

**THE JUGGLING ACT: AN ETHNOGRAPHIC ANALYSIS OF  
CLINICAL TEACHING IN NURSING EDUCATION**

submitted by

Barbara L. Paterson, R.N., B.N., M.Ed.

**DISSERTATION**

in partial fulfillment of the degree of

**DOCTOR OF PHILOSOPHY**

The University of Manitoba

April, 1991.



National Library  
of Canada

Bibliothèque nationale  
du Canada

Canadian Theses Service    Service des thèses canadiennes

Ottawa, Canada  
K1A 0N4

The author has granted an irrevocable non-exclusive licence allowing the National Library of Canada to reproduce, loan, distribute or sell copies of his/her thesis by any means and in any form or format, making this thesis available to interested persons.

The author retains ownership of the copyright in his/her thesis. Neither the thesis nor substantial extracts from it may be printed or otherwise reproduced without his/her permission.

L'auteur a accordé une licence irrévocable et non exclusive permettant à la Bibliothèque nationale du Canada de reproduire, prêter, distribuer ou vendre des copies de sa thèse de quelque manière et sous quelque forme que ce soit pour mettre des exemplaires de cette thèse à la disposition des personnes intéressées.

L'auteur conserve la propriété du droit d'auteur qui protège sa thèse. Ni la thèse ni des extraits substantiels de celle-ci ne doivent être imprimés ou autrement reproduits sans son autorisation.

ISBN 0-315-76887-8

Canada

**THE JUGGLING ACT:  
AN ETHNOGRAPHIC ANALYSIS OF  
CLINICAL TEACHING IN NURSING EDUCATION**

**BY**

**BARBARA L. PATERSON**

A thesis submitted to the Faculty of Graduate Studies of  
the University of Manitoba in partial fulfillment of the requirements  
of the degree of

**DOCTOR OF PHILOSOPHY**

© 1991

Permission has been granted to the LIBRARY OF THE UNIVER-  
SITY OF MANITOBA to lend or sell copies of this thesis, to  
the NATIONAL LIBRARY OF CANADA to microfilm this  
thesis and to lend or sell copies of the film, and UNIVERSITY  
MICROFILMS to publish an abstract of this thesis.

The author reserves other publication rights, and neither the  
thesis nor extensive extracts from it may be printed or other-  
wise reproduced without the author's written permission.

## **DEDICATION**

This dissertation is dedicated to my beloved husband, George Feenstra, the miracle in my life.

## ABSTRACT

It is generally accepted that a practice experience is a crucial aspect of education for the professions. However, little research has been directed toward the basic analysis of clinical teaching behaviour. Much of what has been published in regard to clinical teaching is based on the authors' assumptions about the components of a clinical teacher's role. There has been a paucity of effort to identify these components within a specific conceptual framework. Consequently, clinical teachers in the professions have tended to teach as they were taught and the character of clinical education has remained relatively stagnant throughout the past few decades. This exploratory and descriptive qualitative research study was designed in order to develop a conceptual framework for understanding and explaining what takes place in the realm of clinical teaching in nursing education. The theory of symbolic interaction provided the theoretic orientation for the exploring the meaning and behaviour of six nursing educators in regard to clinical teaching. The research methods employed in the research study were selected in order to identify how the subjects explain reality in their own terms. An ethnographic epistemology, based on the social psychology framework of symbolic interaction, was utilized as a strategy for discovering the contextual reality of the clinical teachers' behaviour. The participants in the study were six clinical teachers in three schools of nursing; two diploma schools and one university generic baccalaureate program. Each of the participants in the study taught on medical-surgical wards in an urban hospital. The research entailed more than 1200 hours of participant observation, as well as interviewing, document analysis and concept mapping. Four major categories of teacher perspectives (i.e., values and beliefs) concerning clinical teaching were identified. A descriptive model of clinical teaching in Nursing Education emerged from the data by means of the constant comparative of data analysis. The Crystallization Model of Clinical teaching in Nursing Education portrays clinical teaching as a dynamic, interactional process in which what the teacher intends is mediated by a variety of contextual and mediating variables. Many of these variables are beyond the teacher's control. Consequently, the research participants generally viewed clinical teaching as a random activity which prohibited the planning for and the anticipation of specific learning events/situations. The essence of clinical teaching is identified in this model as the transmission of the practice of the profession; the presentation of a model of and for reality to students. The implications of the Crystallization Model in relation to curriculum reform, teacher preparation and future research are discussed in the research report.

## ACKNOWLEDGEMENTS

I am indeed fortunate to have experienced the support and encouragement of many individuals throughout my doctoral program. I wish to express my appreciation to the following persons for their contribution to this process:

To Doctor Alexander Gregor, for his continued guidance and reassurance. He taught me a great deal about teaching, discretion, and diplomacy. His mentoring was a significant factor in my ability to succeed in this endeavour.

To Doctor Janet Beaton, for her ability to understand the emotional complexities of qualitative research and to support me when it was needed. She was kind in her criticisms, but diligent in her encouragement of excellence in the research process.

To Doctor Daniel Albas, for his sharing of his experience and knowledge concerning qualitative research. He expanded my understanding of the field to incorporate several theories and disciplines.

To Doctor Raymond Perry, for his challenging and provocative ways of teaching and for all he taught me about how teachers teach and students learn. Being a student in his classes was a rare privilege.

To Doctor Nancy Diekelmann, for her willingness to extend herself and for the major influence her research has had on this work.

To Jan Dick, Dean Care, Leone Banks and the faculty and support staff at St. Boniface Schools of Nursing for their belief in my ability and their many kindnesses. A special thank you for the lunches, dinners and telephone calls throughout the past three years.

To Doctor Jenniece Larsen, Doctor Ina Bramadat and my colleagues at the University of Manitoba School of Nursing for all they have taught me and their continued support of my research.

To my friends and family who have always been there when I have needed them. A special thank you to Gregg and Laura who lent me their children when I needed some perspective and to Irv and Diane who always asked about my studies.

To my husband and children who said this should be called a "desertation" because I was so often preoccupied. Their patience, love, and understanding made this dissertation possible.

To the teachers and students who participated in this research study. They permitted themselves to be vulnerable in order that others could learn about clinical teaching. Their commitment to the study was awe inspiring.

## TABLE OF CONTENTS

	PAGE
ABSTRACT . . . . .	1
ACKNOWLEDGEMENTS . . . . .	2
TABLE OF CONTENTS . . . . .	3
CHAPTER	
I. INTRODUCTION . . . . .	5
Problem Statement . . . . .	6
Definition of Terms . . . . .	7
Assumptions . . . . .	9
Conceptual Framework . . . . .	9
Organizational Report . . . . .	11
II. REVIEW OF THE LITERATURE . . . . .	13
Structure of Clinical Education . . . . .	15
Models of Clinical Education . . . . .	24
Research in Clinical Education . . . . .	32
Issues in Clinical Education . . . . .	44
Summary . . . . .	56
III. THE RESEARCH DESIGN . . . . .	58
Participant Observation . . . . .	59
Interviewing . . . . .	63
Other Methods . . . . .	66
The Sample . . . . .	69
The Setting . . . . .	73
The Role of the Researcher . . . . .	75
Preventing/Minimizing Reactivity . . . . .	80
Ethical Considerations . . . . .	85
Data Analysis . . . . .	90
Limitations of the Study . . . . .	93
Summary . . . . .	95
IV. THE CONTEXT OF CLINICAL TEACHING . . . . .	98
The Teacher's Perspective . . . . .	99
Caring . . . . .	120
Professional Identity . . . . .	133
Temporary Systems . . . . .	143
Mediating Variables . . . . .	164
Summary . . . . .	193

V. THE EXPERIENCE OF CLINICAL TEACHING . . . . .	194
Transmission of Practice . . . . .	197
Assessment . . . . .	221
The Teacher's Response . . . . .	243
Crystallization . . . . .	264
Development of a Plan . . . . .	268
Summative Evaluation . . . . .	272
Summary . . . . .	276
VI. DISCUSSION . . . . .	279
The Role of the Clinical Teacher . . . . .	279
The Teacher's Attributions . . . . .	285
The Structure of Clinical Education . . . . .	293
Implications for Future Research . . . . .	306
Summary . . . . .	309
VII. SUMMARY AND CONCLUSION . . . . .	312
Summary . . . . .	312
Conclusion . . . . .	318
BIBLIOGRAPHY . . . . .	322
APPENDICES . . . . .	374
1. Teacher #1's Concept Map . . . . .	374
2. Teacher #2's Concept Map . . . . .	375
3. Teacher #3's Concept Map . . . . .	376
4. Teacher #4's Concept Map . . . . .	377
5. Teacher #5's Concept Map . . . . .	378
6. Teacher #6's Concept Map . . . . .	379
7. Data Collected . . . . .	380
8. Reactivity Analysis Tool . . . . .	381
9. Ethical Committee Review . . . . .	382
10. Description of Study for Teachers . . . . .	383
11. Consent for Teachers . . . . .	384
12. Description of Study for Students . . . . .	385
13. Consent for Students . . . . .	386
14. A Comparison of Perspectives . . . . .	387

## **CHAPTER ONE**

### **INTRODUCTION**

It is generally accepted that a practice experience is a crucial aspect of education for the professions (Infante, 1985; Rodgers, 1985). Over two decades ago, McGlothlin (cited in Dinham & Stritter, 1986) observed that professions vary widely in their use of clinical experiences to teach the practice of the profession. More recent writers concur with this observation (Dinham & Stritter, 1986; Infante, 1985). All professions agree that the challenge of clinical teaching to transform novice students into practising professionals should be a significant concern within the profession. However, little research has been directed toward the basic analysis of clinical teaching behaviour. In contrast, classroom teaching, which is more highly structured and less vulnerable to the influence of external factors, has been the subject of much study.

Although there is general agreement that the clinical education experienced by students greatly affects their ability eventually to practice in the profession, very little is documented about what actually transpires between faculty and students in the clinical setting. Much of what has been published in regard to clinical teaching is based on the authors' assumptions about the components of a clinical teacher's role. There has been a paucity of effort to identify these components within a specific conceptual framework. Consequently, clinical teachers in the professions have tended to teach as they were taught and the character of clinical education has remained relatively stagnant throughout the

past few decades (Pugh, 1983). There are a number of factors which indicate that the time is ripe for the critical exploration of the current clinical teaching practices in the professions. Declining enrolments are predicted in many professional programs, demonstrating a generalized tendency for enrolment in basic sciences, rather than the humanities and the helping professions (Powell, 1989). Potential students are offered a myriad of career options which do not involve personal risks (e.g., contracting AIDS) and are more lucrative than the helping professions. As well, government and industry are demanding increasing accountability of universities and other educational institutions to provide programs which will develop effective professional practitioners in the most effective and expedient means possible (Fairweather, 1989).

Recently, a number of educators in the professions have identified the study and improvement of clinical education as a priority (Diekelmann, 1990a; Diekelmann, Allen & Tanner, 1989; Dinham & Stritter, 1986; Infante, 1985). However, before appropriate guidelines for effective clinical teaching can be developed, clinical education must be understood within its contextual setting (i.e., what takes place between teacher and student; the factors which influence and direct the teacher in the clinical area). This exploratory and descriptive qualitative research study was designed in order to develop a conceptual framework for understanding and explaining what takes place in the realm of clinical teaching.

### **Problem Statement**

In order to accomplish the purpose of the study, the perspectives of six clinical

teachers in nursing education were sought regarding the nature and experience of clinical teaching. The study was guided by the following exploratory questions:

- 1) What elements constitute a teacher's perspective in the practice setting?
- 2) What are the assumptions a teacher makes about students and teaching which support, or are contrary to, his/her perspective of clinical teaching?
- 3) What internal and external contextual variables associated with the teacher-student, teacher-staff or teacher-patient interaction affect the teacher's perspective of clinical teaching?
- 4) How does this perspective influence the way in which the teacher designs and implements the clinical teaching experience?
- 5) How does this perspective influence the way in which the teacher relates to students, patients and staff in the clinical area?

The study is modelled according to similar research conducted by Janesick (1977), Field (1981) and Tardif (1984). Janesick's study referred to a teacher's perspective in an elementary school classroom; Field described the perspective of four public health nurses; and Tardif presented the perspectives of four student teachers.

### **Definition of Terms**

For the purposes of the study the following terms were utilized as defined:

Clinical - "based on actual observation and treatment of disease or conditions of life instead of an artificial experimentation or theory" (Infante, 1975, p.4).

Clinical area - an institution, home or community agency where a student comes into

contact with patients/clients (through observation, participation and practice) for the purpose of developing competence in the practice of the profession (by means of acquiring the necessary intellectual and behavioral skills).

Clinical teaching - the type of teaching that occurs in the proximity of a patient/client in an individual or group setting; i.e., in a clinical area. This definition of clinical teaching is sufficiently broad to encompass clinical teaching as it is enacted in the professions. However, it is significant that each profession interprets this definition by means of unique structures. For example, clinical teaching in teacher education has been traditionally defined as providing direct teaching experience in a classroom, closely supervised by an experienced practitioner (Zeichner, 1989). The clinical learning experience is intended as the synthesis of all the students have learned in the theoretical portion of their basic education program. Traditional nursing education provides concurrent clinical practice experience for students throughout the basic education program. The teaching role is assumed by a faculty member; nursing practitioners have little, if any, input regarding student nurses' learning in the clinical area (Infante, 1985).

Clinical teacher - a teacher in a basic professional education program who is assigned to teach students in a specific clinical area. This individual may or may not be responsible for some classroom teaching in addition to clinical teaching responsibilities.

Perspective - the way in which an individual consistently defines a succession of similar situations (Shibutani, 1967); the meaning and subsequent decisions an individual derives from that which they encounter in a social context. "A combination of beliefs and behaviours continually modified by social interaction" (Janesick, 1977, p.4). In the clinical

area, the teacher behaves and thinks in a manner consistent with his/her perspective about clinical teaching. This perspective enables the teacher to make sense of his/her world, to interpret and to act accordingly. It is this perspective which the study attempted to describe and define.

### **Assumptions**

The assumptions which underlie the study are the following:

- 1) clinical education is a vital aspect of the curriculum in education for the professions;
- 2) teachers design and implement clinical teaching experiences for students based on their perspective of clinical teaching; and
- 3) clinical teaching in all professions incorporates certain similar components.

The study focused on clinical teaching in nursing education, and it did not investigate the nature or structure of clinical teaching in professions other than nursing. This permitted the scope of the research to remain at a manageable level. However, it is postulated that the study could be replicated in other professions at a future date, thus testing the third assumption. Because the teachers and the students in the study were primarily female, and because males in the study might be readily identified, all teacher and student participants will be referred to in this report in the feminine gender.

### **Conceptual Framework**

The theory of symbolic interaction provides the theoretical orientation for the

research design for this study. Blumer (1967) describes symbolic interaction as a process of interpretation. Symbolic interactionism posits that individuals act and interact on the basis of how they interpret and give meaning to elements in their environment. This interpretation and the decisions which are based on this interpretation lead to a construction of the individual's "self". The way in which an individual consistently defines a succession of similar events depends on his/her perspective (Shibutani,1967).

The theory states three main propositions:

- 1) The effect of a situation is determined by an individual's definition of that situation. For example, a clinical teacher in nursing may define the patient acuity level on the ward as beneficial because she wishes to offer a challenging assignment to her senior students. However, a clinical teacher of beginning students may view the same situation as frustrating because of the difficulty of assigning patients to students who do not have the knowledge or skills to care for them.
- 2) The greater value an individual assigns to a situation, the greater will be its effects in social interactions. For example, a clinical teacher who values autonomy and personal freedom in her teaching will regard restrictions on her clinical teaching imposed by the nature of the program's curriculum as more meaningful than does a teacher who does not maintain the same values.
- 3) It is the perception of reality which defines the consequences of a situation for an individual. For example, if clinical teachers believe that they are powerless to influence students' learning in the clinical area, they will structure their clinical

learning activities accordingly (Burr, Leigh, Day & Constantine, 1979).

According to the theory of symbolic interaction, the meaning of an event must be understood from the perspective of the participants, necessitating that the researcher observe the participants' actions and interpret them at symbolic and interactional levels. Inherent in the theory is the assumption that meanings are derived from social interaction; therefore, behaviour must be observed in its social context (Chenitz, 1986). The research design must be sensitive to the social processes involved in order to capture them effectively (Denzin, 1970). In accordance with the tenets of symbolic interactionism, the researcher must be able to immerse him/herself in the participants' world (Blumer, 1967).

### **Organization of the Thesis**

This chapter has offered an introduction to the study, outlining its purpose and the need which prompted its undertaking. Chapter Two provides an overview of the structure, theoretical perspectives, major research programs and current issues pertaining to clinical education in the professions. This chapter emphasizes the sharing of common issues and concerns in relation to clinical education between the professions, as well as the absence of theoretical frameworks to define and structure clinical education. Chapter Three describes the research design, including the research methods utilized, the nature of the sample population, the setting in which the research took place and ethical considerations pertaining to the research. It also includes a discussion of the role of the researcher and the potential sources of reactivity in the investigation. Chapter Four presents a description of the clinical teachers' perspectives concerning clinical teaching and the variables which

affect their perspectives as they plan and implement clinical teaching. Chapter Five provides a description of the participants' experience of the interactive clinical teaching. A model of the clinical teaching experience is proposed. Chapter Six discusses the implications of the research findings for the development of clinical teachers, for the structure of clinical education in schools of nursing and for further study in the field. The final chapter summarizes the findings of the study.

## CHAPTER TWO

### REVIEW OF THE LITERATURE

There are divergent opinions about the appropriateness of a literature review in a qualitative research study. Glaser (1978) recommends that the researcher does not consult the literature prior to conducting fieldwork because researchers may compromise their ability to make accurate decisions about what is observed or heard. Avoiding the relevant literature permits the researcher to study the setting with an "open mind" but leads to "reinventing the wheel" as previous research findings are rediscovered (Field & Morse, 1985, p.35). Others (Field & Morse, 1985; Stein, Allen & Moxley, 1982) have recommended the review of all literature pertaining to the research topic. However, as one indication for conducting qualitative research is the nonexistence of similar research (Simms, 1981), this review is likely to be somewhat restricted.

The review of the relevant literature in this report is characterized as a selective examination of literature pertaining to clinical teaching in nursing, medicine, social work, and teacher education. To a lesser extent, the literature available in the professions of dentistry, physiotherapy, law, counselling, occupational therapy and speech therapy are also reviewed. The literature was screened for principal criteria in the study. These criteria included the following:

- 1) A model of clinical teaching was described, detailing the process and inter-relationships of clinical education in the profession(s). The existence of literature

which met this criteria was sparse. Therefore, all located literature which met this criteria was included in the review. The majority of this literature was not empirically based.

- 2) Substantive research process in the field was defined as qualitative and/or quantitative research activity which was systematic, structured and purposeful, as well as that which provided sufficient information to reveal the conceptual framework, research design, method of data collection and sample in the discussion of the research (Merriam & Simpson, 1984).
- 3) Issues in clinical teaching were defined as problems, concerns and/or questions, common to all professions, related to the structure and process of clinical education.

The literature informed the researcher about previous research findings which may have had some implications for the study. However, it did not constrain the parameters of the study to those identified in the literature.

This chapter presents a comparative analysis of clinical teaching in the professions. Although the professions differ (both within and among) as to the structure of clinical teaching and the amount of scholarly inquiry concerning it, there is much to be learned from the exercise of identifying the commonalities as well as the differences. Medicine and nursing education have generated the majority of the literature concerning clinical teaching (Dinham & Stritter, 1986). However, other professions have offered equally valuable insights, reflecting the predominant concerns in the profession. For example, counselling education offers the largest selection of writings concerning the effect of the

presence of a supervising teacher on a student's ability to perform in the clinical area.

This chapter provides an overview of the major research programs that organize the bulk of research on clinical education in the professions. The emphasis of the discussion will be the lack of theory development in this research. The chapter concludes with a discussion of the major issues which face the professions today in regard to clinical education and a summary of the implications to the study derived from the literature review. The discussion which follows pertains largely to professional education in North America. The European and Asian experiences are so different that they can be compared to the North American experience only with great difficulty.

### **Structure of Clinical Education**

All of the professions have struggled with common issues in relation to clinical teaching throughout their history as a profession. Each has been influenced by the social conditions of the times. Each has responded to demands from governments and the public for increasingly specialized service. Each has altered the nature of clinical education in response to those demands. Medical education appears to be the most autonomous of the professions in its development. It is a profession which can attest to the significant impact of the faculty on the profession at large, in contrast with professions such as nursing and teacher education in which the faculty are often regarded as "ivory tower" scholars with little understanding of the realities of the profession (Sleightholm, 1985 ; Manning, 1987).

### Evolution of Professional Education

Blauch (1962) identifies three stages of evolution in the development of professional education: (1) apprenticeship; (2) professional training in universities separated from the profession's practice; and (3) integration of apprenticeship experiences with the teaching of theoretical content. The earliest form of clinical teaching in the professions was apprenticeship. In the early apprenticeship period of professional education, the student remained with an expert in the field, the master, until he/she was recognized in the profession as being equally skilled and proficient. The master expected that the apprentice would eventually excel, surpassing his/her knowledge and skills in their field (Infante, 1985). Although the majority of professions have followed the evolutionary path indicated by Blauch, nursing education has a unique history. Infante claims that nursing has never known a true apprenticeship phase. She states that the "masters" in the early schools of nursing (circa 1860) were not experts in their fields but were often inexperienced beginning practitioners themselves. However, Brown noted in her document Nursing for the Future in 1948 (Infante, 1985) that:

By no conceivable stretch of the imagination can the education provided in the vast majority of the some 1,250 schools be conceived of as professional education. In spite of some improvements that have been made in most schools over the years, it remains an apprenticeship training. (p.48)

Ashley (1975) postulates that the tradition of apprenticeship in nursing survived fifty years after it had been divested by the other professions because it instilled "a strong faith in superiors", as well as a submissiveness to authority (p.50).

### Constraints to Baccalaureate Education in Nursing

Nursing education has struggled over the past century to move effectively from the concept of "training" nurses to "educating" them. This advance has been thwarted by a number of societal forces. For example, nursing shortages have historically impeded nursing's move toward baccalaureate education (Grace, 1983). The second phase of nursing education's evolution occurred in the 1950s, considerably after medicine, social work and teacher education had moved away from their service-based agencies and established themselves as separate educational institutions. Similarly to the other professions, nursing moved away from the service-based educational process in order to obtain academic credibility and to reduce the financial burden of service agencies for the education and supervision of nursing students. In the process of achieving educational autonomy, the responsibility for the education of nursing students shifted from nursing service to schools of nursing.

### The Transition From Service to Education

The concept of clinical education flourished with the admission of schools of nursing to the academic arena in the late 1950s and early 1960s. The emphasis of universities on the correlation of theory with practice changed the perception of clinical education in nursing education from apprenticeship under the supervision of a staff nurse to a learning experience directed by a qualified faculty member. When university students started paying tuition, nursing students began to demand quality teaching in the clinical area rather than mere supervision (Wong, 1987). This change drastically altered the role of the clinical teacher. Smith (1968) notes that it inevitably demanded that clinical

teachers be accountable to the students they taught, as well as for the care of patients their students nursed.

Since the 1960s, the number of university-based schools of nursing have increased markedly. The basic education programs in nursing have grown in scope and depth in response to the advances in nursing practice and technology. Teaching strategies appropriate to clinical teaching, albeit few in number, have been developed (e.g., the concept of pre-active conferences). However, clinical education in nursing today remains largely focused on patient care instead of student learning (Infante, 1985). The faculty member is generally portrayed as a supervisor of the students' patient care or as a helper, rather than a clinical teacher.

