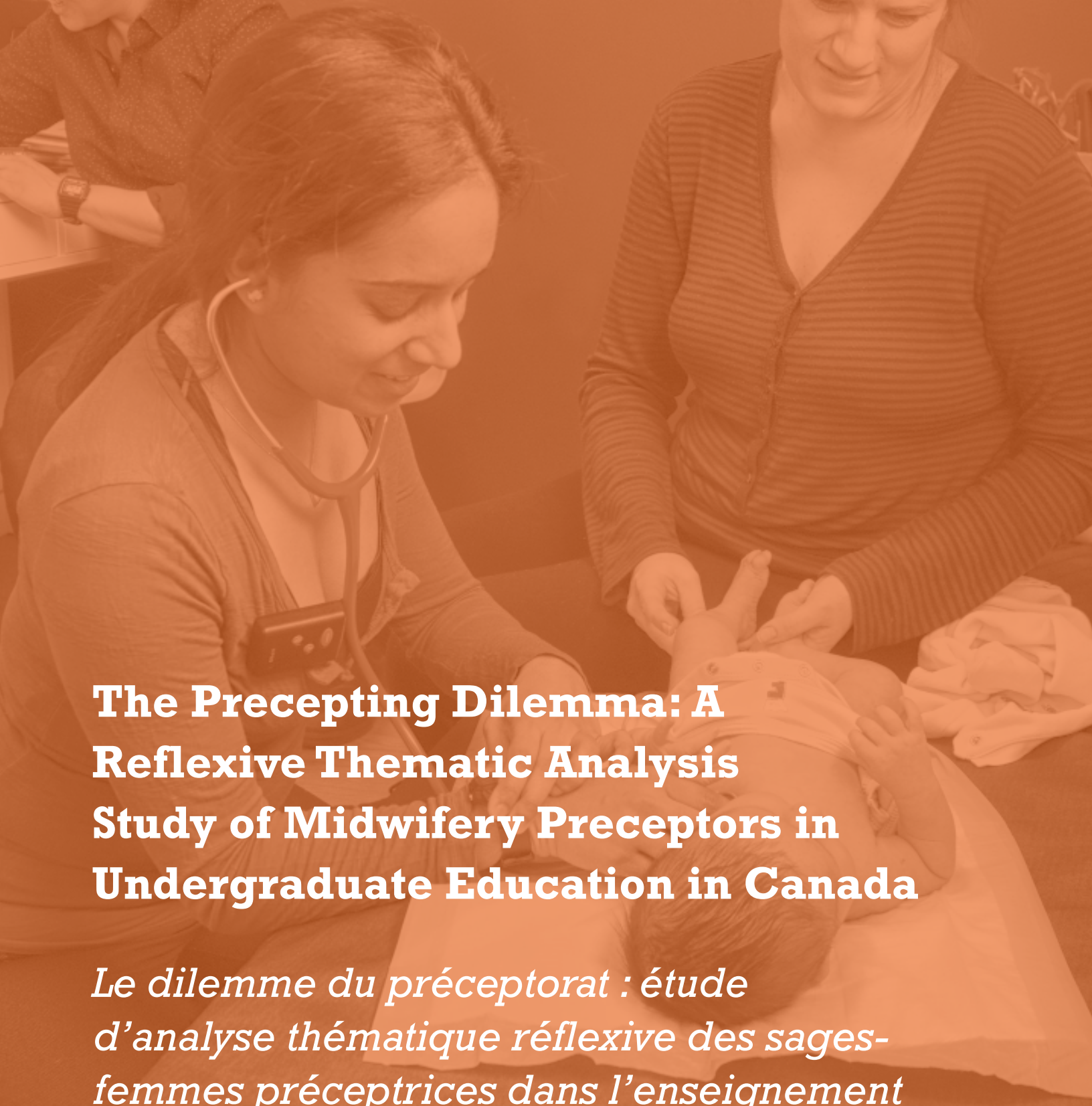

The Precepting Dilemma: A Reflexive Thematic Analysis Study of Midwifery Preceptors in Undergraduate Education in Canada

Le dilemme du préceptorat : étude d'analyse thématique réflexive des sages-femmes préceptrices dans l'enseignement universitaire de premier cycle au Canada

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ABSTRACT

Objective: To generate themes on facilitators and barriers for midwifery preceptorship.

