Role Transition During RN-to-FNP Education

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ABSTRACT
This study examines the role transition that occurs during RN-to-family nurse practitioner (FNP) education, described in an earlier qualitative study that identified a role transition framework of influential positive forces and obstacles. The purposes of the study were to validate the educational phase of the original framework and explore other role transition issues. The study used a descriptive correlational design by asking all FNPs in two rural western states to participate by answering a questionnaire. Findings evidenced a stronger level of agreement with the positive forces than with the obstacles. In addition, two significant relationships were found between the positive forces and obstacles and personal life circumstances. These included personal support systems, which were significant for those who had to travel to class, and personal sacrifices, which were significant for those who had children at home. Further research will focus on testing across nurse practitioner specialties nationally.

Family nurse practitioners (FNPs) are RNs with additional education that allows them to function in an expanded role as primary care providers. Nurse practitioner (NP) education is a time of great excitement, upheaval, and change for RNs, with the ultimate goal of transformation from RN to NP. Although the journey from RN to independent NP continues through the first few years of practice, the education program is the beginning. The journey has been described as a roller coaster of anxiety, stress, and turbulence. New NPs report feeling overwhelmed, inadequate, vulnerable, and isolated as students. Self-doubt is a common emotion. The transformation from RN to FNP has been characterized as more complicated than that of the stages of skills acquisition, novice to expert, described by Benner, Tanner, and Chesla (1996). Experienced nurses feel discomfort as they go from competent nurses to beginning NPs. This has been documented as a “step backward in expertise” (Brown & Olshansky, 1998, p. 55). During the journey, NP students have the responsibility of acquiring new knowledge, as well as learning to use their previous nursing knowledge in new ways. Family nurse practitioners face the challenge of learning primary care, a field that encompasses a broad range of health problems and family situations. Indeed, NP education is a time of change with uncertainty and increased responsibility as RNs struggle to learn and practice a different aspect of nursing (Steiner & Burman, 2000).

This current study of role transition during the FNP educational process builds on previous work exploring the role transition in FNPs (Heitz, Steiner & Burman, 2004). Heitz et al. (2004) used a descriptive qualitative approach with a resulting conceptualization of FNP role transition. A sample of 9 female recent (within 5 years) FNP graduates was interviewed. Open-ended questions were used to identify factors that helped and hindered role transition, how and when the role transition occurred, as well as an overall description of the process. The study confirmed...
that role development begins during the NP educational program and continues after graduation. Role transition was hypothesized to occur in two phases: the educational phase and the postgraduation period (6 months to 2 years). The framework describing the process consisted of positive forces, obstacles, and turbulence as they affected role transition. Defining characteristics of the positive forces and obstacles differed between the educational and postgraduation phases.

The purposes of this current study were to validate the educational phase of the framework developed by Heitz et al. (2004) and identify other role transition issues. Confirmation or expansion of the previous findings may help nurse educators develop new teaching strategies and refine current strategies to aid students in the role transition. The following questions were addressed:

- What was the level of agreement with the positive forces and obstacles identified in the educational phase of the original role transition framework (Heitz et al., 2004)?
- What other factors influenced the RN-to-FNP role transition?
- Was there a relationship between the length of time as an RN prior to FNP education and the positive forces and obstacles identified in the educational phase of the original role transition framework (Heitz et al., 2004)?
- Was there a relationship between personal life circumstances (e.g., age, gender, marital status, having children at home, student status, work status, travel to theory classes) during FNP education and the positive forces and obstacles identified in the educational phase of the original role transition framework (Heitz et al., 2004)?

