THE STUDENT EXPERIENCE: AN ETHNOGRAPHIC ANALYSIS OF THE CLINICAL LABORATORY EXPERIENCE OF DIPLOMA NURSING STUDENTS

by

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ABSTRACT

The study is an ethnographic analysis of the clinical laboratory experience of 38 senior diploma nursing students enrolled in a community college school of nursing. It was undertaken specifically to answer the following:

1. What are the sources of professional-bureaucratic work conflict identified by students during the clinical laboratory experience?

2. How do students behave when they are confronted with perceived professional-bureaucratic work conflicts during the clinical laboratory experience?

3. How do students' experiences with professional-bureaucratic work conflicts during the clinical laboratory experience influence their orientation toward their future role as practitioners?

By means of observing, listening to and interviewing individuals on a specific clinical unit in a general hospital, it was determined that the sample of students saw only partial glimpses of or were largely unaware of the backstage realities, or the things that go on behind the work scene, which might lead to professional-bureaucratic work conflict. There was marked variation among the students in the degree to which these were recognized and acknowledged. These students with previous hospital work experience appeared more aware than their classmates of the existence of backstage realities.

Students who witnessed backstage realities during the course of the study were generally shocked and/or angry. Most students,

however, were unable to predict the far-reaching implications of these incidents in their future role as practitioners.

It is proposed by the researcher that the students' perspectives toward their futures were largely unaffected by their experiences with backstage realities because of the structure of image management in the clinical area. It is within the context of image management that the experience of students is analyzed. This analysis includes the identification and discussion of three specific aspects of image management in the clinical area; namely, territoriality, infallibility and the helping relationship.

The findings of the study offer limited generalizability to Canadian nursing education. They may be applicable only to the particular school of nursing involved in the study. However, the study presents some provocative questions for future research in this area.

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CHAPTER I

INTRODUCTION

Nursing leaders have identified the retention of nursing personnel as the most critical challenge facing the profession today.[1] The average tenure of new staff nurses is six months[2] and the high turnover in hospitals (from 40 to 70% annually)[3] has adversely affected the quality of patient care given in these institutions.[4] The cost of replacing exiting staff of a hospital has been estimated at $20 million.[5]

Many predominantly-female occupations share nursing's concern with attrition. They attribute attrition to the marriage and family committments of practitioners. However, nurses do not demonstrate the pattern of career interruption as seen with school teachers, but rather desertion of their career.[6]

One investigator of the issue of attrition in the nursing profession, Marlene Kramer, attributes the high rates of attrition, particularly within the first year following graduation, to a phenomenon she terms "reality shock."[7] Reality shock occurs whenever an individual leaves a subculture in which she/he feels comfortable and competent, into a new subculture in which she/he feels ill-prepared and insecure.[8] In nursing, 'reality shock' refers to the reactions of a new graduate when she/he encounters "professional-bureaucratic work conflict."[9] Individuals experience this type of conflict when they perceive that there are discrepancies between what

they have been taught in school and what is applicable in practice.[10] A new graduate must confront these discrepancies when, for example, she/he recognizes that tasks such as record maintenance take precedence over nursing activities or that she/he is unable to cope with the dichotomy between school and work values, reality shock may produce severe emotional stress and, frequently, exodus from the profession.[11] One study indicated that almost one-third of a nation-wide sample of nurses left the profession because of disillusionment and dissatisfaction within four years of graduation.[12]

Kramer contends that reality shock is imminent for new graduates because nursing schools and the agencies which employ nurses propagate widely divergent goals and values.[13] Nursing service exists for the purpose of providing patient care; nursing education seeks to provide the student nurse with learning opportunities in order that she/he be able to master nursing skills. The individual who undergoes the role transition from student to staff nurse must change abruptly from "care-receiver" in the academic institution to "care-giver" in the health care institution.[14] The extent to which nursing education and nursing service differ in values and expectations is the extent to which an individual will experience difficulty in undergoing this transition.[15]

Researchers in the area of reality shock in nursing have tended to focus on the experiences of new graduates, rather than of students. Most investigators have assumed that reality shock is a phenomenon unique to the graduate; that students are unaware of disparities between school and practice.[16] It is the intention of this study to question this assumption.

NATURE OF THE PROBLEM

Schools of nursing have been the targets of criticism, particularly over the past two decades. Nursing followed the historical development of occupations, such as medicine, law and teaching, which developed educational institutions with distinct standards and policies as they sought to achieve status as a profession.[17] As these professions emerged, the professional schools became increasingly independent from the field of practice.[18] This has resulted in conflict between the educational and occupational systems of the professions.[19] Teacher education institutions, for example, have been accused of "irrelevant curricula", of being out of touch with the "real world" of teaching.[20] Medical practitioners have charged that some professors in medical schools are researchers, not clinical experts, and are unable to teach clinical medicine effectively.[21] In nursing, educators are often accused of projecting a "highly idealistic view" which is incongruent with the realities of decreased funds and diminishing numbers of personnel in hospitals today.[22] The graduate of nursing education programs is said to be lacking in essential technical skills and inundated with psychosocial theories of patient care. She can "analyze and synthesize but not catheterize."[23] Nursing education's reaction to this criticism has tended to be somewhat defensive.

Educators are frequently openly critical of the practitioners' ability to perform nursing skills as they "should be" performed. Many educators believe practitioners to be too task-oriented to the detriment of the emotional aspects of patient care.[24] So powerful is

this "antibureaucratic ideology" that nursing students, even by the end of their first year in the program, are highly critical of staff nurses.[25]

The reactions of new graduates who confront disparities between school and work have been well-documented by researchers. However, little is known about the reactions of nursing students; those individuals who remain "caught in the middle of a complete dichotomy of standards of care" throughout the tug of war between service and education.[26]

Kramer and Schmalenberg dismissed the student experience as irrelevant to their study of reality shock. They contend that students are not given the opportunity to witness "backstage realities," the "things that go on behind the scenes" in the work setting, and consequently, do not experience professional—bureaucratic work conflict.[27] It may indeed be possible to isolate students from the realities of hospital nursing in a classroom. This would appear to be an impossible task in the clinical area where students must interact in a complex system of communication and role relationships. A student nurse interacts with numerous people (e.g., patients, physicians, staff members) during a clinical laboratory experience. Each of these individuals give her/him signals indicating their expectations of what their role and his/her role should be.[28] Each individual is apt to develop expectations that are in keeping with her/his personal and/or organizational goals and values.[29] If the dichotomy between nursing service and education exists to the extent that is represented in current literature, one might expect that a student in the clinical area would be faced with conflicting

expectations and values, some of which will be incompatible with her/his own or those of the educational program.[30] If students are able to avoid confronting "backstage realities" in the clinical area, we must ask why and how students are protected from this experience.

PURPOSE OF THE STUDY

Investigators of attrition in the nursing profession have concluded that "nurses aren't going to quit their jobs when they can practise the way they were taught in school."[31] Anticipatory socialization training programs have been proposed for new graduates to teach them how to function as effectively in the work subculture.[32] Although the benefits of these programs appear promising, nursing service must cope with the costs of the programs, as well as providing for adequate staff coverage when new graduates must be absent from the units to attend the training sessions. An additional consequence of anticipatory socialization programs is that they suggest that reality shock is inherent in the work subculture. This serves to absolve nursing education of responsibility in the creation and constructive management of professional-bureaucratic work conflict.

The increasing demand for accountability in nursing has made it impossible for nursing education to "exist in splendid isolation" apart from nursing service.[33] Members of the community and the profession are questioning the effectiveness of nursing education programs in preparing nurses to work amid the realities of practice. Educators are being pressured to evaluate the congruence of what is taught in their programs and what is applicable in practice. To do this, there needs to be at least a rudimentary conception of the

values, attitudes and norms of the people located in the various positions within the school and the hospital.[34] Students, as consumers, have the right to expect that they will be safeguarded from being "caught between the millstones"[35] of nursing education and nursing service. In order to afford students this protection, there needs to be a greater understanding than exists at present of the experience of students as they interact with personnel, patients, instructors and each other in the clinical area. Effective strategies of professional-bureaucratic work conflict resolution can only be developed when the conflicts encountered by students, which challenge their value systems, are identified.[36]

The central purpose of this study is to explore the nature of a student nurse's experience with "backstage realities" in the clinical laboratory. Specifically, it seeks the answers to the following:

1. What are the sources of professional-bureaucratic work conflict identified by students during the clinical laboratory experience?

2. How do students behave when they are confronted with perceived professional-bureaucratic work conflicts during the clinical laboratory experience?

3. How do students' experiences with professional-bureaucratic work conflicts during the clinical laboratory experience influence their orientation toward their future role as practitioners?

An underlying assumption of the study is that the clinical laboratory experience is a social situation, consisting of many persons, including the students, interacting with one another in the

physical setting of the clinical area. It is further assumed that this situation may be defined in varied ways by those who perceive it. Students will interact with the other participants in this social situation according to what they perceive the values, attitudes and behavioral expectations of others to be.

Conflict and tension are generated "when the expectations governing social relationships are violated or frustrated."[37] Therefore, a study of conflicts in the clinical laboratory experience reveals what those expectations are; this discovery is essential to the analysis of the student experience and to the purposes of this study. References to conflict in the study do not necessarily denote destructive outcomes. The possible positive functions of conflict (e.g., prevention of stagnation)[38] are acknowledged.

Nursing educators may suggest that the students in the study were not always realistic in their perceptions of conflict. They may feel that students do not have access to all the information necessary to analyze conflict situations in the clinical area and that students are not always able to perceive actual incompatibilities. Throughout the study, every effort was made to validate student perceptions by asking those with whom the students interacted in their clinical laboratory experience to respond to what the students perceived. However, in the study, it is the student perspective which is paramount. Instructors, patients, staff and physicians served to provide a contexual view of the clinical laboratory experience.

An assumption of the study is that it is the student's perception that a conflict exists that is significant and it is his/her perception of the situation which will affect his/her response.

ORGANIZATION OF THE REPORT

This chapter has been designed to offer an introduction to the study, to outline its purpose and the need which prompted its undertaking.

Chapter II reviews past and current issues in nursing clinical education. This serves as a historical framework for the analysis of the student experience in the clinical laboratory experience.

In Chapter III, the methodology implemented in the research is described and its limitations identified. It provides a description of participants in the study and the setting at which the study took place. The role of the researcher and the effects of her presence upon the findings are also examined.

Chapter IV presents a description of the structure of image management in the clinical area, as it affects the role and behavioral expectations of students.

Chapter V provides a description and analysis of the students' experiences with backstage realities and their orientation toward their future role as practitioners.

The final chapter presents a summary of the findings of the study, with implications pertaining to nursing education's role in the prevention and management of reality shock. Included in this chapter are recommendations for future research suggested by the findings of the research.

FOOTNOTES

[1]Canadian Press, "Retention of Nurses Called Major Problem," Winnipeg Free Press, May 8, 1981, p.

[2]M. Kramer and C. Schmalenberg, Bicultural Training and New Graduate Role Transformation (Wakefield, Massachusetts: Nursing Resources Inc., 1978), p. vii.

[3]E.A. Krause, The Sociology of Occupations (Boston: Little, Brown and Co., 1976), p. 121.

[4]S.D. Holloran, B.H. Mishkin and B.L. Hanson, "Bicultural Training for New Graduates," Nurse Education, 5:1 (Jan.-Feb. 1980), p. 8.

[5]D. Cronin-Stubbs and P.S. Gregor, "Adjustments of the New Graduate to the World of Nursing Service," Teaching Tomorrow's Nurse: Educator Reader, ed., S.K. Mirin (Wakefield, Massachusetts: Nursing Resources Inc., 1980), p. 185.

[6]Krause, op. cit., p. 121.

[7]M. Kramer, Reality Shock (St. Louis: C.V. Mosby Co., 1974), p. 3.

[8]M. Kramer and C. Schmalenberg, Path to Biculturalism, Wakefield, Massachusetts: Contemporary Publishing Inc., 1977), p. ix.

[9]M. Kramer and C. Schmalenberg, "Conflict: The Cutting Edge of Growth," Journal of Nursing Administration, 10 (Oct. 1976), p. 21.

[10]M. Kramer, "Educational Preparation for Nurse Roles," Current Perspectives in Nursing Education, ed., J. Williamson (St. Louis: C.V. Mosby Co., 1976), p. 105.

[11]Kramer and Schmalenberg, 1976, op. cit., p. 21.

[12]Kramer, 1976, op. cit., p. 105.

[13]Kramer, 1974, op. cit., p. 23.

[14]Cronin-Stubbs and Gregor, op. cit., p. 184.

[15]Ibid., p. 197.

[16]M. Kramer and C. Schmalenberg, Coping with Reality Shock: The Voices of Experience (Wakefield: Massachusetts: Nursing Resources Inc., 1979), p. 169.

[17]H.O. Mauksch, "Student Learning and Patient Care: Stress or Strength?", Roles and Relationships in Nursing Education (New York: N.L.N., 1959), p. 125.

[18]Ibid.

[19]G. Ritzer, Man and His Work: Conflict and Change (New York: Appleton Century Crofts, 1973), p. 358.

[20]M.L. Cushman, The Governance of Teacher Education (Berkeley, California: McCutchan Publishing Corp., 1977), p. 4.

[21]M.L. Gross, The Doctors (New York: Random House Publishing, 1966), p. 369.

[22]Kramer, 1976, op. cit., p. 97.

[23]Ibid., p. 95.

[24]J. Williamson, "More Professor Than Practitioner," Current Perspectives in Nursing Education, ed., J. Williamson (St. Louis: C.V. Mosby Co., 1976), p. 81.

[25]F. Davis et al., "Problems and Issues in Collegiate Nursing Education," The Nursing Profession: Five Sociological Essays, ed., F. Davis (New York: John Wiley and Sons Inc., 1966), p. 166.

[26]E.J. Knapper, "The Practitioner's Responsibility in Education," Current Perspectives in Nursing Education, ed., J. Williamson (St. Louis: C.V. Mosby Co., 1976), p. 121.

[27]Kramer and Schmalenberg, 1979, op. cit., p. 169.

[28]National League of Nurses, Socialization and Resocialization of Nurses for Professional Nursing Practice (New York: N.L.N., 1976), p. 11.

[29]Ibid.

[30]R.H. Turner, "Role Taking, Role Standpoint and Reference Group Behavior," Role Theory: Concepts and Research, eds., B.J. Biddle and E.J. Thomas (New York: John Wiley and Sons, Inc., 1966), p. 151.

[31]"Reality Shock Can Be Handled On the Job," R.N., 63:6 (1977), p. 11.

[32]Hollaran, Mishkin and Hanson, op. cit., p. 8.

[33]E.J. Knapper, op. cit., p. 120.

[34]J.R. Hackman and J.L. Suttle, Improving Life at Work (Santa Monica: Goodyear Publishing Co. Inc., 1977), p. 33.

[35]Maukseh, op. cit., p. 126.

[36]Kramer and Schmalenberg, op. cit., p. 25.

[37]M. Deutsch, The Resolution of Conflict: Constructive and Destructive Processes (London: Yale University Press, 1973), p. 21.

[38]B.A. Hurley, "Socialization for Roles," Role Theory: Perspectives for Health Professionals, eds. M. Hardy and M. Conway (New York: Appleton-Century Crofts Inc., 1978), p. 44.

CHAPTER II

CLINICAL TEACHING IN NURSING EDUCATION

In the formal classroom setting, nursing students are given the opportunity to explore and debate the elements of practice. However, it is in the clinical area that students confront the realities of nursing. Here, they are expected to "learn the ropes". In the process, they become acculturated to the norms and practices of the work setting.[1]

The significance of the clinical laboratory experience for students has been recognized by nursing educators throughout the history of the profession. The concept of clinical teaching has been an integral portion of nursing education since the first school of nursing was founded in 1860.[2] There have been extensive variations, however, in the underlying philosophy, as well as the structure and administration of clinical teaching programs during the evolution of nursing education in the past century.[3]

Any discussion of the impact of the dichotomy between school and work upon nursing students must take account of its historical origins. If the past is viewed as a reflection upon our present-day thinking, any analysis of the clinical experiences of nursing students must include a discussion of the historical development of clinical teaching programs in nursing.

HISTORICAL DEVELOPMENT

Modern nursing education began with the establishment of St. Thomas's Hospital in London on June 24, 1860 by Florence Nightingale.[4] The school was intended to be a "self-directing, self-supporting educational institution to train nurses."[5] Established at a time in which it was not fashionable for women to work, the program stressed those characteristics which were socially acceptable for women; obedience, devotion to duty and morality.[6] Some investigators view this to be the legacy of the Nightingale system of nursing education; the "ghost of Crimea."[7] Even today, there are individuals entering nursing who are hoping to enhance their ability to be nurturing and self-sacrificing.[8]

The Nightingale system incorporated the apprenticeship concept of education. Some lectures were given by physicians[9] but students learned primarily at the patient's bedside from more experienced nurses.[10] As students progressed in the program, they became the teachers to neophytes. This method of clinical teaching limited learning to what one nurse perpetuated to another.[11]

At the turn of the century, a few nursing educators sought to improve the standards of nursing education programs and to abolish the apprenticeship system of instruction.[12] The introduction of textbooks in 1878 was a significant step toward this purpose.[13] In 1895, the Waltham Training School in Massachusetts established a six-month pre-clinical course for students entering the program.[14] The John Hopkins School of Nursing instituted a similar program of classroom instruction and employed two full-time teachers to teach nursing

procedures to beginning students.[15] This model was by no means universal for schools of nursing of the time; the apprenticeship concept continued to flourish.[16]

Between the years 1900 and 1909, the number of nursing schools in Canada doubled.[17] However, the programs were poorly organized and often subordinated the educational needs of students to the labor needs of hospitals associated with the schools of nursing.[18] Students frequently functioned as cleaning and maintenance staff for the hospitals.[19]

The programs offered by schools of nursing during this period were not standardized. The quality of graduates from these programs varied immensely.[20] No specific qualifications were defined for teachers in schools of nursing. In 1934, only 2% of nursing instructors had any post-basic education.[21]

In 1932, a survey was conducted, under the direction of George M. Weir, of the nursing education programs in Canada. Weir concluded that the "apprenticeship standards" should be abolished in schools of nursing. He recommended the establishment of educational standards for these programs and the upgrading of qualifications of nursing instructors.[22] He also advocated the financial and administrative independence of schools of nursing from hospitals.[23] The Canadian Nurses Association sought to implement these recommendations by establishing a curriculum guide for schools of nursing.[24]

During the years 1933 and 1953, many changes took place in the nature of clinical teaching programs in nursing.[25] Rapid technological changes and developments in the social and behavioral sciences following World War II resulted in dramatic changes in the definition

of the nurse's role. Nurses were suddenly expected to make decisions, based on scientific knowledge, about patient care and to implement and evaluate nursing measures.[26] In order for nurses to function at this sophisticated level, a different concept of nursing education was required from the original apprenticeship programs.[27] Nursing education incorporated this expanding theoretical basis of nursing by developing programs resembling traditional academic education. Increasing emphasis was placed on classroom theory and the service component of earlier schools of nursing disappeared.[28] Most schools of nursing followed the example of Bellevue Hospital School of Nursing which created the position of "ward instructor" to supervise and teach students in the clinical area.[29]

EMERGING PATTERNS OF CLINICAL TEACHING

Nursing education faces a unique challenge in that it must provide clinical experiences geared to needs of three different types of basic nursing education programs; the diploma program, the associate degree program and the baccalaureate program. As this study pertains only to diploma nursing students, the following discussion of emerging patterns of clinical teaching will make reference only to diploma schools of nursing.

The diploma program aims to prepare graduates who can function under supervision as beginning staff nurses to give and plan nursing care.[30] A graduate of such a program receives a diploma and is eligible for licensure in the nursing profession.[31] Although they are generally associated with hospitals, more and more diploma schools of nursing are incorporated in community colleges.[32]

Diploma schools of nursing have progressed from a philosophy of apprenticeship to student-centered education.[33] This is reflected in the changes which have taken place in the clinical teaching programs in these schools of nursing. These innovations began with a two-year experiment conducted at the Metropolitan School of Nursing at Windsor, Ontario. A report of the experiment in 1952 concluded, "when a school has complete control of students, nurses can be trained at least as satisfactorily in two years as in three years and under better conditions."[34] Ultimately, this led to the shortening of the diploma programs from 36 to 20 months.

The shortening of the program and the rapidly expanding theoretical basis of nursing has resulted in a reduction in the number of hours diploma students spend in the clinical area.[35] Educators in diploma programs assert that quantity of time spent in the clinical area "does not necessarily lead to the quality of learning."[36] Repetition of nursing skills is viewed as unnecessary and kept a minimum under the premise that students who understand the underlying scientific principles will be able to perform a specific procedure when required to do so following graduation.[37] "The notion that practice makes perfect can be applied to habit formation, but not to the acquisition of psychomotor skills."[38]

Diploma schools carefully plan and control the clinical laboratory experiences to meet the learning needs of students. Nursing instructors choose which patients are to be cared for by which students and for how long.[39] Students are rarely required to complete a regular hospital shift (eight to twelve hours); their clinical laboratory experience is generally four hours at a time.[40] They

rarely are assigned more than two patients in the clinical area or required to work during the evening and night shifts or on weekends.[41] The program approximates the five-day week, weekends off schedule of other educational institutions.

Diploma students receive limited experience in any one clinical area in order that they may "rotate" through all specialty areas (surgery, pediatrics, etc.) in their program. Teachers in these programs must have a broad clinical basis because they are often expected to function in two or more different clinical areas.[42]

The establishment of diploma nursing programs in community colleges has had a profound effect on the clinical education of nursing students. Community colleges uphold the conviction that every adult is entitled to an education which society is obligated to provide.[43] Therefore, their admission policy is open-door; any adult who desires to further his/her education is eligible for admission to a community college.[44] This open-door policy has influenced the composition of nursing students. The typical nursing student in a hospital school of nursing is between the ages of 18 and 35 and was among the upper half or third of her high school graduating class. She is white and single.[45]

There is no one typical student in community college diploma nursing programs. In no other educational institution will one find such diversity among student backgrounds and goals. Students in these programs are young, middle-aged, male, female, single, married, divorced. They include minority students and students who have not succeeded at previous educational endeavours.[46] They tend to be slightly older than the typical 18 year old university freshman and to

have been employed in nursing or health-related occupations before entering the program.[47] Many of these students previously attended and withdrew from another nursing program.[48] The choice of the program is often made because of financial or time consideration (e.g., they are unable to attend a longer or more expensive program), rather than because of the curricular content of the program.[49]

The needs of this untraditional student demand that nursing education provide him/her with experiences which are commensurate with his/her background. New and progressive approaches to clinical teaching are needed to provide the individualized instruction required by these students.[50] Community colleges have been credited with many educational innovations (e.g., simulation techniques) which they introduced to meet the learning needs of their heterogeneous student group and which have been subsequently adopted by other nursing programs.[51]

CURRENT ISSUES IN CLINICAL TEACHING

The problems confronting nursing education today have their origins in the historical development of the profession. Certain historic issues, particularly those pertaining to clinical teaching programs, have remained unresolved.

Historically, clinical teaching programs in nursing have evolved from training apprenticeships. Initially, practitioners taught clinical skills and procedures to students. As nursing education programs became formalized, the role of clinical instructor became the responsibility of individuals who were associated with the academic institution and not the health-care institution. The role

of the clinical instructor has remained essentially unchanged in this evolutionary process; clinical instructors teach, supervise and evaluate nursing students in the clinical area.[52] However, there has been a shifting of responsibility for this role from person to person throughout history.