Methods: Midwifery preceptors in undergraduate education in Canada were invited to participate in one of three focus groups. A constructivist paradigm and reflexive thematic analysis approach was used for responses that were transcribed verbatim.

Results: In September and October 2020, three focus groups took place comprising a total of 16 midwifery preceptors. Participants represented multiple Canadian jurisdictions and had a range of education, midwifery, and precepting experiences. Two primary themes, "the altruism of precepting" and "the lack of autonomy in precepting," were generated from our analysis of participants' responses. Preceptors also provided suggestions to better enable their role.

Discussion/Conclusion: We interpreted a "precepting dilemma" in midwifery clinical teaching such that there are altruistic influences on the role and also an underlying lack of autonomy. Obligations and nurturing elements contributed to midwifery preceptors' utilitarianism. Exacerbating a lack of sovereignty in precepting were deficits in collaboration and aspects that further marginalized the role. It is imperative for stakeholders of midwifery in Canada to carefully consider how altruism and autonomy of precepting affect the experiential curricula.

This article has been peer reviewed.

RÉSUMÉ

Objectif : Produire des thèmes sur les facteurs qui favorisent ou entravent le préceptorat pour les étudiantes sages-femmes.

Méthodes : Des préceptrices sages-femmes du secteur de l'enseignement universitaire de premier cycle au Canada ont été invitées à participer à l'un des trois groupes de discussion formés. Une approche axée sur un paradigme constructiviste et une analyse thématique réflexive a été adoptée pour les réponses, qui ont été transcrites mot pour mot.

Résultats : En septembre et octobre 2020, trois groupes de discussion constitués de 16 préceptrices sages-femmes en tout se sont réunis. Les participantes provenaient d'un peu partout au Canada et possédaient un éventail d'expériences au niveau des études, de la pratique sage-femme et du préceptorat. Deux thèmes principaux, « l'altruisme du préceptorat » et « l'absence d'autonomie dans le préceptorat », se sont dégagés de notre analyse des réponses des participantes. Enfin, les préceptrices ont formulé des suggestions pour renforcer leur rôle.

Discussion et conclusion : Nous avons constaté dans l'enseignement clinique de la pratique sage-femme un « dilemme du préceptorat », à savoir la présence d'influences altruistes sur le rôle de la préceptrice et une absence sous-jacente d'autonomie. Les obligations et les éléments valorisants contribuent à l'utilitarisme des sages-femmes préceptrices. L'absence de souveraineté dans le préceptorat est exacerbée par le manque de collaboration et des aspects qui marginalisent le rôle davantage. Il est impératif que les parties prenantes de la pratique sage-femme au Canada examinent attentivement l'incidence de l'altruisme et de l'autonomie du préceptorat sur les programmes d'études axés sur l'expérience.

Cet article a été évalué par un comité de lecture.

BACKGROUND

Much to the disdain of educators everywhere, the saying "He who can, does, and he who cannot, teaches," has resurfaced repeatedly since its early twentieth-century appearance in a play by George Bernard Shaw.[1] A powerful rebuttal has been to simply state that those who can, in fact, do teach.[2] Debates aside, one type of educator, the preceptor, is simultaneously *doing* the work of clinical practice *while* teaching. Furthermore, in undergraduate midwifery education in Canada, preceptors facilitate at least half the curriculum[3] while providing evidence-based care in a model that values informed choice, partnership, choice of birthplace, and continuity with clients.[4] Midwifery preceptors, often described as gatekeepers to the profession,[5] mentor and evaluate pre-registrants in the clinical learning environment.[6] Yet, studies exploring the experience of midwifery preceptors in the Canadian context are not prevalent in the published research.[7]