**LITERATURE REVIEW AND CONCEPTUAL FRAMEWORK**

In an early study of role transition of RN to FNP, Malkemes (1974) found that NP students experienced a role change and needed to be provided with guidance to successfully complete the transition. Another early study determined that a transitional period was predictable but varied based on the student’s negotiation skills and role frameworks available to the student (Knafl, 1978). Nurse practitioner students are faced with many challenges when leaving the role of RN to assume the NP role, as well as the increased responsibility encompassed in the student’s new role as an NP (Roberts, Tabloski, & Bova, 1997). Brower, Tappen, and Weber (1988) argued that NP students are not a “finished product” (p. 36) when they complete their education, and further socialization is needed. In a landmark study, Brown and Olshansky (1998) focused on the challenges of NP graduates. In particular, the turbulence characterizing the first year of practice was documented. Further research directed at transitions across the spectrum of NP specialties was recommended. Griffith (2004) studied NP role transition in the United Kingdom and identified two categories as components of the NP transition: experience in the workplace and experience in the academic environment. Experienced nurses transitioning into the FNP student role commonly realize the difference between providing patient care at an expert level versus providing expert primary care. A safe learning environment promotes the critical thinking and synthesis necessary for this new role (Forbes & Jessup, 2004). A safe learning environment is a hallmark characteristic of pedagogy—the theory of adult learning (Knowles, 1980)—and a learner-centered approach to teaching as described by Weimer (2002) promotes this safe environment and learner empowerment needed for the role transition.

The framework developed by Heitz et al. (2004) describes the role transition in two clearly separate phases: the educational phase (phase I) and the postgraduation phase (6 months to 2 years; phase II). Six central categories comprised the framework: extrinsic obstacles, intrinsic obstacles, turbulence, positive extrinsic forces, positive intrinsic forces, and role development. In each phase, the obstacles create turbulence, described as alternating emotions and perceptions, which produces reliance on the positive forces. Continued role development is the result of the interaction between the positive forces and obstacles. New findings were the specific obstacles of personal commitment and sacrifices encountered during the educational phase of transition. A difference in role transition between inexperienced and experienced RNs during the educational phase was also suggested. Trustworthiness of the study was ensured by prolonged engagement with the study participants, member checks, and an inquiry audit. Transferability of the findings was aided by the thick data description.

Transformational learning theory (perspective transformation) has been used to describe a theoretical framework for NP education (Steiner & Burman, 2000). Mezirow (1981) described critical reflection as becoming aware that “why we attach the meanings we do to reality, especially to our roles and relationships…may be the most significant distinguishing characteristics of adult learning” (p. 11). The process of perspective transformation begins with a disorienting dilemma, and NP education can certainly be categorized as a disorienting dilemma. The resultant epistemic and perspective change leads to the development of more inclusive frameworks and can be described as RN-to-FNP role transition.

This study focuses specifically on phase I positive forces and obstacles because faculty play a critical role in the perspective transformation process. A better understanding of the role transition experience from the perspective of nurse practitioners will assist educators in the development of best practices for facilitating epistemic and perspective change.

**METHOD**

**Sample**

This study used a survey mailed to all FNPs in Idaho and Wyoming. Lists of licensed FNPs were purchased from the State Board of Nursing in each state. In Idaho,
312 FNPs were listed, and in Wyoming, 100 FNPs were listed. All FNPs in both states were asked to participate. Four hundred twelve surveys were sent to FNPs in Idaho and Wyoming, and 208 were returned, for a response rate of 50.5%. In Idaho, of the 312 surveys sent, 155 were returned, for a response rate of 49.7%. In Wyoming, 100 were sent and 53 were received, for a response rate of 53%.

The participants were primarily married women between ages 40 and 60 (midpoint mean = 47.2 years, SD = 8.9) with school-age children (Table 1). Most had practiced nursing 0 to 8 years prior to starting their FNP education, and most were between the ages of 20 and 40 years when their FNP education was completed (midpoint mean = 38.7 years, SD = 8.2). During their education, most were full-time students and it was necessary for them to travel to theory classes.