The third stage of nursing education's evolution has not yet been entirely realized. The struggle to separate service from education in the 1950s still dominates the practice-theory structure in the profession. There have been some notable attempts to integrate the two; the Case Western Reserve collaboration model in which department heads are responsible for nursing services and the educational program is the oldest example. A significant consequence of the education-service separation in nursing has been that the relationship between these two divisions of the profession is characterized by territoriality and defensiveness (Kramer, Polifroni & Organek, 1986). Nursing education shares the concerns of social work and teacher education that the practice of the profession which is observed by the students in practice settings is at times outmoded and less than the ideal (Granger & Starnes, 1982; Schwebel, 1985). Most clinical experiences for students in nursing occur outside a university-based hospital. The clinical teacher who accompanies

groups of nursing students as they practise in a variety of health agency settings is commonly assigned the status of "a guest in the house" (Glass, 1971) by the agency staff. The students are regarded as the teacher's "territory" and the interaction with the agency staff is generally minimal (Stanko, 1981). Social work education has attempted a similar structure without much success. In 1971, in response to agencies' expressions of a lack of confidence in graduates' ability to meet the direct service needs of clients, Rothman and James (Frumppkin, 1980) urged schools of social work to develop clinical education for the social work student's first year which would take place in a laboratory setting and be closely supervised by the faculty. They advocated that faculty control and supervise practicum experiences in the field through focused faculty-supervised units, school projects and paid instruction. A few universities initiated the innovations suggested by Rothman and James but the programs were deemed a failure within three years (Waldfogel, 1982). The programs were not financially feasible and they did not meet the needs of the service agencies. Although the literature in social work still expresses discontent with the traditional field arrangements of clinical education, the primary clinical teaching responsibility has remained with the field instructor and not the faculty.

#### Clinical Education Today

It is somewhat ironic that nursing educators early in the profession's history appear to have had a clearer understanding of what clinical teaching is than do those in the present. Nutting (cited in Infante, 1985), for example, advocated introduction of the beginning student to nursing care by means of lectures and observation instead of actually rendering care. The progress which is evident in nursing clinical education since the early

apprenticeship period is that student nurses are no longer expected or encouraged to be passive, unassertive, unquestioning individuals in the clinical area. However, clinical teaching strategies have remained essentially stagnant throughout the years. The notable exception is a very few nurse educators (e.g., Diekelmann; Infante; Tanner) who have called for alternatives to the traditional structure. Diekelmann (1990b), for example, has promoted the need for a "revolution" in nursing education which would result in clinical teaching designed to develop the critical thinking and decision-making skills of student nurses.

Nursing education differs from the other professions in that nursing students are required to care for patients before they have acquired the knowledge base to do so. Students in social work, teacher education, medicine, counselling, dentistry, physiotherapy and occupational therapy are provided with the theoretical basis of the profession, together with some observational experiences in which they have no responsibility for client care, before they are deemed prepared for a supervised field-base practice experience. Infante states that the idea, that a student is not a nurse but is learning to become one, is often forgotten. "Caring for patients" is often believed to be synonymous with learning. Infante (1985) suggests that requiring students to assume this responsibility before they are adequately prepared is unrealistic and results in excessive stress for the students. Bridgman (1983) indicates that some baccalaureate programs in nursing continue to identify the clinical experience as primarily a work and not a learning situation. She proposes that this emphasis on service has impeded the evolution of clinical education in nursing as a theoretically-based, directed process, similar to that which medicine has

achieved.

The structure of clinical learning experiences in nursing, teacher education, social work and counselling is somewhat comparable. Each entails a form of apprenticeship, during which students learn technical skills of the profession by trial and error (Kagan, 1988). However, in nursing, this trial and error learning is closely supervised by faculty; in the other professions, the supervision of the student's learning is the responsibility of the practitioner in the clinical area. Another commonality shared by these professions is the therapeutic or helping emphasis in the teacher-student relationship. Shaplin (1961) has indicated that many aspects of psychotherapy are pertinent to the process of clinical supervision of students (e.g., the teacher assists the student to develop emotional insight; the teacher examines the appropriateness of the student's reactions and responses, and there is an emphasis on student self-evaluation and self-knowledge). The roles assumed by the clinical teachers within each of these professions have been described in almost identical terminology. Bernard (1979) described three major roles for clinical teachers in the profession of counselling: teacher; counsellor; and consultant. These three roles are implicit in almost every supervisory model in counselling and teacher education. For example, Housego and Grimett (1983) describe two supervisory roles as deliberative versus facilitative. The deliberative role closely corresponds with the prescriptively directing role of the teacher. The facilitative role is analogous to the counsellor role identified by Bernard. In nursing education, the teacher (1) must teach students in the clinical area (teacher role); (2) explore the student's feelings and concerns related to the clinical experience (counsellor role); and (3) monitor the care of the student's patients,

offering advice and support as necessary (consultant role). There are some contextual differences in these professions. For example, in social work and counselling, the student and teacher work with an individual or in small groups at an allotted time. In teacher education and nursing, however, the client/patient population is often large. A nursing educator might supervise ten students who are caring for twenty or more patients throughout the day.

Smith (1990) indicates that the similarities and differences between professions must be identified before their influence on the nature and structure of clinical education in the profession can be truly understood. She gives as an example the difference in emphasis on "training" for licensure in professions, such as medical education, as compared to the goal of teaching students "to think like lawyers" (p. 9) in law. She also suggests that the nature of professions such as medicine, nursing, and physiotherapy necessarily constrains the clinical teacher's ability to permit the student to risk error in the clinical area. Law, by contrast, has fewer absolutes in problem-solving; clients are unlikely to be severely harmed if the law student makes a mistake in procedure or sequencing of steps in the solving of a legal problem. All of these professions offer clinical education in a variety of agencies which differ widely in their bureaucratic structure, size and history with the educational institution. The analogy between the structure of clinical education in these professions is not absolutely parallel. However, it does suggest similarities in terms of supervisory roles and the definition of the student-educator relationship.

### Preceptorship

The concept of preceptorship was introduced to nursing education in the early 1980s, primarily as an attempt to maximize the efficient utilization of an agency's educators in order that they might fulfil other aspects of their academic role (Hitchings, 1989), but also to provide role modelling of professional practice to students. Preceptors in nursing education are staff members of the service agency who are required to assist students, generally on a one-to-one basis, to learn clinical skills (Griepp, 1989). This concept is similar to that of the co-operating teacher in teacher education and the field worker in social work. A fundamental concept of preceptorship is that learning will take place if the student is motivated to learn and has a role model to emulate. Preceptorship differs from apprenticeship in that it is a more individualized teaching method and it involves more than the learning of psychomotor skills. It may be compared to the experience in medical education of residents assuming a role both as a provider of patient care and as a teacher of interns and senior medical students.

In the early apprenticeship period of professional education, the student remained with the master until he/she was equally knowledgeable and competent. At varying stages in their development, each profession ultimately moved to a university or college setting. Qualified teachers were hired and the role modelling function of the teacher was less emphasized. Later, the current mode of theory-based programs developed which incorporate both the practice and theory of the profession developed. Although it may appear that some of the professions have returned to the early apprenticeship system, particularly in their clinical education, today's apprenticeship experiences in professions

such as medicine, nursing, social work and teacher education rely on theories of action by which the profession is practised (Dinham & Stritter, 1986).

### **Models of Clinical Education**

The attempts to develop a conceptual framework of clinical education in the professions have been few. Most have not been based on available research, but are instead the result of armchair musings or the juxtaposing of concepts from selected practice or classroom teaching models (Bolton, 1984). Every profession has to some degree grappled with attempting to develop a model which effectively explains the process of cognitive and affective skill acquisition, as well as the teacher-student relationship in clinical education. The task is complicated by the parallel struggle to define the boundaries of some professions. For example, social work has encompassed a variety of models of clinical education which reflect the consultive, administrative or educational functions of a social worker (Lowry, 1983). Most professions have attempted to conceptualize problems and approaches in clinical teaching from other than empirical research premises, reflecting their dedication to practice rather than their devotion to "disciplined inquiry" (Dinham & Stritter, 1986). The models of clinical teaching reviewed in this section of the chapter include both those with empirical derivations and those which have resulted from the author's reflections of their clinical teaching experience.

### **Curricular Models**

Several curriculum models (e.g., the Tyler Model of nursing education) have assumed that identical teaching strategies and practices are inherent in both the clinical

and classroom aspects of the curriculum. Carr (1983) concluded in her study of three clinical teachers in nursing that clinical teaching is not unique if it is considered, as other forms of teaching, to influence students in certain designated directions. However, she also stated that the highly political and spontaneous nature of clinical teaching does not facilitate the practice of traditional classroom teaching strategies.

### Generic Models

Some generic models of clinical education in the professions have been proposed. These attempt to represent some or all of the aspects of clinical teaching. For example, models of psychomotor skill learning have been developed by Bolton (1985), Chenault and Brownford (1978), Hardy (1980), and Russell (1980). Van Buegen's model of agogic action has been utilized in a variety of clinical education settings in Europe in social work, counselling and psychotherapy. It delineates the analytical and interactional steps in the clinical learning situation (Lowry, 1983).

Each of the generic models have inherent limitations in their applicability to clinical education. The psychomotor skill models presuppose that students must achieve technical proficiency before they can be taught and expected to perform nontechnical aspects of the profession. Van Buegen's model does not accurately reflect changes which occur in the teacher-student relationship as the student becomes more independent and confident.

Generally there has not been a uniform acceptance of any one model of clinical education in a profession. The notable exception is medical education which shares common assumptions about the nature of the clinical learning experience (Irby, 1987).

The orientation in medical education is highly academic, valuing problem-solving and independent thinking skills in the learner. It is hardly surprising that medical education has not appeared to have experienced the same degree of ambiguity and confusion about what clinical teaching is as has other professions. Medicine's singular adoption of the three dominant models identified by Irby (problem-centred; experiential; and a combination of individual and team learning) has undoubtedly helped the profession clearly to define and structure clinical education experiences in medical schools.

#### Developmental Models

Counselling educators have demonstrated considerable interest in a model of clinical education which captures the developmental stages of the teacher-student relationship as both undergo changes over time. The profession of counselling has traditionally considered the nature and structure of clinical education to be a high priority because faculty are required to spend a large number of hours in individual supervision of students in order to meet the criteria for certification in the field (Pruitt, McColgan, Pugh & Kiser, 1986). Numerous empirical studies have investigated the principles of the eighteen developmental models of clinical supervision which occur in counselling today (Roehlke, 1984). These models serve as innovative examples of how current research regarding the transition from novice to expert may be utilized in model development. Stoltenberg's (1981) developmental model, based on the theoretical work of Hogan (1964), has been the most extensively tested. In this model, students are depicted as moving, with the assistance of the clinical teacher, from an anxious, dependent and procedure-bound state to a position of self-assurance and independence. Stoltenberg's developmental model

of counsellor education has been tested by a number of researchers (Heppner & Handley, 1981; Rabinowitz, Heppner & Roehlke, 1986 ; Worthington, 1984). All but Heppner and Roehlke (1984) found support for the elements of Stoltenberg's developmental model. However, several of these studies are limited in their generalizability because of their research design. For example, some studies have utilized only one experience level of counselling students (Heppner & Handley, 1981), a single clinical site (Heppner & Roehlke, 1984), or a limited number of clinical experiences which are interpreted to equal a distinct developmental period (Worthington, 1984).

Longitudinal data have not been obtained in any of the studies which have sought to test the developmental models of clinical teaching in counselling. The research has been based largely on the self-reports of supervisors and/or students and has not included direct observation. The relevance of this omission is apparent in the contrast between this and research analyzing the content of supervisory conferences in counselling. Stenack and Dye (1983), for example, discovered in their analysis of audiotaped supervisory conferences, that students preferred their clinical teachers to function in the roles of consultant and counsellor, rather than teacher (using Bernard's description of the three supervisory roles). This finding was in direct contrast to studies relying on the self-report of students which claimed that students prefer didactic supervisory behaviours (Loganbill, Hardy & Delworth, 1982; Worthington & Roehlke, 1979). This discrepancy implies that students prefer didactic clinical teachers in theory only.

Despite its flaws, this research offers a number of provocative insights. For example, Worthington and Roehlke (1979) discovered that one may experience behaviours

and emotions typical of the novice stage of competence (i.e., dependence and anxiety) each time one enters an unfamiliar and new situation. Wiley and Ray (1986) found that developmental level may not be synonymous with the student's or teacher's status (e.g., a beginning student may utilize expert behaviour patterns because of prior related experiences), thus suggesting that a developmental model of clinical education must account for idiosyncratic rates of growth. Although the developmental models offer provocative concepts for clinical education, their underlying assumptions are not research-based and many remain untested (e.g., the assumption that developmental change is always linked to gains in clinical performance; and that the teacher is the best source of information concerning the student's development).

#### Supervisory Models

Teacher education has proposed an array of supervisory models, many of which appear to integrate similar concepts and to differ only in their semantical interpretations. For example, Copeland (1982) distinguishes between a directive and a facilitative model of teacher education supervision. This is analogous to Glickman's (1981) model which discusses directive, nondirective and collaborative modes of supervision. It is also inherent in the empirically derived five-dimensional supervisory model proposed by Gitlin, Ogawa and Rose (1984). Another classification for supervisory behaviour in teacher education has been proposed by Tabachnick and Zeichner (1984) who distinguish between technical-instrumental, personal growth-centred and critical supervision. Nelson and her colleagues (1989) have researched their proposed Heuristic model of supervision in teacher education since 1982. This model offers a combination of traditional approaches, focusing as well

on the supervisory teacher being able to communicate differences between a student teacher's performance and the desired performance. Nelson's research represents one of few attempts in teacher education to develop prescriptive and substantive theory about clinical teaching. The empirical testing of this model has yet to be completed.

### Behaviourist Models

Marsick (1988) describes most professional programs as operating under a behaviourist model of clinical education. In the behaviourist paradigm, performance outcomes which are measurable and observable are valued. Individuals are rated according to standard, expert-derived norms. Problem solving in this paradigm emphasizes objectivity, rationality and step-by-step procedure. Although Marsick agrees that this model is appropriate when clinical experience involves a precise technique which permits no variation, she and others (Kanter, 1983; Peters & Waterman, 1982; Toffler, 1985) have argued that the behaviourist model does not allow for risk taking, independent thinking, creativity and humanitarian values. Lincoln (1985) suggests that today's professions are shedding the behaviourist model and highlighting complexity instead of simplicity; ambiguity rather than predictability; and an awareness of multiple perspectives rather than objectivity. This is apparent in the National League of Nursing's recent consideration of alternatives to the traditional Tyler model of nursing education, as the framework for the accreditation of schools of nursing in the USA (Diekelmann, Allen & Tanner, 1989).

### Innovative Models

Infante (1985) has developed a model of clinical education in nursing which reflects her observations and analysis of clinical teaching throughout the past four

decades. The model advocates student independence rather than "elbow supervision". Clinical learning activities are planned jointly by the student and the teacher according to the student's individual learning needs. The use of preceptors to teach students in the clinical area is carefully designed in this model. Recently, the Thomas Jefferson University of Philadelphia conducted a pilot study of the student outcomes associated with her model (Infante, Forbes, Houli, & Naylor, 1989). The study involved too small a sample to assess adequately the outcomes of this model of clinical education. However, it did indicate that the students, teachers and preceptors who were involved in the testing of Infante's model were greatly satisfied with the method of clinical teaching and learning. Further investigation is required to determine whether this satisfaction was caused by the Hawthorne effect; i.e., the students may have been more inclined to report increased levels of satisfaction because they were being studied and were aware of the purpose of the research (Woods & Catanzaro, 1988).

Some noteworthy research in the area of model-building in clinical education has recently been conducted by Diekelmann at the University of Wisconsin. Diekelmann's Dialogue Model of Nursing has been proposed as applicable to clinical education in nursing (Diekelmann, Allen & Tanner, 1989). The model has a philosophical basis of Heideggerian phenomenology and draws on the research of particular nurses (e.g., Roach, 1986) and educators as a curriculum foundation. The model assumes that experience is the turning around of preconceived notion and beliefs. Students in this model would be rewarded for relating classroom instruction to clinical instruction and for their analysis of disconfirming experiences in which preconceived notions are found to be false. Basic

to Diekelmann's research is the assumption that teachers in nursing do not teach as teachers teach; nurses bring to the clinical education experience facets of their practice as nurses and they teach from that practice (Diekelmann, 1990a). This is not a tested assumption but it raises an important question: can models of clinical education in the professions be generic or should they remain distinctively unique to each profession? The literature which proposes models of clinical teaching has not addressed this question to any significant degree.

### Critique of Existing Models

A criticism of many models is that they are too narrow in scope to envelop all the aspects of clinical education. Many appear to equate supervision with all of the elements of clinical teaching (Rolfe, 1990). They often refer only to the supervisory function of the clinical teacher and therefore cannot guide all the aspects of the clinical teaching experience. They generally assume clinical education to be characterized by periodicity and regularity, failing to account for the randomness and irregularity of events in the clinical area (Bischoff, Faris & Henninger, 1988). They have also failed to generate improved practices in clinical education (Tabachnick, Popkewitz & Zeichner, 1980). Zeichner (1983) encourages the development of models of clinical education which are free from ties with the dominant paradigmatic orientations of the present (e.g., behaviourism; traditional-craft). None of the published writings has appeared to have considered the clinical teacher's role with clients/patients and agency staff in the clinical teaching situation.

## **Research in Clinical Education**

The primary focus of research in clinical instruction has been effective and ineffective clinical teaching behaviours. Historically, these studies have relied largely upon students' perceptions as to which teaching behaviours constitute effective clinical teaching. It has only been within the past fifteen years that the perceptions of faculty have been included in the studies of desirable clinical teaching behaviours (O'Shea & Parsons, 1979; Sleightholm, 1985; Thompson, 1983; Wong & Wong, 1980).

### Effective Clinical Teaching Behaviours

Jacobson's (1966) study of effective teaching behaviours has been the basis for the majority of studies on clinical teaching. Jacobson conceptualized 58 specific teaching behaviours into six major behavioral categories: 1) availability to students; (2) apparent general knowledge and professional competence; (3) interpersonal relationships; (4) teaching practices in classroom and clinical areas; (5) personal characteristics; and (6) evaluation practices. These categories have been sufficiently broad to provide a categorical framework for the research of others (Carduff, 1969; Layton, 1969). No two of these studies have utilized the same questionnaire/instrument tool and consequently, Jacobson's findings remain essentially unvalidated.

It is apparent from a review of the research in clinical teaching in the professions that effective clinical teaching encompasses a variety of specific teaching behaviours, encompassed in Jacobson's original behavioral categories (Bergman & Gaitskill, 1990; Irby, 1978; Marson, 1982; Morgan & Knox, 1987; O'Shea & Parsons, 1979; Rauen, 1974; Stuebbe, 1980). In spite of the methodological problems (e.g., no consistent tool; small

samples) encountered by clinical teaching researchers to date, there is general consensus that articulate, knowledgeable teachers who demonstrate a positive regard for students and who respect their ability and opinions are effective clinical teachers (McCabe, 1985; Zimmerman & Waltman, 1986).

Studies in teacher education have indicated that students' preferences for clinical teaching behaviours change with their level of experience (Copeland, 1982; Copeland & Atkinson, 1978). Beginning student teachers appear to prefer direct, concrete teaching methods. As student teachers gain in experience and self-confidence, their preferences change to indirect supervision and increasing autonomy in decision-making. Pugh (1983), in her extensive review of research pertaining to clinical teaching, has noted that research in this area is in its "infancy" (p.68). There have been few attempts to validate the findings of others or to determine whether the identified behaviours do in fact affect learning by students. Despite the general congruence of the research of what constitutes effective clinical teaching, only one (Stritter, Hain & Grimes, 1975) concluded that further analysis of the clinical teacher's role was necessary.

#### Process-Product Research

Perhaps the greatest gap in the research pertaining to clinical teaching is the absence of studies measuring how specific clinical teaching behaviours affect student learning. Mosher and Purpel (1972) cryptically remark that it is pointless to continue to evaluate effective clinical teaching until we understand how the processes of clinical teaching relate to its product, and until we can define criteria for effective student performance in the clinical area. The research which presently exists in this area is neither

extensive, nor is it particularly revealing (Layton, 1969; Perry, 1968; Pugh, 1983). For example, LaMonica and her colleagues (1976) evaluated the effects of a seven week program to assist volunteer nursing student participants to develop empathy skills in their clinical practice. Observations by the researchers following the program revealed that the subjects' ability to empathize had increased. However, the authors do not appear to have considered the possibility of the Hawthorne effect in this study.

The effectiveness of a variety of methods of feedback (e.g., pupils using electrical switches to indicate when they did not understand the content presented to them by a student teacher; audio feedback; observational feedback; video feedback) has been investigated to a limited extent in teacher education. Feedback from the clinical teacher which included teaching about reinforcement and discrimination was found to be most effective. Although this research defined clinical teaching in very narrow supervisory terms, it made considerable contributions to the field in its definition of student teacher effectiveness by the measurement of specific teaching behaviours. More recent studies (Hall, 1983; Preston & Baker, 1985) have examined the effectiveness of the clinical teaching of student teachers in regard to the student's satisfaction with their supervisory conferences and to changes in the student teachers' teaching behaviours. The most common form of student feedback in current use is individualized student ratings (Seldin, 1984). Although the effect of student ratings feedback on college classroom teaching has been modest, L'Hommedieu, Menges and Brinko (1990) recently concluded in their meta-analysis of 28 relevant studies that several methodological and conceptual flaws served to attenuate the actual strong positive effects of student ratings feedback. Research in the

use of student ratings has concluded that this method of feedback is most effective in producing desired changes in a student teacher's performance when the ratings are supplemented with additional feedback methods, such as consultation with the cooperating teacher, videotapes of the student's teaching or interaction analysis (Levinson-Rose & Menges, 1981; Menges & Brinko, 1986).

### Novice Versus Expert

A number of research studies have been published in the last decade pertaining to the transition between the novice and expert level of professional competence (Benner, 1984; Corcoran, 1986). Most have claimed empirical support for a theory which describes the domains of skilled performance in a profession, although many researchers acknowledge that further study in the area is required. Fuller (1969,1970) has identified three stages of teacher development in the transition from novice to expert: survival (when the teacher is concerned with her/his own adequacy as a teacher); mastery (when the teacher concentrates on the techniques of teaching); and impact (when the teacher becomes concerned with the effect of her/his teaching on students). Sprinthall and his associates (1983) describe the teacher's transition from novice to expert in terms of a progression through the levels of ego, moral and conceptual development. Benner (1984) used an early version of the Dreyfus Theory of Skill Acquisition to describe data obtained in interviews and participant observation of novice and expert nurses. This theory emphasizes factors such as experience, context and pattern recognition in the development of expertise. No single theory has been tested adequately to conclude that it can be supported, negated or revised. Benner and Dreyfus have criticized research methods such

as protocol analysis, problem simulation and computer modelling in this area of study, arguing that these methods cannot effectively capture the processes of expertise (LeBreck, 1988).

The concept of novice to expert has many implications in the study of clinical teaching, both for understanding the behaviours of students and of novice and expert teachers. The majority of studies have investigated the developmental growth of students; few have pertained to the developmental changes experienced by teachers (e.g., Carter, Sabers, Cushing, Pinnegar, & Berliner, 1987; Carter, Cushing, Sabers, Stein, & Berliner, 1988). The research has not concentrated on how the novice can become an expert as much as the differences between novices and experts.

An impressive body of research describes qualitative differences in the expert's and novice's responses to situational problems presented in a variety of complex domains (e.g., computer programming; social sciences; geometry; algebra; word problems). A large part of these differences can be explained in terms of the expert's superior skill in formulating abstractions of the problem, based on related concepts and an established knowledge base. In contrast, novice problem-solving is concrete, with problems categorized into concrete subproblems (Benner, 1984). Leinhardt (1985, 1986) has conducted numerous studies on what constitutes expert and novice behaviour in the teaching of elementary school mathematics. She has concluded that experts are able to cover a great deal more content in an allotted time than are novice teachers. She contrasts the cohesive and flexible methods of the expert with the fragmented activity of the novice.

Studies of the work of managers are particularly relevant to the study of novice-expert clinical teaching. The literature describing the role of managers and executives (Koontz, O'Donnell & Weihrich, 1980; Levinson, 1981) have overlapped to a considerable extent with the descriptions of others (e.g., Lortie, 1975) who describe the roles and functions of teachers. These studies have contributed a great deal to the understanding of how a manager learns to help other people to change. The people-changing status of the management profession is currently receiving considerable attention from researchers in teacher education who identify a similarity between teaching and the personnel managing professions (Lampert & Clark, 1990).