Experiential learning, facilitated by preceptors in clinical and community settings, is cardinal in midwifery education in Canada[3] and internationally.[8] Our study focused on preceptors from the seven current university-based baccalaureate midwifery education programs in Canada.[9] Centring on the facilitators and barriers, focus groups were conducted with midwifery preceptors. Two primary themes, "the altruism of precepting" and "the lack of autonomy in precepting," were generated from the data. Our findings show that midwifery preceptors in Canada face a "precepting dilemma" in which preceptors feel obligated to perform the role but lack the autonomy and collaboration (two essential Canadian midwifery model tenets) to thrive in it. This predicament is an extension of the "caring dilemma" first attributed to the duty of nurses to provide care without the prerogative to control it.[10] A caring dilemma later associated with Canadian midwifery was the ability to organize a care model that did not counterbalance the challenges of noncare work, including precepting.[11] Finally, the caring dilemma has been shown to contribute to the high attrition rate of midwifery undergraduates in Canada.[12]

THE MIDWIFERY PROFESSION AND EDUCATION IN CANADA

Midwifery in Canada, both professionally autonomous and interprofessionally collaborative,[4] is the synergy of its many parts (perinatal and neonatal care, advocacy, research, education, leadership, administration, etc.).[13,14] In 1986, prior to regulation, the first Indigenous midwifery-led birth centre opened in Puvirnituq, Nunavik, Quebec.[15] Coinciding with the first midwifery undergraduates in 1993, provincially regulated midwifery registration commenced in Ontario in 1994.[16] Midwifery care is currently available throughout most of Canada; regulation in the two remaining jurisdictions (Yukon and Prince Edward Island) is projected to occur in the near future.[17,18] Accounting for 11% of the births in Canada in 2019,[19] the caseload model of midwifery care[13] has had high rates of client satisfaction and lower rates of costly medical intervention with good outcomes.[20] Canadian midwifery currently faces many pressures, including occupational stress and sustainable funding, which in turn jeopardizes all associated roles, including preceptorship.[13,21]

METHODS

Study Objective and Methodology

As part of a larger multiple-methods project on the perspectives of midwifery preceptors, this study was formulated from a philosophy and procedures rooted in qualitative inquiry, or what has been called the "Big Q" distinction, wherein the approach is "flexible and organic."[22] Our main objective was to generate themes on facilitators and barriers for midwifery preceptors under a constructivist paradigm using a reflexive approach. Constructivists adopt a relativist ontology and subjective epistemology in assuming that knowledge is not found[23] but rather co-constructed by participants, researchers, and the many realities that shape their experiences.[24] To highlight these multiple realities, the use of the participants' own language and researcher reflexivity in interpretations were prioritized in this study, to promote the trustworthiness of findings.[25] The choice to use reflexive thematic analysis over other methods was due to the emphasis of this research on creating themes across the data versus dissecting individual experiences.[26] Also, reflexive

> Having autonomy in a role is related to feeling empowered to accomplish it.

thematic analysis supports the research purpose of developing outcomes for the consideration of midwifery stakeholders in the wider context of Canadian undergraduate education.[26]

Data Collection

Ethical Considerations

This study was approved by the University of Calgary Conjoint Health Research Ethics Board (REB20-1080), the Mount Royal University Health Research Ethics Board (HREB 102286), and all undergraduate midwifery education programs in Canada through formal ethics applications or by providing University of Calgary ethics approval certificates and study documents. Consent forms were reviewed, completed, and signed by participants prior to their participation in the focus groups.

Sample and Procedure

We recruited a purposeful sample of midwives who had served or were currently serving in the preceptor role with undergraduate midwifery students.[23,27] Study announcements were distributed to directors of undergraduate midwifery programs in Canada and national and provincial midwifery associations for posting in newsletters. Also, an announcement calling for focus group participation was included upon the completion of a national survey affiliated with this study.

In September and October 2020, three focus groups comprising 16 midwifery preceptors were conducted. Originally, the focus groups were planned to meet in person; however, the meetings were conducted online owing to social-distance restrictions adopted during the COVID-19 pandemic. Subsequently, anonymity was maintained if the choice was made to disable the web camera and alter screen names. Participants' responses were recorded verbatim and sent to a third-party transcription service via a secure file share system.