Data Collection
The questionnaire was a researcher-designed tool created from the nine positive forces and five obstacles identified in the original study’s conceptual framework (Heitz et al., 2004). The questionnaire included 12 statements about positive forces and 7 statements about role transi-
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TABLE 2
Participant Ranking of Positive Forces and Obstacles

<table>
<thead>
<tr>
<th>Positive Forces</th>
<th>Mean</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prior life experiences</td>
<td>4.54</td>
<td>0.68</td>
</tr>
<tr>
<td>Preceptor guidance</td>
<td>4.52</td>
<td>0.79</td>
</tr>
<tr>
<td>Personal support system</td>
<td>4.47</td>
<td>0.72</td>
</tr>
<tr>
<td>Optimistic self-talk</td>
<td>4.41</td>
<td>0.74</td>
</tr>
<tr>
<td>Role modeling</td>
<td>4.30</td>
<td>0.86</td>
</tr>
<tr>
<td>Hands-on laboratory experiences</td>
<td>4.29</td>
<td>0.76</td>
</tr>
<tr>
<td>Case studies</td>
<td>3.94</td>
<td>0.92</td>
</tr>
<tr>
<td>Faculty guidance</td>
<td>3.72</td>
<td>1.05</td>
</tr>
<tr>
<td>Faculty support</td>
<td>3.71</td>
<td>1.08</td>
</tr>
<tr>
<td>Standardized patients</td>
<td>3.59</td>
<td>0.97</td>
</tr>
<tr>
<td>Developing acceptance of self</td>
<td>2.82</td>
<td>1.24</td>
</tr>
<tr>
<td>Role separation was difficult</td>
<td>2.76</td>
<td>1.30</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Obstacles</th>
<th>Mean</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sacrifices</td>
<td>4.18</td>
<td>0.97</td>
</tr>
<tr>
<td>Lack of mentoring</td>
<td>3.11</td>
<td>1.15</td>
</tr>
<tr>
<td>Negative preceptor styles</td>
<td>2.95</td>
<td>1.12</td>
</tr>
<tr>
<td>Staff resistance</td>
<td>2.80</td>
<td>1.08</td>
</tr>
<tr>
<td>Negative self-perception</td>
<td>2.67</td>
<td>1.19</td>
</tr>
<tr>
<td>Role confusion</td>
<td>2.49</td>
<td>1.15</td>
</tr>
<tr>
<td>Personal commitments</td>
<td>2.46</td>
<td>1.07</td>
</tr>
</tbody>
</table>

Descriptive statistics were used to identify the level of agreement with the positive forces and obstacles. Means were calculated based on the 5-point Likert scale and ranked from highest to lowest (Table 2). There was agreement with 6 of the 12 positive forces (mean = 4 to 5) but with only 1 of the 7 obstacles.

Research Question 1
Descriptive statistics were used to identify the level of agreement with the positive forces and obstacles. Means were calculated based on the 5-point Likert scale and ranked from highest to lowest (Table 2). There was agreement with 6 of the 12 positive forces (mean = 4 to 5) but with only 1 of the 7 obstacles.

Research Question 2
Of the 208 participants, 117 (56%) responded to the open-ended questions. These questions asked participants to describe any other positive forces or obstacles that influenced their RN-to-FNP role transition. Three of the authors (R.S.H., D.G.M., S.H.S.) performed an independent thematic analysis of the data. Their findings were consistent, which contributed to credibility of the findings. Two main themes emerged: community support and curricular issues. Under community support, participants included health professionals (MDs, other NPs, and RNs), hospitals, and patients. Community support was identified as both a positive force and an obstacle. Some participants identified good to excellent support by physicians and stated that the physicians served as mentors as the FNPs developed their practice roles. Other participants identified negative reception by physicians. In addition, participants identified jealousy and nonacceptance by RNs. There were also concerns about patient acceptance and hospital policies. Curricular issues were identified as obstacles by the participants. Not enough clinical time, poor preceptors, and lack of information about the business aspects of health care were mentioned. Credibility of the thematic analysis was enhanced by comparison of findings by three of the authors (R.S.H., D.G.M., S.H.S.).