Currently, clinical education remains essentially the responsibility of schools of nursing and their instructors. While it is historically understandable that schools of nursing guard their educational autonomy after their struggle to obtain it in the first place, a curious phenomenon has resulted in which nursing education and service, "coexist in space, time and personnel."[53] The head nurse is responsible for providing learning experiences for her/his students. However, the instructor has no authority to direct or control the activities on the unit where her/his students must receive their clinical experience. The head nurse has no direct responsibility or authority for the education of the students who will give care to the patients on the unit.[54] The head nurse and her/his staff are expected to accommodate the students on the unit, without input into the scheduling or planning of student experiences.[55] Practitioners who complain that students disrupt the unit's operations are told by nursing education that students are not to be utilized to render services to the unit.[56] Faculty members frequently observe less than ideal practice by personnel in the clinical area but are hesitant to question these practices because they are "guests" in nursing services' "territory."[57]

The "we" versus "us" syndrome typifies the conflict between nursing education and nursing service today.[58] The conflict is

centered upon the disparities between what is taught about how nursing care "should be" performed and how it is actually carried out in practice.[59] The inclusion of systematized instruction in nursing education programs has widened the gap between school and work.[60] In the apprenticeship system of nursing education, students relied on staff members as role models. Service and education were regarded as one.[61] Students in these programs made the transition to practitioners upon graduation with little difficulty because they had been taught according to the ideals of the hospital.[62] As nursing students began to learn nursing theory in a classroom setting, they lost the opportunity to view patients' symptoms and conditions as they were described. They learned procedures in the ideal environment of the classroom rather than the "real world" of the clinical unit.[63] Staff nurses were no longer expected to teach and became less interested in the concerns and progress of students in the unit.[64] Hospital personnel lost contact with what was being taught to students and performed some aspects of nursing care in a manner which differed from the nursing school's teachings.[65]

Suggestions have been made that nursing follow the example of other professions (e.g., medicine) in reducing the school-service gap by enabling faculty members to participate in various facets of service and vice-versa. Generally, nursing educators have not been receptive to the concept of dual appointments.[66]

The virtue of clinical experience in a professional school is that it projects the reality of practice to students.[67] The primary responsibility of the clinical area, however, is to provide services to clients and the learning needs of students must remain subordinate

to the needs of clients.[68] Nursing education has structured the clinical laboratory experience to meet the educational needs of students (e.g., by reducing the patient load for students) and, in doing so, has produced a less than real practice situation.[69] The hours of the clinical laboratory experience, for example, are rarely representative of the working schedule of graduates. Critics of nursing education charge that this has caused students to be accustomed to leaving work assignments unfinished and to delegating the unfinished tasks to a staff member. This presents difficulties for the new graduate who is expected to complete his/her assignment in the alloted time.[70]

Students are socialized by faculty to meet "all the patient's needs" and to formulate extensive care plans for their patients. While this may be a feasible task with the usual student assignment of one or two patients, it is not possible that any one nurse could carry out patient care in this manner when he/she is faced with the heavy patient assignments (8 to 10 patients) given to hospital personnel. The new graduate is often unable to establish priorities; to decide what should be done first and for whom.[71]

Students generally attend the clinical area during the work week and in the daytime. As family members tend to visit patients during the evenings and on weekends, the student has limited opportunity to interact with patients' relatives and has difficulty doing so upon graduation.[72] The new graduate is often ill-prepared to meet the responsibilities specific to the night shift. For example, she/he has had no experience in assisting a patient who is unable to sleep at night. She/he has also never had the experience

of being without an authority (faculty, head nurse) to consult if crisis arose. On the night shift, the new graduate must often face these crises alone.[73]

Because students spend a limited amount of time in any one clinical area, they are forced to become generalists. As the demand for nursing specialists continues to increase, some question whether nursing education can continue to produce this "jack of all trades, master of none."[74]

Nursing education, as education in all professions, is designed to communicate relevant knowledge about the profession and to provide opportunities for students to attain relative mastery of professional skills.[75] The clinical component of nursing education is generally regarded by both faculty and students to be a valuable and essential element of the program.[76] However, although many other professions have identified the need for additional clinical practice in their educational programs,[77] nursing has drastically reduced the amount of student clinical experience within the last two decades.[78] One medical spokesman commented:

> The patient is the most important source, not only of inspiration but also of information. The function of books, lectures and of teachers are primarily to help students learn from patients. In your better medical schools your third and fourth year students are now essential parts of the patient-care team. They do many of the diagnostic procedures. And they are responsible, under careful supervision, for administering much of treatment which their seniors order. Those older teachers who thought that the kind of medical training which they, themselves, received more than forty years ago was by definition the best possible, opposed these changes. It has taken much faculty infighting among you to initiate them. But there is now general agreement in the USA that a high degree of participation in responsibility for patients is essential for the medical student.
>
> During the same period your trend in nursing has been precisely the opposite. The student nurse spends less time with patients

> and more being educated. It is almost as if we decided that the way to train pilots was to give them a large amount of instruction in aero-dynamics and minimal time in air. Either the people responsible for nursing education are mistaken as regards nurses or your medical faculties are as regards their students. That is the Educational Paradox.[79]

The provision of clinical facilities for student clinical experiences has become an issue in nursing education, particularly in programs associated with a community college. Schools of nursing must depend on agencies, primarily the hospitals, to provide clinical facilities for their students. Faculty must negotiate with the agency for space, clinical area and time. Teachers and students from the community colleges assume "a guest in the house" status in the agency.[80] They must compete with the hospital school of nursing and with other affiliating schools for patients and for space to interview students and conduct conferences.[81] They must constantly defer to the needs and wishes of agency personnel.[82]

Teachers, in affiliating schools of nursing, experience great pressure to avoid the embarrassing experience of their students making a mistake in the clinical area.[83] They tend to structure the clinical laboratory experience so that students are given minimal opportunity to commit errors.

The affiliating students and teachers are often merely tolerated by hospital staff, who resent having to accommodate these intruders into their "territory."[84] Indeed, the status of affiliating schools may be aptly described at times as a "pest in the house." The consequence has been that teachers have tended to isolate themselves and their students from the agency staff.[85]

The issues which confront clinical education in nursing may

appear at first glance to be common to every professional school. Every profession has struggled with the ideology-vocationalism issue, seeking to relate practice and theory.[86] Every profession must make concessions to the agencies which provide clinical facilities for their students. There are inherent constraints within these agencies (e.g., they are more concerned with the demands of clients than with the educational needs of students) which complicate the school-agency relationship.[87]

Even nursing education's concerns about preparing students adequately for the realities of the work world are not unique to the profession.[88] There is inevitably a "reality shock" in the transition from school to work. In law schools, for example, educators are primarily concerned with the communication of the specialized knowledge and skills of the profession.[89] Graduates are often unprepared for the practical considerations (e.g., how to handle clients) of their work.[90] As well, law, like engineering, expects that only a proportion of students will actually practise the profession.[91] Many embark on careers in business, government and politics for which they have received no special training.[92]

The issues in clinical teaching in nursing may not be unique but the structure of the student clinical experience is. Most professions organize their training programs so that the student has some theoretical basis and opportunity to practise skills in a laboratory setting before exposure to the realities of the work-setting.[93] Only in social work and nursing is the practice component introduced at the beginning of the program; often in the first week before they have received much theory or know any skills.[94] Nursing

students are often unprepared for this experience but understand its implicit message--"You are a nurse now and you will be a nurse at all times."[95] Unlike students of most other professions who have a theoretical foundation before they are exposed to the reality of practice, students in nursing assume a dual role throughout the program; that of a student and that of a neophyte practitioner.[96] Nursing is also unique because the clinical experience of students takes place in a life and death setting where their errors could result in disastrous consequences.

SUMMARY

Recurrent themes of diversity, lack of coordination and lack of co-operation have characterized clinical teaching programs in nursing from the outset. Clinical education has progressed from an apprenticeship system, to a combination of formalized education and apprenticeship, to professional education.[97] Yet the remnants of these three phases continue to influence the way in which students are taught in the clinical area. Infante states:

> ... I can safely say that clinical learning activities, the heart of nursing's professional program of study, have been the most widely discussed and yet the least studied of all nursing education activities. Many aspects of clinical learning are taken for granted and many are rooted in traditionalism or 'the way it is always done.'[98]

The attrition rate in the nursing profession has become such that educators are forced to scrutinize their programs and to determine whether or not their teaching practices have hindered the students' ability to complete the transition from student to staff nurse. As the clinical laboratory experience is such a vital aspect

of nursing education, we can no longer rely on traditional clinical teaching methods that are ineffective or inefficient. We need to know which clinical teaching practices enhance student learning and which do not. Only then may we feel free to abandon behaviors which perpetuate the problems of yesterday into today.

FOOTNOTES

[1]A. Gartner, The Preparation of Human Service Professionals (New York: Behavioral Publications Inc., 1978), p. 210.

[2]J.E. Shweer and K.M. Gebbie, Creative Teaching in Clinical Nursing (St. Louis: C.V. Mosby Co., 1976), p. 3.

[3]Ibid.

[4]J. Watson, "The Evolution of Nursing Education in the United States," Journal of Nursing Education, 16:7 (Sept. 1977), p. 33.

[5]As quoted in Watson, Ibid.

[6]B. Bullough and V. Bullough, Expanding Horizons for Nurses (New York: Springes Publishing Co., 1977), p. 211.

[7]H. Cohen, "Authoritarianism and Dependency: Problems in Nursing Socialization," Current Perspectives in Nursing, eds. B. Finn and M. Miller (St. Louis: C.V. Mosby Co., 1980), p. 160.

[8]Schweer, op. cit., p. 3.

[9]Watson, op. cit., p. 33.

[10]Schweer, op. cit., p. 3.

[11]Ibid., p. 4.

[12]Ibid.

[13]Watson, op. cit, p. 34.

[14]Bullough and Bullough, op. cit., p. 212.

[15]Schweer, op. cit., p. 4.

[16]Ibid.

[17]B. Duncanson, "The Development of Nursing Education at the Diploma Level," Nursing Education in a Changing Society, ed. M.Q. Innis (Toronto: University of Toronto Press, 1970), p. 112.

[18]M.S. Infante, The Clinical Laboratory in Nursing Education (New York: John Wiley and Sons, Inc., 1975), p. 17

[19]F. Davis et al., op. cit., p. 170.

[20]Watson, op. cit., p. 35.

[21]Ibid., p. 36.

[22]Duncanson, op. cit., p. 116.

[23]Ibid., p. 118.

[24]Ibid., p. 117.

[25]Schweer, op. cit., p. 7.

[26]Kramer, 1976, op. cit., p. 99.

[27]H. Martin, op. cit., p. 650.

[28]Kramer, 1976, op. cit., p. 99.

[29]Schweer, op. cit., p. 6.

[30]Ibid., p. 18.

[31]Ibid.

[32]A.O. Fabayo, "Nursing and the Community College Movement," Nursing Forum, XIX:2 (1980), p. 187.

[33]Schweer, op. cit., p. 18.

[34]Quoted in Fabayo, op. cit., p. 186.

[35]Kramer, 1976, op. cit., p. 99.

[36]Infante, 1981, op. cit., p. 18.

[37]Schweer, op. cit., p. 17.

[38]Infante, 1981, op. cit., p. 17.

[39]Schweer, op. cit., p. 18.

[40]A. Longsdon, "Preparing for Unexpected Responsibilities," Nursing Clinics of North America, 3:1 (Mar. 1968), p. 147.

[41]Ibid., p. 145.

[42]Schweer, op. cit., p. 20.

[43]D. Prokopec, "The Community College: Historical Roots and Purposes," Canadian Vocational Journal, 15 (May 1979), p. 12.

[44]Ibid., p. 13.

[45]Fabayo, op. cit., p. 188.

[46]E.L. Brown, "Characteristics of A.D.N. Program," Technical Nursing: Dimensions and Dynamics, ed., S. Rasmussen (Philadelphia: F.A. Davis Co., 1972), p. 51.

[47]A.R. Moorhead, "The A.D.N. Student," Technical Nursing: Dimensions and Dynamics, ed., S. Rasmussen (Philadelphia: F.A. Davis Co., 1972), p. 51.

[48]Ibid., p. 52.

[49]Schweer, op. cit., p. 19.

[50]Moorhead, op. cit., p. 56.

[51]Fabayo, op. cit., p. 188.

[52]J.D. Seaton, "Clinical Faculty Issues," Clinical Education for Allied Health Professions, ed., C. Ford (St. Louis: C.V. Mosby Co., 1978), p. 158.

[53]Mauksch, op. cit., p. 126.

[54]Ibid.

[55]H. Martin, "Education and Service: Division and Unity," Nursing Outlook, 7 (Nov. 1959), p. 650.

[56]Ibid.

[57]Ibid., p. 652.

[58]Schweer, op. cit., p. 25.

[59]Ibid.

[60]Cronin-Stubbs, op. cit., p. 194.

[61]Kramer, 1976, op. cit., p. 97.

[62]Ibid.

[63]Schweer, op. cit., p. 5.

[64]Ibid.

[65]Ibid.

[66]F. Davis et al., op. cit., p. 1970.

[67]Gartner, op. cit., p. 210.

[68]Ibid., p. 211.

[69]Ibid.

[70]Logsden, op. cit., p. 147.

[71]M.K. Reeder, "Nursing Practice: A Student's Perspective," Nursing Clinics of North America, 3:1 (Mar. 1968), p. 137.

[72]Logsdon, op. cit., p. 145.

[73]Ibid., p. 148.

[74]C.E. Bradshaw, "Jack of All Trades--Master of None," Nursing Outlook, 13 (April 1974), p. 14.

[75]Ritzer, op. cit., p. 70.

[76]Infante, 1976, op. cit., p. 15.

[77]J.M. Gustafson, "The Clergy in the United States," The Professions in America, ed., K. Lynn (Boston: Houghton Mifflin Co., 1965), p. 85 and W.I. Mickleson, "Practice Teaching: A Solution," Canadian Journal of Education, 5:1 (1980), p. 87.

[78]J. Hamburg et al., Review of Allied Health Education: 2 (Lexington: University of Kentucky Press, 1972), p. 116.

[79]Ibid., p. 116, 117.

[80]H. Glass, "A Guest in the House," Nurses in Practice: A Perspective on Work Environments (St. Louis: C.V. Mosby Co., 1975), p. 178.

[81]Ibid., p. 183.

[82]Ibid., p. 182.

[83]H. Glass et al., Study of the Use of Clinical Facilities by Nursing Students in the Province of Manitoba (Winnipeg: M.A.R.N., 1976), p. 26.

[84]H. Mauksch, "Becoming A Nurse: A Selective View," Social Interaction and Patient Care, eds., W.K. Skipper and R.C. Leonard (Philadelphia: J.P. Lippincott Co., 1965), p. 333.

[85]Glass et al., op. cit., p. 26.

[86]Gartner, op. cit., p. 209.

[87]E.J. Tropman, "Agency Constraints Affecting Links Between Practice and Education," Journal of Education for Social Work, 13 (Winter 1977), p. 13.

[88]Ritzer, op. cit., p. 358.

[89]P.A. Freund, "The Legal Profession," The Professions in America, ed., K.S. Lynn (B ston: Houghton Mifflin Co., 1965), p. 44.

[90]Ritzer, op. cit., p. 70.

[91]Krause, op. cit., p. 163.

[92]Ibid.

[93]Mauksch, 1965, op. cit., p. 330.

[94]Gartner, op. cit., p. 206.

[95]Mauksch, 1965, op. cit., p. 328.

[96]J.L. Green and J.C. Stone, Curriculum Evaluation Theory and Practice (New York: Springer Publishing Co., 1977), p. 92.

[97]Watson, op. cit., p. 37.

[98]Infante, 1981, op. cit., p. 16.

CHAPTER III

THE STUDY

The study of the phenomenon of reality shock in nursing has been largely based on self-reports of nurses who have undergone this experience. These reports have generally lacked detailed analysis of the complex social situation in which reality shock occurs and have usually been removed, to some degree, from the actual phenomena under investigation.

The purposes of this study demanded an in-depth investigation and analysis of the student experience in the clinical area. Although the study was conceived with the presupposition that students learn in the clinical area not only by individual cognitive processes but by interacting with others in that social setting,[1] it was the goal of the study to explore all dimensions of the student experience in the clinical area. A methodology was required which would not require the researcher to restrict the investigation to specific aspects of the situation in order to obtain information relevant to previously defined hypotheses.

ETHNOGRAPHY

The study utilized the ethnographic method of research incorporating direct observation and informal and formal interviews. Unlike most research, ethnography does not require that the researcher formulate hypotheses in advance. He may have some "notion" of what

may prove interesting to study but he does not begin with specific hypotheses to be confirmed or negated by the study.[2] He is less likely than the experimental researcher to overlook phenomena which do not pertain to his expectations or those of a preconceived model. When his observations of the situation are compiled, he analyzes them. Then he attempts to develop hypotheses or theory which will explain his findings.[3] This "grounded theory" may be tested in future research by further observations or experimental methods.[4]

Ethnography has been employed by many social scientists to study aspects of professional education (Oleson and Whittaker, 1968, Bloom, 1971, Olmsted and Paget, 1969, Becker, 1962). In each of these studies, the researcher(s) attempted to describe and analyze specific cultural scenes[5] that students shared with others during their educational program. They demonstrated that students do not always share the same views as those with whom they interact in a particular situation. These differing cultural views[6] are sometimes the basis for misunderstanding and conflict. Bloom, in his study of a medical school, found that faculty and students perceived each other as being opposed to the major goals of the institution. This resulted in a reaction by both in a "defensive type of withdrawal behavior."[7]

Ethnographies in professional education have effectively demonstrated that this methodology represents more than "theoryless fact collecting."[8] Ethnography is a method of "systematically learning reality from the point of view of the participants."[9] Instead of asking, "What do I see these people doing?", the ethnographer asks "What do these people see themselves as doing?."[10] Thus, he is able to obtain a description of the behaviors, beliefs and

expectations of a group of interacting people. Providing such a picture of a way of life of a group people can lead to new insights and advances in knowledge.

THE SAMPLE

The study was conducted with 38 senior nursing students who were enrolled in a two-year diploma program at a community college. They appeared representative of the heterogeneity associated with community college student groups. They ranged in age from 19 to 53 years. Two of the sample were males. Approximately one-third had previously enrolled in and withdrew from another nursing program. Almost half of the students were working part-time at a nursing-related job during the course of the study and the majority had been employed prior to enrollment in the program. Many of the students were married and parents. Three women were divorced and single parents. Approximately one-quarter of the sample had immigrated to Canada from the West Indies, the Philippines or Asia.

The majority of students had entered the program at the community college with a grade twelve education. However, the open-door admission policy at the community college enabled several students to enroll in the program on the basis of a reading proficiency test.

The community college school nursing states as its aim:

> ... to prepare graduates who will enter the work force as beginning practitioners of practical and diploma nursing. The graduates will have an appreciation of the need for continuing education and the ability to identify, use, and benefit from learning situations wherever they occur.[11]

The program incorporates the career ladder concept of nursing

education. This enables students to stop after completing one set of nursing requirements or continue on to the next level. The program includes both the practical nurse and the diploma nurse levels. The first ten months of the program, termed the "certificate year," prepares students to be eligible to write examinations for licensure as practical nurses. The second year of the program, or the "diploma year," prepares the graduate to be eligible for registration in the Manitoba Association of Registered Nurses.

Students may complete the certificate year of the program, decide to work as a licensed practical nurse and return, if they so desire, at a later date to complete the second year of the program.

Persons with previous nursing or related experience may request that their experiential component be assessed. If they are able to demonstrate mastery of content, they will not be required to participate in all aspects of the program. Six of the students in the study sample were licensed practical nurses or registered psychiatric nurses who were able to enroll in the second year of the program because they demonstrated competence beyond the certificate level.

The curriculum of the school of nursing emphasizes generalized concepts rather than isolated facts. Students are expected to implement the nursing process in many different settings as the school relies on a myriad of agencies to provide clinical facilities for its students. Clinical rotations in the diploma year are four weeks in duration, consisting of two six-hour experiences per week. Instructors are assigned to a clinical area and remain on that unit throughout the school year. One instructor supervises 8 to 10 diploma students during a clinical laboratory experience.

Attendance at classes at the community college is optional. The program incorporates a modified version of the modular model of individualized instruction. Students are required to write an exam pertaining to specific modules every two weeks and to achieve a "mastery" score of at least 80%. Students who do not achieve the mastery score are able to write another test during the following week. They must obtain a score on the second test which, together with the score of the first test, equals at least 80%. No other re-write privileges are allowed.

Attendance at clinical laboratory experiences is not optional and students believe that repeated absences in the clinical area may be interpreted by faculty as indifference on the part of the absent student. Students are able to obtain a possible score of 105 in the evaluation of their clinical performance. These evaluations are issued at the end of each clinical rotation by the clinical instructor. Students who obtain an average of less than 66% in these clinical scores at the end of a term (there are two terms in a school year) are unable to continue in the program.

At the time of the study, the students in sample were completing their final two months of the diploma program. Senior students were chosen for the purposes of the study because they have more opportunity to interact with hospital personnel than do students in the certificate year of the program. Beginning students rarely form relationships with hospital staff because their clinical experience is structured so that most student-staff communication is by means of the instructor.[12] For example, a first-year student who observes drastic changes in her/his patient's vital signs would report

this to the instructor, who would, in turn, inform a staff member and relay to the student the staff member's response.

Traditionally, senior students are allowed to become increasingly independent in the clinical area, to prepare them for their role as practitioners. The instructor withdraws some of the support she/he has given the students previously. Students are permitted to carry out patient care with minimal supervision. Thus, the opportunities to interact with hospital staff and to witness "backstage realities" increase in the student's senior year.[13]

Senior students are also more likely than beginning nursing students to be contemplating their future role as practitioners. Hospital staff and doctors are more likely to be viewed as colleagues as the nursing student nears graduation and prepares to become their co-worker in a short time.[14] Beginning students tend to reflect an immediate rather a long-term orientation.[15]

METHODOLOGY

The study took place on a large surgical unit in a non-teaching general hospital. It involved four groups of senior students and two instructors during an eight week period in April and May 1981. The students and their instructors were told that I was investigating similarities and differences between what is taught in the program and what students actually witness in the clinical area. They were assured that their names would not be used and every effort would be made to protect their identity in the report.

At the beginning of each four-week clinical rotation, the students met with me to discuss their concerns and questions about

their role in the study. The subject matter of the research appeared particularly interesting to them and all the students expressed a desire to read the final report.

Because the research took place in one clinical unit, the hospital personnel and physicians remained fairly constant throughout the course of the study. The unit staff were introduced to me and acquainted with the intentions of the study at a conference during the first week. As the unit employs several part-time and casual staff who were not present at the conference, some staff members remained uncertain about my role on the unit even at the end of the eight weeks. This proved to be an advantage as it provided a comparison between the interactions of staff with students when the staff member knew who I was and when he/she did not (further elaboration of this point appears in Chapter IV).

The students were initially apprehensive about the observation component of the study. However, generally they appeared less anxious about being observed following their first experience in this role.

> You know, last night I went home and I said to my family, 'That lady wants to be with me tomorrow and I don't know what she wants'. I was so nervous. But it hasn't been bad at all. I rather enjoyed it. It's fun to be able to talk to somebody about what you're feeling.

Some students were able to tolerate longer, more intensive observation sessions than others. Two students became extremely agitated whenever they were observed at their patients' bedside for any longer than 10 minutes. It was frequently possible, however, to observe students unobtrusively. For example, students frequently interacted with each other and the staff in the unit's conference

room. They were usually unaware that I was taking account of the interaction because I pretended to be engrossed in my notes or a book.

The students nicknamed me "the shadow" in the first week of the fieldwork. All students in the study were "shadowed" at one time or another but some were observed for longer periods and more frequently than others. If I observed that a student appeared distracted or anxious and attributed this to my presence, the observation period tended to be short. Occasionally, it became apparent that students were uncomfortable when I observed them performing certain aspects of patient care, as this excerpt from the field note illustrates:

> I had been observing X (the student) giving her patient a bed bath. The student suddenly became hesitant. She spoke to me, rather than to the patient, about the perineal care she was going to give the patient. She prepared the equipment but made no motion to remove the patient's bedclothes. She repeated to me her intention to give the patient perineal care. I told X that I would observe another student and left the room. Later X said, 'If I were a patient, I'd feel funny about anyone seeing my private parts if they didn't have to. I thought she'd (the patient) feel funny if you just watched.'

As the students became more comfortable with their role in the research, I relied less upon non-verbal cues to indicate when a observation session should be terminated. The majority of the students appeared quite comfortable by the second week of their clinical rotation to tell me that they wished me to leave a patient's room or that they did not wish to be "shadowed" at that particular time.

> I asked X if I could observe her caring for her patient. She said, 'Not tonight, okay. Everything's going wrong and I'll just get flustered if you're there to watch me make all my mistakes.' X and I agreed to meet later in the conference room to discuss her hectic evening and her frustrations about the instructor's expectations as X perceived them.

Students, staff and instructors were interviewed informally in the clinical area, generally immediately after an observation was made (e.g., what did you think when that happened? How did you feel about that?).[16] Staff and faculty interviews were frequently exploratory and covered a wide variety of topics: the individual's attitude toward the diploma students, his/her aspirations in his/her career, his/her views of clinical education and so on. Although the students were the central concern of the study, the interviews with staff and faculty frequently provided added insights pertaining to the student experience in the clinical area.

Students were interviewed individually at the end of their clinical rotation and asked to respond to the following:

1. Describe the kind of nurse you would like to be.
2. Is it possible for you to be this ideal nurse? Why?
3. What adjustments do you foresee you will have to make when you graduate and become a staff nurse?

This terminal interview gave the students an opportunity to express any hidden personal idealism which they were reluctant to acknowledge when interviewed in the midst of their peers.[17] Because the study pertained, in part, to the orientation of students toward their future role as practitioners, it was imperative that they not be prohibited from the expression of idealistic attitudes if they had them.[18]

Note taking was not extensive during the course of observations or spontaneous interviews in the clinical area in order that the researcher remain as unobstrusive as possible. The incidents were sketched in a greatly abbreviated form in a small

notebook as soon as possible after the incident occurred. These were elaborated upon and written in detail after each clinical laboratory experience. The students in the study became so accustomed to my jotting notes in a notebook that when I attempted to tape-record some terminal interviews, they appeared reluctant to respond to my questions and requested that I "go back to writing."