Instrument

The investigatory team developed a semistructured interview guide that was used to obtain demographic information (i.e., educational background, practice, and preceptor experience) and to elicit experiences of facilitators and barriers to the preceptor role. Questions were designed to promote open responses, reflect preceptor perceptions, and encourage discussion among group members.

Data Analysis

In 2006, Braun and Clarke published their polemic article that outlined the thematic analysis process;[28] they have since written extensively about using this method reflexively.[22,26,29] Reflexive thematic analysis, a nonpositivist approach, provides space to tell the story of the qualitative data whereby themes do not emerge but result from organic coding based in the data and interpreted through the researcher's perspective.[29,30] Data from the focus groups were examined reflexively and iteratively, applying the following six steps of thematic analysis:

1. Data familiarization and writing familiarization notes
2. Coding data systematically
3. Generating initial themes from coded and collated data
4. Developing and reviewing themes
5. Refining, defining, and naming themes
6. Writing the report[29]

Qualitative data were uploaded into the computer-assisted qualitative software NVivo version 12 (QSR International, Burlington,

Massachusetts) to aid organization throughout the reflexive thematic analysis process.

Reflexivity

The lead researcher–an India-born spouse, mother, midwife, and educator–was raised in the United States and currently resides in Canada. Her interest in midwifery education stemmed from international exposure to perinatal systems and education in the health professions. She is currently an associate professor in a Canadian undergraduate midwifery program. Because experiential learning is at the heart of midwifery education and because of the significant role of preceptors, it was relevant to research the preceptors' experience in the Canadian context. The reflexive approach to analysis required the lead researcher to question decisions throughout the process. One strategy was to continually ask whether an over- or underestimation of participants' responses used in coding and theming were the result of biases of the lead researcher (a midwifery educator in an academic rather than a clinical setting). Another strategy was to check and re-check whether codes and themes held steady across the entire data set.

Rigour

It was essential that our analytical process was rigorous out of respect for the participants' honest responses and generous offering of time. The lead researcher kept a thorough journal that included reflections and memos written during data collection and analysis. The investigatory team also provided peer debriefing opportunities for coding, theming, and conclusions, contributing to the credibility of our findings.[31] In addition, a detailed audit trail was completed to outline the thematic analysis decision-making process, promoting the consistency[25] and dependability[31] of our techniques. The focus group method of data collection promoted researcher neutrality[25] and minimized the power differential between researchers and participants.[32] Finally our purposeful, national sample of participants with non-identifying demographic data enables the applicability of our findings.[25]

RESULTS

The participants in our study had a variety of midwifery training backgrounds, including Canadian non-degree or undergraduate education, and international diploma, undergraduate, or graduate education. Their range of midwifery work experience was two to twenty-two years of practice, and participants had served as the primary preceptors for a range of one to thirteen students. Those who specified the number of students they had served in an adjunct capacity reported having had two to ten students; however, several spoke of having had "many students."

Two primary themes, "the altruism of precepting" and "the lack of autonomy in precepting," were generated from our analysis of participants' responses. Preceptors also provided many suggestions to better enable their role. (In the following, participants are indicated by number [e.g., participant 3]. The numbers are randomly assigned and not indicative of study identification numbers or the order of focus group membership.)

Theme 1: The Altruism of Midwifery Precepting

Altruism is generally thought to concern conduct that benefits others. Furthermore, the term implies selflessness, especially when there is a cost to individuals for performing altruistic acts.[33] Participants in our study described a "paying it forward" attitude towards precepting to "grow midwifery" in a manner that secures the person-centred model. Participant 3 stated the following:

> *The thing that makes me want to take a student…is a feeling of wanting the profession to grow and feeling grateful for the support I received in my education, so kind of like paying it forward*.

Participants also expressed perceiving preceptorship as a means to fulfill ethical responsibilities towards the profession. Participant 7 stated, "We should have a…moral obligation…. We should value the fact that we want to grow midwifery in a way that doesn't dilute the model." These altruistic tendencies were apparent in other participants' statements, such as the following from participant 9:

> *If you're taught, you should teach and continue that cycle as you move forward…the sense of protecting and guarding our profession and making sure that the people who are representing us as new midwives are doing so effectively and with confidence and with good skills*.