Research Question 3
To determine whether there was a relationship between the length of time a participant was an RN prior to FNP education and the positive forces and obstacles,
Spearman rank-order correlation coefficients with Bonferroni corrections were calculated. No significance was found. But it was interesting to note that without the Bonferroni correction, prior life experience \((r = 0.19, p = 0.007)\), optimistic self-talk \((r = 0.19, p = 0.007)\), and role separation \((r = 0.18, p = 0.009)\), all positive forces, showed weak but positive correlations with years of practice as an RN. Also without the Bonferroni correction, one of the obstacles, staff resistance to role transition \((r = -0.16, p = 0.025)\), showed a weak but negative correlation with years of practice as an RN. Although these did not withstand the Bonferroni correction, using a larger sample may show a relationship.

**Research Question 4**

To determine whether there were relationships between personal life circumstances and the positive forces or obstacles, data were analyzed using either Mann-Whitney U, Kruskal-Wallis, or Spearman rank-order correlation coefficients, as appropriate, with Bonferroni corrections. Only two of the relationships were found to be significant: personal support system \((z = -3.32, p = 0.003)\) and personal sacrifice \((z = -3.12, p = 0.03)\). Those who had to travel to theory class rated personal support system higher on average \((mean = 4.61)\) than those who did not have to travel \((mean = 4.25)\), and those who had children at home rated personal sacrifice as an obstacle higher \((mean = 4.4)\) than those who did not have children \((mean = 3.9)\).

**DISCUSSION**

There was stronger agreement with the positive forces than with the obstacles. Agreement was found with prior life experiences, preceptor guidance, personal support system, optimistic self-talk, role modeling, and hands-on laboratory experiences. The participants neither agreed nor disagreed with case studies, faculty guidance and support, and standardized patient experiences. The only obstacle with which participants agreed was sacrifice. They neither agreed nor disagreed with lack of mentoring. There was no agreement \((mean = 1 to 2.99)\) with negative preceptor styles, staff resistance, negative self-perception, role confusion, and personal commitments. However, it should be noted that agreement with the positive forces could be related to the retrospective recall nature of the study. Participants may have completed both phases of role transition, thus allowing time and experience to fade the memory of some obstacles. In the open-ended question, community support was described as both a positive force and an obstacle, and curricular issues were described as an obstacle.

In the original framework, both positive forces and obstacles were categorized as intrinsic or extrinsic. Intrinsic factors were defined as internal coping mechanisms and stressors. Extrinsic factors were defined as external forces, influences, and stressors. Academic activities were identified as a positive force, with specific mention of hands-on laboratory experiences, case studies, and standardized experiences. Faculty nurturance was specifically described as faculty guidance and faculty support. For this study, these were tested separately in the questionnaire.

The positive forces with the strongest level of agreement were both intrinsic and extrinsic. The intrinsic forces with agreement were prior life experiences and optimistic self-talk, whereas the extrinsic forces were preceptor guidance, personal support system, role modeling, and hands-on laboratory experiences. Standardized patient experiences are relatively new teaching strategies and, consequently, participants who graduated more than several years ago would not have experienced these. This may explain why there was neither agreement nor disagreement. There was no agreement with the intrinsic forces of role separation and acceptance of self-responsibility. The only obstacle with agreement, sacrifices, was intrinsic. The extrinsic obstacle of lack of mentoring had neither agreement nor disagreement.

