well and do it well for the students because they deserve that.”

“I’ve always been interested any idea of teaching. Just because I like mentoring new CRNAs that would come to the practice, I would always make myself really available and I guess it’s a role that I saw myself potentially going into eventually because I like teaching, I love anesthesia. I love giving anesthesia but I like teaching as well . . . I felt that I wasn’t sure if I was exactly ready to transition, but that the opportunity was there, it was in the town I lived in so, I wouldn’t have to move a relocate, and so I figured I would just give it a go and see how it went. And it’s gone well, I mean all things considered.”

Overcoming the Organizational Hump – Include quotes from things that made transition harder

(Change to gerund)

(Alan) “Well initially I was so busy. I re-did every course, so, I re-did every PowerPoint, every test, everything. And I was so busy that when I did work it was in the evening or a shift on the weekend to pick up extra time. But now I really feel that I am in a place where I can get in clinic once a week, so now I am able, as part of my 40-hour salary, I’m working a day in clinic.”

(Charlie) “It was kind of a challenge because we are always fearful of the unknown, you know, I’ve learned that fear sometimes can be a barrier and an obstacle so I forgot about fear and I said hey, what’s the worst that can happen and let’s do it. And I did it, and I’m glad I did it because I’ve learned a lot. It’s been a bit traumatic (laughs), it’s been a bit traumatic because, umm, as I told you at first when you get all this and you take it home then you start learning to manage situations and to forget about them and to think of them when you have to think of them, taking less and less of your work home. It’s an ability that you have to develop when you’re in the Academia and are an administrative person.”

“Being an educator is always feeling like you’re connected to your job”

(Denise) Doesn’t have time for personal research, evenings are not free anymore due to needing to work. “I definitely find that in the evenings I’m working on a piece of simulation material or fixing an exam or responding to faculty related

emails, so, I don't know, I just feel like my evenings are not 100% free like they used to be, and that's definitely been something that we've had to adjust to at my household."

"So I think I had some perspective because I had been teaching part-time for a few years so I knew what was going to be involved in academics. I didn't have any illusions about it being any easier of a job or any less of a time commitment. Um, one of the hardest transitions for me, and I'm sure for a lot of people is you're never away from this job. There is always emails, there is always things to respond to, there is always something else I can be working on, so that can be very draining. With clinical practice you punch out at the end of the day and you're pretty much done at least until your next shift and you can turn your brain off of anesthesia for a while. And you don't get that in academics."

"Now I have the flexibility to attend lobbying events and I would not have had that flexibility to attend before. But I definitely, I've probably had more time for the extraneous activities before academics. It's like you're saying, your time is your time now when you're in clinical practice so I could write more, journal more, engage with others in my evenings cause they were free. Now my evenings aren't even free."

(Gwen) Taking work home, working more hours in the day, "not enough hours in the day to get everything done"

"But that first time teaching all these courses oh, it's just there's not enough time to build in oh, well I feel like there's not enough time to build in the creative piece. So like it has to come the second time around because there's so many things to get done, even with taking work home, and working a lot of hours, it just seems like not enough time in the day to get everything done. So my main focus was to make sure all the content students need is covered and then sometimes I'm able to be a little more creative than others it kind of just depends on what's going on at the school."

"And so the time commitment at the University I do find that it's, well it's very flexible, oh, so if I have a sick kid I can work from home, so that aspect of my stress is now gone. But it is more hours in total over the course of the week. However, I'm still doing an 8 hour shift every week at the hospital so, I mean I still have to get my 40 hours in at some point during the week you know for the University since I'm full-time. So it feels like I do more hours at the school."

(Edward) "We don't clock in at 0700, we don't clock out at 0300, we all contribute to get the job done. And so sometimes that means you know, not a 40-

hour work week, sometimes that means a 60-hour work week, sometimes I'm here late in the evenings, sometimes because our department also runs a continuing education program out of the department. Um, and so that's in addition to your administrative and academic responsibilities uh, and so sometimes those conferences are on the weekend, or sometimes those conferences are held in a different state and so you may be traveling uh, you may be you know away from your family for 4 or 5 days, uh, consecutively when you're working on those types of projects. So that's where it sort of extends beyond the classic 40-hour work week or clock-in-clock-out mentality for sure. And then I totally get what they're talking about like even if I'm on the road at one of these continuing education conferences, I'm still connected to my classes, I'm still emailing my students, I'm still posting assignments to blackboard uh, things like this and so if you're let's say at a conference for 8 hours that day, you may in the hotel room that evening be working on stuff for school. So there's flexibility of the hours but it's definitely not a like clock-in-clock-out kind of job, that's for sure."

"I would say coming up with the workflow was challenging for me because again the idea of coming in and let's say I have lectures to prepare for, I have a course next semester that I'm organizing the objectives for and gathering lectures for, I have a CE conference coming up, maybe I'm going to teach in a lab at the ANA and I have a Vanna talk coming up. So you could imagine you start to get these stacks of assignments on your desk and you're used to coming into clinical where okay today I'm taking care of Ms. Jones, Ms. Smith, and Mr. Thomas. You know and instead . . . wow, there's months of work here in front of me, where do I start and how do I take this one bite at a time? So that was very challenging. Developing a workflow to approach those things . . . there was a lot of trial and error on my part . . ."

Transitioning to academia "it was a very uh, I would say challenging and rewarding if I picked two words you know, that may sound cliché but it's very true. In clinical you know I would show up at 0630 or whatever time, 0600 depending on the day. And you're sort of given an assignment, you're given a schedule, um and you just carry that out. Uh, you know as you transition into the faculty role, it's very different. You're sort of given an end goal that may not uh, be completed for you know, one week, one month, one semester, or a year later. Uh, and then you're sort of navigating uh the scheduling and the organizing and putting those pieces together on your own. So for me, that was a big difference right, in the difference in having a schedule or having a preset assignment versus having sort of an end goal and open window in which to sort of design, organize and complete that goal."

(Frank) “When I was in clinical practice I could go to my day and when I left I was done. With this I am never done, there is always something to be done and I initially would bring a lot of work home and I realized I’ve got to have time off so part of my organization is making sure I am doing work when I am at work and I am living when I am at home.”

“The organizational hump that I, being able to get, know that you have all this content to cover and being able to give everything the amount of time it needs and still get through the semester without rushing or leaving anything left to misinterpretation. Also to get research projects, and meet with students, and make sure you’re not missing anything, that is definitely (laughs). I almost needed assistance with that I think.”

40 hours on paper, 60-70 in reality