Altruism was also revealed as reverence for participants' own preceptors. Participant 13 said, "I liked my preceptors. I thought they were very good teachers, they were supportive, and I felt that now it was my turn to give that back." Other participants expressed a desire to prevent injustices they had experienced or were made aware of regarding clinical teaching in midwifery, as explained by participant 16.

> *I precept because I had really great preceptors, but I definitely saw classmates really struggle, and I felt like if I can provide this space to sort of help people, like, with their anxiety and just be really nurturing*.

For some participants, altruism was also uncovered through preceptors' generosity in sharing their time and experience without the expectation of reimbursement or even an awareness that they would be compensated.

As stated by participants 2 and 13, the participants clearly "enjoy" the precepting role, an enjoyment that emerges from what participant 10 described as a "love" of teaching and that can maintain currency and excitement for practice. However, like participant 8, they also enjoy seeing the "growth" in their students. In a way similar to growing and securing the profession, nurturing and protecting midwifery students also has altruistic undertones with inherent responsibilities. Participant 9 stated that precepting is "a lot of work to care for a student, and my goal is that my student will eventually have the best of me and the best of other people too. It's like seeing that person enter a completely different stage of life." Many preceptors, such as participant 8, even likened their role to child-rearing and use "mothering skills…to build a confident person." Participant 10 described this further, as follows:

> *I find that my role as a parent and a lot of the parenting information that I accessed over the years has been far more effective and applicable than some of the educational stuff…I feel really strongly about creating strong women who know themselves, who are confident when they come out of the program to be able to stand up to the rigours of being on call 24/7 and being the strong shoulders needed to bear the load of responsibility for life and death with our clients. That has driven me to continue to be a preceptor, to counteract some of that culture.*

Theme 2: The Lack of Autonomy of Midwifery Precepting

Autonomy has been described as the ability to self-determine, as in "being autonomous is acting on motives, reasons, or values that are one's own."[34] In the role of perinatal or neonatal care practice, Canadian midwifery is recognized as a self-regulated profession.[4] In the midwifery preceptor role, autonomy would afford an adequate degree of influence in shaping the experiential learning environment. The multijurisdictional representation of study participants provided a spectrum of responses in which preceptors addressed their ability, or lack of it, to choose to precept. For some participants, student placements were desired and even fought for but were not guaranteed; the desire to precept was contrary for others from places with limited preceptors.

Participants discussed how the choice to precept had some degree of self-determination or was primarily influenced by the affiliated midwifery program or clinical team or practice. Participant 16 recounted working on a team with a midwife member who did not want to precept but "felt there was pressure from the rest of the practice." This pressure can be exacerbated in jurisdictions where two midwives are required to be present at all births in all settings or where students have challenges meeting educational birth number requirements and must work with all midwives on a practice

team. Participant 5 described feeling "pushback" when not wanting to precept and perceived that it was felt they "should be taking a student for the university's sake."

In a sense, having autonomy in a role is related to feeling empowered to accomplish it. Participant 2 explained that the allocation of students was not based on "preceptor's skills, talent, or ability [but] about decision-making power," as senior-level students were mainly placed with clinic practice partners to "help out the preceptor." Participant 5 concurred by addressing the "power dynamics" of clinical practice leads and argued that, instead, "it should be up to the individual practitioner of whether or not they want to, whether or not they're ready, and what level of student they feel ready to take on." Participant 9 said that precepting "should not be mandatory…[and more] of a self-selecting process."