The records of the fieldnotes and interviews occupy approximately 500 single-spaced typed pages. Data gathered in this manner and for the purposes of this study did not lend itself to traditional methods of analysis, using statistical tests. Instead, they were analyzed according to Glaser and Strauss's concept of grounded theory.[19] Data collection and analysis took place simultaneously throughout the study. Those observations which were considered noteworthy were categorized according to their properties and inferences. The fieldnotes were coded with numbers pertaining to the major categories under which these observations might be considered. This indexing system enabled a relatively quick method of checking and comparing data.

The data were coded into as many categories of analysis as possible and as data emerged, they were fitted into existing categories or new categories were developed.[20] Constant comparison of data in categories soon started to generate "theoretical properties" of the category.[21] In comparing categories with other categories, some of the relevant or conflicting properties of the categories were also compared. Thus, some categories became integrated.[22] For example, categories titled Powerlessness, Decision-Making, Rescue and Victimization became a broader category, specified

as "The Helping Relationship."

At the completion of the study, the fieldnotes were re-read and categories, which had been previously overlooked, were identified. Categories, which did not appear to have characteristics uniting them with other existing categories, were deleted. The remaining categories were once again compared and integrated, whenever possible, to form broader categories. Thus, the categories Territoriality, Infallibility, and The Helping Relationship are discussed, under the major heading of "Image Management."

The student experience in the clinical area is presented in this report according to the "frame of reference" which has emerged by this method of analysis.

> Thus the theory develops, as different categories and their properties tend to become integrated throught constant comparisons that force the analyst to make some related theoretical sense of each comparison.[23]

THE ROLE OF THE RESEARCHER

Throughout the study, I assumed the role of the student, of the interested person who wants to learn. It was a role I could legitimately claim and one which proved to be beneficial to the study. Students were not told at the onset of the research that I was a former nursing instructor. They were told only that I was a student at the University of Manitoba and a nurse. If the researcher is presumed to be naive, she/he is not expected to be aware of the proprieties of the group he/she is studying. He may ask questions which would not be tolerated by an "insider."[24] It was feared that the students in the study might be intimidated by my former

instructor status or that they might presume that I already understood all aspects of the situation. However, several of my former students were employed in the hospital and the students in the study knew I had been a nursing instructor in short order. I was able to maintain the student role to some degree as I stressed that I was unfamiliar with many aspects of the community college program and had not taught nursing for several years.

Initially, many students appeared to view me as something of an enigma. They were fascinated but slightly skeptical of the concept of an educator who desired to learn about the student perspective. They were particularly interested in my reasons for conducting the study. When I shared my personal goals of the study with the students, they became very supportive of my efforts.

> X and Y (students) asked me to accompany them to the cafeteria for supper. They informed me that they had had a lengthy discussion about the stresses inherent in the clinical laboratory experience and wished to share their conclusions with me. X said, 'It may not be a big help to your study but we remembered that you said you wanted to learn about teaching. We think you'd like to hear what we think about some of things that happens to us on the wards. It may help you if you ever go back to teaching.'

The majority of students indicated their belief that the results of the study would benefit the program and, subsequently, future nursing students.

> I'm really proud about my part in all this. There are a lot of things I would like to see changed about the way we are taught in the school. I don't stand much chance all by myself of changing anything. They're not going to listen to one little student. But they'll read your study and my opinions are in there.

My relationship with the students in the study was reciprocal; a great deal of "give and take" occurred in our interactions with each other. I attempted to remain sensitive to their needs and they,

in turn, shared their concerns and experiences with me.

Trust was a significant aspect of my relationship with the students. Initially, students avoided discussing certain topics with me. If they blurted anything of a confidential nature, they often cautioned me to "keep it to yourself." During the course of the study, I witnessed several students making errors in judgement and/or procedure. These students recognized that I did not discuss my observations with anyone and began to be more trusting that I would not betray their confidences. They, in turn, conveyed this message to their classmates.

> X (a student) took me into her patient's bathroom and whispered, 'Listen, don't worry about the kids in the next group. They'll know they can trust you. A bunch of us sit in the B. Room (the coffee spot at the college) on Fridays and we tell each other about the instructors and what to look out for. Things like that. We're going to put it on the grapevine that they can trust you. I know you could have ratted me about the I.V. I wouldn't have blamed you ... it was a stupid mistake and it could have really been terrible. I'm sure glad you didn't say anything though. That's the last thing I need on my evaluation.

Once I had won a student's confidence, she/he was more than willing to discuss her/his beliefs and perceptions with me. Often students volunteered information which was considered privileged.

> X and Y (students) were looking particularly forlorn after post-conference. I sat down with them and asked them about their morning. X interrupted me and said to Y, 'Show her. Go on. Show her.' Y handed me an evaluation form which had been partially completed by the instructor. X and Y told me they had decided that I should be given an example of this form and of how the instructors marked students in the clinical area. They discussed the method of evaluation at some length. During the course of this discussion, Y said, 'I would never let anyone see this (the evaluation) except for a few friends at the college. Even the other instructors only get to see a part of it. I'll let you see it though. Because I know it'll help your study and you'll never get a chance to see one otherwise. I know you'll understand what we've been saying about evaluations after you see this.

A considerable, but not insurmountable, difficulty in ethnography is that the observer's biases or preconceived ideas may distort his/her findings. The researcher makes observations and interprets them according to what she/he perceives is important. His/her selection of data is influenced by his/her personal experiences and cultural background.[25] As a former nursing instructor I had acquired some of the culture which was to be studied. This proved to be both an advantage and a disadvantage in the study. Because I was familiar with many aspects of the clinical laboratory experience, I may have overlooked significant events or meanings because I have learned to take these things for granted. Clyde Kluckholn explained this phenomenon as, "It would hardly be fish who discovered the existence of water."[26] An advantage of the comparative analysis of data employed in the study was that it enabled me to review the data as I categorized them at the end of each clinical laboratory experience. At times, it was obvious that I had not probed into certain events because I had felt I already knew everything there was to know about the situation or because I thought the event was insignificant to the study. A follow-up interview of the persons involved in the situation the next day often produced surprising findings.

> I reviewed my observations of X (a student) that day. She had spent several minutes searching for a red pen. She required the pen for her charting, but had left her pen at home. I followed her as she went from room to room on the unit in search of a pen. The notes on this even detailed the student's verbalizations of her frustrations about spending time away from the patient to perform this 'menial' task. As I categorized this information, I remembered that the student had asked every staff member for a pen but had not asked the instructor. We had passed the instructor several times in the hallway during the search but X had not mentioned anything about the pen to her.

> The next morning, I told X of my realization and asked why she had not approached the instructor. X said, 'Oh, that's the last thing I would have done. It would have shown up in my evaluation as being careless and forgetful.' When I asked the instructor to respond to this situation as I described it, she replied, 'Well, I don't think I would say anything about one little pen. Heavens! I lose hundreds of pens every year because I lend them to students. But we do have students who come to the ward and they've forgotten their watch and their pen ... well, you have to question someone's interest when they can't even bother coming (to the unit) prepared.'

An advantage of my previous knowledge of aspects of the clinical laboratory experience is that I was aware of certain nuances which may have been overlooked by a naive observer.

An ethnographer faces a problem in that s/he is part of the social situation s/he is studying--s/he cannot fully anticipate how his/her presence has affected what has occurred during the observations.[27] For example, it is difficult to determine whether the students in the study who made medication errors during the observation sessions did so because they were distracted by my presence or because they had not exercised the proper caution in the administration of medications.

I observed, initially, that students' conversations with patients, staff, instructors and other students were often interrupted when another person appeared on the scene. By the time the student had determined what the interloper wanted, the original topic of conversation was generally forgotten.

> X (the student) and Mrs. Y (the patient) were having a conversation about Mrs. Y's doctor. Mrs. Y was expressing doubts about the doctor's management of her disease. The instructor entered the room, stood at the end of Mrs. Y's bed, and asked how Mrs. Y was. She made a few comments about the I.V. (intravenous) drip rate and told the student that the post-conference would be a few minutes later than usual. When she left, X adjusted the I.V. flow for several minutes. Mrs. Y watched her. X then left for lunch and the conversation about the

doctor was not resumed.

I wanted to be able to join people spontaneously in the clinical area and was concerned that this interruption effect might occur. I wore a uniform of distinctive color and style throughout the eight weeks. Students, staff and patients associated me with that uniform and knew I wished merely to observe their interactions. As one patient explained to a staff member:

> That lady in that blue just wants to watch. I don't know her name.

Only rarely did the subjects interrupt their conversations when I joined them.

My role as an "outsider" in the study enabled me to retain a certain degree of neutrality and objectivity but, as the students shared more and more of their concerns, attitudes and feelings with me, they treated me as an "insider." In turn, it became difficult to remain emotionally detached as my relationship with the students intensified. I observed X (a student) most of the morning.

> She was 'frightened' of her patient assignment and concerned that one of her patients would die. Despite her fear, she cared for the patients and made several decisions which she implemented to make the patients 'more comfortable.' She was able to complete all the requirements of the patients' care and, by the end of the morning, she was feeling quite proud of herself.
>
> 'I did it. All by myself. I did it and I did okay. I feel great.' Just then, the instructor entered the room, read X's charting for the morning and pointed out that X had forgotten to chart some pertinent data.
>
> I watched X as she corrected her charting and saw her struggling to keep back tears. Later, she said, 'I always do something wrong. I just can't win.' I was angry at the instructor and judged her as being insensitive.

Whenever I felt that my ability to be objective was threatened, I spent time, away from the students, with the staff and the

instructors. I used this time to interview them or, as in the preceding instance, asking them to define their perceptions of a situation.

> I spoke to the instructor about the incident with X, although I did not refer to X by name. I told her, 'One thing I have seen, which has been difficult for me to understand, is that I will observe a student giving superb care and making decisions. She feels good about that. And you come in, read her charting and your comment is that she has made a spelling error or that she has forgotten to chart a system.'
>
> The instructor responded, 'It's true. I don't know many of the good things a student does because I can't be everywhere at once. I have 10 students, four of them are very weak students. I need to spend most of my time with them. Unfortunately, I have to use the charting to tell me how the student has done and what she has forgotten, many times. I can only pick out a few things that need improvement so that I can help them to become better nurses. I don't have the time for anything else.'

Objectivity may never be totally achieved in an ethnography but subjectivity can be minimized by reporting the findings using criteria that the informants employ to interpret and describe their experiences.[28] Whenever possible, the study incorporates the participants' perceptions and understandings of their experience as they described them to me, in order to avoid the error of interpreting their behavior by my ethnocentric standards.

LIMITATIONS

The composition of the student group in the study is unique to the community college. It is not representative of diploma programs in hospital schools of nursing. It may be hypothesized that, because many of these students are older than the traditional nursing student and have job and/or family committments, that they may be more likely than the younger student without much life experience to

identify conflict situations in the clinical area and to recognize the implications of these in their future role as practitioners.

It may also be hypothesized that individuals who enter a program of individualized instruction do so because of the opportunities for self-direction this program offers. As well, self-directed individuals are most likely to complete such a program.[29] It may be that the study sample represents a group of self-directed individuals and that others who do not possess this quality have left the program before this time. (In September, 1980, there were 99 students enrolled in the diploma year of the program. At the time of the study, 79 students remained in the program.) If self-direction affects the degree to which an individual is socialized into a profession or the work culture, this quality will influence the students' experiences with professional-bureaucratic work conflict and consequently, affects the findings of the study. However, the program at the community college does not offer the self-pacing feature that attracts the self-directed individual to individualized instruction[30] and, in my conversations with the students in the study, I discovered that the majority had entered the program because of its location, financial considerations or time schedule. Most said they were unaware of or had not understood the modular method of instruction before they entered the program.

The time span of the study may be considered by some ethnographers to be a limitation of the research. Some investigators recommend that the study should extend over the duration of the school year.[31] However, the time and energy limitations of this researcher necessitated a more short term ethnographic study.

The sample of students was not large and the rotation of clinical groups prohibited the study of one group of students over an extensive period of time. However, the students appeared to be representative of the student body of the school of nursing (this was confirmed by a member of the administration of the school) and the four groups allowed for a diversity which would have been difficult to attain with one group of students. It was interesting to observe the differences in the groups' behavior and orientation toward their futures. The first two groups tended to be more abstract about their future role as graduates than the groups studied in the last four weeks of the study. As the students neared their graduation date, they became less abstract about backstage realities in the clinical area.

Six of the students in the study had not attended the certificate year of the program. Therefore, peer group interactions may not be representative of programs in which peer relationships are generally formed within the first few months of the program. However, these six students demonstrated different behaviors and expressed differing views than their classmates. These behaviors and perceptions were directly attributable to the students' previous experience with the work world.

The setting contributed to the limitations of the study. The hospital does not provide facilities for medical clinical education and the students in the study did not meet any medical students or interns during the eight weeks. In addition, auxilliary personnel are confined to communication clerks and a few porters. The students did not encounter nursing aides, nursing assistants or

orderlies in the hospital. The hospital is designed according to the Friesen concept of patient care; patients' rooms are structured so that most necessary supplies and the chart are in the room. The goal of the Friesen concept is to increase patient-nurse interaction by ensuring that the nurse is not required to leave the patient's room to obtain supplies or maintain the chart. Primary nursing is incorporated as well; this concept is one of single-nurse accountability for patient care. Patients are assigned a primary nurse upon admission to the hospital and that nurse assumes responsibility for planning, implementing and evaluating the patient's nursing care throughout his/her hospital stay. Whereas in other systems of nursing (e.g., team nursing) the physicians communicate essentially with a few nurses in administrative positions on the unit, in primary nurse, each primary nurse communicates with the patient's doctor about the patient's treatment and progress. The Friesen concept and primary nursing create interaction patterns which are unique to those systems. For example, because the primary nurse has the ultimate responsibility for the patient's care, she tended to "check" the student's care of that patient and to emphasize that the student "should not make any mistakes." Although these interactional patterns may not be representative of hospitals who do not employ these concepts, they are becoming a definite trend. The three newest hospitals in Winnipeg, for example, have been built according to the Friesen concept. Several city hospitals are currently examining the feasibility of initiating primary nursing in their institutions. Therefore, the observation of student interactions in this environment was relevant.

An additional limitation, and one which was not foreseen prior to the study, was that the study involved only two instructors. The significance of the instructor's role in the creation and interpretation of student conflicts was not anticipated. As it is not possible to consider two instructors as representative of the entire faculty (consisting of 30 instructors), any analysis of the findings must take this into account.

The findings of this study offer little scientific basis for generalization concerning Canadian nursing education. They may be only applicable to the particular school of nursing involved in the study. However, the study presents some provocative findings which may have definite implications for nursing education.

FOOTNOTES

[1]N. Foxworthy and F. Schwartz, "Classroom Ethnography and Social Anthropology," Anthropology and Education, ed., C. Lambros (New York: National Academy of Education, 1978), p. 360.

[2]H. Wolcott, "Criteria for an Ethnographic Approach to Research in Schools," Schooling in the Cultural Context, eds., J.I. Roberts and S.K. Akinsanya (New York: David McKay Co. Inc., 1976), p. 25.

[3]W.J. Tikunoff, D.C. Berliner and R.C. Rist, Beginning Teacher Evaluation Study: An Ethnographic Study of the Forty Classrooms of the Beginning Teacher Evaluation Study Known Sample (San Francisco: Far West Laboratory for Educational Research and Development, 1975), p. vi.

[4]Wolcott, op. cit., p. 25.

[5]G.E. Overholt and W.I. Stallings, "Ethnographic and Experimental Hypotheses," Educational Researcher, 5:8 (1976), p. 12.

[6]"The information shared by two or more people that defines some aspect of their experience" as defined by J.P. Spradley and D.W. McCurdy, The Cultural Experience: Ethnography in a Complex Society (San Jose: Science Research Associates Inc., 1972), p. 24.

[7]S.W. Bloom, "The Medical School as a Social System," Milbank Memorial Fund Quarterly, 49 (1971), p. 2.

[8]G. Berreman, "Ethnography: Method and Product," Introduction to Cultural Anthropology, ed., J.A. Clifton (New York: Houghton Mifflin Co., 1968), p. 339.

[9]Quoted in F. Erikson, "Mere Ethnography: Some Problems In Its Use In Educational Practice," Anthropology and Education Quarterly, 10 (1972), p. 182.

[10]Spradley and McCurdy, op. cit., p. 9.

[11]Student handbook of the community college, p. 6.

[12]I.H. Simpson, "Patterns of Socialization Into Professions: The Case of Student Nurses," Sociological Perspectives on Occupations, ed., R.M. Pavalko (Italsca, Illinois: F.E. Peacock Publishers, 1971), p. 171.

[13]Ibid., p. 174.

[14]Ibid.

[15]P.B. Morris and N. Grassi-Russo, "Motives of Beginning Students for Choosing Nursing School," Journal of Nursing Education, 18:5 (May 1979), p. 39.

[16]H.S. Becker, "Practitioners of Vice and Crime," Pathways to Data, ed., R.W. Habenstein (Chicago: Aldine Publishing Co., 1974), p. 38.

[17]H.S. Becker, "Interviewing Medical Students," American Journal of Sociology, 62 (1957), p. 200.

[18]Ibid., p. 199.

[19]B. Glaser and A. Strauss, The Discovery of Grounded Theory (Chicago: Aldine Publishing Co., 1967).

[20]Ibid., p. 105.

[21]B. Glaser, "The Constant Comparative Method of Qualitative Analysis," Issues in Participant Observation, eds., G. McCall and J.L. Simmons (Reading: Addison-Wesley Publishing Co., 1969), p. 220.

[22]Ibid., p. 221.

[23]Glaser and Strauss, op. cit., p. 109.

[24]G. Berreman, op. cit., p. 342.

[25]Spradley and McCurdy, op. cit., p. 34.

[26]Quoted in Wolcott, op. cit., p. 28.

[27]Berreman, op. cit., p. 340.

[28]Spradley and McCurdy, op. cit., p. 18.

[29]P. Cross, Accent on Learning (San Francisco: Jossey-Bass Publishers, 1976), p. 92.

[30]Ibid.

[31]Sanday, op. cit., p. 527.

CHAPTER IV

IMAGE MANAGEMENT

This chapter presents a framework for looking at the process of backstage reality identification and management in the clinical laboratory experience. Before the findings of the study can be understood and analyzed, they must be considered in the context in which they occurred. It is within the context of impression or image management in social interactions that the experience of students in the clinical area will be examined.

Image management was first described by Goffman as a means of analyzing and describing social interaction.[1] He suggested that people attempt to manage the impression that others receive of them. We present ourselves to others in such a way as to gain approval. For example, in an employment interview, an applicant attempts to portray an image of competence and confidence. Image management is neither right nor wrong; it is merely a means of communicating our needs and expectations to others and of manipulating a social situation to create a positive reaction.

Image management may occur as an individual phenomenon but it can also occur with groups of people. In hospitals, for example, nurses commonly project an image for patients that they believe the patient's doctors to be competent and caring. This occurs regardless of whether or not the nurse actually believes this to be true. Goffman described this group image management prevalent in

occupational groups as:

> Thus, one finds that service personnel, whether in profession, bureaucracy, business, or craft, enliven their manner with movement which express proficiency and integrity, but, whatever this manner conveys about them, often its major purpose is to establish a favourable definition of their service or product.... We commonly find that the definition of the situation projected by a particular participant is an integral part of a projection that is fostered and sustained by the intimate cooperation of more than one participant, and moreover, that each member in such a troupe, or cast of players, may be required to appear in a different light if the team's overall effect is to be satisfactory.[2]

During this study, it became apparent that the students attempted to control the conduct of others, particularly their response to themselves. Their self-presentations differed for various audiences. For example, they presented themselves as eager learners to the staff but, to each other, they strove to maintain the image of independence and competence.

The preceding is a brief overview of the concept of image management. It leads to an examination of how students, staff and instructors managed the impression others received of them in the clinical area. While the primary focus of this discussion is how the instructors and staff managed the image conveyed to students, it also includes some discussion of how staff nurses and instructors manage the impression they give each other. There is no consideration of the image management of doctors, visitors or other health-related professionals in this section. Students, particularly those who had not worked as nurses before, tended to remain in the background whenever a doctor entered. They regarded doctors in awe and, even when a physician spoke to a student, s/he was usually extremely reticent. The students' schedule prohibited them from meeting many

visitors in the clinical area

Their interactions with visitors and other health-related professionals were minimal and generally confined to pleasantries.

Image management is achieved in the clinical area primarily by means of territorial boundaries, the threat of making a mistake and the structure of the "helping" relationship. Each aspect of image management is considered herein.

TERRITORIALITY

The message that the students and their instructors were "guests" on the unit was conveyed to them by both the unit personnel and the patients. It was understood by all involved that the unit and the patients therein represented the "territory" of the hospital staff. Similarly, it was assumed that the students were the "territory" of the instructors. While the penalties of "trespassing" were not clearly defined, each individual was aware of the boundaries of his/her territory and the territory of others in the clinical area.

One method of establishing territorial rights was the use of space on the unit. For example, medications are prepared in a small room which can comfortably accommodate no more than five people. It was expected that students and instructors would defer to the unit staff when space in the medication room was at a premium. Consequently, students frequently stood in the entrance, waiting until the nurses were finished before they entered the medication room. However, if a staff nurse entered the medication room and found it to be crowded with students, she tended to push past the students to the medication cupboard and to prepare the medications. The students

would then move into the entrance and wait until the nurse had left before returning to their original position. A similar phenomenon occurred in the staff conference room. If an instructor or a student entered this room and two staff nurses were talking, s/he usually asked their permission to enter or left abruptly.

> (Student to nurse in conference room): Oh! I'm sorry. I didn't realize you were here. I won't be a minute. I was going to look something up but I'll just take my book to my patient's room, if you want to be alone.

The staff's reaction to entering the conference room when students or their instructor were seated in the room was quite different.

> The instructor (X) and the student (Y) were discussing the student's difficulty with charting, in the conference room. Z (a staff nurse) entered the room, lit a cigarette, sat down and opened a chart. Z said to X 'Oh, am I disturbing you? I'm just looking over this chart. Trying to understand something. I won't listen.'

Another well-defined aspect of the staff's territoriality was the ultimate responsibility for patient care on the unit. This responsibility was assumed even during the hours that the patient was being cared for by a student under the supervision of an instructor.

> (Staff nurse to researcher): I always check the students' charting and ask them questions about what they've done before they leave (the unit). You never know if they've made a mistake or if they've forgotten something. And if they've left before I can catch it, there's nothing I can do about it I'm responsible for whatever happens to that patient. It's my responsibility to make sure the student does nothing wrong.

Although the students were allowed to "borrow" the patients, they were constantly made aware by the unit staff that the patients' needs would not be compromised by the learning needs of the students. Many of the staff "checked up" on the students throughout the clinical laboratory experience. The implication appeared to be that the patient required

protecting from the "mistakes" a student could make in her/his patient care. Some of the unit staff were recent graduates from the community college school of nursing and they were particularly diligent in detailing a plan of care for students who were to nurse their assigned patients and in observing the students' care for errors. One recent graduate explained it this way:

> Even if I'm really busy I make it a point to go over the patient and the nursing care plan with the student before she starts in the morning. I tell her exactly what I want her to do and how she should do it. Then I check back with her every hour or so to see if she's done it. Look, I remember when I was a student. I thought I knew it all. I knew nothing. I know the mistakes I made. They're not going to happen with my patients.

When a crisis occurred on the unit or when a procedure was required to be performed quickly, the staff assumed control of the situation. The student was expected to assume a bystander role on these occasions.

> Mrs. X (a patient) was to have her leg amputated at 10:00. She had been unable to sleep the night before and was extremely apprehensive. At 08:00, the surgeon informed the staff that the surgery would be sooner than he had originally scheduled it. Three staff members entered Mrs. X's room. One began taking her vital signs. One checked her chart. Another placed her on the bedpan. A nurse said to Y (the student), 'Sorry about this. I know you're looking after Mrs. X but we've got to get her down there (to the operating room). We'll get her ready. We'll do it all.' When Mrs. X was ready to be transported to the O.R. she experienced chest pains and the surgery was subsequently cancelled. Y reviewed the incident with me. 'What could I say to them? They wanted me out of the way so they could get everything done in a hurry. We had to be practical. I'm just a student and slower than them. They were very friendly but I still felt that I was in the way.'

> X and Y (students) were observing a cardioversion in I.C.U. (Intensive Care Unit). The patient was Mr. Z. He had been cared for by Y and she was holding his hand as the anaesthetist and the nurses prepared the procedure. Mr. Z told Y that he was not certain he would live through the procedure. When they were ready to begin, the staff told Y to 'move out of the way' and to 'stand over there.' Mr. Z looked for Y and could not see her. Later X said to me, 'I felt so sorry for that man. He knew Y.

> He was scared and he needed someone there he knew. But I don't blame the nurses. We would just get in the way. They know what they're doing. We don't.'