The effect of experience on the clinical teacher's performance has been extensively investigated by researchers in counselling education. Marikis, Russell & Dell (1985) determined in their study of counselling supervisors that the more experienced supervisors made more self-referent remarks and spent more time discussing the counselling relationship than did the more novice supervisors. Stone (1980) found that expert supervisors generated more statements indicative of their planning for the counselling experience than did the novices. Other studies have failed to generate conclusive findings about the nature of the differences between novice and expert clinical teachers (Goodyear & Robyak, 1982; Hodge, Payne & Wheeler, 1978; Worthington, 1984).

This area of research has been plagued by ambiguity of terms (e.g., each study has a different definition of the term "expert"), as well as a lack of validation of developed theories. The research to date has not effectively tested the assumption that more experienced clinical teachers are also more effective clinical teachers. Usher (1985) has

determined that adults are often resistant to the idea that they can learn from their own experiences and are not always able to reflect on what they have learned. However, considerable progress has been made in the past few years to correct some of its previous limitations. For example, researchers recently attempted to validate Case's (1978) theory of successive stages of expertise in teaching (Bereiter & Scarmadalia, 1986) and Benner and her colleagues have tested Dreyfus and Dreyfus' (1986) transformation theory of expertise in a variety of nursing settings.

### Ethnographic Research

The nature and structure of clinical teaching according to the perspective of the clinical teacher has been examined in six ethnographic studies, four in nursing, one in physiotherapy, and one in teacher education. The earliest of these was conducted by Glass in 1971 as her doctoral dissertation research. She combined the methods of participant observation and interview to discover the realities of clinical teaching for 53 clinical teachers who taught in various baccalaureate nursing programs. Her analysis by means of grounded theory's constant comparison method produced a comprehensive and provocative view of the world of clinical teachers in nursing. Glass introduced the term "guest in the house" in her research report. This term referred to the teachers' experience of belonging to an institution separate from the clinical agency. As "guests" in the agency, the clinical teachers isolated themselves from the nursing staff in the clinical area and tended to teach defensively. They were also preoccupied with the avoidance of errors by themselves or their students, leading to their avoidance of risk-taking. The concept of "guest in the house" is discussed by Clifton (1979) as the marginal role of the student

teacher in teacher education; by Mesler (1989) as the negotiated order of clinical pharmacists in teaching hospitals; by Scully (1974) as the participative guest status of physiotherapy students in the clinical area; and by Melia (1987) as the role of student nurses in British hospitals. Glass also discovered that the clinical teachers distorted the educational process for their students because of their predominantly present orientation and their promotion of expressive rather than instrumental values in nursing.

Pugh (1980) examined the relationship between nursing faculty's perceptions regarding clinical teaching and their actual practices in her doctoral dissertation research. Her study entailed surveys of both faculty and students. Faculty were asked to identify their role identification as clinical teachers, using semantic differential scales (e.g., "I am a teacher"; "I am a nurse who teaches nursing"). Students were asked to rate the frequency of specific low inference teaching behaviours demonstrated by their clinical teachers, as well as the perceived importance of these behaviours. In addition, the researcher observed the fifty clinical teachers for one day as they implemented their clinical teaching activities. The researcher identified a significant incongruence between the clinical teachers' intentions and their actions. She determined that role identification (i.e., Nurse; Teacher; Nurse as Teacher) in combination with congruent role preparation results in the clinical teacher behaving as she/he intends in the clinical area. However, incongruent role identification and role preparation of clinical teachers in nursing produces incongruence in the teacher's ability to teach as she/he intends. Pugh's study is a milestone in the field as it represents the first intensive effort to describe and analyze the context of clinical teaching from the perspective of the clinical teacher.

Carr (1983) proposed to develop a theory which would effectively describe the process of clinical teaching in nursing. Her thirteen week ethnographic study of three medical-surgical nursing teachers in a baccalaureate program focused on the cognitive processes (monitoring, role rehearsal, information processing and demonstration) employed by the clinical teacher. She concluded that clinical teachers structure learning experiences in the clinical area to socialize the students toward a professional ideal nursing image. The information processing and socialization models of clinical teaching which Carr offers are complex and difficult to rationalize as products of the limited data provided in her report. An interesting and unique aspect of Carr's research is her use of interactional analysis to examine the content of the clinical teacher's interactions with students.

Rosenthal (1987) utilized grounded theory to analyze her observations and interviews of three nursing teachers from two community college programs who taught on hospital psychiatric wards. In her fifteen week investigation, Rosenthal discovered a number of aspects of clinical teaching which were contradictory to those identified by Carr. Rosenthal's analysis of clinical teaching concentrates on the interpersonal interactions of the teacher to a greater extent than Carr's research. This appears to be to some extent a reflection of the clinical area in which the participant observation took place. For example, Carr dismissed the concept of the clinical teacher functioning as a role model to students because she asserted that teachers were only able to model teaching. Consequently, the role model concept was insignificant in Carr's analysis. Rosenthal emphasized the role model function of faculty as nurses to be crucial to student

learning in this clinical area. She stated that psychiatry was intimidating for students. Teachers were required to emulate many of the interactional techniques used by nurses in the area in order to reassure students. She also found that the clinical teachers offered much more personal support and positive feedback than did Carr in her study.

It is significant that although the four ethnographic studies of clinical teaching in nursing refer to similar descriptions of the process (e.g., clinical locations are not controlled for student learning; clinical teaching is unpredictable; the patient and not the student is the primary focus in the clinical area), it is the pioneer study by Glass which most articulately and clearly provides a theoretical context for these findings. Her study is not referenced by either Carr, Pugh or Rosenthal. Although each of the four studies have contributed to the understanding about clinical teaching in nursing education, they have failed to develop a theory which may be effectively utilized in practice.

Scully (1974) conducted a three-month grounded theory study of 31 physiotherapy practitioners who taught students in a New York hospital. Many of Scully's findings appear to reflect the primary role of the clinical teachers in her study; i.e., that of a practising physiotherapist. For example, Scully identified that the clinical teachers in physiotherapy education were primarily concerned with the potential risk to patients of students learning in the clinical area. She concluded that clinical teaching in physiotherapy is "a process of pacing the students to professional competency" (p. 2). Learning experiences in the clinical area were chosen by the teachers in accordance with their assessment of the student's readiness to execute a specific skill safely and efficiently. Scully concludes that the clinical teachers in her study were narrowly focused on the

acquisition of particular skills by the physiotherapy students. She suggests that clinical teaching should be much more; students should also be taught the administrative, teaching, and research skills associated with the practice of the profession.

Calderhead (1988) published a report of his ethnographic study of the clinical experience of ten student teachers during one academic year. The report contains detailed analyses of his interviews with the participants of his research, but does not articulate much about the nature of his sample or his method of analysis. Calderhead's research is unique in that he has included the perspectives of teachers, staff and students about clinical teaching. Some of his findings pose interesting contrasts with the research conducted by Glass, Carr and Rosenthal. For example, he referred to the university faculty's value of reflection on experience which at times caused the student teachers, after they had met with their faculty supervisor, to view the practice of their supervising teachers in a new and often negative light. This resulted in the experience of inner turmoil on the part of the student because the loyalties of student teachers tended to be aligned with the cooperating teacher. Glass, Carr and Rosenthal discuss the clinical teacher's dilemma when required to "make sense of" practices by the agency staff in the clinical area which are inferior to the "ideal" which is taught by the teacher. It is apparent in their research that the loyalties of the nursing student are with the faculty member more than they are with the staff nurse in the clinical area.

#### Teacher Thinking

An additional area of research which promises to contribute to the understanding of the experience of clinical teaching is the study of teacher thinking (for comprehensive

reviews, see Calderhead, 1987; Clark & Peterson, 1986; Mitchell & Marland, 1989; Shavelson & Stern, 1981). A myriad of terminology is used in reference to teacher thought. Terms such as reflective inquiry, teachers as action researchers, teachers as moral craftsmen, self-analytic teachers and scholar-teachers refer to those persons who engage in reflective thought about their work. The dissemination of this research has resulted in an increasing recognition among the professions that the work teachers do requires complex cognitive processing (Carter, 1989). Kagan (1988) discusses how the research pertaining to teacher cognition has evolved in the last decade from linear, unidimensional, scientific models to multidimensional, hierarchical, artistic models of decision-making. Research in this area has primarily focused on the decision-making processes of expert practitioners who practise. Its use in clinical education has been limited. Floden and Klinzing (1990) propose that this area of research may contribute insight into the process of student teacher decision-making, student teacher functioning and student teacher learning, as well as influencing educational policies in teacher education.

The research pertaining to clinical teaching in the professions has focused largely on the definition of teacher effectiveness. Proponents of this method of research assume that clinical teaching can be defined by a particular dimension, that is, its characteristic behaviours and activities (Zimmerman & Waltman, 1986). In general, the majority of research in the area of clinical education has been limited by inadequate research designs, invalid conclusions and a lack of replication efforts. Given that clinical education is a highly complex phenomenon (Lampert & Clark, 1990), the research conducted in this area must include the identification of the existing multiple factors which impact upon it.

Clinical teaching should be studied as a qualitative, as well as a quantitative endeavour, defined by the conceptual relationship which defines it (Short, 1984). Ethnographic research offers the possibility of providing a basis in order that researchers may be able to examine these variables and the network of interrelationships in clinical teaching. However, at present, reviews of the research in the area of clinical education (e.g., Pugh, 1983) have concluded with a statement similar to the following by Davies and Armershek (1969) concerning clinical teaching in teacher education:

A review of the research leaves one with a great feeling of urgency to expiate the study of student teaching; given its ascribed importance in teacher education, it is alarming to find so little systematic research related to it. Discussion and descriptive reports are plentiful, but comprehensive basic study of the processes involved is lacking. (p.1384)

### **Issues in Clinical Education**

Dunkin and Biddle (1974) state that a model of teaching should be able to provide a framework in which one can address the questions which plague the profession concerning the complex issues of teaching. The issues which face the professions today in regard to clinical education include those which relate to who should teach, where should they teach, how should they teach, how should they relate to others in the clinical setting, how should student clinical performance be assessed and what are the characteristics and needs of students which affect the nature of clinical teaching? These issues are a reflection of the lack of a theoretical framework to guide the professions as to the nature and structure of clinical teaching. At present, there exists no model of clinical education which sufficiently addresses these issues in order to provide direction

to the professions as to their resolution.

### Who Should Teach?

The professions have struggled throughout their history with the question of who should be clinical teachers. A number of the professions have experimented with a variety of teacher assignment, utilizing practitioners in the field, educators in the professional faculty or a combination of both. The decision about who is more effective as a clinical teacher, the practitioner or the faculty member, is impeded by the lack of a theoretical framework to guide this choice. Often the decision about which of these three alternatives to choose is based on cost effectiveness rather than educationally-based rationale (Bush, 1977).

### The Practitioner as Teacher

Research in teacher education has suggested that the practitioner who teaches students in the clinical area may have the most powerful impact on the students' learning in the clinical experience (Housego, 1987; Housego & Boldt, 1985; Yee, 1969). However, practitioner-teachers tend to be more practical than theory-oriented. Lewis and Kapplemam (1986) have noted that residents demonstrate a tendency to teach authoritatively, rarely functioning as a role model to medical students. Reynolds and Cormack (1987) present strong arguments against practitioners being clinical teachers because practitioners often lack the necessary teaching skills, time and motivation to teach. Studies of feedback regarding students' clinical performance given by co-operating teachers in teacher education have demonstrated that it is frequently inadequate for the purposes of learning, tending to be highly focused on a few, specific situations (Griffin,

1983).

The logistics, politics and personnel practices which must be examined before a field placement can be arranged can be somewhat overwhelming when agency staff are relied upon to teach students in the workplace. Concerns such as sites for clinical placement, travel time, hours assigned, identification of contacts in both the agency and the professional school and legal responsibility for the student's performance in the clinical area must be negotiated between both parties. Logistical solutions have been offered (Thompson, 1983) in order to expedite this negotiation process, but these have been ineffective in answering such debates as whether students should be placed with clinically strong or weak agency staff in their clinical experience.

If the clinical teacher is a practitioner who is employed by the agency, faculty may risk that students will be negatively socialized to the profession, particularly if the practitioner is a negative role model. Tierney (1987) discusses this concern in the analysis of his observation that residents tend to refer to patients in the commonly accepted jargon of the profession (e.g., "vegetable") in order to signify that they have achieved initiation into the medical profession. He expresses a fear that medical students and interns who are taught by such residents will attempt to imitate this behaviour, believing it to be appropriate to the profession.

Clinical teachers in some professions (e.g., medicine, social work) may be expected to provide service for clients/patients as well as teach students in the clinical area. In medical education, residents' time with students is frequently compromised by the demands of heavy patient care workloads and long, fatiguing days in the hospital

(Morgan, 1987). Trying to fit a student's learning needs into the already crowded schedule of a resident adversely affects the quality of clinical instruction offered to medical students (Wilkerson, Lesky & Medio, 1986). Medical students are often assigned the "scut" work on the ward as the residents compete for the "best" patients and for experience in skills and procedures.

Often practitioners who teach are novices to the profession and are consequently unclear about their roles and responsibilities as a clinical liaison in the field. A survey of 64 field instructors in social work education demonstrated that their expectations of the role of the clinical teacher were extremely diverse (Faria, Brownstein & Smith, 1988). The ambiguity of the agency teacher's role in clinical education is often accentuated when the practitioner teacher must interact with more than one professional program, with differing requirements and structures of the clinical experience for students. The roles of the faculty member and the clinical teacher in these situations are frequently overlapping and confusing (Bandler, 1982). Freeman, Logan and Blackman (1986) found in their study that the social workers who taught students often told students that they were incapable of and not expected to assist the student with problem-solving; that is the responsibility of the faculty supervisor.

#### Faculty as Clinical Teachers

Faculty of university-based professional schools often experience conflicts between their role as gatekeepers to the profession and their academic requirements as faculty (Schwebel, 1985). Pressures to publish and to conduct research, as well as the absence of a reward system in teaching, frequently result in faculty viewing clinical teaching as

a lesser priority (Irby, 1987). Lanier and Little (1986) indicate that faculty who supervise student teachers in elementary or secondary schools are "at the bottom of the stratification level" (p.530) at the university.

Part-time clinical teachers are often regarded as a financially feasible option for universities. Part-time teachers offer another advantage: they are more likely to be experienced with current practices in the profession because they generally work as practitioners in the field when they are not teaching (Morgan, 1987). However, part-time faculty may not attend all faculty meetings pertaining to the clinical experience of students in the program, thereby missing vital information and the sharing of creative approaches (Bandler, 1982; Morgan, 1987; Wood, 1987). Part-time faculty are generally bound by contractual obligations not to exceed a specific number of work hours. This results in the teacher being unavailable to students requiring assistance after the scheduled work hours. In addition, some professional programs are staffed by so many part-time faculty that a student may have two or three part-time teachers per term (Wood, 1987). The effects of this situation on the student's ability to learn in the clinical area have not been adequately investigated.

Clinical teachers in professional schools vary considerably in their educational qualifications, commitment to teaching, status and role responsibilities. In nursing education, for example, new clinical instructors often have had little or no preparation about how to teach (Karuhije, 1986). McColley and Baker (1982) found that only about 50% of new teachers in counsellor education had received any training in clinical teaching; 20% of these had attended one seminar on clinical teaching. de Tornyay and

Thompson (1982) observe that many new teachers in nursing are so intent on proving their credibility to the staff and students in the clinical area that they are likely to be oblivious to many factors which affect learning. Clinical teaching improvement workshops/programs have been described and implemented with varying degrees of success in medicine, dentistry, nursing and counselling (Jewett, Greenberg & Goldberg, 1982; McColley & Baker, 1982; Sorbal, 1989). The need to improve clinical teaching has long been recognized by the professions. One of the early studies in medical education, conducted by Miller and his twelve colleagues (MacKenzie, 1988), concluded that medical educators might be the major obstacle to students' learning in the clinical area. A national survey of dental educators (MacKenzie, 1988) discovered that although the majority of dental educators had not received any formal education about clinical teaching, 95% of the respondents indicated they desired such education.

#### Role of the Clinical Teacher

Beyer and Marshall (1990) state that each of the professions share common stressors among their clinical teachers: heavy workloads, multifaceted role expectations and the university's expectation of professional advancement. Added stressors experienced by nursing faculty include assisting students to cope with illness and the personal tragedies of their patients, as well as satisfying the demands of the service agency for patient care and legal requirements (Goldenberg & Waddell, 1990). Stress in clinical teaching is accentuated by the lack of clarity in the professions concerning role expectations for clinical teachers (Fisher, 1983).

Although there appears to be widespread agreement among the professions as to

the ultimate goals of clinical teaching (i.e., the acquisition of knowledge, skills and self-awareness by students), there exists considerable debate about the nature of the clinical teacher's role. Butler and Elliot (1985) identified three central functions of the clinical teacher in social work: management, helping and education. In teacher education, six roles have been assigned to the co-operating teacher: namely, manager, counsellor, instructor, observer, provider of feedback and evaluator (Turney, 1982). Counselling students have identified similar roles for their clinical teachers (Delaney & Moore, 1966) but have negated the need for management or counsellor roles for the teacher. There exists a clear need to resolve the role confusion which presently exists in clinical teaching in the professions, particularly between the teaching and helping/therapeutic aspects of the teacher's role.

### Evaluation

Another decision which poses many problems in clinical education is the matter of how, when, and where students' clinical competence should be assessed. Evaluation is perceived as a frustrating and awesome task for many clinical teachers in the professions, particularly when they are inexperienced in teaching (Wong & Wong, 1987). It is not uncommon for students in the professions to receive evaluations which are late, inexplicit or lacking in meaningful feedback (Dinham & Stritter, 1986). As in all issues which plague clinical teaching today, the lack of appropriate theoretical frameworks to guide these decisions has resulted in each profession attempting a variety of evaluation methods without satisfactory resolution of the issue. Much of the difficulty with evaluation arises from the struggle of the professions to delineate behaviours which

constitute effective practice. An additional factor is the inherent subjectivity of most evaluation methods and tools. Teachers tend to express that they are "passing sentence" on students when they evaluate them (Wood, 1987) and that they have little confidence to do so. Other problems associated with the evaluation of clinical competence have been identified as the narrow representation of what actually occurs in the clinical area (e.g., tact, physical endurance and tenacity are rarely mentioned in evaluation tools), and the bias toward the assessment of the student's skill and knowledge in the clinical area, to the exclusion of assessments of professional and personal attributes such as honesty, caring, and maturity (Messnick, 1989). Medicine and dentistry report the least degree of difficulty with the issue of clinical evaluation, perhaps because these professions are largely competency-based (Barrows, 1987).

In the majority of professions, it is the individual who teaches in the clinical area who evaluates the clinical performance of students. For example, in medical education, much of the responsibility for evaluation of students is allotted to medical residents (Irby, 1987). However, practical skills are tested in the legal profession by examiners who are not faculty of the law school (Smith, 1990). A disadvantage of this separation has been that both the law schools and the bar examiners at times function at cross-purposes to one another. Smith (1990) states that law schools are reluctant to teach the practical skills tested by the bar exam, and the bar examiners are often unaware of changes in the curricula of law schools.

Patient simulation as an evaluation method has recently been adopted by many medical schools across North America to evaluate the decision-making and diagnostic

abilities of medical students. Patient simulation has been found to be an effective tool in measuring medical students' interpersonal skill competence (Schnabel, 1989). Other evaluation methods (e.g., computer assisted evaluation; self-evaluation; criterion reference testing) have been developed by the professions in order to address the difficulties of achieving uniformity and precision of perceptions of the teacher regarding a student's competence. The limitations of each of these methods as accurate indications of a student's ability to practise a profession are identified by authors such as Swanson (1990), Melnick (1990), and Wilson (1990). The major difficulties associated with evaluation methods other than direct clinical supervision relate to the lack of reliability and validity of specific evaluation instruments, as well as the high costs of developing and implementing these alternative approaches.

### Where Should Clinical Teaching Occur?

#### Choice of Setting

An area which remains largely uninvestigated in the professions today is the identification of criteria to apply in the choice of a setting as most appropriate for the clinical experience of students. As in all issues affecting clinical teaching in the profession, the choice of an appropriate setting for clinical education is difficult, if not impossible, if the ideals of clinical teaching (i.e., what the clinical teacher should do in the clinical area; what teaching behaviours promote learning in the clinical area) are not clear. Bevil and Gross (1981) have developed an evaluation tool to be utilized by nursing faculty in the selection of clinical learning settings. The competency-based tool is intended to be shared only with the faculty and not the agency staff. Irby (1987) discusses

the importance of selecting clinical sites for the placement of students based on the availability of effective staff role models. He states that students need to observe exemplary role models in action and to study the behaviours which constitute effective practice. He makes no recommendations as to how these role models are to be identified.

The choice of an appropriate setting for clinical teaching must take into consideration the divergent perspectives of the service agency and the professional school. Academics are expected to teach, conduct research and publish; the mission of the agency is service. The perspective of agencies is immediate; that of professional schools is distant (Bandler, 1982). The unique perspectives of each produce a service-academia conflict when both are required to work together for the purpose of implementing a clinical teaching experience for students. Faculty at times suggest that practitioners in the field are "out of touch" with current theoretical concepts and often practise in less than the ideal manner (Kaltsounis & Nelson, 1986). Practitioners in the service agencies often accuse faculties of "living in an ivory tower". Medical practitioners, for example, have charged that some professors in medical education are researchers and not clinical experts who are able to teach the practice of medicine effectively (Mangione, 1987). Practitioners have claimed that graduates of professional programs are not adequately prepared by the faculty for the "real world" of the profession (Wood, 1987). The graduate of nursing education programs has been said to be lacking in essential technical skills and inundated with the psychosocial theories of patient care; the graduating nurse is said to be able to "analyze and synthesize but not catheterize" (Kramer, 1976, p.95). Education-practice links may also be affected by factors which are unique to the agency or professional

program (e.g., size, history, degree of specialization, funding sources and stage of development). Resolutions to the service-academia schism (e.g., faculty practice; collaborative programs) have been proposed by many authors (Dexter & Laidig, 1980; Infante, 1986; Joachin, 1982) in the professions but to date, none has reported resounding success with any one solution.

### Draining of Resources

Service agencies are beginning to complain about the overcrowding and the draining of resources that occurs when vast numbers of students utilize their areas for clinical experience. As well, the increasing sophistication in technology and the acuity of patients in health care agencies have become a major concern for educators in the professions. The emphasis of agencies offering highly sophisticated service to clients is necessarily on disease and technology beyond the level of a novice student (Irby, 1987; Morgan, 1987; Stemmler, 1988). In response, professional programs have made some adaptations to the traditional mode of clinical education by the use of some untraditional settings, such as home visits to the well elderly (Bevil & Gross, 1981). However, the research regarding the significance of differences in clinical sites has not been conclusive (Dinham & Stritter, 1986). Recently in the literature there has appeared a myriad of studies examining the costs of clinical education to the service agencies. The findings of this research indicate that agencies suffer a financial loss (due to increased use of equipment by novice learners and the disruption of usual routines, causing decreased productivity) when students learn in their clinical areas (Chung, Spelbring & Boisoneau, 1980; Holenen, Fitzgerald & Simmons, 1976; MacKinnon & Page, 1986). The long-term

benefits of clinical education in service agencies (e.g., recruitment of students who will return after graduation to work in the area) have not been widely investigated.

### The Students

An issue of prime importance to clinical teachers in the professions is how to assist a student who is experiencing difficulties in the clinical area (Hunt, Carline, Tonesk, Yergan, Silver & Loebel, 1989). Very few studies of clinical teaching refer to the cognitive and noncognitive difficulties of students in the clinical area. None gives direction as to how the teacher might intervene effectively. The research conducted in this area has been sparse, weakly analyzed and lacking in theoretical insights. Hoy and Woolfolk (1990) determined in their study of the socialization of student teachers that the beneficial and detrimental consequences of clinical education have not yet been effectively identified in the research.

Student anxiety in the clinical area has represented the majority of research in this field. Generally, anxiety is assumed to be an inevitable outcome of the clinical learning experience. Different authors place differing emphases on the degree of responsibility to be assumed by the teacher for the student's anxiety. For example, positive feedback from the clinical teacher is touted by Barr (1980) as the panacea for eliminating and preventing student anxiety in the clinical area. Research related to student stress in the clinical area has largely occurred in counselling education. These studies (Gysbers, 1964; Monke, 1971; Mooney & Carlson, 1976) are generally correlational in nature. No causal statements can be made from this research regarding how or if clinical teaching behaviours affect student stress.