Many participants spoke of a hidden culture in experiential curricula, one in which final practicum decisions rest with the affiliated educational program and not the individual preceptor. Participant 15 spoke about the educational program's asking multiple times to place students without following through and "then a few months later they came to us to see if we could take a student who was struggling." Disempowerment can even lead midwives to renounce the role, as expressed by this frustrated comment by participant 4:

> *I will probably not take a student. I didn't this year or next year, because I don't like feeling manipulated. I don't like feeling, if you take a second-year now, we will consider you for a fourth-year next year. That is not helpful.*

Focus group participants also commented on their inability to influence critical aspects of their preceptor role, including student progression, the evaluation of learner competencies, and the scheduling of students. Participant 15 discussed the "nuances of the Canadian model," in that "Even though preceptors are responsible for a majority of the curriculum, they may not have the ultimate final say in progression of a student." Participant 13 went further, stating, "Sometimes it does feel like the student isn't ready and there's pressure to move her on anyway." Participant 5 highlighted the possible consequences of "not passing or working with the university…[and their practice] didn't want to upset the university in that we might not get more students later." Several participants described pressure to conform to the university's real or perceived agenda, especially when there was a discrepancy on a student's evaluation. As participant 16 stated,

> *The [education] program was saying, "she's met her numbers and she should finish," and her preceptors were saying, "she really has not attended enough vaginal births; she hasn't even done the cardinal movements of delivery." [The program affiliates] were sort of like "she's fine, her numbers are good." We felt nervous. We were like "What's gonna happen when she gets to her senior placement?" and they're like "Can you catch a baby?" and she's like "Not really. I didn't have all the opportunities I should have" or whatever, but the program didn't seem to appreciate the stress about it from our practice*.

Participant 14 added the following:

> *I feel the pressure to provide experiences for this student to be able to learn, and that's not happening, because she's had a four-day weekend, and we had five births, and now she's short. It's not at all my fault. She needs her time off. It's not her fault. But that's been a huge challenge for me. Those are the sort of situations where the [educational] program is obviously advocating for the student and not the preceptor.*

Finally, participant 12 concluded the following:

> *I guess the goal from the [education] program is to pass everyone, and then the program will find ways to make it happen. Whether it's transferring the student to another practice, having*

extensions, accommodations, I don't know.

The Canadian model of care, while signifying the importance of professional autonomy, also recognizes the value of working within collaborative environments to provide adequate perinatal and neonatal care. The midwifery preceptor, the main educator for clinical knowledge, also requires collaborative relationships with stakeholders to fully function in the role. Our study showed that preceptors faced challenging situations with their collaborative counterparts, which further minimized autonomy in their role. Participant 14 stated that the education program "wasn't there for me, just the student." Deficits in collaboration can cause feelings of isolation. Participant 10 felt "cut off from the university side of things. I'm like in my own little corner, putting all this work into the student, but then if there does appear to be a potential issue, I'm not included in helping to resolve that." Collaboration between the education program and preceptor is especially vital in complex situations. Participant 11 discussed the shortfalls in their experience.

I found that tutors were really out of touch. I didn't find the tutors all that helpful when we were having some challenging situations. I mean some more than others, but overall, I just felt like a lot of times, the solutions that were given were not working for the students or not realistic.

In addition to what participant 6 described as "stress" and the workload of midwifery, many participants described other features that further challenge the precepting role, thus affecting their autonomy. Most prominently, participants found inadequacies in preceptor training–working with racialized and international students and with individuals who have mental health issues and learning accommodations. Participant 2 noted the following:

Two of the most challenging placements I've had with students, both of them were Black. In retrospect, I feel like I had some deficiencies as their preceptor, not really being aware of some of the issues that can come with being a BIPOC [Black, Indigenous, or Person of Colour] student midwife….In the moment, I thought it was just that they were struggling; however, in retrospect, I wonder how much of that had something to do with race and something to do with my own deficiencies.

Various practice-based challenges were discussed. Participant 4 underscored the lack of importance given to rural midwifery practice.

There's no interest in midwives coming to rural parts in Canada in general…Rural practice is not prioritized, not only from the ministry or from our association, but it needs to start at university as well. You're never going to have students interested in rural practice if they've never really experienced it or have been encouraged to be here.

Finally, both new and experienced practitioners expressed having faced challenges in the preceptor role. Participant 1 recounted the pressure to begin precepting right after the new registrant's year. Participant 11 stated, "Still five years in, I feel like I'm just getting my feet under me as a midwife myself, so the idea of being a preceptor still feels a bit overwhelming. I remember feeling that I really want any information and any training that was available to me, but it felt fairly superficial at the time." In contrast, participant 7 declared that precepting "falls to the senior midwives a lot of the time because nobody's stepping up to the plate, and we've made a value statement in our practice."