Persons, other than the hospital personnel, regularly reinforced the staff's territoriality in their communications with the students. The instructors, for example, frequently instructed students to defer to the staff for use of the conference room, equipment and patient's charts.

> Instructor to students in conference: 'I hope that all of you are adding to the nursing care plan in the patient's chart. After all, you may have data that is pertinent to your patient's nursing care and you should share that information with the staff. However, never erase anything that is already in the nursing care plan. Ask the primary nurse's permission first before erasing anything.'

> Instructor to students in conference: 'Sometimes you won't be able to find your patient's chart in his room. Always check at the desk or in the conference room. Someone may have needed it to check a doctor's order or something. Never take a chart from the desk unless you ask permission or leave a note saying where you've taken it. Usually they only need it for a few minutes and you can wait for it.'

Instructors frequently conveyed to students that they should avoid confrontation with the unit staff, patients or physicians. Their implicit message appeared to be, "It's better not to make waves; we're guests here."

> Instructor to students: 'My personal philosophy is that you don't fight battles you can't win. If it's not harming the patient, it's best just to go along with them.'

> Instructor to students: 'Sometimes you have to learn to accept things as they are. They've (the staff) done it this way before we came here and they'll continue to do it after we've left. You're not going to change someone's mind in this short time.'

Patients frequently defined the limitations of the student's role on the unit. They learned, soon after their admission to the unit that the students are essentially transients and cannot be

expected to have the required information or knowledge to answer questions about their progress, prognosis or treatments. Consequently, questions of this nature were generally reserved for the unit staff.

Patients on the unit were generally aware that students did not have the same workload as the staff. Several patients indicated that they knew the students were expected to cater to the patient's every whim. I often observed patients, who were assigned to students, requesting back and elbow rubs and having long conversations with them about their families. These same patients did not expect this care from the staff.

> Patient to researcher: 'I know she (the student) only has me and you can bet I'm going to take advantage of it. Those poor girls on the ward just run all night. They don't have time for these little things.'

The staff tended to reinforce this image of "business" to the patients.

> Staff nurse to patient: 'I see you've got a student today. That's nice. Maybe she'll get a chance to do that shampoo. I haven't had a minute to spare to do it myself.'

Doctors generally conveyed to students that the patients on the unit were the responsibility of the hospital nurses and that students had no right to expect an input in the physician's plan of care.

> Dr. X asked Y (a student) 'Who is Mr. Z's nurse today?' Y replied, 'I am.' Dr. X answered, 'No, no. His real nurse.'

Although the unit and the patients were considered as the unit staff's territory, it was acknowledged that the instructors had territorial rights with the students.

Instructors frequently cautioned the students that they were to be consulted first when the students had a question or required

supervision. The implication was that they were the only ones who could be trusted to teach the students the "correct way" of doing anything in the clinical area.

> X (a student) asked Y (an instructor) 'Can I ask the nurse if I have questions?' Y said, 'Can you give me an example of a question?' X replied, 'Well, let's say I asked her about what the I.V. rate was.' Y answered, 'All right. But just let's suppose the nurse was wrong and you made a mistake. Who would be responsible?' X said, 'Me.' Y replied, 'You see?'.

An underlying assumption was that the staff would not teach the students anything which differed from the teachings of the program or interfere with the instructor's method of clinical instruction. The staff were reluctant to demonstrate to students "shortcuts" or versions of procedures which differed from those taught in the program. This became particularly evident on occasions when the staff member did not know that I was not an instructor.

> The student (X) asked a staff nurse (Y) what she should do about an I.V. set-up which was filled with air. Y began, 'Come with me and I'll show you one of the tricks of the trade.' She stopped abruptly and turned to me. 'Well, I'd better not. You'd better. I wouldn't want to go against anything you teach. Do you want to do it?' I told Y that I was not an instructor and explained my role to her. She hesitated and then said, 'Well, if you're sure you won't mind....' She proceeded to demonstrate to X a method of removing the air from the I.V. tubing which is not sanctioned by the school of nursing because it predisposes to infection. Y's comment to X at the end of the demonstration was, 'You see. You don't learn everything from the book.'

The relationship between the instructors and the staff is indicative of their territorial expectations. For example, although both instructors are licensed practitioners, they must ask a staff nurse to perform many nursing functions on the unit.

> Instructor to researcher: 'I feel so funny whenever a student's patient has a doctor's order that needs a co-signature. I'm a nurse. I could easily just initial it. But I'm never sure whether we have the clearance to do that here. We're from the college. I don't know what the hospital would think about us

doing something like that.'

> Instructor to researcher: 'I used to answer patients' lights on the ward but I don't very often anymore. For one thing, I don't know anything about them and usually all I could say was, 'Well, I'll ask your nurse.' I spent so much time looking for nurses that I should have been spending with the students. I don't do it anymore.'

The unit personnel regularly intimated that they, and not the instructors, were knowledgeable about the patients and the hospital's policies. The instructors consulted the staff fairly frequently about matters concerning the patients or hospital procedure. Each acknowledged that the expertise of the other was in different areas. It is noteworthy, however, to recognize that the staff did not expect the instructors to be clinical experts, as is illustrated by this incident:

> X (the instructor) was explaining to a student about tracheotomy care. Y (a staff nurse) was listening to X's detailed description of the suctioning procedure and commented later, 'Boy! That X sure knows her stuff. What's her background? Where did she work?' I told her. She continued, 'Is that so? Well, she really knows, doesn't she? You don't see many of them (the instructors) who could tell a student about something as sophisticated as trach care. They know the basics, sure. Like IM's and stuff like that. But usually they have to ask us about more complicated things. I'm a little embarrassed. I was explaining something to her just like she was right out of school the other day. I never realized she probably knew all about it already.'

The hospital nurses respected the instructor's territorial rights with their students and were careful not to interfere with the instructors' plans. They did, however, expect to have some input in choosing the patient assignment for students and regularly made suggestions about the "best patients" for the students' experience.

> Staff nurse to researcher: 'I think it's important that she (the instructor) asks us about the patients before she gives them to the students. Most of the time it's okay but sometimes I know something that she doesn't or I don't want the patient to have a

> student who's going to be slow. The patient comes first. If I think he is suffering because he has a student, I'll tell the instructor that she should give the student another patient.'

None of the staff appeared to enjoy reporting a negative item about a student to the instructors but when they did so, they stressed their responsibility for patients' safety.

> Staff nurse to instructor: 'I'm sorry I had to tell you about X (the student). I would have told her but I couldn't find her. After all, I'm the one who is responsible for that patient and, as far as I can see, he's not getting the proper care. I thought you should know. I feel like such a crum telling you. But the patient can't go without things just because the student doesn't do them.'

One aspect of territoriality which was closely guarded by staff, instructors and students in the clinical area was access to their backstage region. In each situation of image management there existed a backstage region which differed from the reality presented to other individuals, considered to be "outside" the group. Access to backstage realities was strictly controlled by members of the group because, if others were to witness these, they would not be able to maintain the image they strive to convey.[3] For example, although staff nurses sometimes purposefully avoided a patient because they were afraid, repulsed or angry, they never discussed this with the students. They asserted that the students would be "devastated" if they were to discover this reality. In fact, the staff would be unable to retain the image of stoic, fearless, unruffled practitioners if this reality were known to students. Another example is that the instructors occasionally expressed their reservations to me about the philosophy and the structure of the community college program but they staunchly defended these among students and/or staff.

Instructor to researcher: 'Sometimes I think we want too much.

> I've come to the conclusion that it's too much to expect a diploma graduate to be able to do a psychological assessment. They just haven't had the experience, the life experience, to be able to pick out psychological problems. You've seen it, I'm sure, as a teacher.' Later, the same instructor said to a student, 'Granted it may seem like we concentrate too much on the psychological but it's so essential. You're the lucky ones. You've been taught how important emotional care is. Other nurses, who graduated maybe 10, 15 years ago, they didn't learn these skills. You'll be able to nurse the total patient.'

Some students did not enjoy nursing, regarding it as too boring or too stressful. A few did not plan to ever practise in the profession. None of these students admitted this to the staff or to the instructors, although their classmates were fully aware of their feelings. The students attempted to portray an image of avid learners to their instructors and their disinterest in the profession was seen by them to be incongruous with that image.

Generally, the backstage regions were most apparent in social interactions among members of the group, particularly in the hospital cafeteria. It was not a coincidence that the staff sat with other nurses at mealtimes, students with other students, instructors with other instructors. If, as happened occasionally, a member of another group joined a party of individuals at a cafeteria table, the conversation never contained evidence of a backstage region.

> Instructor to researcher: 'I was going to join you for supper but I noticed you were with some students and I just couldn't handle that tonight. I needed to be on my own ... you know what I mean? I didn't want to have to watch what I say.'

An interesting phenomenon occurred when two of students (X and Y) interacted with the unit staff. Both X and Y had worked in the hospital previous to their entrance into the program and were well-known to the hospital staff. The staff's reaction to them was different from their reaction to the other students. They were

treated more like staff members than students. Staff nurses tended to share "inside" information with them which they concealed from the students. For example, the staff were skeptical about the skills of a particular surgeon. Although the surgeon was thought to be responsible for a number of surgical mishaps, the staff did not discuss this with the students. They did, however, discuss it with X and Y. X and Y socialized with the unit staff in the hospital cafeteria; the other students did not. The staff did not "check up" on X and Y. They did not make suggestions about X and Y's patient care. It is interesting that, although X and Y were treated as colleagues by the staff, that they themselves felt they were "students" and "outsiders" among the hospital personnel.

> X to researcher: 'You feel a pressure sometimes because they (the staff) are looking at you like they think you've got the answers. They think it's funny that I've only got one patient and that I have to check with the instructor all the time. If I complain about the pressure in the course or all the work we have to do, they just can't understand. It really limits the things I can talk to them about.'

Students who were L.P.N.'s or R.P.N.'s before admission to the program indicated that they too felt they no longer "belonged" among their former colleagues.

> Student to researcher: 'I got a letter yesterday from a friend. She and I used to work together at X (the hospital). She was really angry because they had students on the ward and they were really busy, running their tails off, and the students had just one patient each. She said, 'They are real winners I wish they'd leave us alone. They're more work than anything.' That's what she said 'real winners.' I don't blame her, I know I never understood why we had to be so busy and the students would come to the ward to make a bed and give a bath. But what I didn't understand then and I'm sure my friend doesn't either is that the students have no choice and that looking after one patient and knowing everything about him is a full-time job. I wouldn't tell my friend though. She'd just think I'd lost my mind.'

Each aspect of territoriality was accompanied by specific

behavioral expectations and role definitions. These were revealed most vividly when a member of a group (students, staff, instructors) reacted to a supposed violation of their territorial rights.

> X (a staff nurse) entered the conference room and said, 'All right, anyone seen 15 Bed 2's chart? I left it right on the desk and the doctor's on the phone. I need it right now.' A student handed her the chart. 'So you had it. Please don't take charts off the desk without telling me about it. Leave me a note or something. But please just don't take it.' X turned to the instructor. 'Y, could you remind them about this please? It's so frustrating. Tell them just to leave me a note telling me where you've taken it. I don't mind if they take the charts but I hate like heck to be going all over the ward looking for it.'
>
> Instructor to researcher: 'I often have to speak to X (a staff nurse) about the way she talks to the students. She can be very rude sometimes. I tell her to apologize. If the student does something wrong, I'll handle it, not her.'

INFALLIBILITY

It is a significant aspect of the image management of instructors and staff nurses that they projected an image of infallibility to students. They conveyed to the students that less-than-perfect performance of new skills and application of knowledge is unacceptable. They repeatedly reinforced the need for infallibility in nursing by indicating that the potential for serious error is everywhere. The implication was that the slightest mistake could result in the ultimate calamity: the patient's death. The instructors and the staff told many horror stories which effectively demonstrated the disastrous effects of making a mistake in nursing.

> Instructor to students in conference: 'I knew a nurse once who worked in I.C.U. (Intensive Care Unit). She gave a patient ten times the dosage of digoxin.I.V. He was a visiting professor from Scotland and he was dead within minutes. You can imagine what happened to her.'

Students were generally under the impression that their instructors and most staff nurses did not make mistakes. At times, the nurses on the unit attempted to conceal their errors from the students. Many of the personnel expressed the belief that it would be detrimental to the students if they were to discover that graduates do err occasionally.

> X (a student) was being supervised by Y (a staff nurse) in the preparation of an I.V. medication. X prepared twice the prescribed dosage and Y told the student that the prepared medication was incorrect. X responded, 'Oh, no, I was going to give him twice the amount. I quit.' Y said, 'No, you aren't. If I could quit, I would quit after all I've been through tonight but it wouldn't solve anything. You're learning. You're going to make mistakes. That's how you learn. That's why we have to check you.' Later, I said to Y, 'Even graduates make medication errors.' She replied, 'That's true. We all make them from time to time. But we wouldn't want to tell X that. We wouldn't want X to think that you can make mistakes even after you should know better.'

The instructors structured much of the student experience and their own performance in order that the possibility of students making errors in the clinical area be minimized. They issued a myriad of rules and regulations to the students at the beginning of each rotation. Students were required to 'ask permission' or 'check with someone' almost constantly.

> Instructor to students in conference: 'The first time you do a procedure here I want to see it. Even if you have your check-off (the student's performance in the procedure was judged to be satisfactory by another instructor). After all, I'm responsible for you here and I've got to know you can do things before I let you do them to the patients.'

> Instructor to students: 'They've got a new rule here that students have to be accompanied by a nurse to open the patient's valuables cupboard. Something was stolen from it just recently. So when you want to lock up the valuables, you've got to get a nurse to unlock the cupboard and be with you when you put it in.'

The students in the study spent a phenomenal amount of time

searching for persons to approve decisions or to supervise procedures. As the unit is composed of approximately forty rooms and because the traffic of staff in the hallways is minimal (because of the Friesen concept), the students were often required to spend 15 minutes or more looking for a particular staff member.

> I accompanied X as he searched for someone to supervise him preparing and giving a narcotic analgesic. First, he looked for the instructor. After searching in the areas she was usually found (e.g., the medication room), he asked different students whether or not they had seen her. Finally, he concluded that she was not on the unit. Then he looked for a staff member to supervise him preparing the narcotic. After several minutes, he found a nurse who agreed to supervise him. She suggested, however, that he locate the keys to the narcotic cupboard and return when he had them. X walked the length of the corridor, calling in the rooms for the nurse who had the keys. Someone told him to 'hit the bell on the desk' and he returned to the nurses station to ring the bell. A nurse came out of one of the rooms and gave him the keys. He then experienced difficulty in locating the nurse who had agreed to supervise him. He walked up and down the corridor until he found her. The nurse watched X take out a narcotic medication and she co-signed the narcotic record book. Just then the meal trays arrived on the unit and she said, 'I'm sorry, X, I'll have to go. You'll have to get someone else to watch you give it.' X looked for 'someone else' for a time and then approached the same nurse. 'I'll help you give out the trays if you'll help me give the needle.' She agreed and he handed out the trays for several minutes. When this task was complete X and the nurse went to the medication room to prepare the medication. When X finally gave his patient the analgesic, the patient was experiencing a great deal of pain. She said to X, 'I thought you were never coming.' I replied, 'I'm sorry. Because I'm a student I have to get someone to check me. Sometimes it's hard to find someone.'
>
> The duration of this incident was 42 minutes.

The preceding incident is illustrative of the frustrations that the students experienced in their efforts not to make mistakes. It was by no means an uncommon incident; it occurred at least once to each student on every clinical day.

Most students had little faith in their ability to make decisions in the clinical area. Generally, they accepted a decision

they had made only after it had been approved by a staff member, classmate or the instructor. Students frequently stressed to me the importance of checking their decisions.

> Student to researcher: 'I never, never do anything for the first time without checking it first. I ask a nurse or look it up in the text or ask one of the others (students). I have to do that. I'd make a mistake otherwise.'

It was common for students to "check" a decision with more than one resource. Still, many remained unconvinced they were not going to make a mistake if that decision was implemented.

> X (a student) could not decipher from her pharmaceutical text what kind of drink she should give the patient with castor oil. She determined it should be something which would disguise the taste but could not decide upon orange juice or grape juice. Over a 20 minute period, X checked with two drug information texts, a medical-surgical textbook, three classmates and two staff nurses. Finally, she decided upon orange juice. She said, I hope I made the right decision. Did I make the right decision? I hope I made the right decision. What if it was the wrong decision?'

Sometimes students feared that they would be making mistakes if they followed the decisions of others. Some students trusted no one in this regard and literally checked every directive that the unit staff had issued about the patients' care.

> X (a student) checked the dosage of her patient's medication in a pharmaceutical text before administering the drug. I asked her, 'Do you have to check that information?' She replied, 'Oh, yes. Anyone could have put down that order on that chart. They could have written 20 pills or something.' I said, 'Isn't the doctor's order checked by two nurses before it is placed in the chart?' She answered, 'Yes, that's right. But I still check. I don't want to make a drug error because they didn't do their job right.'

Many students remained convinced that the only way to prevent errors in nursing is to know everything about the patients, their conditions and treatments. Staff nurses frequently told the students "horror stories" which demonstrated their clinical competence, especially during times of crisis. They also served to remind the

students how much they were required to know in order to make correct decisions in nursing.

> Nurse to student: 'I had this patient once. A young fellow, maybe 25. A really nice guy. He had an appendectomy and everything was going along fine when I was in his room and he starts clutching at his chest and gasping for air. I knew right away that he'd had a pulmonary embolus. I started recussitation right away but he died anyway.'
>
> Staff nurse to students in conference room: 'Don't worry. You'll get so you can spot an alcoholic from miles away. It comes with experience. We had a patient here a couple of years ago. I just knew he was a drinker right from the start. There were signs. He'd broken his leg in an accident. One night, I go into his room and he's just about to have a slug of whiskey. Someone must have smuggled it in. I went over to his traction and said, 'If you take one sip, I'm going to undo this (the traction) and your leg's going to come crashing down on the bed.' I must have looked like I meant it because he handed over the bottle.'

The students often compared their performance to this image of "super-nurse" as conveyed by the staff. They inevitably concluded that they had much to learn before they would be able to function at the same level of competency.

> X (a student) had catheterized an elderly arthritic and senile lady. The procedure had required that I and the instructor help to position and divert the patient, who was very reluctant to undergo the catheterization. After the catheterization, X said, 'What if I was alone and had had to do that alone? What would I have done? I couldn't possibly have kept all the equipment sterile and kept her legs open and helped her to relax all at the same time. I know the staff could have done it, though. They could have managed alone.'

Most students believed that they should be like their instructors; "walking textbooks." However, in their interactions with the instructors, it was always painfully apparent to them that their instructor's clinical knowledge was far superior to their own.

> X (the instructor) asked Mrs. Y (the patient) about her fears concerning her upcoming surgery. X was able to give Mrs. Y a great deal of information about some of the aspects of surgery which concerned her. X said to me, 'I felt really good about that. I was able to help her because I attended a conference on

> colostomy care last year. I learned a lot of tips at that conference.' Mrs. Y told me, 'I think X is wonderful. She helped me a lot you know. She knew so much.' The student, who was caring for Mrs. Y commented, 'I don't know how they (the instructors) do it. You're feeling like you're doing a pretty good job and then they come in and say things to the patient you've never heard of before. The patient wonders why you haven't told her and you think I'll never knew enough to be any good at this job.'

It did not occur to the students that the instructors are generally able to structure discussions in the clinical area so that they discuss only those areas with which they are familiar.

The instructors propagated their omniscient image by structuring questioning sessions so that they never ended without the teacher having to provide the answer.

> I observed X (the instructor) asking Y (a student) questions about his patient's surgery. Y was able to answer the four questions about the anatomy and physiology involved and the three questions pertaining to the management of the disease process. Finally, X asked, 'What does this woman's having children have to do with her care upon discharge?' Y said, 'I don't know.' X gave Y a lengthy explanation of the restrictions against lifting after this particular surgery. Later Y said to me, 'I hate that. I knew everything about that surgery and the patient. I knew about lifting. But the way they ask questions ... well, who would know what they want? It's a no-win situation.'

The instructors appeared to be unaware that their questioning sessions invariably communicated to students that they did not know enough to be "safe" (i.e., not make mistakes) in the clinical area. The instructors often seemed to enjoy these sessions, believing that their questions fostered critical thought among students.

> I observed X (the instructor) quizzing Y (the student) about aspects of her patient's care. Afterwards X said to me, 'I really enjoyed that, you know. It's so rare that I get the time to spend with students and really teach them things. I love it when I'm able to.' Y said later, 'I just dread those drill sessions. She asks one question after another, fires them at me. I don't even have time to think and she's asking me another one.' I asked Y about some of the topics which X had covered in the session. Y said, 'I couldn't tell you one thing she said to me. I was so

> nervous. All I could think of was 'please go away.' I know she's very smart but I hate those drills of hers.'

Another means by which the instructors communicated to students that nothing less-than-perfection would be tolerated in nursing was the way in which they reviewed a student's performance of a new skill. No matter how well they had performed the procedure, the instructors indicated that there was "still room for improvement." One student termed it the "I'll always know better than you" phenomenon.

Positive feedback was rarely given by the instructors without a suggestions of how to improve upon the performance or without a discussion of a negative aspect of the student's performance.

> Instructor to student: 'I really liked the way you told Mr. X (the patient) to move on his right side and you got him over on that side just fine. However, there's a better way of doing it and I'll show you.'

The fear of making mistakes pervaded every aspect of the students clinical laboratory experience. Students must adapt to the physical layout, the charting system, the system of nursing, the instructor, the staff and the myriad of rules and regulations specific to the hospital and/or the unit. As many of the rules and procedures are unwritten and often unspoken, known only to "insiders," the student could feasibly be able to give skilled nursing care and yet commit several "errors" in a day.

> X (a student) secured a requisition form around a urine sample with an elastic band. The communication clerk said, 'Are you planning to send that like that?' X asked 'Like what?' The clerk replied, 'Like that. With the requisition sticking out like that. Here I'll show you.' The clerk proceeded to demonstrate 'the correct' method of securing the acquisition. 'We do it this way,' she said.

Students attribute the fear of making mistakes as the major

cause of their anxiety in the clinical laboratory experience. Without exception, all students described their clinical experience as extremely stressful.

> Student to researcher: 'It's 90% stress, 10% pure stamina. You spend most of your time trying to find someone to check something or living in dread that the instructor will find you and ask you a thousand and one questions. Everyone, even the patients, are more comfortable on the ward than you are.'

> Student to researcher: 'Everyone is just waiting for you to make mistakes. The patients know that you're a student and they're afraid you'll hurt them. The primary nurse wants to make sure you don't forget something so she comes in every few minutes to check up on you. And the instructor is waiting to pounce on you to ask you three million and two things about your patient. No wonder I never relax around here. Everybody's out to catch me doing something wrong.'

Occasionally, a nurse would tell a student that she was nostalgic for her student days, implying that the student role is less stressful than the role of the staff nurse.

> X (a staff nurse) told Y (a student), 'I just loved being a student. It was fun. We had one patient, lots of time to do things. Lots of time to read and look things up.' Y said to me later, 'I just hate it when they say things like that. If being a grad is worse than a student. Lord have mercy.'

Students were particularly apprehensive when they feared they might make a mistake or not know an answer during what they called the instructors' "drill sessions." Instructors commonly isolated a student for a period of time in the unit in order to ask her/him a series of theory-based questions. Often, this questioning took place in the corridor or in the medication room, where others were usually present. Each instructor had her own style of questioning (e.g., one was more direct and curt than the other). However, both asked questions which were often ambiguous and both did not allow the students a great deal of time to formulate an answer.

It was common for such a questioning session to take place as the student was preparing to perform a technical skill for the first time. The students claimed that this method of questioning made them "so nervous" they were unable to perform the skill well.

The following conversation took place between the instructor (X) and a student (Y):

X: What can occur with this?
Y: This?
X: What can occur with a menisectomy?
Y: Uh.
X: What can occur because the meniscus is removed?
Y: Arthritis.
X: What kind of arthritis?
Y: Rheumatoid.
X: Why? Explain it to me.
Y: Well, I guess it involves the synovial membrane.
X: Remember. The answer must be clear. It must make sense.
Y: Am I on the right wave length? I don't understand.
X: No. You have the wrong arthritis. It is osteoarthritis.

X (the instructor) and Y (a student) were in the medication room preparing an IM injection (Y's first). While Y as withdrawing the medication from an ampule X watched her intently. Y's hands began to shake. X asked her what was 'the most important thing to remember in withdrawing medication from ampules?' Y replied, 'Not to contaminate the needle.' X said, 'No. It's to make sure there are not bits of glass in the solution.' Then she asked, 'What are the possible sites for giving an IM?' Y identified these and then was requested by X to demonstrate the sites on her. Y did this correctly but X suggested a modification for determining a dorsogluteal site. They entered the patient's room and X asked Y to review the procedure. She forgot a few steps of the procedure and X reminded her of them. At this time, Y's hands were shaking noticeably and she was perspiring profusely. X asked her a few questions about the side effects of the medication and provided the answers when Y did not know them. When X and Y approached the patient, Y explained what she was about to do. The patient said, 'This is your first needle, right? I can tell.' Y gave the injection and forgot to pull back on the plunger to check the position of the needle. Later, she told X, 'I don't know what happened to me. I knew that. I was just so nervous.'