Studies of nursing students have identified their major stressors in the clinical area as the teacher, new and unfamiliar situations, and being evaluated (Pagana, 1989). Conversely, their most satisfying experiences are reported to be working closely with the agency staff when the roles and responsibilities of both are clearly defined. This finding has been replicated in social work and medicine (Brook, Ingleby & Wakeford, 1986; Mangione, 1987).

### The Patients/Clients

Extremely little has been written about clients/patients in the clinical learning process. No model of clinical education currently exists which addresses how clinical teachers should relate to patients/clients in the provision of learning experiences for students. Infante (1985) has questioned whether beginning nursing students can effectively care for patients before they have the necessary level of skill and knowledge to give quality patient care. She also raises the concern that students add to the already large number of persons who read a patient's chart and the danger of breaching confidentiality is increased. Morgan (1987) has expressed a similar concern in medical education, particularly in regard to the increasing acuity of patients in teaching hospitals.

### **Summary**

A brief overview of the literature pertaining to clinical teaching in the professions has been presented in this chapter. It has provided a small glimpse of the factors and underpinnings which interpret how the professions define and structure clinical education. It is readily apparent in the preceding review that the progress made by the professions

with regard to explaining and developing clinical education has been laboured, fragmented and woefully inadequate. The general overall view is one of a search for definitions and structure of clinical education, with a resounding emphasis on problem resolution. The lack of theoretical frameworks to address mutual issues and concerns regarding clinical education is a recurrent theme.

The issues in clinical education today are complex, defying simple solutions. Currently none of the models of clinical education effectively addresses them, although the models proposed by Infante and Diekelmann appear promising. The discussion of issues in this report is not comprehensive (e.g., the issue of how specialization in the professions has affected clinical instruction has not been acknowledged) but it suggests the immensity of the problems and concerns to be addressed in any study of clinical teaching in the professions. It is striking that there has been so little sharing between the professions as to their individual struggles to resolve current issues.

## **CHAPTER THREE**

### **THE RESEARCH DESIGN**

The research methods employed in this research study were selected in order to identify how the subjects explain reality in their own terms. An ethnographic epistemology, based on the social psychology framework of symbolic interaction, was utilized as a strategy for data collection and analysis (Ellen, 1984). Ethnography originated in the research of early cultural anthropologists. Its current definition is frequently clouded by the terminological preferences of the researcher (e.g., Zigarmi & Zigarmi [1980] define ethnography as entering the natural setting in order to conduct field research; Stoddart [1986] defines it as the end product of field research; Leininger, 1985 refers to ethnography as immersion into the cultural experience of others by nurses). However, the essence of these diversified definitions is that ethnography is a process by which the researcher attempts to describe and interpret social interactions between people; the science of cultural description (Wolcott, 1975).

During the past forty years, ethnography has undergone considerable refinement and change (Bryman, 1988). This resulted in methodological and conceptual confusion. One example of the advancements to occur in this period has been the rejection of the researcher as the passive notetaker, who possesses absolute objectivity and neutrality (Ellen, 1984). Ethnographers now embrace the concept of the researcher who functions as a subjective soaker of the culture they study. A "new ethnography" has emerged

which is distinguished by highly sophisticated techniques designed to extract cognitive data (Spindler, 1988). Wolcott (1987) describes the new ethnography as characterized by the rendering of a theory of cultural behaviour which is relevant and plausible and can be used to understand the contextual reality of the subjects' behaviour.

Ethnography was selected for this study because the perspectives of clinical teachers regarding clinical teaching has not been widely studied. According to Erickson (1986), ethnographic research methods are most appropriate when the researcher is seeking to identify the meaning-perspectives of particular individuals in specific events. He identifies the key questions in such research as "What is happening here, specifically"? and "What do these happenings mean to the people engaged in them"? Other reasons for selecting ethnography in this study of clinical teaching include: 1) ethnography is well-suited to the study of the process of professional education (Yunker, 1979); (2) ethnographic studies provide a description of events which may not be available or may be contradicted in self-reports by the subjects (Pugh, 1980); and (3) ethnography provides an opportunity to investigate complex phenomena such as teacher-student interactions within their contextual setting (Rosenthal, 1989).

### **Participant Observation**

The primary research strategy utilized in the research study was participant observation. The term "participant observation" implies more than either participating and observing. It is a field study which may involve a number of modes of data collection (Wolcott, 1987). This study employed passive participant-observation, interviewing,

content analysis of the teacher's documentation, and concept mapping.

The teachers were observed as they taught in the clinical area and as they interacted with the students in the pre- and post-conference stages of the clinical learning experience. A total of 1242 hours of participant observation occurred over the span of ten months in the study. The method was particularly advantageous for observing the teachers' everyday experience in clinical teaching. Often aspects of clinical teaching were so routine and familiar to the teacher that, when asked to comment later, she would often reply that she "had no idea" she had done what had been observed. Participant observation revealed patterns of the teachers' behaviour, as well as providing a direct experiential and observational access to their world of meaning. It entailed tracking, observing and at times, eavesdropping. Tracking the clinical teacher involved following her around as she taught in the clinical area and in pre- and postconferences. Tracking afforded observations of the teacher's activities and her interactions with others as she taught. In between her clinical teaching activities, the teacher "talked out loud" about her perceptions and feelings concerning the situations which arose in the clinical teaching experience. Becker (1985) concludes that a volunteered statement from an informant is less likely to reflect the researcher's biases and preconceptions than one which is made in response to an action (e.g., asking a question) by the researcher. Although the teachers avoided talking to the researcher when they were busy with students, staff or patients, they occasionally were so involved in explaining something to the researcher that they did not notice students or staff waiting to speak to them. Early in the study, this was to present difficulties for two groups of students who reported their concerns to their clinical

teacher.

Teacher #6 to researcher: The students talked to me when you left last week. They said they had some difficulty approaching me about a question or a concern because I was always busy talking to you. I told them that it was so much fun to have someone to talk to about all this. I never had the opportunity to before. But I told them I was here primarily for them, not you, and they should feel free to interrupt us if they needed me. (Fieldnotes: February 8, 1990)

Following these incidents, it was decided that the researcher would signal the clinical teacher whenever another person was waiting to talk to the teacher, and the teacher was not aware of the other person's presence. As well, the teachers regularly asked for feedback from the students as to how the researcher's presence was affecting their learning. These strategies appeared to resolve the difficulty.

Observing the teacher was frequently conducted in an unobtrusive manner. For example, the decisions of the teacher as to which student(s) required the most supervision were readily observed by means of standing in the hall of the unit and observing which rooms the teacher entered and the time she spent in each room. Eavesdropping occurred simply by overhearing people discussing events or situations. Much of the eavesdropping in the study occurred when the clinical teacher met other teachers at coffee or lunch. What was said by the teacher group was frequently the impetus for the researcher to inquire later as to its meaning of the clinical teacher. Becker (1985) proposes that informants may respond differently when they are alone with the researcher than they will when they are with other people. For example, the clinical teachers frequently reported to their colleagues about a student's clinical difficulties in a highly negative and punitive manner. However, later they would discuss the student's difficulties in a much more

positive and optimistic manner.

It is well-established that the very presence of the researcher can affect what is being studied (Berg, 1989; Morse, 1990). If participants are aware that they are the subjects of a research study, they may experience the Hawthorne effect. Generally this effect is short-lived in qualitative research (Berg, 1989) but it may be minimized or prevented by a myriad of strategies (e.g., unobtrusive notetaking) designed to promote researcher invisibility (Berg, 1989; Glaser & Strauss, 1967; Stoddart, 1986). The invisible researcher is able to be present in the research setting, capturing its essence without influencing it (Stoddart, 1986). In the reality of this research study, invisibility was difficult to obtain. The researcher was well known to many of the faculty of the three schools of nursing and to many of the nursing staff of the three hospitals at which the participant observation took place. Initially in the study, the clinical teachers occasionally sought the researcher's advice, particularly in crisis situations about matters pertaining to their clinical teaching (e.g., a staff nurse complained about a student's care; a student quarrelled with the teacher). Students who were aware of the researcher's background in nursing education at times requested assistance when the teacher was not present. Hospital staff who recognized the researcher frequently stopped her and inquired about the purposes of the research. This generally occurred during observation of the clinical teacher's activities in the clinical area and affected the behaviour of the teacher, student and researcher. One clinical teacher threatened to have the reason for the researcher's presence "tattooed" on the researcher's forehead in order that "we can get on with our business without being stopped every five minutes". Much of this behaviour abated over

time. In retrospect, it appears to have been largely a reflection of the "stress of entry" (Field & Morse, 1985, p.91) inherent in the beginning phase of fieldwork. Gentle reminders by the researcher to the nursing staff that she was working as a researcher in the clinical area and should not be disturbed appeared to resolve the difficulty. Hospital staff apparently became used to the researcher's presence and stopped interrupting or asking questions. Students and teachers stopped seeking the researcher's advice within a few weeks of the initiation of the research. Clearly stating the research goals at the beginning of the study, and as necessary throughout the research, served to counter the possibility of students or teachers viewing the researcher as an advisor or teacher (Rosenthal, 1989).

### **Interviewing**

An additional data-gathering technique utilized in the study was dramaturgical interviewing. Dramaturgical interviewing occurs within the context of a symbolic interaction framework and presupposes that the interviewer and interviewee encounter one another in a "face to face interactionary performance" (Berg, 1989, p.14). The interviews which occurred during the research were of two types. Structured interviews occurred at the beginning, middle and end of the study. Interview schedules were developed according to the guidelines recommended by Patton (1980). Accordingly, interview questions were formulated from a list of categories which had arisen from the pertinent literature and/or the data previously gathered. For example, at mid-study Teacher #2 was interviewed. A major category which had presented itself in the observations of her teaching was

"Nursing Staff's Influence on Teaching". Questions relevant to this category which had not previously been answered by Teacher #2 included "How does the number of LPN's affect what students do and learn in the clinical area?" and "What will you tell and not tell your administration about the difficulties you experienced with the staff in the clinical area?"

The initial interviews were tape recorded. However, one teacher expressed discomfort with the recording process. By mid-study, all the teachers stated that they were "used to" the researcher taking notes. Three stated they preferred the notetaking method of recording to that by a tape recorder.

Much of the interviewing of the teachers was conducted by means of unstandardized interviewing. The interview questions were generated by situations which had arisen in the clinical area or to which the teacher alluded in her conversations with the researcher or other teachers. Generally unstandardized interviewing occurred at coffee/meal breaks or immediately following the clinical learning experience. Occasionally, it occurred when the teacher was not busy in the clinical area. However, it was difficult to locate a place on the unit where private conversations could be guaranteed.

A significant aspect of the interviewing process was the use of the teachers' personal language in formulating interview questions. Becker and Geer (1969) caution interviewers to heed the respondent's language in order to prevent misinterpretation of either the interview question or the interviewee's response. The importance of this was illustrated on several occasions. As well as minimizing the possibility of misinterpretation,

this technique generally resulted in the teachers giving more comprehensive and reflective responses to the interview question. For example, Teacher #1 often discussed students as "internal" or "external thinkers" in reference to their degree of dependence on the teacher. When asked to describe how the degree of dependence affected her manner of teaching a particular student, Teacher #1 stated that her role as a teacher was to encourage independence and to discourage dependence. However, when asked how a student's being either an internal or external thinker affected her clinical teaching, she replied:

We need to mould the students to become internal thinkers. They may go to the next teacher who will let them stay external but I think it's important to help them think for themselves. So far I have not received any complaints from the students. I hate nurses who do things by rote.  
(Fieldnotes: October 12, 1989)

An advantage of the researcher being an "insider" in nursing education was that the researcher, by virtue of her experience, could speak the language of those in the field. A disadvantage was that, at times, the researcher had her own terminology for specific concepts and considerable self-monitoring was required to avoid imposing these on the informants.

Interviewing was particularly productive in clarifying and expanding upon what had been observed by the researcher. It also provided a means of validating the researcher's impressions/observations. It is significant that in comparing initial, mid-term and final structured interviews, the final interviews are considerably more extensive in the range of teacher perceptions and affective content than those conducted at an earlier time. This difference could be related to the increased trust of and rapport between the researcher and the interviewees over time. It may also be attributed to the development

of the researcher's interviewing skill with experience.

### **Other Methods**

As well as participant observation and interviewing, the study also entailed document analysis. The teachers shared with the researcher various forms of their documentation of students' clinical performance (i.e., contracts, anecdotal records; skill check-off lists; mid-term and final evaluations). These were compared to the clinical teacher's statements and observed behaviour in relation to the specific students and her general perspective concerning clinical teaching. Document analysis frequently generated further interview questions. It also confirmed or disconfirmed several emergent categories in the collected data.

Concept mapping was utilized at the completion of the field study as a strategy to assist the participants to articulate their knowledge, beliefs and values concerning clinical teaching. Novak and Gowin (1984) have defined a concept map as "--- a schematic device for representing a set of concept meanings" (p.15). Concept mapping provides a visual representation of an individual's mental model of a problem or situation, highlighting the relationships which exist between the central concepts of the individual's map (Danby & Bernard, 1990). Concept mapping enables teachers to move beyond technical rationality in their thinking about the clinical teaching process. It assists teachers to explicate and clarify their assumptions about clinical teaching, as well as to assess the consequences of their teaching behaviours to others (Van Manen, 1977).

The participants in the study were asked to formulate a concept map of their view

of clinical teaching in accordance with the guidelines for concept mapping detailed by Novak and Gowin. In order to stimulate their thinking about clinical teaching, the teachers were provided with a list of major categories which had emerged from their individual data set in the research. The teachers expressed varying degrees of initial concern related to their ability to complete a concept map. Consequently, the procedure suggested by Novak and Gowin was altered significantly. The teachers met individually with the researcher, following a period of time in which they reviewed the list of categories and made some initial attempt to define their view of clinical teaching. During this meeting, clarification was sought about concepts or relationships between concepts which were unclear to the researcher. At times, this questioning initiated a revision of the original concept map by the teacher. Because the teachers were frequently unclear about the meaning of specific categories (e.g., the term "mnemonics" was puzzling to the majority of participants), the teachers were asked to articulate their concept map of clinical teaching in their own words. Later, the teacher and researcher discussed how and if the categories could be substituted for the teacher's terminology. In this exercise, the researcher was forced to substantiate and explain the categories to the satisfaction of the participant. This had an unexpected benefit of validating some categories and suggesting some doubt about others. The researcher mailed each participant her concept map three months after the concept mapping session. At that time, the participants were asked to review their map and to make revisions as necessary (see Appendices 1-6 for the final concept maps).

The exercise of concept mapping was particularly helpful as a means of validating

emergent categories of data and the relationships between them (dimensional matrixes). It did, however, result in some problems. For example, the teachers experienced difficulty differentiating what occurred in their clinical teaching because of various contextual and mediating factors and what was their perspective about clinical teaching. Consequently, although one teacher frequently disparaged evaluation because it was contradictory to her philosophy and values concerning clinical teaching, she included it in her concept map (Appendix 3) because "it was a requirement of the school". Only in discussion with the individual teachers did these incongruities become explainable. Another difficulty was that the teachers assigned different semantic interpretations to their concept maps. The term "evaluation" was interpreted to be verbal feedback (Appendices 4 and 5), the student's self-evaluation (Appendix 4), a formal written evaluation (Appendices 1, 2, 3 and 6) and the documentation by the teacher of students' clinical difficulties (Appendix 1). Teacher #4 suggested that the exercise of participating in the research had made her "more reflective about clinical teaching". She proposed that the study required her to reflect about her teaching more than she would have done if she was not a participant in the research. She also suggested that this reflection may have caused her to change her teaching style. The researcher did not observe any significant changes in this teacher's clinical teaching during the course of the study, nor did the teacher report any changes in interviews. It may have been helpful to test this teacher's assumptions about the effects of reflection on her perspective about clinical teaching by requesting that the participants to complete a concept map at the onset, as well as at the completion, of the fieldwork. This may have served to identify changes which occurred in the teachers' concept maps

over time.

The procedure of data collection in this research study entailed a variety of data collection methods, including participant observation, interviewing, concept mapping and reviews of documents. Each strategy measures different facets of social reality (Bryman, 1988) and together they add to the depth and richness of the findings of the study. Triangulation of research procedures, as well as the utilization of a variety of settings and the diversity of the study sample, were attempts by the researcher to provide procedural rigor in the research, in order that data be accurately obtained and recorded (Burns & Grove, 1987). The relationship between the research questions, the theoretical framework of symbolic interaction and the methods of data collection are detailed in Appendix 7.

### **The Sample**

The participants in the study were six clinical teachers in three schools of nursing: two diploma schools and one university generic baccalaureate program. The researcher contacted the director of nursing in four schools of nursing and requested permission to address the faculty regarding the research project. Three directors gave their permission for the researcher to request volunteers to participate in the research. One director stated that the teachers in the school of nursing would be "too stressed" by the research and she refused to permit the researcher to discuss the research with the faculty. Each of the subjects volunteered to participate in the study following a presentation made by the researcher to the faculty of her school of nursing.

The inclusion of both diploma and baccalaureate programs was intended to permit

a comparison sampling to determine whether or not the unique mission and structure of each program would affect the teacher's perspective about clinical teaching. Two of the teachers taught on a part-time basis as clinical teachers in the university baccalaureate program. Both teachers had never taught in a school of nursing prior to the time of the study, although both had considerable experience teaching in other settings (e.g., community education programs; professional conferences). One of these teachers was prepared at a R.N. level. Although both teachers had been students in the registered nurse baccalaureate program at the university, they were not familiar with the curriculum of the generic undergraduate program. They stated they had received negligible orientation to the school upon employment. They also rarely saw or interacted with other members of the university faculty. Because of their unfamiliarity with the university program, any postulations made about the effect of the nature of the nursing program on the teacher's perspective must be made with considerable reservation.

Four of the participating teachers were full-time medical-surgical nursing clinical teachers in diploma schools of nursing. The average length of experience as a clinical teacher in the sample was 2.8 years; three of the teachers had one year or less of clinical teaching experience. One teacher was prepared at the master's level; one is currently enrolled in a baccalaureate program of nursing and has a R.N. diploma; the remaining were prepared at a baccalaureate level.

The sample size in an ethnographic study is determined by the purposes of the research, as well as by constraints such as subject availability, and time (Bowers, 1986). Originally, the sample size was restricted to four teachers because it was anticipated that

the data base would be extensive, considering that each clinical teacher interacts with a vast number of people in the course of a clinical day. The precedent for utilizing four participants in research of this kind has been established by Field (1982) and Tardif (1984) who have concluded that this number of subjects permitted the researchers to investigate adequately the perspectives of the various actors and to fulfil the intentions of the research. However, because two of the teachers were part-time and only worked for half of the academic year, a decision was made to expand the number of subjects to six.

A number of researchers have determined that students in professional programs change from the beginning to the end of the nursing program in regard to their values, attitudes, and degree of autonomy in the profession (Eisenberg, 1983; Knafl & Burkette, 1975; Windsor, 1987). However, no studies were located which have identified the effect these changes have on how the teacher interacts with the students and interprets his/her role as a clinical teacher. It is also not known if the time of the year affects the clinical teacher's perspective. For example, does the teacher change in her/his interactions with the students as the teacher's workload increases toward the end of the academic year? For this reason, it was decided that the research would take place over the course of an entire academic year and that both junior and senior students would be involved. Two of the teachers in the study taught senior (i.e., second year diploma) students in the clinical area. Two of the participants were clinical teachers of first year diploma students. The university program does not provide a medical-surgical clinical experience for senior students. Consequently, only teachers in the second and third year of the university

program were invited to participate in the study.

The entrance requirements for students in the three programs involved in the study did not differ dramatically, except in the definition of 'mature student' for admission. The university program required 'mature students' to have demonstrated academic proficiency in four university courses prior to enrolment in the school of nursing. The diploma schools accepted students in this category if they were over the age of 21. One participant in the research study stated that one of the students in her clinical group had not engaged in a formal academic activity for 15 years prior to entering the diploma school of nursing. It was the impression of three diploma program teachers in the study that university nursing students "are younger, smarter and have more social supports than diploma students".

Because of the unique structure of the three programs, it was not possible to study all six teachers during the course of an academic year. For example, Teachers #4 and #6 were hired by the university program to teach in the clinical area for a eighteen week term and were involved in the study only for this time period. Because of difficulties encountered in obtaining access in certain institutions, Teacher #5's participation in the study was confined to six months of the ten month academic year.

Each of the six teachers was assigned groups of students on a rotational basis (four to ten students per group; rotations of four to eight weeks). Two of the teachers (#1 & #2) traded groups of students after the first semester of the program. This permitted the researcher to observe not only the teacher's individual response to and interactions with specific students but also to note the students' responses to changes (i.e., new teacher;

new ward; new expectations). These seventeen students were observed for a duration of 20 weeks in the study. The responses of these students to the researcher over time were significant. In general, they appeared to "get used to" the researcher's presence with time. However, if the researcher was away for a prolonged time (e.g., Christmas break), there was a noticeable degree of awareness by the students of the researcher's presence when the researcher returned.

Teacher to researcher: I suspect some Barbara effect today. They haven't seen you for a few weeks and they are more hesitant today than they've been in the last couple of weeks. (Fieldnotes: February 9, 1990)

### **The Setting**

Each of the six clinical teachers who were participants in the study taught on medical-surgical wards in an urban hospital. It is necessary to identify some of the commonalities and differences in the setting characteristics in order to appreciate fully how these affected the clinical teacher's ability to teach and the nature of the data obtained in the setting. Five of the teachers taught on wards in one of two tertiary care teaching hospitals; one teacher taught in a smaller (one third of the bed capacity of the larger hospitals), non-teaching, community hospital. The degree of patient acuity, the sophistication of technological equipment, the number of persons performing specialized services in the clinical area at any one time and the general pace of activity were significantly greater in the larger hospitals. However, even in the tertiary care hospitals there existed notable differences between specific wards regarding these variables. For example, three of the teachers taught for half the year on wards where the primary focus

was rehabilitation and palliation, not restoration or cure. These wards more closely approximated those of the community hospital.

Four of the teachers (#1, #2, #3 & #5) taught in a clinical area in the same institution in which their school of nursing was located. Two taught in a hospital setting affiliated with, but outside of, their employing agency. Four of the teachers had taught on the ward in the previous academic year, and of these, two had taught on the same ward for more than three years.

Access to the clinical agency was provided by the Ethical Review Committee and/or the Director of Nursing of each of the three hospitals. The Director of Nursing or his/her delegate described the nature of the research in writing to the head nurse and nursing supervisor of each ward on which the research would take place. The researcher arranged a meeting with the head nurse of each ward and answered any questions about the project. The researcher requested that the head nurse inform the nursing staff that the research did not require their participation in the study. However, the focus and purpose of the study was clarified for any of the ward staff who requested further explanation. Generally, this introductory procedure facilitated a pleasant and uncomplicated research experience on the wards. However, the participant observation method remained a mystery to many nurses who questioned its validity and significance in comparison with the traditional bio-medical research model. Several nurses asked, during the course of the research, if the researcher "felt silly just hanging around like that" and one concluded that "if you can get a Ph.D. for that, it's amazing".

The wards differed as to their physical structure and the allocation of nursing staff.

Two wards were long and narrow, resulting in difficulties for both the teacher and the researcher to locate each other whenever a temporary separation had been required (e.g., a student requested to speak privately to the teacher). Interviews with teachers on wards which provided private space (e.g., conference room) for her to meet with students were considerably more frequent and in-depth than those with teachers who were necessarily concerned about being overheard in a public room.

### **Role of the Researcher**

A dominant theme in the relevant literature is the discussion of the researcher roles available to participant observers, particularly in regard to the dangers of over-involvement with those being observed (Berg, 1988; Burgess, 1982). Gans (1982) states that even if the researcher wishes to remain marginal to the participants, the participants soon demand of the participant observer some degree of personal involvement. In theory, the marginal role of the researcher affords the luxury of viewing people, events, and situations in a detached, analytical manner. However, because the participant observer is not a cardboard cut-out figure but a person with human needs and desires (Ellen, 1984), the marginal role is often awkward and artificial. The researcher has personal as well as professional needs for support and acceptability (Gans, 1982), for belonging and community (Ellen, 1984). This situation becomes more complex as the researcher is required to maintain a rapport with the participants and to be continually tactful and socially sensitive throughout the duration of the research. As well, being human, the researcher develops specific likes and dislikes for participants and is required in the

marginal role to disregard these for the purposes of the research.