Preceptor Recommendations

When given the chance, the preceptors provided many suggestions as to how to enhance the preceptor role. Participants' recommendations are summarized in Table 1.

Table 1. Summary of Preceptor Recommendations

Topic	Participant(s)	Examples
Preceptor Training	2, 5	Provide more training for precepting BIPOC, international bridging students, and students with mental health challenges and learning accommodations.
	12	Provide a workshop with many preceptors present, and facilitate a discussion on how others precept and what teaching methodologies are used.
	15	Provide documents for teaching specific skills versus a one-to-two-day workshop.
Preceptor Resources	7	Create smartphone applications for relevant preceptor information.
	14	Provide more online resources (e.g., chat rooms) for specific topics (i.e., documentation and giving students feedback).
Feedback for Preceptors	2	Provide ongoing evaluation of preceptors from the educational program.
	3, 9	Require more student feedback on whether adequate independence was given during clinical events.
Preceptor Support Mechanisms	1, 4	Create a new university clinical support role with clinical visits or check-ins.
	9, 11	Utilize mentors with a designated role in the clinical practice, or preceptors who have more experience in clinical teaching.
Preceptor Reimbursement	9	Cover parking costs for preceptor training.
	3	Compensate preceptors of junior students for increased preceptor workload requirements.
Other Ways to Contribute	1, 8	If not able to precept, find other ways to contribute to midwifery education.
Time Off from Precepting	8, 11	Breaks from precepting needed to practice midwifery and regain appeal of teaching.
How to Precept	14	Important to go over “what if” scenarios with students.

BIPOC, Black, Indigenous, and People of Colour

DISCUSSION

The Dilemma of Caring and Precepting

Expanding on the caring dilemma, the paradox represented by our themes was interpreted to be a precepting dilemma: participants associated altruism with the role while simultaneously lacked the autonomy to successfully undertake that role. Reverby described the caring dilemma in nursing as the obligation to care without sovereignty. This quandary between "altruism and autonomy"[10] has been applied to other women-dominated professions such as midwifery.[12,35] Bourgeault et al. discussed the midwifery caring dilemma, using the midwifery profession in Ontario in the early 2000s as a case study. Their central argument was that the organization of midwifery care (e.g., determining caseload numbers, wage for shared-care practice, and off-call time or part-time work) affords the ability to provide the valued type of care (e.g., continuity).[11] Ironically, this midwifery model was developed under the ethos that building true partnerships with care recipients minimizes occupational stress and burnout.[11] However, the on-call requirements "can impose a caring dilemma on midwives, potentially pitting their interests as professionals, and in some cases as partners and mothers, against the interest of their clients."[11] The authors of the study, which was completed when there were approximately 300 midwives in Ontario, showed that even with some level of autonomy in the structure of care, a dilemma was still present due to the obligations of noncaring work, including precepting and administrative commitments.[11] Currently, three Canadian provinces with undergraduate midwifery education programs have fewer than 300 midwives actively practicing, thus limiting the pool of preceptors and placing further burdens on all the roles midwives play, both professionally and personally.[19]

Reverby described the caring dilemma in nursing ensuing from a historical, religious, familial, and economic basis to what has been deemed "women's work."[10] The history of regulated midwifery in Canada as a "grass roots," "women's rights movement"[4] has precipitated a commitment to the profession in the manner that only a struggle for existence can yield. Although the number has steadily increased over the last 27 years, in 2019 there were only approximately 1,900 registered midwives in Canada;[19] this history contributes to the altruism of precepting as a means to fortify the future workforce. For study participants, growing and protecting both the model and learners were selfless motivations for precepting.