The fear that they would harm a patient by making a mistake was particularly overwhelming when the patient required procedures with which the student was unfamiliar and when the patient appeared

critically ill. To some, the stress in these situations was incapacitating. Students, who were overwhelmed with the patient's diagnosis or treatment, often became mysteriously ill on the second clinical day of the week (the second day is the most demanding; students do little more than get to know the patient and research his illness on the first evening). This pattern occurred with alarming frequency.

> X (a student) had been assigned to two patients requiring heavy care. Both patients had I.V.'s. The student was obviously flustered in the evening and the instructor spoke to her at some length about the inadequacy of her care. At supper, the student said she had begun to 'ache all over' and felt generally ill. The next morning, she did not come to the unit, reporting she was ill. The next week, X said, 'It's the strangest thing how I get sick so suddenly some times. I felt much better the next day. Sometimes I think I'm allergic to the wards.'

Many students, who found the technical aspects of nursing too stressful, avoided these procedures whenever possible. Several indicated a preference for the psychological aspects of patient care.

> X (a staff nurse) told Y (instructor) that a student had refused to do a catheterization. The student had apparently explained, 'I'm only interested in emotional care. I don't really care about things like catheterizations.'

THE HELPING RELATIONSHIP

The relationship between students and their instructors and students and the staff is generally one in which the students need help and the others are capable of giving it. Although this is often the basis for a satisfying co-operative work experience in social situations, the students found many facets of their relationship with staff and instructors to be frustrating and demoralizing.

Both staff and instructors appear to regard most students as

essentially hopeless without their guidance and supervision. They frequently defined their role as one in which they prevented students from making mistakes and protected the patients from the fallibility of students.

> Instructor researcher: 'Whenever I'm having trouble deciding about what to do about a particular student, I try to think about her looking after someone I love. If I don't feel comfortable about her doing that, then I don't feel comfortable about her looking after anyone else. I couldn't stand for it to be on my conscience that I let someone go by who is going to be unsafe.'
>
> Instructor to researcher: 'I have four, maybe five, students right now who are questionable. I don't know whether I can trust them or not. I have to watch out for them all the time to be sure they aren't going to do something disastrous. The other students, the good ones, are left pretty well on their own because I've got to spend most of my time making sure that the weak ones don't get into trouble.'
>
> Staff nurse to researcher: 'I can't let them (the students) make mistakes. I'm the one who has to look out for the patient. I feel sorry for them (the students) but I know, if I don't check up on them, something will be left undone or it'll be done wrong.'

It is noteworthy that both instructors told me and the staff that many of their students required almost constant supervision. This did not change throughout the study, despite the fact that the students would soon graduate and become practitioners.

> Staff nurse to researcher: 'Poor X (the instructor). She says this is the worst bunch yet (of students). She says that they are really poor. Poor thing. She's run off her feet trying to watch all of them.'

The instructors believed that they were forced to confine the majority of their efforts to evaluating and supervising students because of the large student ratios in the clinical area.

> Instructor to researcher: 'We keep saying that we should have smaller clinical groups but we still get 9-10 at a time. That's just an impossible number. There is no way you can do anything but pick up a few things that they (the students) should improve upon. There's no time to teach them anything.'

The staff and the instructors defined "helping" in unique ways. The unit personnel tended to "help" students by answering their questions or performing a procedure for them.

> X (a student) was experiencing difficulty in calculating the I.V. drip rate. X said to the nurse in the room, 'I have so much trouble with this. I just can't seem to get it through my thick head. My instructors tried to help me but it didn't work. I just have to get this. This is a surgical ward. There's lots of I.V.'s here. Do you think you can help me?' The nurse calculated the I.V. rate on a piece of paper and then explained in painstaking detail how she had arrived at that answer. Afterwards X commented to me that the nurse had treated X as if she were 'a child.' 'I hate it when they act like you don't know anything.' I asked X if she knew why the nurse had explained the calculation in such detail. X replied, 'Well, she's only trying to help. She doesn't know that I'm not an idiot. I do understand some things.'

The instructors, however, rarely gave a student the information s/he required without first requiring that the student "look it up" in the patient's chart or a textbook. They consciously avoided "spoonfeeding" their students.

> Instructor to researcher: "Of course they want the easy way out. They want you go give them all the answers. But I tell them right at the beginning, 'This isn't kindergarten. Look it up.'"

Instructors tended to view "helping" as evaluation of a student's clinical competence. Generally, this was interpreted as "pointing out to students where they should improve."

Occasionally, a student did not follow the instructor's suggestions for improvement or did not perform a skill as a staff nurse had demonstrated. At these times, the instructor or staff nurse expressed feelings of frustration about the student and implied that the student was lazy, unmotivated or beyond "help."

> Instructor to researcher: 'Just last week I told her that she had to know how to spell those words correctly by today and I would be checking to see that she did. I just looked at her chart and she spelled the very same words wrong again. Can you

believe it? God! Why does she do that to me?'

Staff nurse to researcher: 'She asked me what I thought about what she should do with the order and I told her. Two minutes later I see she did just the opposite. She's really stunned. Some people you just can't help.'

The students expected to be "helped" by the unit staff and often referred to their student status when requesting information or assistance.

X (a student) required a co-signature in order to prepare a narcotic analgesic. X approached a staff nurse and said, 'You know, I have to have a nurse sign narcotics for me. I can't find my instructor. Can you sign for me?'

X (a student) had a patient with a Sage pump. X was unsure of how to change the heparin syringe in the pump and asked a nurse to demonstrate it to her. 'I've never done this before. I saw one in the college but that was ages ago. If I just watch you, I know I'll be able to do it when my instructor comes. You must be awfully busy. I'm sorry to bother you. But I have to learn this.'

The students tended to be highly critical of nurses who were reluctant or unwilling to "help" them.

X (a student) asked a nurse to check the identification information on a bag of blood. The nurse responded, 'I'm too busy right now. You'll have to ask someone else.' Later, X said about this nurse, 'She's the type who hates students. She'll do anything to make it miserable for us. How long would it have taken her to check that blood for me? She could have done it. She just didn't want to.' When I pointed out that the nurse had been genuinely busy because of a crisis which had occurred with one of her patients, X said, 'It doesn't matter. Even if she wasn't busy she wouldn't help me.'

X (a student) was to give an intramuscular injection for the first time and had to be supervised. The instructor had gone for supper. X asked a nurse to watch her give the I.M. The nurse said, 'If it's your first time, I'd rather you did it with your instructor so she could correct you. I'm sorry.' X commented to me later, 'If she has ruined my only change to give an I.M. I'm going to be really mad. It wouldn't have killed her to come with me. She probably thought it was going to kill the patient.'

Most students admitted that their student status was not without its privileges. It often protected them from having to

assume the ultimate responsibility for aspects of patient care of which they were unsure. The students promoted their image as eager learners to this advantage.

> I asked X (a student) about what she had felt when a doctor had informed us that the hospital's council of surgeons had passed a motion that nurses should remind doctors to complete the diagnosis section on X-Ray requisitions. Although X had appeared to be listening to the doctor, she replied, ' I don't know. I wasn't really paying attention. We don't have much to do with doctors. Usually they come into the room and just ignore you. Sometimes they ask me questions and I never know the answers. I tell them I'm just a student. Then they'll ask the nurse.'

> Mrs. X (a patient) was discouraged because of her prolonged convalescence. She asked the student if it was possible that the doctor had been negligent in her treatment. The student replied, 'I don't really know what to tell you. I haven't been here (on the unit) very long. I think you should ask the nurses. They have the information. I don't.'

Although the students frequently requested assistance from the unit personnel, their relationship with the staff was far less intense than their relationship with the instructors. Their interactions with the staff were, in part, limited by the territoriality rights assigned to instructors. As well, staff members had limited input into the evaluation of a student's performance. Students recognized that it was the instructor, not the staff, who had the power to terminate a student's future in the program. Consequently, the instructor became the students' main source of approval. Students devoted much of their efforts and energy toward winning or retaining that approval.

Many students characterized their relationship with their instructors as essentially a power struggle. They believed that the instructors maintained the power in the relationship, particularly in matters pertaining to evaluation and promotion.

> A group of students were unhappy about a mark they received on a group assignment. The students were uncertain about how the faculty had arrived at that particular grade and requested clarification. Several students expressed the belief that this action would not change their mark but agreed to submit the request. The assignment was reviewed by the faculty and returned, without clarification, with the same grade. A student said to me, 'You see, it doesn't pay. We're at their mercy. They say, 'that's the way it is' and we can't argue. They're the bosses.' An instructor told me later, 'They would have stood a chance if they had queried the content section but they didn't. They just asked us to look at it. I wanted to tell them in the worst way but I can't.'

Perhaps the most pervasive force in conveying to students that they were powerless was the evaluator role of the instructor. Students regarded clinical evaluations as essentially negative and fearsome. It was their perception that their performance was viewed by everyone in the clinical area and, at any time, without warning, the instructor could learn of an incident which would seriously jeopardize the students' future in the program.

> X (a student) seemed to be priming her patient (Mrs. Y) for the possibility of her instructor's visit. 'If my teacher asks you, maybe you could show her how I taught you your breathing exercises.' I asked X if my interpretation of her behavior was correct. She replied, 'Sure. Listen, Z (another student) didn't tell her patient something once but she told the teacher she had. I guess you know by now that sometimes we lie to stay out of trouble. Anyway, the teacher checks this out with the patient and wham. Z is failing clinical. It's pretty gross when even the patients are helping to grade you.'

The students attributed a great deal of stress to the method of clinical evaluation used in the program (see Appendix A). They complained bitterly about the subjectivity of the marking system and the inconsistencies between instructors. Students constantly referred to their past clinical marks in conversations with me; no matter how high these marks had been, the students were concerned that the instructor would regard them less favourably than previous

instructors and they would fail the clinical rotation. The students made frequent reference to other students who had been "doing well" in the clinical portion of the program and then were asked to leave the program because an instructor had failed them in one rotation. The instructors insist that this is an unrealistic fear; a student must attain an average of less than 66% in a term (four clinical rotations) before they are considered to have failed the clinical portion. However, this fear is representative of "the threat of failure" which pervades many aspects of the student experience.

> Student to researcher: 'There are so many opportunities to fail in this program, you can't breathe. You can fail your exams on the modules. If you fail that, you might even fail the re-write. You can fail a clinical rotation. You can fail the exams in some of the courses. You can fail a major assignment. You can even fail the final exam and be out in the last week of the program. You spend all your time and energy trying not to fail.'

One consequence of the evaluation tool used in clinical evaluation was that students frequently determined their priorities according to what is rated most heavily in the form. For example, the form implies that written aspects of nursing are extremely important.

> Student to researcher: 'About 1/3 of the evaluation has to do with how well you can do the nursing care plans or your assignments or chart. I was here for a few months before I got smart and realized that people were copying each other's nursing care plans. I always chart really well. I know where they (the instructors) are impressed and where they're not. I can spend all morning with a patient giving him super nursing care and the instructor won't notice. If I chart nicely, she'll notice that.'

Most students believed that the key to survival in the clinical laboratory experience is to conform to the instructor's concept of an ideal student.

In order to conform to this image, the students went to

elaborate lengths to determine which qualities the instructor approved of, as well as those she disapproved of. Prior to the clinical rotation, the students quizzed their classmates, who had already completed the rotation with the instructor, about the instructor's likes and dislikes. All students came to the unit on the first day of the rotation with a composite picture of the instructor's ideal student. These views varied greatly as is illustrated by these statements by students:

> She really likes sex. Anything to do with it. Some of the kids have her for homeroom teacher. They say she loves it when you bring up the subject.
>
> My friend had her last rotation. She said you should research everything you can about the patient. I mean, know everything there is to know. Because she'll ask you. She'll fire the questions at you and you'd better know the answers.
>
> She likes you to need her. You have to tell her how much you're learning here.
>
> This girl in our class--X--do you know her? Well, anyway, X is quite outspoken. She says what she thinks. Tells it like it is. She and Y (the instructor) didn't hit it off at all. Y doesn't like opinionated people.

Students often provided the instructor with information about their nursing care which they thought might predispose her to evaluate them favourably. For example, it was common for students to include incidents in conference with the instructor and the other students which demonstrated the student's theoretical knowledge or nursing abilities. While the majority of the students appeared to do this unconsciously, some admitted that they deliberately introduced subjects, particularly in post-conferences, which conveyed to the instructor that they were capable, competent and caring in their nursing care.

(Student to researcher) 'You've got to have at least one 'insight gained' in every post-conference. You know ... you pretend you've learned something which has just changed your whole way of nursing. Usually you say you did such and such wrong before but now you've seen the light. It helps if you can say that you learned this thing from the instructor.'

Students frequently distracted the instructor from asking questions about nursing theory in post-conferences by introducing a controversial topic, generally of a psychosocial nature (e.g., should you tell a terminally ill patient that she/he is dying?). These topics elicited a great deal of discussion and generally occupied the duration of the conference.

The importance to students of knowing what the instructor expects was clearly illustrated when the students in one instructor's group expressed their apprehension that the instructor was "new to the college." They felt that they had not been able to divest enough information about this instructor in order to fully anticipate how they should behave during the clinical rotation.

(Student to researcher) 'Not many kids have had her (the instructor) so I don't know much about her. Some things but not much. I hate it when you don't know what to expect.'

Students often emphasized the significance of the instructor's expectations to me by indicating that their futures in the program were at stake if they did not comply with these expectations.

(Student to researcher) 'Everything you do goes on that damn evaluation. If she doesn't like you, she gives you a low mark. If you fail clinical, they can make you leave even if your marks in the exams are okay.'

X (a student) told me, 'Y (a student) told me that the thing you have to do with Z (the instructor) is to tell her she's pretty, that she looks nice , her haircut is attractive. Apparently she loves it.' I asked X 'Will you do that?' X replied, 'Yes. Listen, at this stage of the game, I'm not about to risk them kicking me out. If she says 'Kiss my butt,' I'm going to bend over and do it.'

One quality which the students identified as a "must" to win the instructor's approval was that the student appear well-versed in nursing theory. The majority of the students indicated that their instructors are extremely knowledgeable. They stated that they knew they "could never be" their instructors' equals in this aspect of nursing. The students appeared to spend a great deal of time and energy trying to predict what questions the instructor would ask in the clinical area. Inevitably, the student expressed to me that s/he had "studied the wrong thing" when researching the information necessary to plan a patient's care.

> X (a student) told me she had studied 'all evening' about her patient's surgery. 'She'll (the instructor) really be impressed. There's nothing she can ask me about vagotomies and pyloroplasties that I don't know.' At the end of the day, X said, 'would you believe it? She didn't ask me one thing about the surgery. My patient had a retinal detachment last year. It was on the chart but I didn't look it up. She quizzed me on retinal detachments. Next time I'm going to study the small details. I wasted all that time studying vagotomies and pyloroplasties.'

> I observed the instructor quiz X (the student) about the patient's surgery and post-operative teaching. She asked X a total of 12 separate questions pertaining to the subject. X was unable to answer two of these. X's comment about this questioning session was, 'I blew it. I didn't study anything about the diet. I should have known she would ask that and I didn't even study it.'

Many students were as anxious about asking the instructor questions as they were about being asked. Often, they chose not to risk the consequences by asking a question.

> Student to researcher: 'I used to ask the instructors lots of questions but I learned not to. It would show up on the evaluation as 'the student is unsure of many things' or they would say I depended on them too much. If you don't ask any questions though, it's just as bad. They'll say you never 'communicated your needs' to the instructor or you are too smart for your britches. You're damned if you do and damned if you don't.'

Some students attempted to solve the issue of asking the

"right" questions by asking a question to which they already knew the answer.

> X (a student) was researching her patient's illness in a textbook before post-conference. She commented, 'It says here the digestion of food if a person is in shock makes the blood go to the stomach and deprives the vital organs of circulation. They fed my patient. She's in shock.' At post-conference, X asked, 'I have a patient who's in shock. She is very hungry so the nurse gave her some supper. Wouldn't the digestion of the food deprive the vital organs of blood? Digestion needs a blood supply, right? So wouldn't it be dangerous to feed her?'

A few students expressed the fear that they had conformed for so long to the instructors' expectations that they had lost some of their uniqueness.

> Student to researcher: 'I feel like a chameleon sometimes. I'm trying to stay out of trouble and to do what they want. But I think I've lost something along the way. I don't really know what I want any more or know why I do things. I know I'm not as creative anymore.'

> Student to researcher: 'I started off with my way of doing nursing care plans. I liked them. I used them. Then one instructor liked one thing her way and another liked something else ... pretty soon I can't recognize it anymore. They've become sheets of paper, just to get the marks.'

I frequently observed students doing something for which they had no other explanation than it was the instructor's expectations that the student do so. This occurred despite the fact that the instructor occasionally indicated that this was not her expectation.

> X (a student) was searching for some time for her patient's primary nurse. She said, 'I can't go for lunch until someone's looking after the patient.' Y (the instructor) met X in the hallway, asked what she was doing and suggested that X could decide to go for lunch without informing the nurse as long as the patient knew where X was and could call a nurse by means of a call bell attached to the bed. X continued to search for the primary nurse. When I asked why she had not followed Y's suggestion X replied, 'I just couldn't rest knowing I'd be responsible for whatever happened while I was away.'

> X (a student) said to me: 'I've really worked hard on this care plan. I hope Y (the instructor) appreciates it.' I said, 'Didn't

> Y say you didn't have to do a care plan this week?' X replied, 'Sure but she doesn't really mean it. She wants us to have one.'

A few students suggested that the instructors expected and wanted students "to need" them. This was particularly evident when one of the instructors became ill and was forced to leave the students on the unit without an instructor. When she returned, she asked the students about their experiences.

> 'How did you find it without me?' X (the instructor) asked. There was a few minutes silence. Y (a student) said, 'I loved it' and proceeded to describe her satisfaction at discovering that she could function independently of her instructor. X asked her, 'Do you think your experience was good because I wasn't here or because you just had a good day?' Y hesitated and then said, 'I guess ... I suppose it's because it was a good day. Nothing really went wrong.' When the other students indicated that they, too, had enjoyed the experience, Y asked them 'Don't you think you felt better knowing that Barb was around in case you got into any difficulty?' Again, there was a silence. Z (a student) answered, 'No, we don't think of her as an instructor. We didn't ask her anything. She's just one of us.' X said, 'Yes. But she was here in case you ran into difficulty. Obviously you had none and that's good.' Later Y said to me, 'I couldn't believe it. She didn't want to hear about us being able to do anything without her. She doesn't want us to grow up.'

Although the students were often forewarned by the instructors that their graduation date was approaching and they would then be independent practitioners, the instructors constantly gave the students the implicit message that students need their teachers. It became obvious, as well, that the instructors had some reservations about the ability of students to function independently.

> Instructor to students: 'Some of you may have noticed that I've given you two patients. Don't freak out. I'm around all the time if you need help. If you can't find me, just write on the blackboard here, when you need me and where. Some of you with two patients will probably write, 'Help! I need you all night'.'

> Instructor to students: 'I come with you now. Your conscience. I am with you. But what will you do when I'm no longer there to guide you, to help you make the right decisions? I won't be with you much longer.'

> Instructor to students: 'Some of you have been asking whether or not you need to do a nursing care plan for your patients on your last week of clinical. Some of you are quite ready to plan and implement your nursing care without it. Others of you still haven't a clue how you can use a nursing care plan as a guideline to make decisions about your patient care. You are the ones who still need to do it, even if it is your last day with an instructor.'

Among each other, the students appeared cynical about their instructors and their program. They often spoke of "not caring" what the instructors thought of them and jested about the clinical evaluations.

> One student to another: 'Well after today, she's (the instructor) sure to fail me. Oh, well. So I'll go on holidays a little earlier than I had expected. So what?'

In individual conversations with the students, however, they were in awe of their instructors' clinical knowledge and expertise. They were also extremely concerned about the instructors' evaluation of their performance.

The students tended to tell each other what they considered to be the most dramatic events of the clinical laboratory experience. Usually these pertained to unfamiliar procedures which were attempted successfully or "frightening" patients (e.g., patients with a great deal of equipment attached to them). Every coffee and meal conversation included some reference to image management of the instructor.

> One student to another at coffee; 'You can never let her suspect that you're scared. If she senses it, she'll never let up. You've got to act confident even if you're petrified.'

Only a few students appeared to believe that the impression of competence and cynicism given to their classmates was a reality. Most students indicated that their instructors and the staff nurses

were knowledgeable and competent and that they felt incompetent in comparison. They regarded many of their classmates with similar awe. Generally, this view was based on the classmates' reports of his/her performance on the unit. My observations suggested that the students' perceptions of their classmates' nursing ability is not always accurate.

> X (a student) was asked to withdraw from the clinical portion of the program because she was judged to be clinically unsafe. Y (another student) said to me, 'I don't understand it. X was a good nurse. If they told her to go, I'm dead for sure.' When I asked Y how she knew X was a 'good nurse' Y replied, 'She could handle anything and never get in a flap. She told us about how she looked after this patient once who had bled all over and X knew just what to do.'

In order for students to portray the image they desired as a group, they relied on one another to act appropriately and to maintain the image. Students who did not conform to this image were considered disruptive by their classmates and they often brought subtle and some not so subtle pressures to maintain the solidarity of their behavior.

> X (the instructor) was away for a day. During that day, Y (a student) asked Z (another student) to watch her give the patient an injection. She asked Z if she had determined the ventrogluteal site correctly. Z indicated that the needle should be given at a lower site but Y disagreed and gave the needle as she had originally intended. The needle hit the patient's hip bone.
>
> When X returned, she asked the students in conference about their experiences on the day she was absent. Y said, 'Well, I suppose you know. Oh, well, never mind. I'll tell you later in private.' The other students immediately began asking Y to elaborate. 'What's this?' ... 'I don't know what you're talking about and I'll die if I don't know.' 'Now you've really made me curious. You've got to tell us.' Y became increasingly adamant that she did not want to share the incident with her classmates and repeated, 'It's all right. It's just something between X and myself. No one would be interested anyway.' Finally, X interceded and said she and Y would 'talk about this later.'
>
> After the post-conference, Z overheard X and Y discussing the incident. Y insinuated that Z had agreed with her about the IM site, and implicated Z in the responsibility for hitting the

> patient's bone. Y encouraged Z to confirm her story. 'Well, I had checked the site with Z. We were pretty sure it was the right one. Weren't we Z?' However, Z neither denied or confirmed Y's statements.
>
> Later, Z indicated to me that she had been 'shocked' that her friend had 'betrayed' her. She felt that Y had violated the unwritten student agreement. 'Students don't rat on one another and they don't get someone in trouble just to make themselves look better.' It is noteworthy that it had not occurred to Z to tell the instructor her version of the incident. She explained, 'I could have told X the truth but I just couldn't do that to her. I knew she's just trying to keep up her marks in clinical. Last time she was with X she got a really high mark in her evaluation. She's really nervous that she won't be able to get such a high mark this time. She'll do anything to make sure she gets a good evaluation.'

When the other students learned about this incident they were angry at Y. Although they continued to interact with her, they made frequent references in their conversations with her to "brownnosers" and "certain people you can't ever trust." When Y said she was not going to attend a social event for the students, one of her classmates replied, "Okay, you go and study and get the highest marks. We've earned a good time and we're going to have it. Marks aren't everything."

Certain students attempted to use the positional power of the student group to appeal to the administration of the school about certain aspects of the clinical laboratory experience. Generally, these students were unable to elicit the co-operative support necessary to attain the required attention from the administration. The students intimated that their classmates' desire to convey to the faculty an image of eager learners who inquestionably conform to the instructors' standards is far more powerful than their desire to achieve student solidarity.

Some students believe that the evaluator role of the

instructor hinders the formation of a trusting, interpersonal relationship between themselves and the instructor.

> Student to researcher: 'I'd like to have a real honest-to-goodness heart-to-heart talk with X (the instructor) one day. She seems like a very nice person. But here, I can't remember anything but she's an instructor who'll give me my evaluation. I have to watch what I say all the time. I think she's going to put anything I say on the evaluation.'

The instructors are aware that their role as evaluators presents a dilemna; students will continue to be wary of confiding in an individual whom they believe is expected to judge their performance. However, the instructors could offer no viable solutions to this problem.

In their interactions with students, the authority of the staff and instructors remained essentially unchallenged. The students were frequently resentful of the dependency the helping relationship enforced but generally believed themselves to be incapable of independence.

An additional consequence of the dependent role of students was their self-concept. Generally, they regarded themselves as incapable of making independent decisions and lacking in the required skills and knowledge to be independent practitioners. All the students noted that their self-esteems had suffered as students in the program.