Gans (1982) discusses the tendency of participant observers to meet their personal needs by pretending participation. The internal conflict that results leads to the researcher's experience of guilt and often to overidentification with the participant. Overidentification can cause the researcher to adopt the participants' way of thinking, producing confusion and the loss of critical faculties necessary for data analysis (Hutchinson, 1986).

The research paradigm adopted for the present study is in accordance with that recommended by Connors (1988) and is characterized by reciprocity, collaboration and dialogue in the researcher-participant relationship. Connors states that it is impossible to obtain thick, rich descriptive data if the researcher and participant are emotionally distant. Participants in this research paradigm are assumed to be partners in the research process. As such, they decided, with the researcher, which of the field notes would be reproduced in the research report. The priority of the research became to involve the participants in "formulating the conditions of inquiry" (Simons, 1989, p.119) rather than simply requesting that they conform to the research conventions.

The decision to adopt this paradigm was reached with much hesitancy, fearing that reciprocity of the researcher-participant relationship would result in overidentification and the loss of critical analysis. Although the possibility of reactive effects must be scrupulously controlled, a number of benefits have resulted from the reciprocal relationship. The participants have expressed their appreciation that they share the "ownership" of the data. They have been encouraged to discuss openly with the researcher

how the research process affected them. They are not expected to wait for the publication of the research report to discover how the researcher has interpreted their world. They have given the researcher feedback when they have believed her to have misinterpreted data. They frequently suggested revisions in the research process (e.g., one teacher recommended that students be responsible for introducing the researcher to their patients because the teachers were often too distracted or busy to remember to do this).

The role of this researcher could be described as an "insider". She is well known as a nursing educator and an administrator to many of the nursing staff and the faculty of the hospitals and schools of nursing involved in the research study. The "insider" role facilitated access to and rapport with the participants. Researchers who are perceived as strangers or outsiders may encounter difficulties earning the trust and confidence of the participants (Glazer, 1982). Participants may be reluctant to confide in the researcher until a rapport and trust is established. Geer (1964) indicates that a researcher who is familiar to the participants prior to the research should avoid mannerisms or dress which distinguish the participants from him/herself. Selecting a neutral, approachable role is less threatening to participants than the role of a teacher or an authority. A danger of the "insider" role is that, because of the researcher's familiarity with the field of study, both the participants and the researcher may assume too much, neglecting the familiar and the subtle (Rosenthal, 1989).

Oleson and Whittaker (1968) recognized in their research study that the student nurses they studied attributed six major roles to them (e.g., friend; undercover agent) which in turn affected the participants' interaction with the researchers. Authority roles

may be attributed to the participant observer; the interaction in these situations is typically one-sided, flowing from the researcher (Cassell, 1982). Particularly at the onset of this research study, the participants attributed a variety of roles to the researcher. For example, initially, one teacher frequently referred to the researcher's experience as a nurse educator in her requests that the researcher give her feedback about how she had handled specific situations which had arisen in her clinical teaching.

Students occasionally spoke to the researcher when she was separate from the clinical teacher (e.g., waiting for a city transit bus). On these occasions, they generally provided information about a situation involving themselves in the clinical area and suggested that it would be beneficial to them if "the teacher knew the whole story". One student who had failed her clinical rotation met the researcher on the street and stated that she felt she could confide in the researcher because the researcher was "so kind and understanding" (the researcher had never spoken to the student).

Many of the roles ascribed to the researcher by the clinical teachers have been identified in debriefing sessions, generally following each clinical observation day. In the discussion of the day's events, the teacher often shared her perceptions about the research process. In turn the researcher was able to comment on the role ascriptions which had been observed (e.g., "I wonder why you asked me if you had done OK with X [student]. Why do you think you wanted my opinion on your performance when you know that the research is not about evaluating you?"). Occasionally, teachers and students tested their role ascriptions (e.g., "I know you're not supposed to help me with this but I really need someone to figure this out for me before X [teacher] gets back"). Each time, the

researcher reminded the teacher/student about her researcher role, refrained from giving solicited advice and, when necessary, directed them to refer the matter to someone else (e.g., the program administrative personnel).

Leininger's (1985) model of stranger-friend has been useful in interpreting this behaviour. Leininger's model supposes that participants will initially protect their backstage realities from the view of the researcher. As long as the researcher remains a stranger (i.e., someone who is unknown and unpredictable), the participant may exhibit signs of territoriality and distrust. With time, the researcher who becomes known and trusted by the participants will be permitted access to the backstage realities of the research setting. During the first few weeks of the study, the participants were far more protective of their reality than they appeared to be toward the completion of the field study. Field and Morse (1985) propose that the entry stage of fieldwork is crucial for the researcher; this is the time when establishing the trust of the participants is of paramount importance. It is also the phase of the research in which the credibility of both the research and the researcher will be tested.

The participants began to share their mistakes with the researcher by the second month of the research. Previously, they often shielded the researcher from their errors/omissions (e.g., telling the researcher that she would be "bored" attending a postconference and then much later admitting that she had not wanted the researcher to know that she had planned to ignore the curriculum's agenda for the conference that day). As the teachers and the researchers developed a trusting relationship, the teachers contributed more detail and rich, descriptive data to the research. They began to refer to

past situations in their experience as clinical teachers and to reflect on their meaning. They also began to express signs of caring (e.g., one teacher brought the researcher a flier about supportive shoes because she was concerned about the effect of prolonged standing on the researcher's health). These behaviours are suggestive of Leininger's friendship stage of the researcher-participant relationship.

Occupational roles of the researcher may also influence the participant observation research process. Rosenthal (1989) issues a warning to nurse researchers to avoid intervening in patient care too frequently. Frequent intervention may be interpreted as criticism or the researcher may come to be viewed as a problem solver. The temptation for the researcher to intervene in patient care was difficult at times, particularly when a patient called out to the researcher and the nursing staff did not appear to heed the patient's needs. Occasionally, because to do otherwise would have been awkward and embarrassing, the researcher assisted the clinical teacher by retrieving an article which had dropped on the floor or by performing a minor activity associated with patient care (e.g., pulling up a siderail). These interventions were documented in the fieldnote transcripts and analyzed as to their effects on what was being observed.

### **Preventing/Minimizing Reactivity**

Individuals engaged in qualitative research are faced with the challenge of dual responsibility for systematic, scientific inquiry and a responsibility to the research participants. The role and relationship dilemmas which arise make qualitative research particularly vulnerable to certain invalidating or contaminating effects (Robinson &

Thorne, 1988). A significant concern in this regard is the occurrence of reactivity.

Reactivity has been traditionally defined by behavioral scientists as the response of research subjects to the presence and behaviour of the investigator (Woods & Catanzaro, 1988). The classic instance of reactivity is the Hawthorne effect when research subjects alter their usual behaviour in response to being studied (Berg, 1989). Defining reactivity in qualitative research only as far as to its effects on the research subjects denies the relational and interactional context of such research. A major characterization of qualitative research is that it depends on the relationships the researcher establishes to elicit data. In the process of establishing the trust and confidence of the participants, the researcher uses the self in interaction within the dynamic social context (Davis, 1986). The researcher abandons the idea of absolute neutrality, accepting instead that "there is no way to study a thing without changing it" (Sandelowski, 1986, p.34) or being changed (Cassell, 1982). The emotional investment which is always present as the researcher responds to those being studied affects the researcher's perception and interpretation of data (Drew, 1989). This has been discussed by various authors in terms of researcher "enmeshment" (Swartz & Jacobs, 1979); "immersion" (Robinson & Thorne, 1988); and "going native" (Bowers, 1986; Oleson & Whittaker, 1968).

Sources of reactivity in qualitative research have been identified as the researcher's overidentification with the participants (Berg, 1989); the personal characteristics (e.g., gender) and demeanour of the researcher (Ellen, 1984); the researcher's agenda (e.g., entering the research setting with the intention to correct or improve it) which contravene the goals of the research (Berg, 1989; Ellen, 1984); the presence of the researcher (Glaser

& Strauss, 1967; Stoddart, 1986); the emotional context of the situation being observed (Connors, 1988); and the roles ascribed by the participants to the researcher (Oleson & Whittaker, 1968). A number of strategies to prevent/minimize reactivity in this research study have previously been discussed in the report (e.g., triangulation; unobtrusive observation; remaining in the field long enough to observe the familiar, routine world of the participants, as well as the atypical or sensational). The following strategies were also employed by the researcher in this study:

- 1) the researcher maintained a diary to record her emotional and physical status during the study. These entries were regarded as sources of data to be analyzed for the information they contained and contributed to the research. The "reactionary passages" (Drew, 1989) in the diary were helpful to the researcher in that they resulted in an emotional catharsis, often assisting her to regain her emotional equilibrium and objectivity in the study;
- 2) the research notes were organized to include observations (fieldnotes), interpretations (memos), and comments about the methodological process used (method notes). The method notes contained the researcher's account of her personal reactions to an event or situation, as well as anything else which may have influenced the data collected. As recommended by Glaser and Strauss (1967), the researcher attempted to remain continually self-reflective, noting changes in herself as an observer over time by means of self-evaluation. This required that the researcher honestly acknowledge and meticulously report her feelings, attitudes and behaviour which may have influenced the research process;

- 3) participants' statements and behaviour were compared when the researcher was present and when the participant was unaware of the observer's presence (Becker, 1985);
- 4) the participants (and students) were asked at least once a month in what ways, if any, the presence or actions of the observer seem to have affected the phenomena in question (McCall, 1969);
- 5) data were identified which were never provided spontaneously to the researcher but only upon elicitation by the researcher (Becker, 1985);
- 6) the researcher attempted to attend at all times to the meanings and categories that the participants used to define and construct their world (Emmerson, 1987);
- 7) the frequency and distribution of data were checked in order to assist the researcher to identify behaviour unique to specific individuals, groups and situations (Becker, 1985). An additional benefit of this strategy is that it may identify whether the researcher has formed alliances with certain participants or avoiding certain individuals because of her personal needs and likes/dislikes.
- 8) field notes were written as soon as possible following an observational period to prevent forgetting important details and the researcher consciously avoided discussing the data until after the field notes were completed (Berg, 1989);
- 9) the researcher left the field for a time (maximum one week) when fatigue, boredom or discomfort affected her ability to remain alert and to record data accurately (Davis, 1986; Cowles, 1988). As well, regular breaks from the field were scheduled for the researcher to conduct data analysis (One in every four

weeks). However, because of the conflicting schedules of the participants, this schedule was not always followed;

- 10) the researcher developed a tool for the appraisal of data regarding possible reactive effects because existing tools of this nature (e.g., Becker, 1985; McCall, 1969) were too cumbersome and time consuming for the large amount of data collected in the study. The tool is based on Wiseman's (1987) identification of five factors which shape interactive behaviour: emotional valence; distribution of power; importance of the interaction; goal of the interaction; and the effect of normative or cultural criteria. An example of the use of the appraisal tool is detailed in Appendix 8. The tool has proven to be particularly beneficial not only in the identification of many of the possible reactive effects but also in directing further observations and questioning in the research. The limitations of the tool are that it requires subjective analysis by the researcher. The results of the reactivity analysis are ultimately a reflection of the conscientiousness and self-reflective ability of the researcher (McCall, 1969);

Some of the sources of reactivity in participant observation research and the strategies which were used to minimize/prevent the occurrence of reactivity in the study have been presented in this section of the report. It is not possible to delineate all sources of reactivity within the confines of this report. However, the ability of the researcher to look back thoughtfully on what happened, to recapture the situation and total process of what happened and how the people in the study responded to the researcher is of paramount importance.

### **Ethical Considerations**

Oskamp (1984) has derived the following ethical precepts from various ethical codes in the social sciences to be applied to qualitative social research: 1) social scientists should avoid harmful consequences to research participants; (2) all research participants should be told about the research and the likely impact on them so they can give meaningful informed consent to participate; (3) research participants should not undergo any unusual invasion of privacy; (4) deception of research participants should be avoided as much as possible and used only where it is essential to the accomplishment of a highly desirable goal and has been previously approved by a ethics review committee; and (5) research participants should be debriefed soon after the research is complete in order to inform them about the research findings and allay any remaining anxieties. These precepts formed the ethical guidelines for this research. Appendix 8 outlines how the precepts were implemented in the study. The proposal for the research study was reviewed and approved by the Ethical Review Committee of the School of Nursing of the University of Manitoba (see Appendix 9).

### **The Teachers**

The teachers who attended a presentation by the researcher to request volunteers to participate in the study received a description of the study (Appendix 10) which summarized the purpose and procedure of the research, as well as informing the prospective participant of the freedom to ask questions of the researcher and to refuse to participate in all or some of the aspects of the research. Informed consent was obtained

from the six teachers who volunteered to participate in the study (Appendix 11). The researcher met with each group of students assigned to a teacher participant in the study immediately prior to their first clinical experience with that teacher. The purpose of the research was explained to them and they were given the opportunity to ask the researcher questions.

### The Students

The students received a description of the study (Appendix 12), containing similar information to that received by the teachers. They were also asked to complete a consent form (Appendix 13) within an allotted time period (usually 24 hours) and to hand it to the researcher personally or in her office mail slot (the researcher was given office space at two of the three institutions). All of the 172 students signed the consent form, permitting the researcher to observe the teacher participant when she was interacting with the student. Twelve of these students requested some limitations to the consent (e.g., "Not to watch me when I do a procedure for the first time".) All but 13 of these students indicated they wished to obtain a summary of the research findings at the completion of the study.

### Others

Hospital staff, patients and visitors received a verbal explanation of the research when they requested it. However, at times when the teacher or the researcher observed that someone was watching the researcher intently, this information was volunteered.

Although the researcher wore a hospital name tag, it was difficult to read for many patients because the typing is superimposed on a coloured photograph of the individual. The researcher wore a lab coat and street clothes so as not to be confused with a nurse. However, she was on occasion mistaken for a physician or a hospital administrator.

Initially, the teachers had agreed that it would be best for them to introduce the researcher to patients when they saw the patients in the morning of a clinical day. However, the teachers often did not see certain patients until the latter part of the day (e.g., because they were too busy with one student; because the patient was off the ward for a diagnostic test) and they often forgot to introduce the researcher at that time. Some patients asked about the researcher's role directly; others stared intently and waited for an explanation. One patient motioned to the teacher and told her in a whisper to, "Be careful. There's a lady over there taking down everything you say". When the participants and the researcher discussed this concern, it was decided that the students would assume the responsibility for introducing the researcher to their patients. When students forgot to do this, the teacher or researcher assumed this role.

Nursing staff were often reluctant to ask the researcher about her purpose on the ward and generally confronted the teacher, in the researcher's absence, to ask about the research. It had been anticipated that the head nurses would convey the information about the study to the staff but this did not happen beyond a note in the staff communication book (which many nurses did not read) or an announcement in a staff meeting (which many nurses did not attend). Other staff (e.g., physiotherapists; ward clerks) were also initially curious about the researcher's presence. Explanations concerning the researcher's

goals and purposes were a significant part of the researcher's role during the initial two months of the research. These were rarely required after this time period. One unexpected effect of the researcher's presence was that certain physicians who observed the researcher taking notes during their interactions with patients assumed the researcher was interested in the physician's behaviour. The nursing staff on three hospital wards indicated that they wished to hire the researcher because specific physicians "are so much nicer to their patients when she's around".

### The Researcher

The continual data gathering in ethnographic research depended a great deal on the personal ethics of the researcher to guide the study. According to Bryman (1989), researchers in the end must "define for themselves what is ethical in qualitative research" (p.135). This entails a counterbalance of the researchers' perceptions of personal integrity, their responsibilities to their profession and to themselves, and the effects of research activities for their subjects. The researcher was continually required to make decisions about which situations should be observed and which should not. For example, students who were obviously anxious about their clinical performance and who were being closely supervised by their teacher were obviously negatively affected by the presence of another observer when they performed a clinical skill (e.g., they made more errors than usual). The researcher made a decision not to observe these students but to instead interview the teacher about her interactions with the specific student. Students occasionally asked that the researcher not enter their patient's room because their assessment was that their

patient would be negatively affected by the presence of another person in the room. The researcher did not observe teacher-student interactions when the student or teacher indicated she wished to speak privately (e.g., when a teacher spoke to a student about her body odour). However, the teacher discussed these incidents with the researcher after the private discussion, unless the discussion was confidential.

At times, the researcher chose not to directly observe the teacher in interaction with specific patients, because of the sensitive and private nature of the interaction (e.g., a patient was crying about her terminal diagnosis and the teacher was comforting her). An ethnographer is frequently privy to information outside the realm of the study which may have ethical implications (e.g., observing an incident of malpractice). The consent form (Appendix 11) details the procedure for the researcher's management of such a situation. There were times, thankfully few in number, when the researcher experienced a "professional tug of war" (Kim, 1983) between the research goals and patient advocacy. It was wrenching on these occasions to witness behaviours of professional staff in the clinical areas which contradicted the edicts of professional and ethical behaviour. Current theorists recommend two strategies to tackle these dilemmas in participant observation research: (1) avoid intervention until the end of the research study because it may result in the participants perceiving the researcher as a problem-solver or a critic and it may also cause the researcher to experience role conflicts (Arhbold, 1986; Field & Morse, 1985; Swanson, 1986); and (2) intervention should occur when the ethical obligations to the participants or to others in the study take precedence over the goals of the research (Davis, 1986). The "tug of war" experience was always shared with the teacher who was

also a bystander on these occasions. In each of these situations, the teacher eventually reported the incident to an authority in the school of nursing or, infrequently, confronted the individuals involved.

### **Data Analysis**

Fetterman (1990) states that analysis in ethnography takes place in each stage of the research, from the statement of the problem to the writing of the research report. This analysis is iterative and frequently cyclical. Data analysis in the research incorporated the major elements of constant comparative analysis, a method of data analysis developed by Glaser and Strauss (1967) for use in grounded theory research. These elements are detailed in Appendix 7. The constant comparative analysis is accomplished in four stages: 1) comparing the data to each conceptual category; (2) integrating the categories and their properties; (3) delimiting the emergent theory; and (4) writing the theory (Glaser & Strauss, 1967). In contrast to most other data analysis methods, the data collection and analysis occur concurrently, rather than as separate sequential phases of the research process. Agar (1980) describes this dialectic process in the following passage:

--- Glaser and Strauss came up with the elegant statement that in ethnographic research, data collection and interpretation are done concurrently rather than being separately scheduled parts of the research. In many sociological surveys, for example, a questionnaire is designed. Then interviewers go out and "collect the data". The data are then coded and keypunched. Only then does the analysis begin, with the machine-readable data manipulated according to some statistical procedure. In ethnography --- you learn something ("collect some data"), then you try to make sense of it ("analysis"), then you go back and see if the interpretation makes sense in the light of new experience ("collect more data"), then you refine your interpretation ("more analysis"), and so on. The process is dialectic, not linear. (p.9)

The focus of data analysis in the research study was the organization of the many categories which emerged from the data. The data from field notes, interviews, and document analysis were examined comparatively by the researcher who then coded them, indicating by name or term the class of behaviours or situations represented in the data. Emerging categories, referred to as "coded categories" (Strauss, 1987), were identified in the field notes and transcripts by underlining significant words or phrases. This step in the analysis was repeated until the code was verified and yielded no further properties (i.e., the category was saturated). For example, one coded category which was identified early in the study was the "Teacher As Public Relations Official". Sub-categories of this category were also coded (e.g., "Staff Expectations of Teacher" and "Staff Expectations of Students"). Further properties of this category were identified as additional indicators of the conceptual code and the category was renamed "Relations with Nursing Staff" and later, "Temporary Systems".

The coding and analysis of data by means of the constant comparative method may be likened to completing a gigantic jigsaw puzzle. The categories were developed by means of inductive inference, derived from patterns which emerged from the data. The data was ferreted out into discrete categories which were then "fitted into logically, interrelated categories" (Carr, 1983, p. 123). This process assisted the researcher to identify the central elements of clinical teaching and the relationships which exist between them.

The identified categories were developed, checked, revised, and rechecked until the category was saturated. An example of this saturation process occurred in the refining

of the category initially entitled "Helping Students". For some time in the study, the teachers demonstrated a number of behaviours which they stated were designed to help a student experiencing clinical difficulties to succeed in the program. One of these helping behaviours was identified as arranging for the student to meet with the teacher and a member of the school administration to discuss the student's difficulties. However, following one such meeting, the teacher commented, "Well, now she knows for sure what she has to do to pass. And if she doesn't do it, she's out". Further discussion with the teacher revealed that a concealed agenda of this meeting, known only to the teacher and the administrator, was to convince the student that there was little chance of her being able to fulfil the requirements of the school and that she should withdraw from the program. It became apparent that some behaviours were disguised as helping, but were in fact efforts to remove or extinguish the student from the program. This revelation directed the researcher to ask all the participants how they determined when they should stop helping a student and what behaviours they then employed. It also guided specific observations of the teachers' behaviour in relation to students they perceived as unable or unwilling to be helped. The final result was the development of a category separate from that of "Helping", entitled "Extinction".

Miles and Huberman (1984) suggest that plausibility is the opiate of the researcher who utilizes the constant comparative method. If researchers believe that the emerging categories are commonsensical, congruent with their world view, they are likely to assume that they are correct. The strategies recommended by Glaser (Burgess, 1982) and Miles and Huberman were utilized in the research to prevent premature patterning of data and

data-conclusion incongruence. These included using Glaser's eight criteria (e.g., the density of emergent categories) and checking the fit between the schema and the original data. As well, the recommendations of Sandelowski (1986) were adopted in order to ensure the fittingness of the analyzed data in an ethnographic study. Fittingness refers to the applicability of the findings of the research study in the experience of readers outside of the immediate, local context of the study.

The validity of ethnographic research has been widely debated (Bowers, 1986). Most authors have concluded that traditional external validity measures are inappropriate in this kind of research because ethnography represents the subjects' lived experience. The most appropriate measure of validity for an ethnographic study is the subject's validation of emerging categories (Strauss, 1987). Likewise, because symbolic interactionism assumes that meanings are constantly evolving over time, replicability is not guaranteed in this type of research. Ethnographic researchers may address the issue of replicability of their research findings by identifying conditions under which the theory would be expected to apply (Bowers, 1986).

### **Limitations Of The Study**

The major limitations of the research relate to the nature of the sample population. The six clinical teachers volunteered to participate in the research. Their willingness to volunteer may have been a reflection of their interest in and the importance they attached to clinical teaching. It may have also reflected their willingness to discover more about the concept of clinical education, particularly as three of the teachers had no or little

experience as a clinical teacher. If these suppositions are true, it may be postulated that teachers with a lesser interest or need may have interpreted the clinical teaching experience quite differently than did the six participants. As well, the small number of teacher participants limit the generalizability of the findings to other clinical teachers in nursing. However, if the findings "fit" in the experience of clinical teachers outside the immediate local context of the research, these possible limitations are not significant concerns.

It may be argued that the clinical teachers may have attempted to demonstrate what they considered to be ideal teaching practices when observed by the researcher and, thus, the findings are not representative of the teacher's actual practice. Berg (1989) refutes this argument in his review of qualitative research methods, stating that such an effect of participant observation research is short-lived. As well, several strategies were effected to counter this occurrence (e.g., triangulation of data collection methods).

The variability of medical-surgical wards used in the study may have been a contravening variable in the research. Although it was decided to restrict the sample to teachers of one specialty area (i.e., medicine-surgery) so as to equalize the study population, the teachers taught in clinical areas which bore little resemblance to one another in regards to patient acuity, focus of nursing care and typical workload. For example, the teachers commented that they teach differently on wards in which the focus is rehabilitative medicine versus an acute medical ward.

Although the variability of clinical sites may be a limitation of the study, it also strengthened the conceptual relevancy of categories devised from the emergent data. For

example, the identification of the acuity level of patients in the clinical area as a variable mediating the teacher's ability to teach as she intended was derived from the comparison of the six teachers' responses to the different clinical areas. One teacher in the study changed from a geriatric rehabilitative ward to an acute surgical ward in the middle of the academic year. The comparisons which could be made concerning her teaching behaviour on both wards proved to be extremely valuable in identifying the effects of this mediating variable on clinical teaching.