Nurturing in Professional Work

The caring dilemma has also been experienced by midwifery students in Canada. The attrition rate for undergraduate midwifery students in Canada is disproportionately high,[12] and intention to stay in the profession is lower for students after exposure to clinical learning.[36] Neiterman et al. observed the effects of the caring dilemma experienced by undergraduate midwifery learners in Canada. They found that the irony for some students was that the call that led them to the nurturing work of midwifery persuaded them to leave it and return to familial duties, especially when the realities of providing continuity of care were fully realized.[12]

For several participants, the nurturing qualities of preceptors were equated with parenting. Although the joys of rearing midwives-to-be may be plentiful, the responsibility for that work can overwhelm an already heavy load for midwives, especially if the role is perceived to have additional responsibilities aside from clinical instruction (i.e., an obligation to foster resilient practitioners who can uphold the values of the model). The majority of midwives in Canada are not cisgender men; as such, it is likely that the association between precepting and nurturing is a gendered issue, especially for individuals who are drawn to the profession itself for its caregiving aspects.

Finding the equilibrium between professional and personal lives as a gendered issue for women has been widely discussed. Is the placing of ideal weights of career and family to balance the scale of fulfillment still an impossibility for women? Perhaps, however, paid work for women does not necessarily lessen the emotional obligations of unpaid work. In 1964, Bernard and Riesman coined the term "academic momism" and described how the patience and lenience of women academics led to a dependency of students but was also particularly useful in some situations.[37] El-Alayli et al. found gendered discrepancies in academia and reported increased "time, personal, and emotional

demands" from students. They also reported that students requested special favours and friendship from female professors more often than from male professors.[38] The preceptor and student assignment in undergraduate midwifery education often continues much longer than a traditional academic term. One can imagine both positive and negative influences these lengthier educational relationships have on preceptors who predominantly identify as women.[12] Exploring the experiences of midwifery preceptors in our study underscored gendered aspects such as nurturing and parenting in the preceptor role.

Autonomy and Collaboration in Preceptorship

Autonomy and collaboration are two Canadian midwifery model tenets central to the practitioner role. From participant responses, it was inferred that these principles are not necessarily absolute for other midwifery tasks, such as precepting. However, for midwives to thrive bearing the great responsibility of educating their successors in a nation without a long history of regulation, they require an equilibrium of autonomy and collaboration with stakeholders. Across the data set, there were various dichotomies regarding self-determination and power imbalances in the role. However, most participants seemed to express an obligation to precept, with a real or implied pressure from their clinical practice or educational program. In some cases, practice leads had the sole ability to place senior-level students where they were deemed more helpful to the practice (e.g., with midwifery clinic practice partners or owners). Other preceptors felt that nonclinical university affiliates held the authority on student progression and that these decisions were not made in collaboration with the individuals actually doing the clinical teaching. Finally, interdependence in the precepting role was made more difficult by inadequate training, rural settings, shared-practice models, and at either end of the range of years of experience.

STRENGTHS AND LIMITATIONS OF THE STUDY

The purposeful sampling technique meant that interviewees had experience in midwifery precepting in Canada. Although we cannot make assumptions about whether individual biases contributed to participation in this study (e.g., overly positive or negative preceptor experiences), the demographics of our sample indicate that the participants represented multiple jurisdictions and had a range of education, midwifery, and precepting experiences, thus contributing to the applicability of our findings. We targeted undergraduate midwifery education. However, preceptors commented on mentoring international bridging students; as such, it was included in our findings. It would be relevant to diversify findings on facilitators and barriers for preceptorship in a future study targeting educators in accelerated or Indigenous community-based programs, students, and directors and faculty of midwifery education programs.

CONCLUSION

The meaning of the "precepting dilemma" is that midwifery preceptors, utilitarian in their justification for precepting, lack the power to control many important andragogical elements of it. Our study participants described various altruistic influences on precepting (e.g., obligations to the care model and nurturing). Although there are many positive aspects to the role, preceptors expressed an underlying lack of autonomy (e.g., powerlessness in student progression decisions or the structure of the clinical learning environment). Exacerbating this lack of autonomy were deficits in collaboration and aspects that further marginalized the role (e.g., the setting or type of clinical practice, inadequate preceptor training, and level of experience). Preceptors in our study offered several examples of ways to be empowered in their role. It is imperative for stakeholders of midwifery in Canada to carefully consider how to balance the altruism and autonomy of precepting. We are not there yet.

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