> Student to researcher: 'I couldn't get over how I, an adult who had been self-sufficient for years, have been made to feel like a kid again. Sometimes I can't decide the simplest things. I either think someone's going to sue the pants off me or the teacher's going to kick me out. I've never felt so worthless, so inadequate in all my life.'

> Student to researcher: 'I come in in the morning and I'm feeling good about myself. Two hours later I figure I don't know anything. They (the instructors) make you feel like you're this small

(indicating with her fingers). I want to stand up sometimes and yell that I'm a good person and I do a good job of most things. How is it that here I mess everything up? Can't do anything right.'

Frequently, the students were so preoccupied with their subordinate role as students that they frequently attributed the casual comments of others as indications that they were incompetent.

Miss X (a patient) yelled from inside her room, 'Leave me alone and don't come back for at least half an hour.' The student said, 'I guess she doesn't like students. I wouldn't blame her. To be this sick and have us learning on her is pretty terrible.' Later, Miss X told me she had no idea who she had yelled to but was frustrated that she had had no privacy in the hospital and had wanted to be alone for awhile.

X (a student) overheard a patient say she was reluctant to have a student look after her. X said to me, 'I would just hate to think that the poor lady ... she can't even get out of bed ... would be stuck with me, a student, even if she didn't want me.'

The students often utilized each other to bolster their confidence or to analyze a stressful situation in the clinical area. However, invariably students related incidents to their classmates in such a manner as to inspire sympathy and support.

X (a student) had been chastized by the instructor for neglecting her patient that evening. A staff nurse had reported to the instructor that X had not been with the patient for most of the evening and had not given him the necessary care. At coffee with her classmates, X said, 'I'm so afraid of what's going to happen with Y (the instructor). I'm trying my best but she makes me so nervous I can't do anything. I know I really bombed out today but I just can't seem to do anything right when I'm around her.' The other students assured X that she is a 'good nurse' and that Y has had a similar effect on other students in the past.

X (a student) charted physical assessments in detail on her two patients, although she had not actually carried out the entire examination. Y (the instructor) was skeptical that X had done the assessments as she had charted. Z (another student) told X later, 'You're crazy. You charted two assessments right after we got on the ward. You know she (Y) checks the charts in the morning. If she sees you've done two assessments in five minutes, naturally she knows you've been lying. You should have changed the time--charted it at 09:00 or something.'

Students varied in the degree to which they felt victimized in their relationship with the staff or the instructors. Students, who had previously received poor clinical evaluations, were particularly unlikely to defend themselves when criticized by the instructor or a staff nurse. These students truly felt unimportant in this relationship.

> X (a student) had a patient who required oxygen. The patient said she was uncomfortable with the mask and became very agitated whenever X put it on her. X finally took off the mask and said to the patient, 'There's another way of receiving oxygen. There are little tubes that fit in your nostrils. I'll see about getting you those.' The patient indicated that she had had oxygen by nasal cannula on a previous admission and had been 'more comfortable' with that apparatus. Y (the instructor) entered the room at that moment, commented that the patient required oxygen and that the mask was off. When the patient said that she 'hated the mask,' Y told X she 'Should have seen about an alternative method.' Y then approached the staff nurse about a nasal cannula. X said later, 'I've learned from experience not to say anything. If you defend yourself, they think you're making excuses or that you don't accept criticism well. I just keep my mouth shut and try and stay out of trouble.'

SUMMARY

This chapter has presented a discussion of the ways in which staff, instructors and students manage the impression they portray to others. Generally, instructors and staff presented an image of being "in control" to students. Image management of the student reflected their pre-occupation with their present status of "student." They expended much of their efforts toward staying out of trouble and avoiding errors. They attempted, whenever possible, to conform to the instructors' expectations of student behavior and attitudes.

Students regarded their instructors, and to a lesser extent the staff, as their rescuers; these individuals helped them to

avoid making mistakes in the clinical area. As in most rescuer-victim relationships, the rescuers rarely expected the students to succeed without their help.[4] If, in spite of a rescuer's efforts, a student made mistakes or was less-than-proficient, the rescuer tended to brand the student as unmotivated or hopeless. The rescuers assumed the complete burden of supervising students in order to prevent them from committing errors.

The students frequently felt victimized in their relationship with their rescuers. They were resentful of the powerlessness this relationship enforced but believed themselves incapable of anything but the dependent role. The consequences of this victimization were that students demonstrated varying degrees of incapacitation and anxiety in the clinical laboratory experience. Also associated with this was the resultant lack of self-esteem and a resignation to the dependency enforced by the victim status.

It is apparent that students expect to and are expected to assume a dependent subordinate role. Students utilize this role to elicit help and support from the staff and the instructors. The unit personnel and the instructors enforce this role in order that they may maintain their position of competency and authority. The consequences of this have definite implications for the students' perceptions about professional-bureaucratic work conflict.

The following chapter describes the students' experiences with backstage realities during the course of the study. It is in the analysis of these findings that the issues of territoriality, infallibility and the helping relationship will be further discussed as to their impact in the student experience with professional-bureaucratic work conflict.

FOOTNOTES

[1]E. Goffman, The Presentation of Self in Everyday Life (New York: Doubleday and Co. Inc., 1959).

[2]Ibid., p. 258.

[3]Ibid., p. 301.

[4]C. Steiner, Scripts People Live: Transactional Analysis of Life Scripts (New York: Grove Press Inc., 1974), p. 236.

CHAPTER V

BACKSTAGE DISCOVERIES

This chapter is a description of the students' experiences with backstage realities during the course of the study. It is presented according to the following categories: "Some people do not care," "Some people are incompetent" and "Doctors have more power than nurses." It is difficult to separate the emotional and behavioral reactions of the students from any discussion of their experiences with backstage realities and this has not been attempted.

The students were often oblivious to many actual incidents of backstage realities. It is significant to the purposes of the study to identify those. Possible explanations for this phenomenon is proposed as well.

The chapter ends with an account of the students' orientation toward their future role as practitioners, and the influence of their experiences with backstage realities upon this orientation.

EXPERIENCES WITH BACKSTAGE REALITIES

A recurrent theme of many incidents of backstage realities in the clinical laboratory experience was "Some people do not care." The students were generally shocked and disappointed when they discovered that some professionals lacked a sense of committment to the patients or a devotion to duty. They were particularly aghast when they suspected that a nurse or doctor was less than conscientious

in the performance of technical skills.

> Student to researcher: 'I really get confused when the staff tells you to do something and you have been taught it's wrong. I mean, you're just a student and you don't feel right telling her she's wrong. Like today when the nurse went with me to give an I.M. She didn't even find the site, she just pointed at the hip and said, 'Give it there.' I told her I needed the practice and I wanted to find the site just so's she wouldn't be offended. But can you imagine? She would have given it without checking the site first.'

All the students were surprised to discover that some nurses have a carefree attitude about medications and that the administration of medications was not perceived by some of the staff to be the terrifying and serious task that the students believed it to be.

> Student to researcher: 'My patient needed something for pain. He didn't have much pain but the only order left was for 50 or 75 mg. of Demerol. The nurse said, 'Never mind. Give him the Demerol. It feels good.' I gave it to him but I didn't like it.'

> Dr. X ordered one dosage of aminophylline for Mrs. Y (a patient). Dr. Z ordered another dosage of the same drug without being aware of the previous order. The student asked the nurse which order should be followed. The nurse replied, 'Oh, it doesn't really matter. You've got a doctor's order. Choose the last one.' The student said, 'Can you believe it? She didn't even care.'

A few students witnessed incidents in which the person perceived to be apathetic about his/her work was a physician. These students were incredulous that such physicians existed.

> X (a student) cared for Mrs. Y (a patient) who had undergone a radical mastectomy. Mrs. Y told X that she had seem Dr. Z five months ago because she had spotted a breat lump during her regular breast self-examination. Dr. Z had apparently ignored it, saying he would watch it. Five months later, he diagnosed a malignancy.
>
> X spoke about this situation to her instructor (A). 'I don't understand. How could he be allowed to get away with that? That was criminal. Just because he didn't bother sending her for tests, she might lose her life. How can he get away with it? I never thought a doctor could do something like that.' A replied, 'Well, just as there are all sorts of garage mechanics to fix your car, there are all sorts of doctors. Personally, I choose my garage mechanic very carefully.'

One aspect of nursing care in which students often perceived the unit staff to be uncaring was the psychosocial. Only three incidents were observed during the course of the study which revealed that some nurses do not regard the psychosocial aspects of nursing to be significant. However, most of the students were adamant that this area of nursing was neglected by staff nurses. Frequently, they attempted to demonstrate to the staff that this aspect of patient care was worthy of consideration.

> X (a student) charted a page of physical assessment on her patient, a woman who had essentially recovered from surgery and was about to be discharged. I asked X how her charting might change if she was assigned eight instead of one patient. X replied, 'Well, there's a lot in here. I could leave out. Like I don't really have to chart that she has no cyanosis 'blueing of the skin caused by hypoxia) I guess ... I guess I could leave out most of it. But I wouldn't touch the emotional part.' (The 'emotional part' was three sentences relating to the patient's eagerness to be discharted and her satisfaction with the hospital stay). I asked X 'Why?' She answered, 'Well, the staff don't very often chart things like that. Some of them graduated quite a while ago. We know how important the psychological part is but they don't. So I always include it to remind the staff that it is very important.'

> Student to researcher: 'Sometimes you see nurses who avoid dying patients.' I said, 'You do?' X replied, 'Well, I haven't really seen any but I've read about it. The nurses who avoid them (dying patients) are afraid of their own inadequacies. We have been taught about that so we know how to talk to dying patients.' I asked X 'have you talked to many dying patients?' X replied, 'One or two. They weren't actually dying. They just thought they might die or it looked like they might. It wasn't very different from talking to ordinary patients.'

The students frequently pointed to the patients charts as indications that the staff did not always care about their nursing functions. Particularly upsetting to them, perhaps because their instructors stressed that they "should know everything in the patient's chart," was the evidence that some nurses did not know or seem to care about charting or the information contained in a chart.

> X (a student) showed Y (a staff nurse) that the patient's X-Ray report had revealed a tumor in an area which differed from that identified on the admitting diagnosis. The patient was scheduled for surgery to remove the tumor the next morning. Y studied the report in the chart and said, 'Humm. It does say that, doesn't it. Oh, well.' X asked Y what would be done about this incident. Y replied, 'Oh nothing. Someone will see it before he goes into surgery.'
>
> X said to me later, 'I'm sure not impressed, that's for sure. She didn't even know it was on the chart and she didn't seem to care. I'm thinking ... I wonder how many times they (the staff) would not even see something like that on the chart. It's really frightening.

Closely associated with the "Some people don't care" realities discovered by the students in the study were those which may be described as "Some people are incompetent."

The students defined incompetence in some unique ways. For example, they were preoccupied with attaining proficiency in certain technical skills and tended to memorize these step-by-step. They generally regarded procedures to be unmodifiable and became uneasy when they observed the staff nurses employing short cuts or modifying the procedure.

> X (a student) was preparing an I.M. injection. Y (a staff nurse) was supervising her. Y said, 'What are you doing?' X answered, 'I'm going to withdraw the demerol and atropine into two syringes. That's the way they taught us.' Y said, 'Well, I don't know about that. It seems kind of crazy. We put it all in one needle. Don't bother with that nonsense.'
>
> X said to me later, 'I go along with them if I can't prove it's dangerous but I hate it. I always feel like I'm doing something not quite right. Not totally safe. The teacher would be mad if she knew I'd done it.'

The instructors frequently told students, who experienced a situation similar to the preceding incident, that it was "the application of the principle" which was the prevailing concern.

> Instructor to student: 'As long as it's not going to hurt the patient and you can see it's an application of the principle, you

> can do it (a procedure) the way the nurse suggested. You can't fight everything, you know.'

The students did not usually appear to recognize applications of principles in forms other than the ones they had learned in the program. They often seemed to equate modifications to procedures as a loss of structure. They craved structure because it defined the behavioral expectations in a specific situation and provided a sense of certainty.

> X (a student) could not find a graduate cylinder in which to measure the patient's urine. Y (a staff nurse) indicated that a possible alternative would be to use another patient's equipment. X said, 'Is that legal here?' Y nodded. X said 'I don't know. It sounds wrong to me.' Y asked, 'Why? What's wrong with it? You are just measuring the urine, not taking a sample. You'll wash your hands before and after. So what's wrong?' X replied, 'I'm not sure exactly but we've always been taught just to use the patient's equipment. No one else's. I don't know how this fits in this case but it seems all wrong. I don't think I could do it and feel all right about it.'

Another definition of incompetence was "making mistakes." There were only a few such incidents in the study but each were characterized by the following: (1) the student believed the error to be morally wrong, (2) the student believed the error to be preventable and (3) the student expressed the view that it was a positive experience to learn that nurses and other professionals do make mistakes at times.

> Student to researcher: 'That nurse gave a patient the wrong medication yesterday. I just knew she was going to make a med error one day. She's so casual about them. I don't even think she checks the bottle with the chart. I can see absolutely no reason for making medication errors if you just check and check and check again. You know what though? It was kind of nice knowing that we (students) aren't the only ones who make mistakes. Even though it's a little discouraging to think you'll still be making them when you graduate.'

Another category of backstage realities discovered by the

students was "Doctors have more power than nurses." It is noteworthy, however, that this issue was a central one on the unit; it culminated in the resignation of several senior nursing staff members in the hospital shortly after the completion of the study. The students were virtually unaware of the paternalism which many physicians demonstrated in my observations. They interpreted "power" to mean that the staff nurses consulted the physicians for what the students perceived to be minor decisions and that the physician had the ultimate say.

> Student to researcher: 'It seems as if the nurses here call the doctor for every little thing. They (the doctors) must get annoyed, being called so often. I think the nurses could decide some things on their own but they seem afraid to do something that will get anyone mad. I guess the doctor is the boss and they want to be sure he would approve of the decision.'

There were notable differences in the reactions of students to backstage realities depending whether or not they had previous work experience in nursing. Those who had worked before their admission to the program or during the program, on weekends, tended to be less shocked. They had generally encountered these realities in the work field beforehand and had learned to accept that some of them existed.

> Student to researcher: 'I've learned that some shortcuts are necessary, especially when I work weekends. Like medications. I never check them four times like they teach you here. You have to have faith in yourself that you can check it once and maybe twice and not make mistakes. When you have the numbers of patients I do at work, you don't have the time to check and re-check.'

These students were also more aware of the budgetary and personnel constraints of hospital nursing. However, all the students, including those with work experience were disturbed when they

discovered someone they perceived to be incompetent or uncaring.

> When I was an L.P.N., I met nurses who didn't care but the R.N.'s seemed to know so much and I looked up to them. Soon I'm going to be an R.N. and I find that they are no different. Some of them don't care about nursing either. Who am I going to look up to now?

Generally, the students believed that these discoveries could not be generalized to include all nurses, all physicians and so forth. They believed them to represent a minority. The implication that "there are some bad apples in every barrel" was present in most students' emotional reaction to the backstage realities.

> Two students (X and Y) went to ICU to view a telemetry tape on X's patient. (Telemetry is a continuous monitoring of cardiac rhythyms in a central base. The patient was on the unit but his heart rate and rhythm appeared on a screen in ICU.) They found Z (a staff nurse) talking on the phone. She was the only nurse in the unit as the others had gone for supper. X observed that her patient's rate was 0 and the screen showed a flat line. She tried to attract Z's attention and Z motioned to her that she would talk to X and Y after she completed her telephone conversation. When Z was finished, she said, 'Now, how can I help you?' X pointed to the patient's screen. Z replied, 'Oh that's nothing. Was he okay when you left him?' X nodded. Z said, 'Oh well then. His batteries are probably just weak or dead. You'll have to change them.' Y asked, 'Shouldn't an alarm have gone off when it went flat?' Z answered, 'Oh, I shut the alarms off. They go off every time a lead (the electrode leads) falls off or a battery gets weak. We'd never get any work done. We watch it (the screen). If it's flat, we ask a nurse on the unit to check it.' Y said to me later, 'I'm really appalled. That nurse didn't even realize his (the patient's) ERG was flat. What if he had arrested?' I asked Y if she thought this nurse was typical of nurses in ICU. She replied, 'Goodness no. You have to be very good to be an ICU nurse. She could have been someone that just helps at suppers--a float (a nurse who is assigned to any unit which is short of staff) maybe ICU nurses would never turn off the alarms. She's just an example of the dolts you see sometimes who have managed to graduate.'

In the preceding discussion of the students' back region discoveries, the examples chosen were representative of those discoveries made with the greatest frequency. Although many more

examples could have been chosen, it is noteworthy that less than one third of the fieldnotes are accounts of students experiencing professional-bureaucratic work conflict because of something which they observed.

The discovery of back region reality did not tend to be the "upending experience" which Schein describes as common in such an experience.[1] Usually, it did not "dramatically and unequivocably upset or disconfirm"[2] a major assumption that the student had about nursing or the role of others in the clinical area. The students were angry, disgusted and shocked at these discoveries but usually these emotions were directed at the individuals involved. The incidents were generally thought to be atypical of the work subculture and no assumptions were made that these incidents were significant in the students' definition of his/her future role as a practitioner. A notable exception was the three students who witnessed a surgical mishap. The discovery that physicians are not infallible and that nurses sometimes participate in a cover-up of a physician's mistake was particularly traumatic for these students.

> Students to researcher, after witnessing an operation in which the scalpel 'slipped': 'I don't know whether I'll ever trust a surgeon again. I know I'd never have surgery unless I was dying. What really killed me was that I knew and everyone else knew that he had slipped and cut off the guy's areolar ring--Well, I didn't know until he said, 'Whoops. I've cut off the areolar ring'--anyway, he had to graft it back on and everyone just pretended it didn't happen. They didn't tell the nurses in the recovery room and he told the patient that the surgery was uneventful. If that graft doesn't take, the guy (the patient) is in for big trouble. The whole thing makes me very wary of surgeons. If I had surgery, I don't think I'd believe the doctor if he said everything had gone okay.'

It is significant, however, that these students recognized the implications of the discovery only as it affected patients and

their families. They did not consider or foresee the conflict this situation would engender if they, as staff nurses, were required to convey to patients that their surgeons were competent. They did not envision that they might ever feel compelled to "cover-up" a physician's mistake in order to manage the image that patients have of the physician's competence.

UNRECOGNIZED REALITIES

It occurred to me during the beginning weeks of the study that the students were not generally observant about the back region of nursing. Whenever incidents occurred, seemingly 'right under their noses,' they frequently caught only partial glimpses of the backstage reality or did not pay attention to the occurrence. The ability to identify these cues and recognize the backstage realities was, of course, individual. Some students because of previous experiences or personal attributes, were more perceptive than others in their interactions with staff, physicians and other professionals in the clinical area.

At the conclusion of the study, it is apparent that the students were largely unaware of backstage realities because they generally did not have access to backstage regions and because they were largely preoccupied with fulfilling the expectations they believed to be associated with the student role.

The students in the study discovered several backstage realities during their interactions with the unit staff, physicians, other health-related professionals and their instructors. They did not, however, experience specific incidents of backstage realities in

their interactions with patients or the patients' visitors. Their interactions with the visitors were few and did not achieve a depth which warranted the discovery of a back region. Although some of the patients gave the students cues, the students were generally unaware of image management or backstage reality among patients.

> Mr. X (a patient) made several lewd comments about Y's (a student) anatomy. He made several demands for Y to 'fetch' magazines, his shaver and drinks. At one point, he said, 'Get your little ass over here and rub my back.' When Y asked why he had addressed her in that way, he answered 'You're supposed to do what I ask, you know. That's why you went into nursing.'
>
> Y said later that she felt that Mr. X was concerned about his future. 'You couldn't blame him. I know he treated me like a slave but he didn't really mean it. He's just angry at being here.'

The instructors frequently implied in conference with the students that patients' behavioral aberrations were merely a matter of the nurses' definition of the situation. The students, who had worked as L.P.N.'s or R.P.N.'s before entering the program, were skeptical about this presumption. However, the other students believed this view to be an accurate portrayal of the situation.

> Instructor to students in conference: 'You may have noticed that in Nursing '81 (a nursing journal) they often had articles ... I think its called 'My Most Difficult Patient' or something like that. They usually tell about some patient who was difficult to handle. Have you ever noticed that at the end of these stories it always turns out that it was the nurse who had the problem, not the patient? It is very true that we often label patients as demanding or whatever but it really is our problem. We should ask--'What are we doing or not doing that is causing this demanding behavior?''

Although I observed several incidences when a student did not recognize backstage realities, only a few of these could be attributed to the student's lack of clinical knowledge. A lack of medical knowledge and clinical inexperience did account, however, for

some incidences which involved physicians.

Three students were present when a physician made a "mistake" in the operating room. In each case, the student did not understand the anatomical and surgical terminology enough to comprehend that a mistake had been made. They learned of it only incidentally, after the surgery, and the staff nurses avoided discussing these incidents in any detail with them.

> X (a student) had observed a surgeon palpate a thrombus (clot) in a major artery, without first clamping the artery. X presumed this was part of the normal surgical procedure. Soon after the surgery, the patient had a severe stroke and her circulation to her legs and kidneys were impaired. X overheard two nurses in ICU say the doctor was a 'butcher' and he had 'done it again.' X cared for the patient in ICU. The nurses never discussed their opinions about the surgery or the surgeon with X. When X asked one nurse why the patient had become so ill, the nurse replied, 'Oh, little bits of clot went all over her body and obstructed her circulation. It was a complication of surgery.' Another nurse, several feet away, said softly to herself, 'Yeah. A complication of the surgeon.' Several days later X indicated to the nurse that she suspected that the palpation of the artery had resulted in the patient's condition. She recounted, 'I knew they didn't want to talk about it, just from their manner I just knew.' When the patient died, X said to me, 'Surely one of the nurses in the operating room will say something. Or the anaesthetist. Surely they will. Just because the lady was old and had no relatives here ... surely they wouldn't let her die without exposing that doctor.'

Students remained largely unaware of the fact that hospital care does not always cure patients; it can, in fact, make them more ill. Perhaps this occurred because they lacked the experience and/or knowledge to evaluate a patient's medical treatment. However, it is likely that students were often unaware of their patient's progression because of their clinical schedule. One student, a former L.P.N., said that it was her observation that students in the program experience difficulty viewing the patient as having had a past or having a future; the present is paramount.

> I really feel sorry for these kids. They come from a completely different hospital and they are supposed to know everything about this one. And they never get to experience the bonding with patients you get when you're working. They come in, look after someone and then never see them again. When you work, they are your patients and you get to see them improve day by day. You see them go home. As a student, you don't get that feeling of satisfaction.

A major reason that students overlooked or ignored backstage realities was that they were extremely conscious of the limitations and expectations of the "guest" role on the unit.

Students did not expect to make decisions about the plan of care or to function as a member of the unit team. They were fully aware of their status as "guests" and respected the staff's territorial rights with patients. Consequently, whenever the staff discussed a patient's plan of care, students frequently assumed they were not included in the discussion and did not listen. Many backstage realities were revealed in these discussions.

Students were given few opportunities to interact with visitors, doctors or other professionals because of their clinical schedule and because these individuals tended to seek information from the staff. Because students rarely knew a great deal about the unit's functioning and because they believed they had no right to participate in the staff's relationship with visitors, physicians and professionals, they tended to avoid interactions with these persons. Consequently, students remained essentially unaware of the backstage realities presented by these individuals.

> Dr. X interrupted the staff nurse's discussion of the patient's circulatory status and said, 'Now, hold on here. Who's the doctor around here? You or I?' When I asked Y (the student) about her reaction to this, she replied, 'I wasn't really listening. If it doesn't concern me, I don't usually listen.. I was busy thinking about the exam on Monday.'

The students were particularly "unobservant" about backstage realities pertaining to the distribution of power in the work setting.

Students who witnessed the power struggle did not recognize it for what it was. This was due, in part, to their assumption that doctors have certain rights inherent in their position.

> Dr. X wrote on the chart, 'You've had two days to get that sage pump and I won't stand for it any longer. I demand that it is here TOMORROW. You've had long enough.' Y (a student) read this and said to me, 'Poor man. He's trying to do his best for the patient and this is putting a halt to everything.' Both Y and I knew that Dr. X had been told that every sage pump in the hospital was currently in use and that it would take two days to get one for this patient. Alternatives had been suggested but Dr. X had insisted upon this particular pump.

One explanation of the students' ignorance of the power struggle between nurses and some physicians on the unit was that most of this was hidden from the students' view. They were not given access to this inside "secret." Nurses and instructors did not discuss with the students the underlying message of administrative policies which controlled the nurses' independence and decision-making powers.

> Staff nurse to researcher: 'We've been doing physical assessments for some time now. We're getting pretty good at it. But now the doctors have issued a memo saying that our charting on it is too lengthy and they want it shortened because it is too time consuming for them to read. You know what that means. They don't like us being in their territory and they are going to force us to give it up.'

ORIENTATION TO THE FUTURE

The students in the study viewed their future role as practitioners in highly abstract terms. It is noteworthy however, that as the students became closer to their graduate date, they became less abstract.