One teacher commented that the process of participating in the research study had enabled her to become more reflective about her clinical teaching. It is possible that clinical teachers do not engage in this reflection process unless prompted by a request for rationale of their usual practices. It is also possible that the teachers may have changed their teaching behaviours during the research study because of their reflections. However, both the teachers' statements and the researcher's observations belie this.

### **Summary**

This chapter has detailed the data collection and analysis procedures utilized by the researcher in the study. It has explored some of the issues which arose in the fieldwork study, as well as identifying some of the limitations of the research. A predominant theme in the chapter has been that of meaning. The researcher has proceeded with the assumption that she brings to the field a world of meaning which must be acknowledged, and tested in the exploration of the worlds of meaning of the participants. The participants shared the process and the findings of the research with the researcher,

validating and challenging how the researcher interpreted their experience of clinical teaching. It is this interpretation which is presented in the following chapters.

## **CHAPTER FOUR**

### **THE CONTEXT OF CLINICAL TEACHING**

The research study entailed an investigation of both the context and the actual experience of clinical teaching in nursing education. This chapter includes a discussion of the teachers' perspectives about clinical teaching as well as the contextual variables in which clinical teaching occurs. The clinical teacher's perspective and the contextual variables affected the manner in which the teacher interpreted situations/incidents which arose in the clinical area, as well as the way she implemented clinical teaching activities and evaluated her teaching performance. It is the teacher's perspective regarding clinical teaching and the context in which the teaching experience occurs which determine how the teacher makes decisions in the clinical area. The teacher's perspective consists of her theoretical, knowledge and value claims in regard to clinical teaching. It is representative of what the clinical teacher believes to be right and good about clinical teaching; it does not necessarily reflect the teacher's actual behaviour as she taught in the clinical area. The contextual variables discussed in this chapter include: caring, professional identity, and temporary systems . The chapter also identifies a number of mediating variables which influenced how the teacher participants were able to effect their perspectives of clinical teaching. The elements of the context of clinical teaching are represented in schematic format in Figure 1.

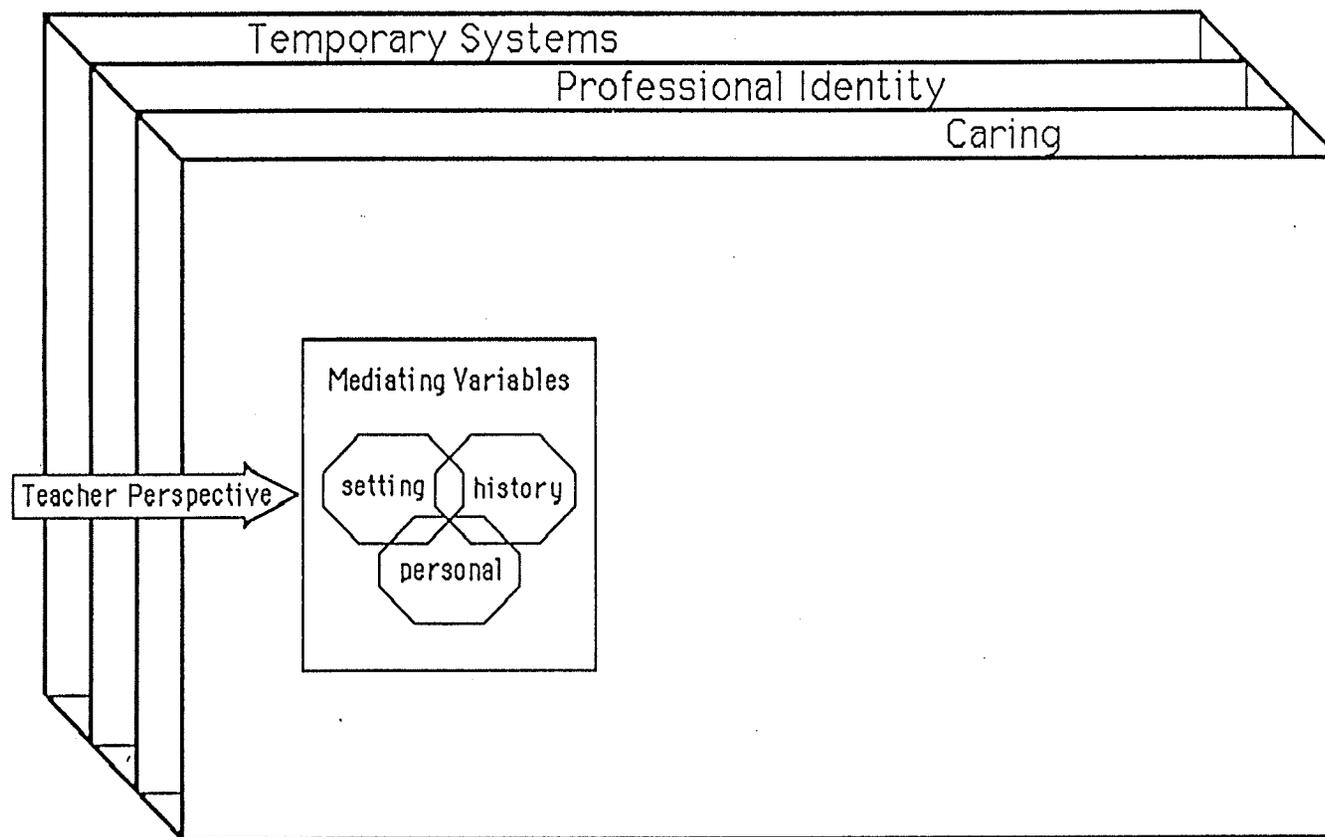


Figure 1. The Context of Clinical Teaching

### The Teachers' Perspectives

The perspectives of the six teachers regarding clinical teaching were identified by means of their initial, mid-term and final interviews; their statements during the field study regarding their beliefs and values concerning clinical teaching; and their conceptual map. They frequently revealed their perspective in their use of metaphors concerning clinical teaching. For example, three teachers referred to "mothering" beginning students; one referred to the clinical teacher as a "manager" of student learning; and all of the teachers referred to their role as "juggler" of the student, patient and staff needs in the clinical area.

To researcher: One time I experienced a situation in which I was coordinating it all on the ward. All the students, all the patients, all the questions from the staff. I lost it. I couldn't prioritize. I couldn't remember things. It was very frightening. Other teachers have described acting like an air traffic controller who's lost it but that was my first and only time. (Fieldnotes: November 21, 1989)

To researcher: Sometimes I feel it is just impossible to juggle all their needs. There's the patients' needs, the students' needs -- both individual and group--- and the staff's needs. I can't seem to see to it all. The acucheck and one subcutaneous took me over an hour. (Fieldnotes: December 7, 1990)

The perspectives of each of the six clinical teachers are compared in Table A. The analysis of their perspectives assumes that clinical teachers approach the tasks associated with clinical teaching, attend to the salient features of specific situations/incidents, and interpret their own performance in accordance with their goals and values in relation to clinical teaching.

#### Central beliefs

The six teachers shared some central beliefs about clinical teaching. All believed

clinical teaching to be an integral part of nursing education and that they, as clinical teachers, are able to affect positive student outcomes in the clinical area. The teachers differentiated between a sense of personal versus general efficacy in clinical teaching; i.e., they believed that they were able to influence positively students' learning in the clinical area; but, in general, it is the students who determine the extent to which they learn in any clinical experience. The less experienced teachers (#2, #4 & #6) initially stated that clinical teaching has a powerful and direct impact on student learning. However, as they gained experience as clinical teachers during the course of the research, they modified these statements in the realization that they were unable to affect all students equally. At the end of the academic year, they expressed the belief that students may choose to learn or not learn in the clinical area (e.g., "They learn in spite of us at times") but that their personal teaching strategies influenced positively most students' learning. Teachers #2 and #6 also demonstrated a tendency to focus their efforts on the students they believed they were most likely to affect.

The six teachers stated that errors were inevitable in learning, although they differed as to their perceptions of permitting students to risk error in the clinical area. All six teachers were generally forgiving and supportive of students who had made errors, providing the student acknowledged his/her accountability for the error and "learned from the experience".

To researcher: I check her (student's) medications now because she goofed up one time and gave the wrong dose. What concerned me was that she really didn't know she had done anything wrong until the nurse pointed it out. (Fieldnotes: March 28, 1990)

A student told the teacher that she had "just realized" she had made a medication error. The teacher had supervised the intravenous medication administration but the student admitted she had not "really read" the patient's identification band and had administered the medication to the wrong patient. The teacher gave her specific directions about what she should do and who she should tell about the error. She said: You're obviously very flustered about this, X. We'll deal with it and it will be fine. Do you want me to give the other patient Y (medication) or do you want to do it?

Later, the teacher told the student that the error had been "a good lesson". She said: Let me say this though. I'm confident in your ability to do the right thing. Although you've made one error, everything else has been good. The ticket now is how are you going to get back onto the horse? (Fieldnotes: February 27, 1990)

On questioning a student, the teacher discovered that student had omitted exercising her patient's legs because she was afraid that the patient's osteoporosis had caused her limbs to be too fragile and that they might break.

That's honest of you to admit that. Now what could have helped you in this situation? (Fieldnotes: November 13, 1989)

Success, both theirs as a teacher and that of the students, was viewed as the result of perseverance and effort. Failure was perceived as resulting from a lack of effort and/or a lack of commitment to the individual's role as a teacher or student. The teachers varied considerably in regard to other aspects of clinical teaching. Their similar and different goal orientations, differing ways of perceiving and responding to information, as well as their differences in self-regulatory behaviour are represented in Appendix 14.

#### Predominant Goal Orientation

Three of the teachers' demonstrated goal orientations representative of the structures of teacher motivation classified by Ames and Ames (1984). The authors' classification system was useful for categorizing the clinical teacher's predominant goal orientation in regard to clinical teaching. According to Ames and Ames, a teacher possesses a "value-

belief framework" about teaching, or goal orientation, which determines how the individual will respond to specific situations arising in their teaching experience. The authors have identified three systems of teacher motivation (ability-evaluative; task mastery; moral responsibility) which they believe categorize the major ways in which teachers perceive and interpret information about themselves as teachers and their teaching. For example, the ability-evaluative category implies that the teacher's main goal in teaching is ego-protection and the enhancement of his/her self-esteem. Consequently, student failure is viewed by such a teacher as the direct responsibility of the student. Success of students, however, is perceived as due to the teacher's skill and efforts. In contrast, the teacher who assumes a moral responsibility goal orientation is primarily concerned with the welfare and development of students. In this orientation, the teacher blames him/herself for student failures and credits students for positive outcomes. In the task mastery orientation, the teacher focuses on the educational goals for the student, concentrating on what and how important specific tasks are for the student's learning.

As in every attempt to classify the complexities of human behaviour, the system proposed by Ames and Ames did not totally address the variations within the individual teachers. The teachers participating in the research study attested to different goal structures or a combination of goal structures at different times in the research. For example, Teacher #3 was initially more moralistic in her goal orientation and became more mentoring-oriented during the academic year. This appears to be somewhat reflective of the nature of students she taught; i.e., as the second year students in the diploma program neared graduation and the period of professional autonomy, the

mentoring orientation became increasingly applicable. The orientations represented in Appendix 14 are indicative of the predominant goal orientation of each clinical teacher during the research study. They were determined by counting the transcribed fieldnotes which were deemed to be representative of each goal orientation and identifying the orientation which encompassed the majority of fieldnote items.

#### Effect of time

Comparisons were made between the individual teacher's statements regarding their perspective over time during the study. It is significant to note that in general, value claims (e.g., the teacher's primary concern) identified in the teachers' initial interviews do not contradict the perspectives they diagrammed in their concept maps at the end of the research. There were, however, substantial differences during the course of the study in the teachers' knowledge claims concerning clinical teaching. For example, Teacher #6 altered her beliefs about questioning students in the clinical area because of student feedback and her observations regarding the impact of the questioning on student anxiety. She did not revise her value of evaluating students' knowledge or her value of the teacher as gatekeeper to the profession because of these situations. She merely changed her strategies to accomplish her intentions. Although the teachers spoke about how their practice as a clinical teacher would and had changed because of their reflections concerning recent teaching experiences, no major changes in their value claims were identified during the course of the research. This may be explained by the timing of the final interview and the concept map. These occurred at the end of the teacher's academic year, shortly before their summer vacation period. It is conceivable that teachers do not

reflect upon their teaching to the degree that it will result in an alteration of value claims unless they are in an environment which offers physical and psychological space, free from the demands of the academic institution (i.e., a vacation). Four of the teachers reported they had previously made changes in their values concerning clinical teaching while reflecting during the summer months about their previous year.

Last year I almost killed myself trying to get all the skills I could for my students. I figured that this would be probably their only time in quite awhile to be on such a busy surgical ward and to get all this practice. But during the summer, I've thought about it a lot. Sure they had lots of skills but I rarely got the chance to talk to them about how they were doing or about their patients. Plus I was exhausted. I was afraid they'd go into second year (of the program) and the other teachers would think I had not done my job. I decided to still try and get them as many skills as I can but to be more realistic. They'll get the opportunity to do IV's (venipuncture) with someone else if they don't do it with me. Plus I knew that just because someone left X (ward) without IV meds (intravenous medications), that didn't mean I was a bad teacher. I knew that it was OK not to be all things for all the students. (Interview, August 20, 1990)

It is conceivable that changes in the teachers' value claims concerning clinical teaching would have been identified if the concept mapping strategy had been utilized at the end of the teachers' summer vacation and at the beginning of a new academic year.

#### Ability-evaluative

The teachers in the study who had previous clinical teaching experience stated that they had evolved their goal orientations over their years of clinical teaching experience. They indicated that when they were new clinical teachers, their orientation was largely ability-evaluative, focusing on themselves, their abilities and the image they portrayed as teachers. They stated that they expended much energy in the early stages of their clinical teaching career determining what was expected of them by the school, by the students,

and by the staff in the clinical area. Students who failed the clinical rotation were viewed by teachers in the ability-evaluative stage of their development as negative "reflections" of the teacher's ability to teach. Successful students were perceived as having been directly influenced by the teacher's interventions, resulting in positive outcomes for the student.

Teacher #6 demonstrated many of the behaviours representative of the ability-evaluative category. At the beginning of her clinical teaching experience, Teacher #6 confessed to spending "hours each night" memorizing pertinent information about all the medications her students were to administer the next day.

To researcher: In the last rotation I thought I had to sign everything the students gave. It's not hospital policy and I just couldn't manage to give it up. I looked up all their drugs in the first rotation. At first, I thought I had to know more than them about their drugs. Now I realize it's just not possible. I can help them to the limit of my experience and I try to keep notes on any new drug I don't know. But sometimes the best I can do is tell the student where she can get the information. That's the reality.  
(Fieldnotes: February 1, 1990)

Teacher #6 regularly volunteered to perform complex procedures, particularly venipuncture, for the nursing staff, in order to attain and maintain a credibility in their eyes.

The teacher told the researcher that she regularly performs "difficult venipuncture" on the ward.

To researcher: I need it for my own practice. To maintain my skill. Also, it helps if the staff sees me as a valuable resource when it comes to this. It hasn't hurt that they know I can get one in where others fail.  
(Fieldnotes: February 1, 1990)

This teacher expressed a great deal of frustration and insecurity about not fully understanding the role of the clinical teacher.

I had hoped to help these students with problem-solving -- what you do with what you see-- as well as assessment, organization and meds (medications). I don't see how I'll get around to it in four short weeks. I would like to know what is really realistic to expect of students in this rotation. (Fieldnotes: February 6, 1990)

I try to focus on those students who are bright. I want to maximize their potential. But at the same time I'm supposed to weed out the students who aren't going to make it. It's a very difficult part of this job. I don't yet understand the criteria I am supposed to use to say someone is incomplete (has not passed the clinical rotation satisfactorily). (Fieldnotes: March 15, 1990)

She regularly attempted to define the expectations of others (i.e., patients, staff, students, other faculty) regarding her role by asking for feedback about her performance as a clinical teacher. She frequently altered her teaching activities in response to this feedback.

To researcher: All my students seem nervous today. I'll try and loosen up a bit, especially about their meds (medications). Maybe I'll try and watch them with their meds without them knowing that I'm watching instead of asking them a lot of questions. (Fieldnotes: March 1, 1990)

In post-conference, a student complained that she had "wasted time" waiting for #6 to supervise her preparation of medications. #6 said she was "aware" of their frustrations and asked if they had "any ideas about what we could do about this". She continued: The med (medication) problem we have been having lately has to do with the increased number of meds each of you is giving. I will now assume that your drug cards are present and with you at all times. I'll check new meds whenever possible but it will no longer be necessary for me to ask you so many questions about each drug. (Fieldnotes: March 15, 1990)

Teacher #6 attempted to fulfil the curricular responsibilities of her role by seeking information in this regard from the coordinator of the program, as well as from other faculty. However, because she was not familiar with all the intricacies of the curriculum, she was frequently faced with incongruities between her practice as a clinician and what the students had been taught. She responded to these occasions by emphasizing the

necessity to "do as you have been taught", while at the same time intimating that a more experienced nurse would choose her method of practice.

To student performing nasogastric tube insertion: What I'd do with him is to be fairly aggressive. I'd like to correct you about one thing. Maybe they taught you in the lab (nursing skills laboratory) to flex the head back but, in my experience, it works best to flex the head forward. (Fieldnotes: March 1, 1990)

To student as they attempted to correct the problem of too much solution in the intravenous buretrol: This isn't really too Kosher but when you're on the ward working, you can do this to fix it (disconnected tubing at insertion site). (Fieldnotes: March 15, 1990)

More experienced clinical teachers in the study indicated that the ability-evaluative phase of their teaching career enabled them to be self-reflective because their prime concern at that time was how they appeared to others and their ability as a clinical teacher. This self-reflection led them to reconsider many of their initial teaching practices and to eventually alter their goal orientation to reflect a less introspective perspective. Teacher #6 illustrated a similar pattern in her first clinical teaching experience. At the end of the academic year, she relied on and sought less the approval of others. She stated that in her self-reflection, she had become "more confident" of what her role as a clinical teacher was and how she should implement it.

#### Moral Responsibility

Teacher #4 was also an inexperienced clinical teacher at the onset of the research. However, she did not demonstrate the ability-evaluative goal orientation. She attributed this to her extensive "life experience" in a variety of fields and to her self-reflections about teaching patients, families, and nursing staff as a clinician. She stated that her personal philosophy in her interaction with others is represented in the moral-

responsibility orientation she demonstrated in her clinical teaching.

To researcher: I believe that if you feel good about what you're doing, it is easier to make brain connections, to keep your channels of communication open. Students who feel good about themselves demonstrate a willingness to learn, a striving, a curiosity, a pleasure in learning. (Interview: December 14, 1990)

The moral-responsibility framework emphasizes the teacher's role as the protector of student welfare and the facilitator of student learning. Teacher #4 viewed her role as clinical teacher as primarily "a catalyst of student learning" (see concept map - Appendix 4). She focused on the abilities of herself and the ward staff to help the students achieve their learning goals. She stressed the concepts of teamwork and dependability in her discussions with students.

To students: In a couple of weeks, I'll be wanting you to have your breaks with the staff. You'll have an opportunity then to learn more about your profession. (Fieldnotes: October 23, 1989)

To students: I believe that a very effective way of utilizing the learning opportunities on this ward is to have you learn from one another. For example, X (student) did Foley care on Mrs. Y last week. Tonight, she'll show Z (student) how to do it. (Fieldnotes: November 13, 1989)

She attempted to provide learning experiences for students in which she anticipated success. She emphasized that the clinical teacher's main role is to "make students feel they are worthwhile and competent". Students who performed satisfactorily in the clinical area were acknowledged by Teacher #4 as directly causing the desired outcome. However, she searched for what she had "done wrong" or "could have done better" whenever a student failed to perform satisfactorily in the clinical area. This introspection was accentuated by her inexperience as a clinical teacher and her lack of awareness about what was "normal" or "usual" in clinical teaching.

Teacher #4 met with students on the ward immediately before their clinical experience was to begin. The students bombarded her with questions about terminology they did not understand, as well as physicians' writing in the patients' charts. Later, she said to the researcher: Am I doing something wrong? They all spoke at once and they had so many questions. (Fieldnotes: October 23, 1989)

Unlike Teacher #6, this teacher did not rely entirely on feedback from others to identify her strengths and limitations as a clinical teacher. The indicators of her ability as a clinical teacher came from the satisfaction she received when a student overcame a clinical difficulty and achieved his/her learning goals in the clinical area.

The moral-responsibility goal orientation was also predominant in the perspective of Teacher #5. Like Teacher #4, she perceived errors to be a learning opportunity for students.

To researcher: I usually allow them (students) a time or two with grace. Until then, I don't expect them to do it perfectly. (Fieldnotes: January 17, 1990).

To researcher: The first time a student does a procedure, I walk them through it. Some teachers evaluate students according to how much interference they have required (from the teacher) but I treat at least the first time as a learning experience. (Fieldnotes: February 28, 1990)

Another similarity between the two teachers who indicated a moral-responsibility orientation was their approach with the ward staff during clinical learning experiences. Teachers #4 and #5 advocated a close, teamlike relationship with the clinical teacher, the students and the ward staff, primarily because such a relationship was viewed as supplementing the clinical teacher's teaching activities. The teacher's definition of her role with the nursing staff in the clinical area is perhaps reflective of Teacher #4's dual role as a teacher and a clinician in the same clinical area; and Teacher #5's role as a teacher

in a small community hospital.

At change of shift report, Teacher #4 introduced students to their buddy nurses and introduced the charge nurse. She said to the nursing staff: We are giving meds (medications) until 1230. We're anxious to learn BP's (blood pressures). Anyone got experience for them in BP's? How about assisting someone to feed? (Fieldnotes: October 31, 1990)

(Teacher #5 to researcher) I don't mind if the staff helps if I know the kid (student) can do it. But if I'm trying to see what the kid can do, I'd rather they didn't. (Fieldnotes: March 16, 1990)

Teacher #5 differed from Teacher #4 in other aspects of her perspective. For example, Teacher #4 viewed students as "growing" as professionals and as persons, requiring the nurturing and support of the teacher to maximize their personal and professional development. She frequently observed that she did not understand why the students appeared so dependent on her, although she emphasized the helper role of the clinical teacher in the majority of interactions she had with students.

The students told Teacher #4 that they needed her help because they were "panicking" about deciphering information from the patient's chart. Teacher #4 sat down with them and assisted them to locate and understand the applicable information in the charts. Later, she said: Is that feeling a little more comfortable now? Remember -- you're not alone. There's not just me but your buddy nurse as well. (Fieldnotes: October 30, 1989)

Teacher #5 stated that clinical teaching was similar to "forming a partnership" in which the student was helped over the rough, unfamiliar terrain of his/her journey throughout their socialization to the profession. Role modelling of the practice of the profession was deemed to be a significant aspect of the clinical teacher's role in this perspective (see concept map - Appendix 4). This teacher viewed the helper role of the clinical teacher as analogous to "giving a student a map and sending her on her way". Student dependency on the teacher was not identified as a major concern by Teacher #5.

### Task Mastery

Teachers #1 and #2 demonstrated a task-mastery goal orientation in their clinical teaching. Their primary focus was the student's ability to master learning goals established by the teacher and the curriculum. These teachers evaluated their performance as clinical teachers based on their ability to provide learning experiences which would result in student mastery.

I went through all the student evaluations yesterday. I've been feeling like I haven't done much this semester and I've been getting away with it. But I realize that only two students have one criteria (learning goal) they need to work on. They are all doing pretty well. I don't know if I'm slipping or what. But obviously I've given them enough. (Fieldnotes: April 19, 1990)

They also attributed student success and failure to their ability to provide appropriate learning experiences.

To researcher: It has been a difficult term in relation to things in my own life. I've not been as proactive, not as on top of things that were happening on the ward so they could get the best learning experiences. I felt I left the term not giving the students as much as I normally do. (Interview: January 10, 1990).

They often stressed to the students that success in the clinical area is interpreted according to the degree of autonomy achieved by the student in the performance of specific tasks.

To researcher: The reward you get for struggling through Term 1 is at the end of the term, you're bored because the students are so independent. (Fieldnotes: February 15, 1990).