Agreement with prior life or workplace experience supports findings by Griffith (2004) and was not a surprise. However, the lack of agreement with faculty guidance and support as a positive force was surprising. Hands-on laboratory experiences were clearly found to be a positive force, and this is certainly part of the academic environment. In the smaller Heitz et al. study (2004), faculty guidance was a dominant positive force, whereas in this study, preceptor guidance was found to be more important. Although faculty are responsible for introducing didactic information and a new practice framework for epistemological perspective change, it is the experiential learning of clinical practicum where FNP students apply the knowledge. Thus, the participants in this study indicated that the clinical preceptors facilitate the actual role transition to a higher degree than do the faculty. This finding emphasizes to educators the importance of appropriate preceptor selection. However, a more learner-centered teaching environment, as described by Weimer (2002), may promote student perception of faculty guidance as an important component of role transition. In the environment discussed by Weimer (2002), content is “used,” not “covered,” to establish knowledge foundation, and the faculty roles become “guides, facilitators, and designers of learning experiences” (p. xviii). Power is shared among faculty and students, and students are thus empowered in their learning.

An interesting finding was the lack of agreement with obstacles that could be considered the opposite of positive forces for which agreement was found. For example, preceptor guidance was found to be a positive force, whereas a negative preceptor style was not found to be an obstacle. Optimistic self-talk described previously in the literature (Kolp & Sete, 2001) was a positive force, yet negative self-perception was not found to be an obstacle. A personal support system was important, whereas personal commitments were not considered to be an obstacle in role transition. Perhaps the message for nurse educators is that the fostering of positive forces may be a more important focus than amelioration of obstacles.
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Heitz et al. (2004) suggested that both role separation and transition might be more difficult for experienced RNs. In this study, the strongest level of agreement was with prior life experience as a positive force, whereas there was no agreement with role confusion as an obstacle. However, there was a weak positive correlation of prior nursing experience with optimistic self-talk and role separation. Optimistic self-talk was a skill more readily used by experienced RNs. Role separation was more difficult for those RNs with more experience, although prior life experience was identified as a positive force. There was a weak positive correlation between years of experience and role separation, but a negative correlation between years of experience and staff resistance to transition. The longer a student had been a practicing RN, the less effect staff resistance had on role transition but the more difficult role separation became for the RN. The staff was more accepting of an experienced RN moving into a different role and therefore less negative, whereas the RN had difficulty with the role separation. However, the variable of work experience may not be particularly meaningful because a majority of participants were experienced RNs.

Although these findings were not statistically significant, they suggest interesting trends in educational methods. All faculty need to be aware of the potential role separation difficulty. It may be helpful to prepare experienced RN students for the potential difficulty and create ways to support them through the transition. Having experienced FNP faculty share stories and evidence about role separation difficulty may be beneficial to help students anticipate this potential problem. Perhaps forming small peer groups of experienced FNP students may be helpful to support one another and facilitate the transition. Further research with a larger national sample across the NP specialties is needed to explore the role transition of experienced and less experienced RNs.

The open-ended questions were intended to elicit the role transition issue during the educational process. However, the responses included comments about role transition after graduation, as well as during the educational process. This implies that the participants did not separate their role transition, but rather viewed it as a whole. This finding is consistent with previous studies indicating that the role transition occurs over time, beginning with education and continuing up to the first 2 years of practice (Brower et al., 1988; Heitz et al., 2004). Although the purpose of this current study was to validate the educational phase of the framework developed by Heitz et al. (2004), it is clear that future research should include both phases.

The two major themes of the open-ended responses were community support as both a positive force and an obstacle, and the obstacle of curricular issues. It is interesting to note that although there was no agreement found with negative preceptor styles or staff resistance, both were mentioned as obstacles in the responses. It may be that those who found these to be obstacles were concerned enough about them to make written comments and may reflect only the occasional negative preceptor experience. Lack of agreement found with the questionnaire may indicate that, in general, preceptor experiences are positive. Perhaps further study may clarify this apparent contradiction.