Without exception, the students expressed a desire to be able to give emotional care to their patients. Many suggested it was the only inherently rewarding aspect of nursing.

> Student to researcher: 'The thing I like to do best is to talk to patients. I'm willing to put up with the skills you have to do; all the procedures. But if I don't get to talk to them because I'm so busy doing technical things, I'll quit.'

The instructors reinforced this view at times:

> Instructor to students: 'When your patient goes home, he's not going to remember what kind of needle you gave or how you adjusted the I.V. He's going to remember what kind of person you are. How kind you were. How you talked to him.'

Technical proficiency and organizational skills were also mentioned as goals of many of the students. Most were frustrated, some embarassed, that they were graduating without having experience in many technical skills and having more than two patients.

> Student to researcher: 'I feel sorry for any hospital that hires me. They're going to have to train me for a long time before I'm any good. Sure I've got the theory. But I've never even seen a catherization yet.'

> Student to researcher: 'I'll have trouble at first, organizing things for eight patients instead of two. It'll take me quite awhile and I'm scared that I'll never know how.'

Most students believed that technical proficiency and organizational skills would be achieved with "practice."

Several students looked forward to "teaching staff nurses how to chart properly" and how to "write nursing care plans." Most students did not predict a time restriction which would limit their ability to write extensively in the patient's chart or in nursing care plans.

Only a few students articulated any concerns about the transition from student to staff nurse: the rest thought that

achieving their freedom from the student role would be "glorious."

> Student to researcher: 'I think I'm going to miss being a student sometimes. Even though that's hard to believe. I know, as a student, I have my instructor. I also don't have to take the total rap if I make a mistake. It'll be scary when I can't rely on those things.'

Few students indicated they would miss their instructors upon graduation. Several stated that they knew they could "always ask a colleague" if they needed information or assistance.

Most students believed that their relationship with staff nurses as colleagues would be similar to their relationship with their classmates. They expected to feel secure in that new relationship, almost immediately upon employment.

The students foresaw few incidents of professional-bureaucratic work conflict in their work as staff nurses. They believed that most of these would be attributed to one or two "bad apples". They predicted that they would manage this conflict by "reasoning with" the individuals or accepting the situation.

This concept of avoiding confrontation was constantly reinforced in their experience as "guests" in the clinical area, particularly by their instructors.

> X (a student) was angry at Y (a staff nurse) who interrupted her every few minutes to suggest something or question X about her care. X consulted Z (the instructor). Z cautioned X, 'Don't bother about her. If you need anything at all, come and get me, not her. It's best to avoid her altogether. If she comes in a lot, I'll stay with you and she won't bother you.'

Many students indicated they would not continue to work on a unit which tolerated "sloppy" nursing care or "shortcuts."

> Student to researcher: 'If I don't like it where I go, I'll quit. If they sit in the nurse's room talking and their patients need them, I'll quit. I can just see my work record. Four months here. Four months there.'

In general, the students compared their future role to the student role and believed that being a staff nurse would be infinitely more rewarding and less stressful. As one student explained:

> No more evaluations. No more tests. No more teachers. Give me reality shock. It'll be a snap compared to what this (the program) has been like.

Several of the students with previous nursing experience were planning to return to the agency where they had worked prior to the program. They did not predict any conflicts which might arise because the staff of that agency had known them as functioning in a different role.

It was particularly gratifying to all the students to look forward to experiencing a continuity in their patient care.

> Student to researcher: 'When you're a student you never get the satisfaction of seeing anyone get better or going home. You tend not to get too attached to patients because you just have them for one or two days. I'm looking forward to <u>really</u> establishing a relationship with a patient.'

It is extremely significant that four of the students in the study did not plan to nurse upon graduation (two wanted to be flight attendants, one a clown and the other was uncertain). Approximately a third of the sample stated they wished to work in a psychiatric or extended care setting. These areas were perceived as "unstressful" and "very rewarding" because they focus on the psychosocial needs of patients. Over half of the students said they hoped to attend the university nursing program in the future; most of these wanted to eventually become nursing instructors. It was fascinating that these students viewed the nursing instructor role as one which evoked a great deal of respect. They spoke of the great deal of "power" associated with the role.

In general, it can be said that the students experiences with backstage realities in the clinical area do not appear to have had much impact on the students' orientation toward their future role as practitioners. They remain highly idealistic. Unlike the medical students in Becker's study, they are not filled with "informed idealism"[3] which tells them what to expect and to fear in nursing practice.

This is evidenced in their apparent lack of awareness of backstage realities and the implications of these to them as practitioners. Another evidence of their idealism was their long list of statements which began, "I'll never ..."

> Student to researcher: 'A student failed last year because she let an I.V. run dry. I'd never let that happen. Never.'
>
> Student to researcher: 'I'd never give up talking to patients. I might make the bath a little shorter but I always take time to talk.'
>
> Student to researcher: 'I'm never going to make a medication error. I'm going to copy down all the information about all the drugs in a little book and look it up before I give it.'

FOOTNOTES

[1]E. Schein, "The First Job Dilemma," Psychology Today, 1:10 (March 1968), p. 25.

[2]Ibid., p. 26.

[3]Becker et al., op. cit., p. 425.

CHAPTER VI

SUMMARY AND CONCLUSIONS

The study is an ethnographic analysis of the experience of 38 senior diploma nursing students in the clinical area. By means of observing, listening to and interviewing individuals on a specific unit, it was determined that these nursing students saw only partial glimpses of or were unaware of the backstage realities, or things that go on behind the work scene, which might lead to professional-bureaucratic work conflict. There was, of course, marked variation among students in the degree to which these were recognized and acknowledged. Students with previous work experience demonstrated that a certain amount of learning had taken place as a result of prior upending experiences and they were better able than their classmates to read and respond to environmental cues and clues.

The emotional reaction of students, who witnessed backstaged realities, was generally shock and/or anger particularly in incidents involving physicians, but most students were unable to predict the far-reaching implications of the incidents in their future role as practitioners.

It is proposed by this researcher that the students' perspectives toward their futures were largely unaffected by their experiences with backstage realities because they were preoccupied with fulfilling what they perceived to be the expectations of the student role and because others in the clinical area managed to

portray an image to the students which denied them access to the back region of hospital nursing. Students in professional schools are encouraged by their educators to become involved in only matters which are relevant to getting through the program.[1] Toward the end of the program, this preoccupation with school becomes unnecessary as the student recognizes that s/he will graduate and that their participation in school is ending.[2] The students in this study did not express a certainty that they would graduate (Indeed, as many had predicted, one of their classmates was asked to leave the program in the last month of the diploma year), nor did they indicate a readiness to graduate. To be sure, they were eager to graduate but they appeared particularly unprepared to greet the realities which would confront them.

The students tended to fix their expectations of the work role according to the perspectives they had acquired in the program. They chose to work mainly in areas in which they perceived they could excel; these areas tended to be perceived as unstressful and slow-paced. There was a definite affinity for areas in which the students believed the psychosocial aspects of patient care are as important, if not more important, than the technical aspects.

Professional schools attempt to mold the entering idealism of students to become more professional and specific.[3] There appears, however, to be a great disparity between the perspective the students acquired in the school of nursing and the immediate perspectives enforced by the practice setting. Pedagogically speaking, this is a disastrous situation; it impedes the transformation from student to practitioner.

It appears as if the program has produced "professional students" rather than professional nurses. They are eager to learn and many plan to continue learning. However, many are reluctant to accept responsibility and avoid making decisions.

A senior nurse on the unit commented that the graduates of the program often experienced difficulties in establishing priorities upon graduation. This is hardly surprising considering that their only experience in establishing priorities has generally been, "what will impress the instructor most?"

The autonomy of the students in the study was hindered by the structure of the clinical experience and the image management by others in the unit. The faculty reinforced dependency by emphasizing the ultimate calamity--making a mistake. The implication that if a student made a mistake someone would die, interfered with the students' desire to act independently. There was also an assumption by students that there is only one right way to do things; any other way is defined as a "mistake" which might endanger the patient's safety.

The authoritarian nature of the instructor-student relationship interfered with the students' desire to ask questions and caused many students to devote their efforts to winning the instructor's approval. The instructors reinforced the ideology that students should do all things perfectly, in part because of their own tenuous status as "guests" in the staff's territory.

Confrontation by students of faculty was strongly suppressed. The threat of the clinical evaluation enforces this. The risk is too great. Confrontation of staff and physicians is also suppressed.

The faculty cannot risk the staff or physician's retaliation; they are after all, just "guests".

The students in the study had learned how "to play the game" with their instructors while knowing that their attitudes as well as their performance were under scrutiny. It is doubtful, however, that the rules of this game have applicability in the work setting and one must question whether students experience difficulty "unlearning" this method of image management when they graduate.

Williamson states that nursing faculty tend to be surrogate mothers,[4] rather than a consultant or a co-ordinator. It would appear that both the faculty and many of the staff have adopted this role toward students. One can only surmise what will happen to these students when they leave "mother's nest" and are expected to fly on their own.

The students tended to believe that if they "could only stick it out to graduation" they would be independent and self-sufficient. They believed they would experience a new-found freedom and autonomy when they were no longer under the scrutiny of authoritarian faculty and staff members. Unfortunately, it is a reality that the nursing profession expects new graduates to take full responsibility for their actions and yet remain subservient.[5] The reality may prove to be too distasteful to some of the students in the study.

It is particularly upsetting that the students in the study appeared to have such low self-esteems. The transition from student to staff nurse requires that the student have a high self-esteem for, in order to accept the values of others and attempt to influence others towards change, she/he must value him/herself highly.[6]

An additional concern is that the faculty and the staff encouraged the students to strive toward their ideal of a competent nurse. This ignores the fact that each student is an individual. As the philosophy of the community college is that each student has unique learning needs, this does not appear to be in accordance with the stated aims of the school of nursing.

IMPLICATIONS OF FINDINGS

It is important to point out that student responses and beliefs are treated in this study as data that describe this clinical laboratory experience. They tell what patterns of social experiences exist and contribute to inquiry about the determinants of these patterns (why they occur) but are not direct indicators of what behavior patterns should be.

The true benefits of this study would be realized if a follow-up study investigated the actual experiences of these students as graduates. Until this time, the implications of the findings are limited to informed predictions. It appears likely that many of these students will be unprepared to manage the reality shock which awaits them. Because they have been nurtured in their dependency as students, it is possible that they will mourn the loss of their instructors upon graduation. Many may, as they currently plan to, become students again. It is highly probable that the students will have to learn to find the rewards inherent in the technical aspects of nursing; their total concern with psychosocial aspects of patient care is unrealistic in areas where nurses are assigned 10 to 12 patients and expected to perform mainly technical skills.

It is a reality that, in most clinical areas, a nurse is distinguished by the skill level of the tasks s/he performs rather than by how close a relationship s/he has with patients.

It would appear from the findings of the study that the students are given little opportunity to discuss the realities that exist in the work setting. The subjugation of the nurse to physicians, for example, is rarely alluded to. Nursing educators must be prepared to admit that these realities exist before they can teach students to manage them. Admitting that they exist does not mean that the practices are accepted but it is the first step in preparing students for the workworld.

The students in the study may have recognized and had more access to backstage realities if their relationship with the staff had been more collegial. The structure of the clinical laboratory experience (the short rotations, the presence of the instructor) does not predispose to this collegial relationship. As long as students remain "outsiders" they will not be able to view the back region of nursing.

The study poses some question about the program's sanctioning of student autonomy, questioning and resistance. The rating system of clinical performance, for example, raises some concerns. The purposes of the study do not include assessing the effectiveness of the evaluation tool. However, as it has a significant effect on student behavior, it should be examined. Research indicates that there are both disadvantages and advantages to the grading system of clinical performance, in comparison with the pass-fail system.[7] The findings of this study indicated that the school of nursing should

determine the effectiveness of their present method of evaluation for their program and their students. There was frequent evidence that the faculty and staff members did not always behave with students as they professed to believe. A dramatic example of this was the questioning techniques employed by the instructors. The instructors believed their questioning stimulated students to think; the findings of the study suggest, however, that it sometimes hindered student thought process and their performance. These questioning techniques need to be evaluated as to their effectiveness in fostering critical thought.

In theory, the program appears to stress self-direction. Instructors certainly emphasized to the students that they were responsible for attaining required information. This appears, however, to be a double message. Students are told to be independent, to be self-directed in their learning but never make a mistake. The impact of this message is to increase the anxiety of students in a clinical laboratory experience. Rather than emphasizing the potential for serious error in nursing, perhaps instructors should teach students where the margins of safety are wide and where they are narrow in patient care. They could encourage and assist students to discriminate between these intelligently.

Instructors must also consider that perhaps perfection is an unrealistic expectation in the performance of new skills or the application of knowledge. This does not imply that patient safety should be compromised; merely, that we should examine how realistic our expectations are. For example, is it realistic to expect that a student be able to discuss the action of a duiretic on the convuluted

tubules of the kidney in order to administer that duiretic?

The instructor-student relationship did not appear to be entirely positive or satisfying to either individual. The instructor spoke of their frustrations and feelings of being overwhelmed by their responsibilities to "help" students, some of whom would fail in spite of their efforts. The students mistrusted and resented their instructors. It would appear that this relationship will continue to be unproductive unless students are able to voice their needs and make decisions without fear of reprisal. Assertiveness training may assist students in this regard. As well, instructors must recognize their role in enforcing student dependency and confront this realization.

It is also highly possible that many of these students will find their present methods of conflict management unsatisfactory and will learn new ones or leave nursing.

Confrontation is a necessary and a positive means of managing a conflict situation. The students' role models (instructors and staff) generally preferred to avoid confrontation and to ignore or close their eyes to a great deal of what was seen. These individuals must explore the example and role model she/he presents for students.

It is obvious that the students were uncomfortable in their interactions with physicians and were generally reluctant to speak to them. As the physician-nurse relationship is an integral aspect of nursing, the program may wish to include physicians as lecturers or demonstrators in clinical laboratory experiences. As well, faculty could encourage students to interact with their patient's physicians.

The instructors were concerned about their student ratios in

the clinical area. They pointed to their inability to observe all the students as an indication that smaller ratios were called for. However, one must question why these instructors were supervising students so closely when they would be practitioners in less than a month. It appears equally ludicrous that students in their last month of the program were required to research their patients and write nursing care plans in order that the instructor be able to evaluate their ability to plan and evaluate patient care. This is not a requirement of the work setting and conveyed to students an implicit message: We, your teachers, do not believe you are ready to graduate. The implications of this are mind-boggling.

CONCLUSION

The study has indicated that Dr. Marlene Kramer was apparently correct. Nursing students are protected from many backstage realities in nursing and do not experience reality shock before graduation. However, this study would have to be repeated using samples of students from other diploma schools of nursing and a greater sample of instructors before the findings can be generalized to nursing programs other than the one studied.

The study poses some interesting questions for further research. What kind of questions stimulate creative and critical thinking in the clinical laboratory experience? What attributes should a clinical instructor possess in order to present students with a role model which inspires them to think and act autonomously? Do students experience backstage realities more if the instructor is not present on the unit? If the duration of the clinical experience is

more continuous?

The study provided me with a great deal of incidental learning, of benefit to me as a nursing instructor. For example, because I asked questions in order to understand the student's experience, I asked questions which probed a student's response. Students frequently credited me with teaching them a great deal throughout the study; I did not provide any information. The questions merely stimulated the student to pose other questions and to reach her/his own conclusions. I also gained a healthy respect for the student grapevine; the information conveyed in this manner is positively astounding.

The study has contributed to the investigation and analysis of nursing education's role in the production of reality shock among graduates. If nursing education is to contribute to the management of the problem of attrition in the nursing profession, it must first acknowledge its contribution and then be prepared to honestly evaluate the values it transmits to students. Nursing education will not be required to sacrifice its standards to prepare nurses more realistically for practice.

FOOTNOTES

[1]Ibid., p. 423.

[2]Ibid., p. 432.

[3]Ibid., p. 433.

[4]Cohen, op. cit., p. 165.

[5]Ibid., p. 160.

[6]Kramer and Schmalenberg, op. cit., p. 167.

[7]E. Gould, "Satisfactory-Unsatisfactory Grading in the Evaluation of Clinical Performance in Nursing," Journal of Nursing Education, 17:8 (Oct. 1978), p. 36-46.

BIBLIOGRAPHY

BIBLIOGRAPHY

Books

Anderson, B.E. Nursing Education in Community Junior Colleges, A Four-State Year Experience in the Development of Associate Degree Programs. Philadelphia: J.B. Lippincott, 1966.

Becker, Howard et al. Boys in White. Chicago: University of Chicago Press, 1961.

Bennis, W.G. et al., eds. Interpersonal Dynamics. Homeusod, Illinois: The Dorsey Press, 1968.

Bermosk, Loretta Sue and Corsini, Raymond J., eds. Critical Incidents in Nursing. Philadelphia: W.B. Saunders Co., 1973.

Biddle, Bruce J. and Thomas, Edwin J., eds. Role Theory: Concepts and Research. New York: John Wiley and Sons Inc., 1966.

Brown, E.L. Nursing for the Future. New York: Russell Sage Foundation, 1948.

Bullough, B. and Bullough, V., eds. Expanding Horizons for Nurses. New York: Springer Publishing Co., 1977.

Bush, Mary Ann and Kjervik, Diane K. "The Nurse's Self-Image." Kjervik, Diane and Martinson, Ida, eds. Women in Stress: A Nursing Perspective. New York: Appleton-Century Crofts, 1979.

Carnegie Commission on Higher Education. Continuity and Discontinuity: Higher Education and the Schools. New York: McGraw-Hill Book Co., 1973.

Clark, B.R. The Open Door College: A Case Study. New York: McGraw-Hill Book Co. Inc., 1960.

Clifton, James A. Introduction to Cultural Anthropology. Boston: Houghton Mifflin Company, 1968.

Committee on the Function of Nursing. A Program for the Nursing Profession. New York: Macmillan Co., 1948.

Cushman, M.L. The Governance of Teacher Education. Berkley, McCutchan Publishing Corp., 1977.

Davis, F. et al. The Nursing Profession: Five Sociological Essays. New York: John Wiley and Sons Inc., 1966.

Davis, M. et al., eds. Nurses in Practice: A Perspective On Work Environments. St. Louis, C.V. Mosby Co., 1965.

Deutsch, M. The Resolution of Conflict: Constructive and Destructive Processes. London: Yale University Press, 1973.

Dolan, J.A. Nursing in Society: A Historical Perspective. Philadelphia: W.B. Saunders, 1973.

Filstead, J., ed. Qualitative Methodology: Firsthand Involvement with the Social World. Chicago: Markham Publishing Co., 1970.

Ford, C., ed. Clinical Education for the Allied Health Professions. New York: C.V. Mosby Co., 1978.

Gartner, A. The Preparation of Human Service Professionals. New York: Behavioral Publications Inc., 1976.

Glass, H. et al. Study of the Use of Clinical Facilities by Nursing Students in the Province of Manitoba. Winnipeg, M.A.R.N., 1976.

Glazer, B. and Strauss, A. The Discovery of Grounded Theory. Chicago: Aldine Publishing Co., 1967.

Goffman, E. The Presentation of Self In Everyday Life. New York: Doubleday and Co. Inc., 1959.

Green, J.L. and Stone, J.C. Curriculum Evaluation Theory and Practice. New York: Springer Publishing Co., 1977.

Gross, M.L. The Doctors. New York: Random House, 1966.

Habenstein, R.W. Pathways to Data. Chicago: Aldine Publishing Co., 1970.

Hackman, J.R. and Suttle, J.L. Improving Life at Work. Santa Monica: Goodyear Publishing Co. Inc., 1977.

Hamburg, J. Review of Allied Health Education: 2. Lexington: The University Press of Kentucky, 1972.

Hardy, M. and Conway, M., eds. Role Theory: Perspectives for Health Professionals. New York: Appleton-Century Crofts Inc., 1978.

Heidgerken, L.E. Teaching and Learning in Schools of Nursing. Philadelphia: J.B. Lippincott Co., 1965.

Howe, J.A., ed. Adult Learning: Psychological Research and Applications. Chichester: John Wiley and Sons, 1977.

Infante, M.S. The Clinical Laboratory in Nursing Education. New York: John Wiley and Sons Inc., 1975.

Innis, M.Q., ed. Nursing Education in a Changing Society. Toronto: University of Toronto Press, 1970.

Jaco, E.G., ed. Patients, Physicians and Illness. New York: The Free Press, 1972.

Johnson, J. and Perry, F. Readings in Student Teaching. Dubuque, Iowa: Wm. C. Brown Book Co., 1967.

Kalisch, P.A. and Kalisch, B.J. The Advance of American Nursing. Boston: Little, Brown and Co., 1978.

Kramer, M. Reality Shock. St. Louis: C.V. Mosby Co., 1974.

_____ and Schmalenberg, C. Bicultural Training and New Graduate Role Transformation. Wakefield, Massachusetts: Nursing Resources Inc., 1978.

_____ and _____. Coping with Reality Shock: The Voice of Experience. Wakefield, Massachusetts: Nursing Resources Inc., 1979.

Krause, E.A. The Sociology of Occupations. Boston: Little, Brown and Co., 1976.

Lamb, A. Primary Health Nursing. London: Butler and Tanner Ltd., 1977.

Lambros, C., ed. Anthropology and Education. New York: National Academy of Education, 1978.

Leininger, M. Nursing and Anthropology: Two Worlds to Blend. New York: John Wiley and Sons Inc., 1970.

Litwack, L., Sakata, R. and Wykle, M. Counseling, Evaluation and Student Development in Nursing Education. Philadelphia: W.B. Saunders Co., 1972.

Lynn, K.S., ed. The Professions in America. Boston: Houghton Mifflin Companu, 1965.

McCall, G. and Simmons, J.L., eds. Issues in Participant Observation. Reading: Addison-Wesley Publishing Co., 1969.

Merton, R.K., Reader, G.G. and Kendall, P.L., eds. The Student-Physician. Cambridge, Massachusetts: Harvard University Press, 1957.

Mirin, S.K., ed. Teaching Tomorrow's Nurse: A Nurse Educator Reader. Wakefield, Massachusetts: Nursing Resources Inc., 1980.

Montag, M.L. Evaluation of Graduates of Associate Degree Nursing Programs. New York: Teachers College Press, 1972.

N.L.N. Instructional Innovations: Ideals, Issues, Impediments. New York: N.L.N., 1977.

_____. Twenty-Fifth Annual Report of the National League of Nursing Education. Baltimore: The Williams and Wilkins Co., 1919.

_____. Roles and Relationships in Nursing Education. New York: N.L.N., 1959.

Oleson, V.L. and Whittaker, E.W. The Silent Dialogue. San Francisco: Jossey-Bass Inc., 1968.

Pavalko, R.M., ed. Sociological Perspectives on Occupations. Itasca, Illinois: F.E. Peacock Publishers, Inc., 1971.

Pfefferkorn, B. and Lottman, M. Clinical Education in Nursing. New York: Macmillan Inc., 1932.

Psathas, G. The Student Nurse in the Diploma School of Nursing. New York: Springer Publishing Co. Inc., 1968.

Rasmussen, S., ed. Technical Nursing: Dimensions and Dynamics. Philadelphia: F.A. Davis, 1972.

Rezler, A.G. and Stevens, B.J., eds. The Nurse Evaluator in Education and Service. New York: McGraw-Hill Book Co., 1978.

Ritzer, G. Man and His Work: Conflict and Change. New York: Appleton-Century Crofts, 1972.

Roberts, J.I. and Akinsanya, S.K., eds. Schooling in the Cultural Context. New York: David McKay Co. Inc., 1976.

Roberts, M.M. American Nursing History and Interpretations. New York: Macmillan Inc., 1954.

Schneider, H.L. Evaluation of Nursing Competence. Boston: Little, Brown and Co., 1979.

Schweer, J.E. and Gebbie, K.M. Creative Teaching in Clinical Nursing. Saint Louis: The C.V. Mosby Co., 1976.

Skipper, J.K. and Leonard, Robert C. Social Interaction and Patient Care. Philadelphia: J.P. Lippincott Co., 1965.

Spradley, J.P. and McCurdy, David W. The Cultural Experience: Ethnography in a Complex Society. Chicago: Science Research Associates, Inc., 1972.

Steiner, C. Scripts People Live: Transactional Analysis of Life Scripts. New York: Grove Press Inc., 1974.

Strauss, A. Professions, Work and Careers. New Brunswick, New Jersey: Transaction Books, 1968.

Tikunoff, W.J. et al. Beginning Teacher Evaluation Study--An Ethnographic Study of the Forty Classrooms of the Beginning Teacher Evaluation Study Known Sample. San Francisco: Far West Laboratory for Educational Research and Development, 1975.

White, D.T. Abilities Needed by Teachers of Nursing in Community Colleges. New York: N.L.N., 1961.

Wiedenbach, E. Meeting the Realities in Clinical Teaching. New York: Springer Publishing Co. Inc., 1969.

Williamson, J., ed. Current Perspectives in Nursing Education. St. Louis: C.V. Mosby Co., 1976.