To researcher: I told X (student) that it's time she was more self-directed in her time plans. I arranged to meet with her right before her clinical (day) this week to give her cues but she has to be more independent soon. (Fieldnotes: March 9, 1990).

Both teachers concentrated heavily in their clinical teaching on the need to supervise students, particularly when they were performing new or unfamiliar clinical tasks. Both

Teacher #1 and #2 utilized strategies to advertise to the students as to their location in the clinical area at all times: Teacher #1 used a stick-on patch on the door of the room; Teacher #2 used a sign to indicate her whereabouts. Both Teacher #1 and #2 emphasized the necessity of ensuring that students were able to provide "safe patient care". Diekelmann (1988) states that many nursing educators in her research emerged as gatekeepers to the profession. The assumption that the clinical teacher must protect patients from "unsafe" nursing care given by students was central to the perspectives of Teachers #1, #2 and #6. Teacher #1 indicated that as students became increasingly independent in their functioning in the clinical area, the need to supervise them decreased.

Teachers #1 and 2 relied on the structure of the curriculum to identify the major learning goals for students in the clinical area. When ambiguities arose about how these were to be realized, they often consulted with other faculty. They often "judged" the fairness of their expectations of students according to the responses of the other faculty. Teacher #1, who had more clinical teaching experience than Teacher #2, tended more often to disregard the advice of other faculty, particularly if it conflicted with her beliefs about clinical teaching.

To researcher after discussing with three other teachers at coffee about what is appropriate to expect of students in regard to assessment: I've decided I'm not going to yield to the coffee pressure. These first years (students) don't have to be pushed any more than they're ready. (Fieldnotes: November 3, 1989)

To researcher: The students don't have much information on their meds (medications) today. They're having trouble sorting out all that pharmacology but they get the basics. I don't expect them to know any more than I do. But I do expect them to know how to get the information. One teacher here demands so much information. I tell the students that I'll teach them her system if I find out they are going to get her as a teacher.

Otherwise, they only have to know the basics. (Fieldnotes: November 3, 1989)

Teacher #2 described her perspective regarding clinical teaching as a "transfer" of learning from the teacher to the student in the clinical area. The student in this perspective is regarded as "a vessel to be filled" (Fox, 1983, p.153). Accordingly, Teacher #2 frequently issued short statements to the students, intended as the commandments of the profession.

Statements made to one student during a four hour clinical experience: (1) One other thing since I'm here. Never, never hang urinary drainage bags on the rails. (2) Never, never leave your narcotics unattended. (3) Always put your cap (injection cap) in there. (4) Never, never recap your needle with your hands. You might prick yourself. (Fieldnotes: February 22, 1990)

To students: Rule #61474. The bed by the door is #1; bed #2 is by the window. Last year, we had a student who bathed the wrong patient. (Fieldnotes: October 18, 1989)

As well, she indirectly suggested to the students that they needed the teacher in order to learn the practice of the profession effectively.

Teacher #2 told the researcher that she had a "bad cold" in the previous week and had come to the clinical area to teach. She had previously told a student that she should not come to the clinical area with a cold because it might jeopardize the health of the student and the patients. When the researcher asked her to explain this contradiction, she replied that the cold "had gone through the whole (student) group" and she had been "very ill". She continued: we don't get replaced when we are sick and I just couldn't be away when the students were ready to do their vital signs. (Fieldnotes: October 18, 1989)

Teacher #1 described her role as a clinical teacher to shape or mold students into independently functioning professionals. In her concept map of clinical teaching (Appendix 1), she stressed that the goal of clinical teaching is to "help the students to

function" "in order that they be able to give safe patient care". She defined her personal satisfactions in clinical teaching to be when students, by means of her interventions, were able "to put it all together" in their socialization into the profession.

To researcher: These are the rewards of teaching. The student who could recognize that her patient had a C1-C2 collapse because of what I told them last week. Students who put together pieces of data to make a whole picture are so gratifying to me. (Fieldnotes: October 12, 1989)

Both Teacher #1 and Teacher #2 emphasized the provision of "challenging" learning experiences for students in the clinical area. "Challenge" was generally defined by these teachers as the provision of a learning experience which entailed complex and often sophisticated tasks. They frequently presented theoretical content and/or learning experiences in addition to that which the students had already learned in the classroom or the laboratory portion of their curriculum.

The researcher observed that the teacher taught about X (disease) in the clinical area, although the students had not yet taken physiology or pathophysiology content in their classroom lectures. The teacher replied: It is necessary to discuss the basics of the disease process in order that the students not harm their patients and for them to have a better understanding of what their needs are. I don't discuss this practice with the other faculty because the curriculum is not structured this way. It is structured to introduce healthy patients before unhealthy processes are introduced. The feedback from students about this has been very positive, however. They have said it has made the clinical experience more meaningful and interesting. (Fieldnotes: October 11, 1989)

To researcher: We are going to do IV meds (intravenous medications) before they actually get the skill in the lab. I know that sounds awful but if I don't do it that way and I wait until the students are finished their lab in it, I miss out in the opportunities to give them practice in this skill and they leave me not having the opportunity to do any. Some of them will be going to wards for their last posting which don't have IV meds. It seems a shame when Y (ward) has so many IV meds not to take advantage of the opportunity here. (Fieldnotes: February 22, 1990)

Teachers #1 and #2's relationship with the nursing staff in the clinical area was defined by the teachers' expectation that the staff assist them to provide meaningful learning experiences for the students.

To researcher: I found three students and asked them if they wanted to watch a cortisone injection into a joint on the ward. I ask the staff to let me know if anything unusual or interesting is happening on the ward. That way I can avail myself of all the available learning opportunities on the ward for my students. (Fieldnotes: November 30, 1989)

### Mentoring-Professional Identity

The goal orientation adopted by Teacher #3 was not represented in the Ames and Ames structure of teacher motivation. Her perspective of clinical teaching stressed trust in the student's ability to succeed in the clinical area. She told students that they were the "owners" of their learning experience and adopted strategies such as contracting (a written agreement developed by the teacher and the student which details what the student is required to learn, as well as the student's learning goals in the clinical experience) in order to assist the student to identify what he/she desired in their clinical learning experiences. Self-disclosure of both herself and the student in the teacher-student relationship was actively promoted.

To researcher: I say to them that this rotation is dessert. They are free to ask any questions they didn't know in first year and aren't sure they really know it now. I tell them they are all passing. It's time to ask whatever they want and know it won't be held against them. (Fieldnotes: April 2, 1990)

To researcher: Students often come to me thinking I have all the answers for them. I tell them that this is your rotation. You own it. I can help you but you must decide what you want to learn. (Fieldnotes: April 2, 1990)

In this perspective, the teacher's primary concern is assisting students to develop

their individual identity as a professional. The student is encouraged to define for him/herself how they wish to practise the profession. The teacher functions as the mentor who guides, challenges and supports the student as he/she develops this definition. She utilizes her experience and knowledge in the profession to promote the growth and development of the student as a beginning professional.

A student withheld an analgesic because her patient's blood pressure was 94/58. She discussed her decision with Teacher #3.

Find out his baseline BP (blood pressure) and tell me what it is.

"It's 94/56".

So, do you think you should continue to withhold the analgesic?

"No".

That's right. But you had more information. Look at his pulse. It's 72.

Would you expect him to have a pulse of 72 if he was in shock or bleeding? (Fieldnotes: January 4, 1990)

Teacher #3 was writing a clinical experience contract with a student: Anything from your last evaluation you'd like to include?

"Yes. I need to be more independent in problem solving".

You have put down here to increase you assertiveness. Is this a real problem or is this just something you want to work on? Is it the way you do it that's the problem and you don't feel very good about it? Or is it that you're hesitant to approach someone?

"Well, it's more like I have difficulty explaining things to people if I'm nervous - especially doctors". (Fieldnotes : April 9, 1990).

Teacher #3 stated that she found it "almost impossible" in her perspective of clinical teaching to present the practice of nursing to students as a series of commandments which must never be broken. Her preference was to assist the students to "see the whole picture" and to make informed decisions about their patient care.

To researcher: I hate telling students, "This is what you do in all situations". You can feel the walls closing in as you say it. You know that's not how it is in nursing. I hate it. (Fieldnotes: October 25, 1990)

To students: Reality is that you don't do things by the book all the time. Sometimes you have to calculate the risks of the different alternatives open

to you and then make a decision. Remember there's a difference between a dumb and a calculated risk. (Fieldnotes: November 21, 1990)

She also stated that it was contrary to her perspective to strive for "absolute consistency" between the clinical teachers in the school of nursing. Although she acknowledged that a certain degree of consistency was desirable among the teachers, she emphasized that teachers, as well as students, needed to practise their profession according to their individual styles and preferences.

To researcher: Consistency, and how we (clinical teachers) are always stressing the need for it (consistency of clinical teachers' behaviours), puts my hair up. In the real world, where do we see consistency? Students react to differences between teachers as differences in their experience as teachers. Some take more risks with skill, for example. I think the real danger in insisting that all the teachers be consistent is that it will stifle individual styles of teaching. Teachers will stagnate that way. (Fieldnotes: January 8, 1990)

She frequently confronted the inconsistencies within the profession itself and encouraged the students to enter into dialogue about how they as practising professionals would cope with these.

To students: The nursing profession contradicts itself. They tell you that nurses should think for themselves but you're supposed to follow policy. And once you've made a decision, you're to check with at least one other person. (Fieldnotes: October 25, 1990)

The rewards in clinical teaching for Teacher #3 were observing changes and growth in the students' ability to discover meaning concerning occurrences in the clinical learning experience. The essential process was deemed to be the mutual sharing of ideas and knowledge, not the transmission of facts.

To researcher: X had a bad week in the middle of the rotation. She was blindly following everything she was told. I talked to her about that. This week she's much more questioning. (Fieldnotes: January 8, 1990)

To researcher: X (student) had a patient with CHF (congested heart failure). In her head-to-toe assessment, she had completely missed that his IV (intravenous) was two hours behind. When I brought it to her attention, I asked her what she was going to do about it. She said she needed time to think about it. Then she said she would speed it up. I brought up this situation at conference and the brighter ones wanted to slow it down. All of the others said under no circumstances would you speed it up. (November 19, 1989)

The mentoring orientation of Teacher #3 may at first appear analogous to the helper role advocated by Teacher #4. Teacher #4 identified the coaching, enabling, supporting and guiding skills of the clinical teacher to be essential to function as a "catalyst" to student learning in the clinical area. These same skills are inherent in Teacher #3's perspective regarding the mentoring of students. The major difference between the two perspectives is that Teacher #4 viewed these strategies as ways in which the clinical teacher may "help" the student. Her teaching interventions were designed to benefit the student by enhancing the students' learning and welfare. Teacher #3, however, stated that her goal was to utilize these strategies to empower students to "think for themselves".

To student: Now let me come at this from another direction. What are the risks of giving her demerol? What are the risks of not giving her demerol? Write them down and see which list is longer. (Fieldnotes: October 25, 1989)

A student came to Teacher #3 and said she was not sure what to do because her patient was moaning in pain and the night nurse had reported that she had withheld the analgesia because the patient's blood pressure was 90/50. #3 replied: I'd appreciate knowing more about this problem before I can help you.

"Well her BP is baseline. It was 92/52 on admission." OK. That's more like it. That's what I need to know. (Fieldnotes: November 21, 1990)

The teacher-student relationship in the mentoring orientation was viewed by

Teacher #3 as a partnership, mutually beneficial to both her and the student. Reciprocity was characteristic of the interactional process in her clinical teaching. In addition, Teacher #3 emphasized the future role of the students as practising professionals. The other five teachers focused on the present needs of the students.

Teacher #3 to student: Why did you walk with Mr. X down the hall? Why was it necessary for you to go with him?

"I had nothing else to do so I thought I'd keep him company".

What if you had eight patients and this man had come to expect that you'd walk with him? Would you appreciate that then? Why don't you tell him that he's OK to walk alone now? (Fieldnotes: November 19, 1989)

It is important in the discussion of the teachers' perspectives that no one perspective be regarded as the ideal or most effective. Each was associated with definite implications concerning how the clinical teaching experience was implemented and evaluated by the teachers. For example, those teachers with a task-mastery orientation frequently questioned why their students were so "fixated" on the tasks of nursing.

To researcher: They get so stressed if their meds (medications) are a little late because I'm caught up with someone and can't be there to supervise them. X (student) has an OD (once a day) med and it can certainly wait a half hour or so. But she is fit to be tied over it. (Fieldnotes: March 19, 1990)

Both teachers stated that beginning students in the profession need to master the tasks of nursing before they are able to approach the complex interrelationships and the critical analysis necessary to solve clinical problems and to make decisions about patient care.

Teacher #3 attested to receiving many personal rewards (i.e., "making a difference"; "watching them grow"; "learning from them and with them") in the mentoring relationships she established with self-directed students who appeared to welcome the autonomy and challenge of such a relationship. However, she frequently expressed her

frustration when she encountered students who did not choose to enter into the mentoring relationship or did not possess the skills and confidence to assume the role of one who is mentored.

To researcher: X (student) came to me yesterday and said she only had Mr Y (patient) and she didn't think that was enough. I said, "Well, it's up to you. But talk to Z (student) who had him last week and she'll tell you if he's enough work for you. You decide if you want another patient.? She said, "But who should I choose?" I said, "That's up to you". She wanted me to made the decision for her. I just won't do it. (Fieldnotes: October 25, 1989).

### Caring

Caring in nursing entails

---- those human acts and processes which provide assistance to another individual or group based on interest in or concern for that human being(s) or to meet an expressed, obvious or anticipated need. (Leininger, 1980, p.135)

Benner, in her address to nurses attending the Celebration 1990 Conference in Winnipeg, Manitoba, stated that caring is "the primary constitutive role of the nurse". The research study revealed that the clinical teachers, as nurses, also encompass the caring concept as integral to their practice as nurse educators. Caring, defined as the ability to attend to the needs of another while respecting their individuality and personhood (Gaut, 1986), was demonstrated by the teachers in their interactions with students, patients and staff in the clinical area. Teacher #6 referred to caring as "the heart of clinical teaching" (see Appendix 6).

The activities of the teachers which revealed the extent of their caring included attentive listening; getting to know an individual; acting as an advocate; instilling hope and vision; touching; being patient; being humble; being accepting; being fair; and

nurturing. These behaviours were often implemented concurrently and were frequently indistinguishable from one another. Each of these behaviours reflected elements such as concern, compassion, alleviation of stress, support and encouragement. Each was offered as a means of direct or indirect help to another person. Leininger (1984) differentiates between two types of caring: scientific - judgements and acts of helping based upon factual information or knowledge; and humanistic - creative, intuitive or cognitive means of helping others. In the research study, these two types of caring were intertwined and generally indistinguishable in the practice of the clinical teachers. The caring aspects of clinical teaching in relation to patients and staff will be discussed elsewhere in the report. This chapter will focus on the ways in which the clinical teachers demonstrated caring to students.

### Listening

Each of the clinical teachers spent considerable amounts of time both in and away from the clinical area listening to the concerns of students. In general, the teachers believed that even student concerns which were not directly related to the student's clinical experience would ultimately affect the student's ability to learn and perform in the clinical area. Listening was viewed as having four main purposes: (1) it communicated to the student the teacher's concern and interest in him/her as an individual; (2) it provided a cathartic effect which then permitted the student to concentrate more effectively on his/her studies and clinical performance; (3) it assisted the teacher in determining the sources of a student's clinical difficulties; and (4) it permitted the teacher an opportunity to assess the factors which may have influenced the student's ability to

learn in the clinical area. The teachers communicated frequently to the students that their office doors were "always open" to them. Teachers indicated by means of cartoon-like signs on their office doors and formal schedules when they were available to meet with students to listen to their concerns. Frequently, they took individual students for coffee to the hospital cafeteria following the clinical experience in order to "talk things out". Three of the teachers stated that students are "more comfortable" talking to the teacher in the cafeteria than they are in the teacher's office. One teacher commented, "They think 'evaluation' when they come to my office and they think 'chat' when we're talking over coffee".

The teachers in the study were often unsure about what they should do as follow-up concerning information which had been shared with them by the students. For example, often students told them about horrendous personal situations (e.g., sexual abuse; alcoholism; marital infidelity) which were affecting their ability to learn, yet they refused to see a counsellor about these concerns. As well, students sometimes asked for special dispensations because of unusual circumstances or stressors in their personal lives.

To researcher: Several students have come to me to say they are having personal problems and pressures and that I should consider that when I make out their (patient) assignment. I haven't quite figured out yet what I should do about that. I don't want to stress them unnecessarily but, at the same time, I don't want them to lose out on the opportunity to learn. (Fieldnotes: February 6, 1990)

At times, the clinical teachers altered their expectations and requirements of the student because of the students' personal concerns.

To researcher: X (student) came to see me yesterday about her personal problems. They are overwhelming. I've given her a mild assignment today to help her get her things together. She needs to feel good about what she

does. (Fieldnotes: November 3, 1989)

The teachers were often offered confidential information from students concerning the difficulties experienced by one of their classmates. The teachers did not encourage this practice and generally stressed that the students should convince the classmate to speak to the teacher directly about these matters. Although at times they admitted to being "tempted" to hear this type of information, the clinical teachers refused it because, to do so, would constitute a breach of the other student's confidentiality and would demonstrate "not caring" for that student.

A difficulty frequently encountered by the teachers was when students confided that it was the stressors associated with the curriculum which were interfering with their learning. This was particularly problematic for the teachers when they disagreed with the practices or aspects of the program which the students found to be stressful.

To researcher: A thing that concerns me about this program is the time element. They (students) are in class all day before they come here and they usually have exams or major assignments to prepare for during the week. I would rather that they came to clinical (the clinical area) energized than overwhelmed. There is only so much a human body can stand. I think these students are fairly stressed by the demands on them. (Fieldnotes: November 21, 1989)

Each of the teachers discussed clinical teachers in their faculty who were known to be the major sources of student anxiety in the school of nursing. These teachers were described as being "overly demanding of the students"; "too harsh"; "uncaring about students" and believing that "having unrealistic expectations of students makes you a competent teacher". The clinical teachers in the research stated that they had "little respect" for such teachers and that "they should never be allowed to teach".

### Knowing

All of the teachers stated that it was "necessary" to know their students in somewhat of a personal way in order to maximize the positive student outcomes associated with clinical teaching. Knowing about who the student was as an individual, with individual needs and interests, was believed to enhance the teacher's ability to provide "meaningful learning experiences" for the student and to minimize student anxiety in the clinical area. The clinical teachers "knew" their students by observing their patterns and styles of learning and by listening to their statements regarding themselves and others. At times, the teacher expressed a need to "know" a student in order to validate an aspect of a student's confession of which the teacher remained sceptical.

To researcher: X (student) told me in the first interview that she had a low self concept. She said she was easily dismayed (in the clinical area). It's hard to know at this point if she's being manipulative or genuine. I guess we'll see. (Fieldnotes: November 21, 1989)

"Knowing the student" was closely aligned with "accepting the student"; the teacher's realization and acknowledgement that the student is similar in personhood to the teacher but yet is quite distinct. Each of the six clinical teachers during the course of the research occasionally made revisions to their usual teaching activities and behaviours in order to accommodate the specific needs of an individual student. They were most apt to ignore or minimize student errors when they "knew" the student and accepted that there were unique factors which influenced the student's reactions in a particular clinical experience.

To researcher: The first time that X (student) did meds (medications) was very traumatic for her. She was very nervous about giving meds and she was upset with herself that her drug research had gone poorly. I'm trying

to make it so that her next experience goes smoothly. I've told her what information she needs and I'm telling her it will be fine. (Fieldnotes: February 22, 1990)

To researcher: She's like that with procedures, I've noticed. She reviews them but she's very tentative and asks a lot of questions the first time. Generally, the second time is much better. (Fieldnotes: April 11, 1990)

To researcher: One time I had a student who lied about checking her patient's arm band. There was no arm band. I wanted to give her the benefit of the doubt. I said, "Did you think you had checked it but you actually hadn't?" She said, "No". She'd lied. Then she cried and told me she was under a lot of stress. She was a repeating student and she was so afraid of being caught making a mistake that she lied. It was out of character for her. I think it's sad they are so afraid of being evaluated negatively that they are prepared to lie. (Fieldnotes: March 28, 1990)

#### Acting as an Advocate

The teachers were often protective of students, particularly when the teacher perceived that a patient or staff member had compromised or was about to compromise the student's psychosocial or physical welfare. In these occasions, the clinical teacher "stepped in" and prevented the perceived abuse by functioning as the student's advocate.

The teacher discovered at the end of the morning that the student's buddy nurse had not talked to the student and had left her alone to handle a combative, disoriented and extremely ill patient. She located the nurse at the nurses station and told her "the student would benefit" from the nurse being in the patient's room "as frequently as possible". (Fieldnotes: March 9, 1990)

The teacher met a nurse in the hospital cafeteria and told her that a student would be unable to give a high fleet enema before she left the clinical area that day. The nurse appeared annoyed and asked the teacher twice if she was sure the student could not perform the procedure. The teacher replied: I don't think she could manage that and still be off at 1330. Later to researcher: I hated to do that to them (the staff) but I had no choice. X (student) is exhausted after that catheterization, she hasn't had lunch yet and she still has to do her charting before post-conference. (Fieldnotes: March 19, 1990)

At times, the teachers applied their own experience as students and nurses in empathizing with students in the clinical area. On these occasions, the teacher interpreted the student's need for advocacy according to the fears and anxieties which the teacher had personally experienced as a student or as a clinician in the past.

A student's patient had died unexpectedly after a cardiac arrest in the ward hallway. A nurse asked the student if she wanted "to wrap the body". The teacher told the student that this was "not necessary".

Later to researcher: I could never wrap someone I had looked after. For some people, wrapping a body gives them closure. But not me. I told X (student) she should take an extra long coffee break instead. (Fieldnotes: February 13, 1990)

### Instilling Hope

The teachers generally offered their students a hope and vision of success in the clinical area. There were exceptions to this behaviour and these will be discussed in detail in the next chapter. However, in general, the teachers attempted to instill in the students a sense of self-confidence by means of positive feedback concerning their clinical performance and expressing their confidence in the student's ability. Frequently, they "set students up for successes" in accordance with the teacher's personal definition of student success. This was generally accomplished by assigning the student to patients whom the teacher knew had provided positive and rewarding experiences for other students in the past. As well, they often encouraged students to visualize a positive performance in anticipation of an actual performance event.

To researcher: Some of the weaker students I assign two patients. It helps them with their organizational skills and it also makes them feel special because the rest of the students only have one. (Fieldnotes: November 22, 1989)

To student: Tomorrow when you come (to the clinical area), you'll have

a better time plan. You'll say to yourself, "I'm going to have a better day today". (Fieldnotes: November 30, 1989)

### Patience and Support

The majority of interactions which the teachers had with students during the study were characterized by patience, fairness, humility and nurturance. The teachers frequently expressed their value of patience and fairness in clinical teaching, often criticizing themselves harshly when these constants were not strictly enforced. The teachers stated that students should not be aware if the teacher was "in a bad mood" or was distracted by negative influences in her own life.

To researcher: Not looking harassed as a teacher when you are harassed costs you something. I come to work a half hour earlier just to have coffee and to have time to get ready for all the questions that are going to be thrown at me right when I get on the ward. (Fieldnotes: October 25, 1989).

According to the participants in the research, clinical teachers "have a responsibility to remain calm and objective at all times". The only allowable exception was when students directly compromised patient safety.

To researcher: I hate it when I have to get sharp with students. But they (students) knew she (patient) wasn't supposed to get out of bed alone and they just stood there and watched her while she tried to. I had to snap at them to lift her leg or they would still be there watching her. (Fieldnotes: November 30, 1989)

Fairness in clinical teaching was defined by the clinical teachers in the research as "never humiliating the student in front of others"; "always getting the whole story, including the student's side, before you blame a student for something"; and "treating the student as an individual worthy of respect and the teacher's attention". Positive feedback was frequently delivered in front of patients and staff; negative feedback was always

given to students in private. Students were often told that "no question is stupid" and encouraged to ask the clinical teacher any question which required an answer. One teacher stated that it is "imperative that students feel they will not be laughed at or scowled at when they need the clinical teacher's help".