Curricular issues identified included “not enough clinical time.” This perpetual concern of students should be noted by nurse educators and, in fact, will be addressed in the future as NP programs transition to the clinical doctorate. It is important to help students realize that the role transition takes time to occur and that knowing how to learn, rather than knowing how to handle every potential clinical situation, is more important. Students must be reassured that although it takes time to become an independent expert FNP, they will know enough by graduation to be safe. Lack of knowledge about business in health care practice was the other curricular issue mentioned as an obstacle. A similar topic was presented at the 2006 National Organization of Nurse Practitioner Faculties annual meeting and a need identified for a Business 101 course in nurse practitioner curricula (Viens & Jackson-Allen, 2006). Clearly, this continues to be a curricular issue.

IMPLICATIONS FOR EDUCATION

As suggested by the lack of agreement with obstacles, it may be more important for nurse educators to foster positive forces than to ameliorate obstacles. However, the curricular obstacle of business practices should be addressed. Educators can control some of the positive forces and encourage the development of others. Preceptor guidance was identified by participants as a positive influence on role transition. This finding reinforces the importance of mentor-preceptor selection, as previously identified in the literature (Kelly & Mathews, 2001). It is also important for educators to strengthen support for preceptors to maintain this positive relationship. In addition, the findings indicate the need for educators to provide adequate hands-on laboratory experiences. The preceptor and laboratory recommendations are particularly important in primarily online learning programs. Although participants did not identify the need for a change in learning environment, a learner-centered environment may foster the perspective transformation needed for role transition and increase student perception of faculty’s influence as a positive force. Educators should encourage the development of coping mechanisms, such as a strong personal support system and the skill of optimistic self-talk. Optimistic self-talk is defined as internal reinforcement that helps maintain a positive mental attitude and confidence in knowledge and skills. Perhaps something as simple as private and group discussions or reflective journals about how each student can strengthen his or her support system would be helpful. Optimistic self-talk can be practiced in peer discussion groups and reflective journals. In particular, educators need to be cognizant and appreciative of student sacrifice.

Educators should be aware of the significant correlations found between personal life circumstances and the
positive forces and obstacles, particularly personal support and sacrifice. These issues should be addressed with current and potential students. A personal support system was significantly more important to students who needed to travel to attend classes. Personal sacrifice was more of an obstacle for students with children at home. Although traveling to class may become less of an issue as distance programs offer didactic coursework online, students with children at home will undoubtedly continue to experience personal sacrifice. The importance of family partnership and personal support systems during FNP education are issues that need to be discussed both at the time of admission and program orientation.

**CONCLUSION AND IMPLICATIONS FOR RESEARCH**

A limitation of this study was that only FNPs from two rural western states were surveyed. FNPs from more populous areas may not agree with the positive forces or obstacles identified or with other findings. In addition, the study included only FNPs. Thus, further research should include testing the modified phase I and the original phase II of the framework for validity nationally across NP specialties.

The strong level of agreement in this study with the positive forces and obstacles, particularly prior life experience, preceptor guidance, personal support system, optimistic self-talk, hands-on laboratory experiences, role modeling, and personal sacrifices, lends creditability to the RN-to-FNP framework developed in the original study. However, modification of the original phase I in the conceptual framework for RN-to-FNP role transition is suggested by the findings. The revised framework should include the positive forces prior experience, preceptor guidance, personal support system, optimistic self-talk, and hands-on laboratory experiences. Case studies, faculty support and guidance, and standardized patients should also be included because participants rated these forces as between agree and neither agree nor disagree. A larger and more diverse sample may offer more information about these. The obstacles included in the revised framework would be sacrifices, lack of mentoring, and the curricular issues of “not enough clinical time” and “lack of business knowledge.” Open-ended questions or a qualitative study could clarify community support, found to be both a positive force and an obstacle, and identify how faculty could be more influential in the role transition. As mentioned earlier, the inclusion of phase II issues in the open-ended responses indicates a need to test both phases of the framework. The issue of role transition continues to be studied and to be a topic of interest among NP educators. Of particular concern is how online programs, increasing in availability, affect role transition. This should also be a focus of future research.

**REFERENCES**