Zeitz, A.N. et al. Associate Degree Nursing. Saint Louis: C.V. Mosby Co., 1969.

Periodicals

Anderson, B.E. "Some Paradoxes in Nursing." Teachers' College Record, 54 (Jan. 1953), 213-6.

Arkava, M.L. "Social Work Practice and Knowledge: An Examination of Their Relationship." Journal of Education for Social Work, 3 (Fall 1967), 5-13.

Barham, V.Z. "Identifying Effective Behaviors of the Nursing Instructors Through Critical Incidents." Nursing Research, 14 (1965), 65-9.

Barr, F. "Are Your Students Positive About Their Experience in the Clinical Area?" Canadian Nurse, 79:9 (Oct. 1980), 48-50.

Becker, Howard. "Interviewing Medical Students." American Journal of Sociology, 62:2 (Sept. 1956), 199-201.

Bell, E.A. "Antidote for Reality Shock." Journal of Nursing Education, 19:4 (April 1980), 4-6.

Besel, L. "The Private and Professional Self." Canadian Nurse, 70:11 (Nov. 1974), 21-3.

Blainey, C.G. "Anxiety in the Undergraduate Medical-Surgical Clinical Student." Journal of Nursing Education, 19:8 (Oct. 1980), 33-6.

Bloom, Samuel W. "The Medical School as a Social System: A Case Study of Faculty-Student Relations." Milbank Memorial Fund Quarterly, 49 (1971), 1-179.

Bradshaw, C.E. "Jack of All Trades--Master of None." Nursing Outlook, 13 (April 1974), 14-15.

Brock, M.A. "Bridging the Gap Between Service and Education." Supervision Nurse, 13 (July 1974), 26-7.

Brodt, D. "Excellence or Obsolescence." Nursing Forum, 9:1 (1970), 19-26.

Brown, Bob Burton and Vicery, Tom Rusk. "The Belief Gap in Teacher Education." The Journal of Teacher Education, XVIII (Winter 1967), 417-21.

Browne, M.N. "Coping with Future Shock: Two Styles of Critical Thinking." Contemporary Education, 49:4 (Summer 1978), 207-10.

Bullough, B. and Bullough, V. "A Career Ladder in Nursing Problems and Prospects." American Journal of Nursing, 71 (1971), 1938-43.

Cass, Dorothy E. "Expectations of the Staff Nurse in Nursing Practice." Nursing Clinics of North America, 3:1 (Mar. 1968), 111-115.

Chafen, Richard. "Human Images: Teaching the Communication of Ethnography." Anthropology and Education Quarterly, 8 (1977), 8-11.

Chaudhari, U.S. "Questioning and Creative Thinking: A Research Perspective." Journal of Creative Behavior, 9:1 (First Quarter 1965), 30-34.

Cicatiello, J. "Expectations of the Associate Degree Graduate: A Director of Nursing's Point of View." Journal of Nursing Education, 13 (April 1974), 22-25.

Collum, W. "Bringing Nurse Education Out of Isolation." Hospitals (June 16, 1980), 195-97.

Conant, L. "Closing the Practice--Theory Gap." Nursing Outlook, 15 (Nov. 1967), 37-39.

Corcoran, S. "Should a Service Setting Be Used as a Learning Laboratory? An Ethnical Question." Nursing Outlook, 25:12 (Dec. 1977), 771-6.

Corwin, R.G., Taves, M.J. and Haas, J.E. "Professional Disillusionment." Nursing Research, 10:3 (1961), 141-44.

Coser, R.L. "Role Distance, Sociological Ambivalence and Transitional Status Systems." The American Journal of Sociology, 72 (1966), 173-87.

Cross, K.P. "Our Changing Students and Their Impact on Colleges: Prospects for a True Learning Society." Phi Delta Kappan, 61 (May 1980), 627-30.

Desbiens, B., Peter, L. and Wigle, M. A Comprehensive Demographic Study of Community College Students." Journal of the Association of Canadian Community Colleges, 2:3 (Autumn 1978), 97-102.

Deutsch, M. "Conflicts: Productive and Destructive." Journal of Social Issues, XXV:1 (1969), 7-41.

Dillon, J.T. "Using Questions to Depress Student Thought." School Review, 87 (Nov. 1978), 50-62.

Dunn, H. "Facing Realities in Nursing Administration Today." American Journal of Nursing, 68:5 (May 1968), 1013-18.

Eisenstadt, S.M. "Reference Group Behavior and Social Integration: An Explorative Study." American Sociological Review, 19 (1954), 175-84.

Erickson, F. "Mere Ethnography: Some Problems in its Use in Educational Practice." Anthropology and Education Quarterly, 10 (1979), 182-187.

Fabayo, A.O. "Nursing and the Community College Movement." Nursing Forum, XIX, 2 (1980), 181-192.

Fienberg, Stephen. "The Collection and Analysis of Ethnographic Data in Educational Research." Anthropology and Education Quarterly, 8 (1977), 50-57.

Fischbach, F.M. "Personal Growth and Learning of Students in an Open-Ended Clinical Experience: A Motivational Philosophy." Journal of Nursing Education, 16:2 (Feb. 1977), 30-33.

Gall, M.D. "The Use of Questions in Teaching." Review of Educational Research, 40:5 (1970), 715-720.

Garrett, A., Manuel, D. and Vincent, C. "Stressful Experiences Identified by Student Nurses." Journal of Nursing Education, 15 (Nov. 1976), 9-21.

Geis, G.L. and Pascal, C.E. "Consequences of Learning." Learning and Development, 27:2 (Oct. 1970), 1-6.

Gilmour, M. et al. "The Disadvantaged Student in Nursing Education." Journal of Nursing Education, 13:4 (Nov. 1974), 2-12.

Gould, E.O. "Satisfactory/Unsatisfactory Grading in the Evaluation of Clinical Performance in Nursing." Journal of Nursing Education, 17:8 (Oct. 1978), 36-47.

Grandjean, B.D., Atken, L.H. and Bonjean, C.K.M. "Professional Autonomy and the Work Satisfaction of the Nursing Educators." Nursing Research, 25:3 (1976), 216-21.

Greenhaus, J. and Badin, I. "Self-esteem, Performance and Satisfaction: Some Tests of Theory." Journal of Applied Psychology, 59 (1974).

Group, T.M. and Roberts, J.T. "Exercising the Ghosts of the Crimea." Nursing Outlook, 22:6 (1974), 368-72.

Guerin, D.H. "Do You Underestimate Your Students? Journal of Nursing Education, 20:4 (April 1981), 17-21.

Gullahorn, J.T. "Measuring Role Conflict." American Journal of Sociology, 61:4 (Jan. 1956), 299-303.

Gwen, J. "The Nurse Education and Professional Socialization: Issues and Problems." Nursing Papers, 7 (Summer 1975), 11-13.

Hales, L.H., Bain, P.T. and Rand, L. "The Pass/Fail Option: The Congruence Between the Rationale for and Student Reasons in Electing." Journal of Educational Research, 66 (1973), 295-8.

Hamner, W.C. and Tosi, H.L. "Relationship of Role Conflict and Role Ambiguity to Job Involvement Measures," Journal of Applied Psychology, 59:4 (1974), 497-499.

Helm, E. and Schwier, M.E. "The General Educator and Education for Nursing." Teachers College Record, 57 (Jan. 1956), 248.

Hipps, O.S. "The Integrated Curriculum: The Emperor is Naked." American Journal of Nursing, 81 (May 1981), 976-80.

Holloran, S.D., Mishkin, B.H. and Hanson, B.L. "Bicultural Training for New Graduates." Nurse Educator, 5:1 (Jan.-Feb. 1980), 8-14.

Hooker, B.C. "The Diploma School of Nursing: An Option in Post-secondary Education." Journal of Nursing Education, 16:3 (March 1977), 36-41.

Hutlemeyer, C. "Managing Your Time." Nursing 81, 11:5 (May 1981), 7-11.

Hymes, D. "Qualitative/Quantitative Research Methodologies in Education: A Linguistic Perspective." Anthropology and Education Quarterly, 8 (1977), 165-175.

Infante, M.S. "Toward Effective and Efficient Use of the Clinical Laboratory." Nurse Educator, 6:1 (Jan.-Feb. 1981), 16-9.

Jacobson, M.D. "Effective and Ineffective Behaviors of Teachers of Nursing As Determined By Their Students." Nursing Research, 15 (1966), 218.

Johnson, J. "The Education/Service Split: Who Loses?" Nursing Outlook, 28:7 (July 1980), 412-415.

Johnson, T.W. and Stinson, E. "Rule Ambiguity, Role Conflict and Satisfaction: Moderating Effects of Individual Differences." Journal of Applied Psychology, 60:3 (Mar. 1964), 329-333.

Jones, S.L. and Jones, P.K. "Nursing Student Definitions of the 'Real' Nurse." Journal of Nursing Education, 16:4 (April 1977), 15-21.

Karlins, M., Kaplan, M. and Stuart, W. "Academic Attitudes and Performance as a Function of Differential Grading Systems: An Evaluation of Princeton's Pass/Fail System." Journal of Experiential Education, 37 (1969), 38-50.

Kleinman, S. "Making Professionals into Persons." Sociology of Work and Occupations, 8:1 (Feb. 1981), 61-87.

Kood, L. "Preparation for Community College Teaching." Journal of Higher Education, 21 (June 1950), 309-17.

Kramer, M. "The New Graduate Speaks." American Journal of Nursing, 66 (Nov. 1966), 2420-2424.

_____ et al. "Effect of Teacher and Situational Variables on Student Achievement." Nursing Research, 17 (Jan.-Feb. 1968), 10-18.

_____ and Schmalenberg, C. "Constructive Feedback." Nursing '77, 77 (Nov. 1977), 101-104.

_____ and _____. "Conflict: The Cutting Edge of Growth." Journal of Nursing Administration (Oct. 1976), 19-25.

Lewis, E. "The Associate Degree Program." American Journal of Nursing, 64 (May 1964), 78-81.

Logsdon, A. "Preparing for Unexpected Responses." Nursing Clinics of North America, 3:1 (March 1968), 143-152.

Martin, H.W. "Education and Service: Division and Unity." Nursing Outlook, 7 (Nov. 1959), 650-653.

Mattia, G.D. and Sharp, S. "Minimum Threshold Requirements at Douglas College." Journal of the Association of Canadian Community Colleges, 3:1 (Spring 1979), 56-66.

Morris, P.B. adn Grassi-Russo, N. "Motives of Beginning Students for Choosing Nursing School." Journal of Nursing Education, 18:5 (May 1979), 34-40.

Murgatroyd, S. "Observing Adult Learning Groups: Procedures and Problems." Studies in Adult Education, 9:2 (Oct. 1977), 177-95.

Mutzebaugh, C. and Dunn, J. "The Teacher as a Reinforcement Machine in the Teaching-Learning Process." Journal of Nursing Education, 15 (Sept. 1976), 27-33.

Overhold, G.E. and Stallings, W.I. "Ethnographic and Experimental Hypotheses." Educational Researcher, 5:8 (1976), 12-14.

Palmer, M.E. and Deck, E.S. "Teaching Assertiveness to Seniors." Nursing Outlook, 29:5 (May 1981), 305-10.

Pearson, B. "Considerations for Student Clinical Assignments." Journal of Nursing Education, 16:4 (April 1977), 3-5.

Prokopec, D. "The Community College: Historical Roots and Purposes." Canadian Vocational Journal, 15 (May 1979), 12-15.

Quann, C.J. "Pass/fail Grading--An Unsuccess Story." College and University, 49 (1974), 230-35.

Rauen, K.C. "The Clinical Instructor as Role Model." Journal of Nursing Education, 8 (Aug. 1974), 33-40.

Reeder, M.K. "Nursing Practice: A Student's Perspective." Nursing Clinics of North America, 3:1 (March 1968), 135-142.

Roberts, M.J. and Powell, C. "The Rape of Geriatrics by Fundamentals Nursing Instructors." Journal of Gerontological Nursing, 4:5 (Sept. Oct. 1978), 35-37.

Roscow, I. "Forms and Functions of Adult Socialization." Social Forces, 44 (1965), 35-45.

Rutherford, R. "What Bothers Staff Nurses." American Journal of Nursing, 67:2 (Feb. 1967), 315-318.

Sanday, P.R. "The Ethnographic Paradigm(s)." Administrative Science Quarterly, 24 (Dec. 1979), 527-538.

Sanders, M.M. "Stressed? Or Burnt Out?" Canadian Nurse, 76:9 (Oct. 1980), 30-3.

Schein, E. "The First Job Dilemma." Psychology Today, 1:10 (March 1968), 27-37.

Shibutani, T. "Reference Groups As Perspectives." American Journal of Sociology, 60:6 (May 1955), 562-69.

Siegel, A.E. "Reference Groups, Membership Groups and Attitude Change." Journal of Abnormal and Social Psychology, 55 (1957),

Simpson, I. "Patterns of Sociolization into Professions: The Case of Student Nurses." Sociological Inquiry, 37 (Winter 1967), 47-54.

Sleeper, R. "Nursing Education in Evolution." New England Journal of Medicine, 271 (1964), 27-30.

Smith, D.M. "Myth and Method in Nursing Practice." American Journal of Nursing, 64 (Feb. 1964), 68-72.

Smith, E.E. "The Effects of Clear and Unclear Role Expectations on Group Productivity and Defensiveness." Journal of Abnormal and Social Psychology, 55 (1957), 213-17.

Stuart-Siddall, S. "Backwoods Nursing." Nurse Educator, VI:3 (May-June 1981), 14-17.

Stubbins, H. "The Profession's Expectations of Undergraduate Education." Social Worker, 35:2 (May 1967), 64-70.

Stuebbe, B. "Student and Faculty Perspectives on the Role of a Nursing Instructor." Journal of Nursing Education, 19:7 (Sept. 1980), 4-9.

Tindall, B.A. "Ethnography and the Hidden Curriculum in Sport." Behavioral and Social Sciences Teacher, 2:2 (1975), 5-18.

Trabue, M.R. "What Traits Should Junior College Teachers Possess?" Junior College Journal, 21 (Nov. 1950), 140-2.

Tropman, E.J. "Agency Constraints Affecting Links Between Practice and Education." Journal of Education for Social Work, 13 (Winter 1977), 8-14.

Turner, R. "Role-Taking, Role Standpoint, and Reference Group Behavior." American Journal of Sociology, 61:4 (Jan. 1956), 316-28.

Vachon, M.L.S. "Care for the Caregiver." Canadian Nurse, 76:9 (Oct. 1980), 28-30.

Varley, B.K. "Social Work Values: Changes in Value Commitments of Students from Admission to M.S.W. Graduation." Journal of Education for Social Work, 4 (Fall 1968), 67-76.

Voight, J.W. "Assessing Clinical Performance: A Model for Competency." Journal of Nursing Education, 18:4 (April 1979), 30-3.

Warnock, F.N. and Baszynski, A. "Student Nurse Plus Continuity of Care Equals Quality Care." Journal of Nursing Education, 16:3 (March 1977), 12-16.

Watson, J. "The Evolution of Nursing Education in the United States: 100 Years of a Profession for Women." Journal of Nursing Education, 16:7 (Sept. 1977), 31-38.

Weber, C. "Pass/fail: Does It Work?" N.A.S.S.P. Bulletin, 58 (1974), 104-6.

Wong, S. "Nurse-teacher Behaviors in the Clinical Field: Apparent Effect on Nursing Students' Learning." Journal of Advanced Nursing, 3 (1978), 369-372.

_____ and Wong, J. "The Effectiveness of Clinical Teaching: A Model for Self-Evaluation." Journal of Advanced Nursing, 5 (1980), 531-37.

Wooley, A.S. "The Long and Tortured History of Clinical Evaluation." Nursing Outlook, 25 (May 1977), 718-720.

Zurcher, L.A. "Learning the Seaman Role in a Total Institution." Sociological Inquiry, 37:1 (1967), 28-98.

Unpublished Sources

Batcher, E. Emotion in the Classroom: A Study of Children's Experience. Ph.D. dissertation, University of Toronto, 1979.

Bryce, R. et al. The Community College in Canada: Present Status/ Future Prospects. Edmonton: University of Alberta, 1971 (Mimeographed).

Griffin, A.E. The Improvement of the Educational Preparation of Instructors in Pre-service Programs in Nursing in Ontario. Ph.D. dissertation, Columbia University, 1963.

Peterson, E.L. The Medium Is the Message: An Ethnographic Analysis of Cultural Learning About Sex-Roles in Secondary Schools. M.Ed. dissertation, University of Manitoba, 1979.

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Appendix A

Nursing (Diploma)

CLINICAL EVALUATION TOOL

Student: _____

Instructor: _____

Date: _____

Clinical Area: _____

Agency: _____

TIMES LATE: _____ ABSENT: _____

A. BEHAVIORAL CHARACTERISTICS:

	(1)	(2)	(3)	(4)	(5)	Comments
I. Coping	At loss in a new and/or stressful situation. ___	Needs/seeks considerable help and guidance. ___	Functions in new and/or stressful situation with moderate help. ___	Adjusts to new and/or stressful situation & minimal guidance. ___	Adjusts readily to new and/or stressful situations. ___	
II. Dependability and nursing judgement	Does not/is unable to perform assigned tasks even with direct guidance of instructor ___	Needs a great deal of supervison in order to complete assignments. ___	Variable - works inconsistently at assigned tasks. ___	Dependable; will seek help if needed; frequently acts on own in handling/common situations. ___	Consistently completes clinical assignments thoroughly. Frequently acts on own in handling unusual situations. ___	

N.B. behaviors not appropriate to student may be crossed out.

		(1)	(2)	(3)	(4)	(5)	Comments
III.	Interest and initiative	Apathetic; excessive absenteeism. Written assignments usually late/not submitted.	Indifferent; minimal effort to learn an/or preparation for clinical practise; often tardy	Interested; usually punctual. Allows sufficient time for preparing for clinical practise.	Takes initiative for own learning by utilizing a variety of resources. Punctual.	Punctual. Formulates relevant ideas and shares them. Utilized variety of resources and demonstrates the application in clinical practice. Seeks new learning situations.	
IV.	Self-Awareness	Hostile and antagonistic when dealing with a discussion on own assets and limitations.	Defensive; denises/ unware of need for improvement when discussing own assets and limitations. Little recognition of how own behavior, grooming and feelings affect others.	Accepts ideas on own limitations and assets. Little recognition of own limitations and assets. Uses guidance for self improvement.	Accepts ideas on own limitations and assets. Identifies some on her own. Implements suggestions for self improvement.	Can identify limitations and assets. Initiates steps for improvement.	
V.	Accountability	Tries to cover up or deny obvious error. Failes to report an error or omissions.	Usually blames other persons or things for problem.	Reluctantly acknowledges responsibility for own actions and may report errors to an appropriate person.	Takes initiative in reporting errors to appropriate person.	Consistently accepts responsibility for own behavior and consequences.	

B. RELATIONSHIPS

	(1)	(2)	(3)	(4)	(5)	Comments
I. Interpersonal Relationships (Clients/ Significant Others)	Difficulty forming relationships even in uncomplicated situations. Biases are blatant but not recognized.	Able to form helping relationships but this may be inconsistent and the range may be limited. Acknowledges biases.	Aware of inconsistency in forming helping relationships. Gains insight and attempts to deal with biases. Beginning skills in analysis.	Generally forms helping relationships but has some difficulty in unfamiliar situations. Is usually able to analyze own limitations.	Analyzes thoroughly and suggests plausible alternatives. Fairly consistent in ability to form helping relationships in unfamiliar situations.	
II. Interpersonal Relationships (Instructor/ Staff/Peers)	Is unable to initiate relationships with instructor staff, or peers.	May initiate relationships with colleagues but shows unnecessary deference to authority figures. Unresponsive to needs of peers.	Interacts with instructor/ staff, peers. Does not seek out feedback on a regular basis rather, does so in crisis situations.	Shares responsibility for initiating interaction with staff/ instructor/ peers. Regularly seeks feed back.	Regularly discusses clients progress with staff. Is sensitive to the needs of peers.	

C. NURSING PROCESS

	(1)	(2)	(3)	(4)	(5)	Comments
I. ASSESSMENT: 1. Data Gathering	Cannot identify data	Cannot identify pertinent data.	Cannot identify significance of data collected	Can identify significance of data collected.	Continually revises data base	
2. Problem Statement	Continual difficulty in formulating assessments	Unable to identify the majority of client problems	Identifies most client problems.	Identifies overt and some covert problems.	Identifies all client problems both overt & covert.	
3. Priorizing	Unable to priorize.	Occasionally able to priorize.	Priorizes in common nursing situations.		Able to priorize in more complex situations with minimal guidance.	
II. PLANNING: 1. Objective Setting	Unable to state objectives.	States objectives for care but inappropriate to client's problem	Usually states objectives pertinent to client's problem.	Sets realistic objectives pertinent to client's problem with minimal guidance.	Independantly sets realistic objectives pertinent to the client's problems	
2. Criteria setting	Unable to state criteria	Unable to state appropriate criteria	States criteria with much guidance	States most criteria with minimal guidance	States complete and specific criteria	

C. Nursing Process (Con't)

	(1)	(2)	(3)	(4)	(5)	Comments
3. Plan of approach	No evidence of a plan		Needs some assistance in formulating a workable plan of approach		Has a realistic functional plan of approach.	
III. IMPLEMENTATION: 1. Knowledge Base eg. Growth and Development, Basic Science Interpersonal social relation, Nursing theory	Gives nursing care without understanding concepts and principles for nursing. Unable to give scientific reasons for client's behavior or nursing activities.	Has difficulty relating knowledge to behavior in common situations.	Is able to relate knowledge to client's behavior in common situations.	With assistance uses knowledge to anticipate client's behavior.	Independantly uses knowledge to anticipate client's behavior. Questions situations which violate underlying principles.	
2. Interventions	Intervenes randomly without evidence of organization	Frequently needs assistance/extra time to complete client's assignment. Does not adapt procedures to client's situation.	Is able to priorize interventions.	Intervenes in an organized manner with minimal assistance.	Compares/ contrasts several approaches. Selects best plan of care. Successfully carries out plan in an organized, efficient way. Is adaptable	

C. Nursing Process (cont'd)

	(1)	(2)	(3)	(4)	(5)	Comments
3. Skills	Carries out even simple procedures with great difficulty Frequently awkward; not consistently safe in giving care.	Manipulates equipment correctly after many trials. Because of concentration on the skill, is unaware of the effect, on the client. Ensures client safety during procedure.	Skill dexterity increases with practice. Assures physical and psychological comfort during procedure.	Safe in utilizing basic skills with a minimum of supervision	Transfers scientific principles learned in one area to a new but related situation.	
IV. EVALUATION	Unable to evaluate.	Does not base evaluation on specified criteria.	Bases evaluation on specified criteria.	Correctly states out comes of nursing actions as successful or unsuccessful.	States realistic modifications to unsuccessful internventions.	
D. TEACHING:	Fails to recognize teaching opportunities even when they are pointed out. Does not take responsibility for teaching information given; may be inaccurate or inappropriate.	Seems unaware of teaching opportunities or effect of statements made when not in a structured teaching situation. If teaching situation is planned for information given is only factual and not individualized to the client situation.	Recognizes overt opportunities for teaching and attempts to carry through teaching plan.	Recognizes teaching opportunities. Sets climate for effective interchange. Is aware of level of understanding of others in teaching situation. Carries through a teaching plan and evaluates effectiveness.	Recognizes subtle teaching opportunities and institutes measures to meet the same.	

	(1)	(2)	(3)	(4)	(5)	Comments
E. VALIDATION	Does not question inconsistencies; draws conclusions States and/or works on inferences and assumptions.	Inconsistently validates. Often works on inferences and assumptions.	Knows to validate but unsure when and with whom. At times draws inappropriate conclusions.	Validates with the appropriate person when needed.	Attempts to problem-solve that which appears unclear. Utilizes resources for clarification appropriately.	
F. CHARTING AND REPORTING	Redundant; writing frequently illegible; spelling poor; disorganized and inaccurate; frequently forgets to chart	Observations good but poorly expressed. Sometimes forgets to chart. Needs much help in recording and reporting; spelling poor. Includes irrelevant data.	Adequate and neat, legible. Fairly well expressed. Records and reports with guidance from instructor.	Notes are concise and informative Accurate spelling Records and reports correctly with minimal guidance.	Independantly records and reports correctly. Consistently uses correct medical terminology	
G. CLIENT ADVOCATE	May act in opposition to client's needs or decisions.	Acts to ensure client's rights; Relates to the client according to his level of understanding.	Ensures that client's rights are respected. (Includes privacy and confidentiality) Recognizes client has a major responsibility in his own health care and supports in decisions.	Fosters the client's participation in planning and evaluating his own care.	Ensures client's access to quality health care.	

Instructor's Comments: Areas for Improvement:

Student's Comments:

STANDING: _____

DATE REVIEWED: _____

"I hereby signify that I have read this evaluation."

SIGNATURE: _____ _____

Student Instructor