A student asked the teacher how to remove the suction bottle from the wall in her patient's room. When the teacher went into the room, she discovered that the student had attempted to remove not only the suction bottle but the wall bracket as well. She had used her scissors to loosen the screws of the bracket and it was hanging by one corner from the wall. The teacher explained that the bracket is a permanent feature and that only the bottle should be removed. When the student left the room, the teacher looked around the room, asked the researcher if anyone was nearby and then burst into laughter. (Fieldnotes: October 25, 1989)

When a student intimated that a clinical teacher had been "unfair" in her assessment of the student, the clinical teachers in the study considered such a situation to be "critical" and a "direct attack on the (teachers') ability to relate to students as a teacher". They generally responded by reviewing all the data they had amassed about the student's clinical performance and requesting that a trusted colleague review it as well. Three teachers confessed to "feeling betrayed" whenever a student accused them of unfairness.

The clinical teachers stated it was essential that students know that teachers are not infallible; that mistakes are inevitable and "even teachers make mistakes". They indicated that students who know that their teachers are not perfect are more likely to risk making errors in the clinical area and to report them honestly when they occur. Accordingly, they frequently referred to errors they had committed in the past and acknowledged errors they made during the clinical learning experience in order to

minimize the social distance between themselves and the students and to communicate their understanding and acceptance of student errors.

To student: You can only deal with the immediate situation. I forget about things too, sometimes. I need a plan to help cue me about who I'm supposed to supervise for what. You need a plan too. (Fieldnotes: November 19, 1989)

The teacher apologized to a student for giving her the wrong information about a patient. She said: I'm sorry. It's my mistake but I'm learning too. (Fieldnotes: October 23, 1989)

Nurturance was common in the teacher-student interactions observed in the research. However, the teachers differed as to their interpretations and expressions of nurturance. Teachers of beginning students were more likely to state that these students had a need for "mothering" behaviours of the teacher. Teachers of more experienced students spoke often of "cutting the apron strings" and "getting beyond babysitting" in their relationships with students. Teacher #3 defined nurturing as "helping students to think for themselves and to feel good about what they can do". Nurturing was generally demonstrated by comfort measures, designed to increase or maintain the student's psychological comfort and ease.

To researcher: I sent X (student) off the ward for lunch. We'll do his dressing in the afternoon. He's had enough of me watching him and asking him questions. He can't think straight. (Fieldnotes: February 22, 1990)

To researcher: When I'm talking to the women (students), I notice that their necks are beginning to flush up. I know then that I need to back down and make them feel less threatened. (Fieldnotes: March 27, 1990)

To researcher: I decided to give X (student) her mid-term evaluation one week later than the rest of the students. I wanted to see if she might do better last week and I thought that if she heard she was failing, it would be the end of her. She did much better that week after she calmed down. (Fieldnotes: February 22, 1990)

The teachers frequently gave "one armed hugs" to students, particularly when students had communicated they were frustrated or unhappy. The teachers touched a student's arm or placed their hand briefly on a student's hand whenever the teacher wished to communicate support and understanding by touch. They often made statements such as "You look as if you could use a hug" to students immediately before they actually hugged them.

### Teacher Concerns

All of the clinical teachers agreed that clinical teaching is relational in nature and that, in order for students to trust the teacher and learn effectively, they must feel cared about by their teachers. Caring was so pervasive a theme in their clinical teaching that it was not surprising that the clinical teachers identified the most problematic student as one who did not appear to care about his/her patients and about nursing.

To researcher: I don't know what to do about X (student) and her attitude. I thought I'd assess her as we go along. It's so hard for me to understand why someone wouldn't care for these patients. I'm not sure about this but it sounded like he (patient) was insisting he get out of bed. I don't know what to do about it. I guess I'll just have to watch her with other patients. (Fieldnotes: November 13, 1989)

To researcher: The students who get under my skin are the ones who look totally disinterested and look like they'd rather go skydiving than to be here [sic]. I don't usually give them the most challenging patients first. I save those for the students who are really motivated. (Fieldnotes: March 22, 1990)

The teachers often expressed their frustration that caring, which they considered to be integral to nursing, is so difficult objectively to evaluate for the purposes of documenting student clinical performance. They indicated that it was "almost impossible" to document with objective data a student's lack of caring about a patient, as long as the student were

technically proficient in her/his nursing care.

The teachers commonly expressed their anxiety about evaluating students' clinical performance. Negative or unsatisfactory summative evaluations were often perceived by the teachers to be "contradictory" to their role as the student's caregiver. The teachers rationalized this contradiction at times by emphasizing that evaluation was "a necessary evil", dictated by the school of nursing. Teachers who expressed a belief in their role as a gatekeeper to the profession indicated that expulsion of "unsatisfactory" students from the school of nursing is necessary in order to prevent "unsafe nurses from caring for the unsuspecting public". They often stated that a negative evaluation helps the student to identify why nursing is not an appropriate career choice for him/her and thus, is "ultimately good" for him/her. As well, they frequently referred to the amount of time a student with many clinical difficulties requires from a clinical teacher. They stated that for the benefit of the other students in the group, the clinical teacher "needs to be able to spend her time with all of the students, not just the ones who are in trouble". However, during the course of the research, the teachers experienced much sorrow and frustration about the clinical evaluation of students.

To researcher: I hate to give negative criticism to students. When I find I have to give it, I resent it. (January 17, 1990)

To researcher: I hate this. I've only had a few unsatisfactories (student clinical performance is deemed unsatisfactory) and the amount of grief and stress they cause you is exhausting. (Fieldnotes: May 25, 1990)

Two of the four teachers who "failed" a student in their clinical rotation during the research reported that they experienced the somatic and emotional signs of grief (e.g., insomnia; lack of concentration; altered eating patterns; spontaneous periods of crying)

immediately following this experience. They also stated that the process of obtaining sufficient documentation to justify their evaluation of such a student was "extremely stressful". Another problematic situation for clinical teachers in relation to caring was when they did not know how to help a student; when the usual methods of giving care did not result in the expected positive outcomes for students.

To researcher: X (student) is a problem because she never gives definite clues to me about how she is doing. She has panic in her voice and yet she says everything is fine. And she answers questions in such a way that it is almost impossible to determine what she is thinking. (Fieldnotes: March 27, 1990)

The teachers created emotional meaning in their relationships with students by investing emotion in the students whom they taught. This emotional investment involved both attachment to and separation from students. The clinical teachers were aware of the time limits of their relationship with students, determined by the structure of the curriculum in their school of nursing. Clinical rotations for students were generally four to six weeks in length. The teachers expressed much frustration about "getting to know and to care about" a group of students, only to have them leave in six weeks and to be replaced by another group of "strangers". Two teachers acknowledged that they had learned to cope with this bonding-termination-bonding cycle as clinical teachers by becoming "bored with" students after a certain length of time, usually by the last week of the clinical rotation.

To researcher: It's time to give students up to another teacher. I feel like I've taught them everything I want to. Now I'm ready for Term 2 and new faces. (Fieldnotes: November 16, 1989)

Caring of students by the clinical teachers was revealed in a number of ways,

each intended to communicate to the student that he/she was esteemed and valued as a unique individual. In order for the teacher to implement these caring actions, she obtained knowledge about the student and was aware that there were specific things which could improve the situation for the student. The caring actions were implemented by the clinical teachers, based on the knowledge they had about the student and chosen because the actions were believed to be the most likely to effect positive change in the student. This change, identified as necessary and "good for" the student, was used to justify the choice and implementation of these caring activities.

### **Professional Identity**

Reynolds (1985) and Hughes (1985) have noted the similarities which exist between the clinical teacher-student and the nurse-patient relationship. Stuart and Sundeen (1987) give practical significance to this observation in their suggestion that students develop empathy for their psychiatric patients because they have experienced this kind of caring in their relationship with their clinical teacher. It is apparent in the analysis of data arising in this study of clinical teaching that clinical teachers in nursing education teach as they nurse. It is also evident that their identification with their role as nurses, teachers or nurse-teachers provides a context in which the teacher teaches in the clinical area.

When one is a nurse, one's primary focus and emphasis is the patient. When one is a teacher, the student is the priority. When one is a teacher in nursing, who is the primary concern and what implications does this decision have in clinical teaching? The

six teachers in the study wrestled with this question without total resolution. The six clinical teachers in the study assumed a predominant professional role identity which determined to a large extent the amount and type of their interventions with students in the clinical area. For example, those teachers who attested to a primarily teacher orientation were reluctant to nurse patients with their students, stating that to do so would interfere with the student's opportunity to learn from experience. Teachers who described themselves as enacting the nurse-teacher role in clinical teaching stated that students learned the practice of the profession best by observing and participating with the teacher as she nursed patients. One teacher who regarded her role as primarily teacher-nurse was willing to nurse patients with students as a means of teaching, but also emphasized to students that they needed to "learn for themselves by caring for patients by themselves".

### Primary Role

#### Teacher

Although their conceptions about their primary role differed in specific circumstances, generally Teachers #1, #2 and #6 attested to a teacher role in clinical teaching; Teacher #4 ascribed to a teacher-nurse role; and Teachers #3 and #5 identified their priority role as nurse-teacher. Four of the teachers (#1, #2, #4 & #6) emphasized to the students that the "patient is their first priority" and frequently "sat on (their) hands" to prevent themselves from "interfering" in the student's nursing care. They emphasized the "teacher as a detached supervisor" role in the majority of teacher-student interactions. The notable exceptions were when they developed a distrust of a student's ability to "provide safe patient care"; when they suspected that a student did not empathize with a

patient; and when they wished to demonstrate or "role model" a clinical skill. At these times, they frequently "took over" the student's care, often relegating the student to the sidelines as an observer.

To student at the patient's bedside: That turning sheet is a little low. We'd better change it.

The student replied that she had "just turned" the patient and "he said he had pain" when she did so.

The teacher said: I'll just show you.

She then turned the patient, finished bathing him and put on his ankle supports as the student watched. (Fieldnotes: November 10, 1989)

Teachers #1, #2 and #6 often commented that it was important for the nursing staff and the students to "know that teachers still remember how to nurse". Each assumed a regular nursing task in the clinical area, assuming that observers would interpret this as the teacher enacting her nursing role.

To researcher: I like them to see me hand out trays on the ward. When you get beyond a certain level in nursing, no one expects you to do the mundane things. I see this as role modelling. (Fieldnotes: October 27, 1989)

To researcher: I like to make beds with students. I usually find it a good time to go over things with the student. It's a good time to talk. She also said that this gave her an opportunity to show students that she "was not above doing things like making beds". It also makes her "feel more useful". (Fieldnotes: October 19, 1989)

### Teacher-nurse

Teacher #4 attested to a professional identity of primarily teacher but she also stated that in order to transmit the practice of the profession to students, a teacher must nurse. She demonstrated this concept by "helping" students to nurse their patients, whenever she perceived that they were encountering difficulties. At these times, she tended to "help" the student by assuming the responsibility for the patient's care.

A student reported to the teacher that her patient was refusing the oxygen because it was uncomfortable for him. She said she had explained the rationale for the oxygen to the patient but he had refused it. The teacher went into the patient's room.

To patient: X, it's really important to have oxygen on so you can breathe better.

Patient: OK. Whatever you say. (Fieldnotes: November 16, 1989)

### Nurse-teacher

The two remaining teachers (#3 & #5) nursed patients with the students. They indicated to the student that the student was "the patient's nurse" but they often functioned as a team with the students to resolve clinical problems or to make complex decisions regarding their patient's care.

The teacher and the student, working together, took 1 hour 45 minutes to coax and cajole the student's patient, who had recent surgery, to stand at the side of her bed.

To researcher in hallway when she was going down the hallway to find some equipment they needed: She's (the patient) afraid she's not going to make it. She's tired of fighting.

At one time as she held the patient's shoulders, the teacher said to the student: Why don't you go and get her meds (medications) and I'll stay with her here?

The physiotherapist came in the patient's room after they had finally put the patient back to bed and was prepared to do her chest exercises.

The teacher told the physiotherapist: You can't. We've just finished with her. We've been working with her for the last hour and a half just to get her to cough. You'll have to come back in the afternoon.

Later to student: How are you?

"I don't know. I'm pretty unorganized today".

You handled yourself very well today. We accomplished a lot with X (patient). (Fieldnotes: February 27, 1990)

These teachers were committed to transmitting the practice of the profession by nursing with their students. At times this proved to be a problematic stance. For example, a clinical teacher who spent a great deal of time with one student and her patient, in order to dialogue with the student about nursing, was unavailable during that time to respond

to the learning needs of the other students.

### Patient Advocacy

The six clinical teachers assigned specific students to care for certain patients because of the experiences and skill practice the patient offered. However, the learning needs of the student were rarely considered to be more significant than the patient's needs for care.

A student asked the teacher if she could "please, please" watch a nurse performing a clinical skill. The teacher replied: No, no. You first are responsible for your patients. You see to that first and look after your learning needs after. (Fieldnotes: November 13, 1989)

Frequently, the teacher refused to assign students to a patient because she believed that the patient's best interests would not be served if they were to be cared for by a student.

To researcher: He's a long term patient on this ward. He's quite stoic. It's hard to watch when a student is flustered around him and is making things worse for him. I try to give this kind of patient only so many rookies in their stay. (Fieldnotes: October 25, 1989)

As well, the teachers sometimes chose to assign a patient to a student because of the patient's needs for individualized care.

To researcher: X's (a teacher's) friend is a patient on the ward. She had kind of a bad experience. I decided that seeing as how she was post-op (following surgery) and she needed a lot of assistance and she could use some TLC (tender loving care), I'd assign her to a student. (Fieldnotes: November 30, 1989)

To researcher: I've given X (student) quite an ill patient. She's from the same Y (cultural) background as he is and I thought it would be good for him. He doesn't speak English and X can talk to him in Z (native language). (Fieldnotes: February 22, 1990)

It is significant that although all the teachers adopted this practice, teachers #1, #2 and #6 stated that such a practice was contrary to their knowledge claims about clinical

teaching. They stated that patient assignments should be made on the basis of the experience/skill practice they offered for the student to meet her/his learning needs. This is an example of the contradiction which exists between intent and behaviour which was discovered by Pugh (1980) in her examination of role identification by clinical teachers in nursing.

The teachers in the study, even those teachers who assumed the predominant identity of teacher, functioned at times as advocates for the patients' rights and needs when they supervised the students providing care.

The patient informed the teacher that a group of neurologists were to visit her in a few minutes for the purpose of assessment. She stressed how much she was looking forward to their diagnosis. The teacher said to the student who was just starting to prepare the patient's bed bath: Well, X. You should hurry and get this done. I think she has other priorities than you this morning. (Fieldnotes: October 12, 1989)

The teacher was supervising a student performing a catheterization. The student was quite slow and the patient began to complain loudly that he was uncomfortable. He begged the student to "get on with it". The teacher told the student: OK. Take time to think it through but hurry it up a bit. We started at a quarter to. (Fieldnotes: April 11, 1990)

The teachers also functioned as advocates for the patient when they perceived that the patient was being mismanaged by the nursing or medical staff. Teachers #3, #4, and #5 regularly communicated to the staff their recommendations regarding patient care. Teachers #1, #2 and #6 more often made these recommendations in an indirect manner (e.g., suggesting to a patient that he might ask his doctor why he was receiving a medication) or discussed the incident solely with the students.

All of the teachers admitted that they experienced personal conflict when they assigned a student they distrusted or disliked to a patient of whom the teacher had grown

fond or whom she perceived as needing "special care". This was particularly problematic for the three teachers (#1, #2 & #6) who believed that one way of testing students' ability was to assign them to the patients who required the most sophisticated and complex care.

The teacher gave X (student) feedback about her "manner" with Mr. Y, a patient who had been on the ward for several months and of whom the teacher admitted she was "especially fond". She told X that she seemed not to have had "much to do with older people before". She indicated that X had not told Mr. Y about what she was about to do and had treated him as "if he were senile". She said: Actually, he's a very articulate man. Later the teacher told the researcher that X wants to work in the operating room when she graduates. The teacher said: I think I could have predicted that one. (Fieldnotes: February 13, 1990)

The teachers generally utilized this method of assessment (i.e., assigning patients requiring complex levels of care to a student) for students who were given "one last chance" to succeed in the clinical area before they were given a failing grade in the rotation. These teachers often stated that they were unsure about the ethics of assigning the sickest patients to the weakest student. However, they continued to adhere to this practice.

### Nursing and Teaching

The similarities between how the teacher explained the practice of nursing to her students and her perspective of clinical teaching was remarkable. For example, teachers who stressed that nurses assist patients by meeting their physical and psychosocial needs also attested to a belief in the clinical teacher as the determiner of how student learning needs would be identified and met. Teachers who expressed a belief in students and clinical teachers collaborating together to meet the student's needs for learning emphasized the necessity of active involvement of patients in their plan of care. The teachers' value claims, both as clinical teachers and nurses, were also revealed in the

messages they gave students about nursing care. For example, the teachers commonly stressed to the students the value of being "busy" as a nurse.

The teacher saw three students talking and laughing in the hallway in the clinical area. She said to them: You guys check to see if your resource nurse needs any help? The students replied that their resource nurses were "at coffee". The teacher asked them: So, are there any other nurses who need help? The students said, "We'll check". (Fieldnotes: November 3, 1989)

To students standing in hallway of the ward: Try to be off at 1400. You're supposed to be off at 1415. Ask yourself if you have nothing further to do what can you do to take advantage of this time waiting for (post) conference? (Fieldnotes: February 6, 1990)

However, they also expressed great discomfort when they as teachers were not needed and, hence, not busy. They, as their students, learned to look busy even when their work had been completed.

To researcher: There comes a time in each rotation when the students are quite independent and I have to struggle with not doing anything. You don't want the staff to see you as lazy or not caring about what the students are doing. (Fieldnotes: November 29, 1989)

The teacher commented to the researcher: There is very little to do today. The students are really very independent. She then helped the staff move furniture from a room on the ward to transfer another patient into that room. The researcher asked her if this was one of her responsibilities as a clinical teacher. She replied: No. I don't think this is teaching anymore. I think it's being useful. (Fieldnotes: April 12, 1990)

To researcher: Last week was terrible. All the students did extremely well. I felt completely useless. (Fieldnotes: November 30, 1989)

### Conflicts

All of the teachers were faced with occasions when patients on the ward demanded their time or services as a nurse. These occasions often conflicted with the students'

demands for the teacher's assistance and support. The teachers responded to these occasions according to their definition of their professional identity as a clinical teacher. For example, Teacher #2 viewed her primary role to be that of teacher. Unless the patient's safety was jeopardized by her inaction, she generally avoided "nursing the patients".

A disoriented elderly patient in the hallway called out to the teacher requesting help.

To student: Let's go this way (sidestepped patient).

Later to researcher the teacher stated that she avoids these patients at times "because if I didn't I'd never have time for my students". She admitted that this decision was "difficult" for her as "a nurse hates to hear someone call for help and then have to turn away from them." (Fieldnotes: October 19, 1989)

A patient sitting in the hall was calling loudly for a nurse when the students were observing a nurse give foot care on another patient in the hallway. The students were experiencing difficulty hearing what the nurse was saying because of the patient's cries. The teacher went to see what the lady wanted and spent several minutes with her, missing most of the foot care demonstration. Later she told the researcher that the patient was one "who catches you and never lets you go". She said she usually tries to avoid being "trapped" by the patient.

During the foot care demonstration, a confused patient wandered through the ward doors and set off an alarm. The teacher repeated the following statement twice to the researcher: I didn't even notice her going through those doors. One minute she was standing by me and the next minute she was through the doors. (Fieldnotes: October 26, 1989)

Teacher #4, who believed her role to be one of teacher-nurse, experienced frequent conflict in similar situations, particularly because the patients in her clinical area were accustomed to receiving nursing care from her. She attempted to identify specific "teaching" and "nursing" times for herself, the nursing staff and the patients. However, she frequently experienced difficulty maintaining these boundaries in actual practice.

A patient continued to call for Teacher #4 despite the fact that she was

obviously busy talking to a student. Teacher #4 answered her "Just a minute, X. I'm busy right now." Later, after she was finished with the students, she went to the patient and said, "OK, X. What were you trying to say to me just now?" (Fieldnotes: October 24, 1989)

As the teachers came to know and to care about many of the patients they assigned to their students in the clinical area, patients occasionally utilized this relationship to request specific favours from the teacher. Again, the clinical teacher's response could be predicted by her identification with the teacher, nurse-teacher or teacher-nurse role. For example, one teacher who attested to primarily a teacher role identification was not swayed by a patient's request to have a student be assigned to care for her because the teacher believed the patient would not provide an appropriate learning experience for the student.

To researcher: Mrs. X (patient) called me into her room last week. She was worried I might not give her a student again. She had Y (student) dancing to her orders last week. She told me, "I am a very unusual case. I could teach them lots of things".

The teacher later stated that she would only assign this patient to a student "if it was going to provide a learning experience for the student". (Fieldnotes: November 22, 1989)

Teachers #3 and #5, assuming a nurse-teacher role, addressed these requests according to the perceived advantage of the requested activity to both the patient and the student. If they perceived the advantage to be significant to the patient and the request did not greatly compromise the student's learning, they tended to present the situation to the student as an opportunity to demonstrate caring for the patient. For example, a patient asked the teacher if a student could give him a bed shampoo. No student had been assigned to care for him that day. The teacher asked a student who had completed her work if she would "do this poor guy a favour" and wash his hair. The teacher told the

student that the patient had not had his hair washed "for weeks" and "he really would appreciate it". Teachers #1, #2 and #6 generally regarded similar patient requests from the perspective of their students' needs for learning experiences.

The professional identities of the six clinical teachers were not straight-forward. They often attested to specific desires and ideas about their role as a clinical teacher but were unable effectively to resolve the dichotomies which arose in practice. For example, although Teacher #6 indicated in her concept map of clinical teaching (Appendix 6) that the student was her first priority, she was often called upon by the nature of her role as a nurse to respond to the patient's needs before those of the student caring for them.

To researcher: X (student) has trouble with hand to eye coordination. She went to do an IV med (medication) and I had to correct her in front of the patient; tell her that she had to do something else. The patient was anxious. He told me later that she had made him nervous. I said not to worry because she was doing fine. He trusted me so he relaxed when I said that. (Fieldnotes: March 1, 1990)

All of the teachers questioned their priority as a clinical teacher: i.e., is it the patient or the student? Teachers #3 and #5 were convinced, however, that it was their identity as a nurse which "speaks most loudly" to their students in their socialization to the profession. They, more than the other teachers, were willing to abandon the concept of the clinical teacher as a "detached supervisor" and, for the sake of the students' learning about the profession, adopt a nurse-teacher role.

### Temporary Systems

The clinical teacher and his/her students represent a temporary system within the permanent culture of the clinical area in which they teach. Temporary systems are a "set

of diversely skilled people working together on a complex task over a limited period of time" (Goodman & Goodman, 1976). They tend to include individuals who have never worked together beforehand (e.g., the teacher is assigned a new group of students in each clinical rotation) and who do not expect to work together again. Temporary systems rely strongly on the interdependence between themselves and a permanent system. However, there are generally no procedures or rules which exist within a profession to dictate how this relationship should be enacted.

### Consequences of Temporary Systems

Although the task assigned to the temporary system may be perceived as critically important to the profession at large, it is frequently viewed as inconsequential and a nuisance to permanent systems within the profession. Temporary systems are often formed with the expectation of "making a difference" in the profession. They experience difficulty evaluating their success in accomplishing this objective because of their reliance on feedback from the permanent structure, whose members are often reluctant to give such feedback. Temporary systems are usually not encouraged by the members of the permanent system to make any lasting changes in their functioning. Common examples of temporary systems include auditing groups, negotiating teams, political task force commissions and research and development projects (Goodman & Goodman, 1976).

The separation of nursing education and practice has resulted in teachers in nursing being regarded as a stranger in the system in which the student is learning to be a nurse (Holloway & Penson, 1987). Clinical teachers are rarely viewed as 'proper' members of the work setting in which they teach. Clinical teachers in nursing education

are generally assigned to a specific clinical area for the duration of the clinical learning experience (e.g., six hours per day, three days a week). Their permanent role is as an employee of the school of nursing. In the clinical area, they assume a temporary role. Clinical teachers experience a feeling of being somewhat akin to the nursing staff, because they are all nurses, but distant and alienated from them, because the nursing staff has developed a permanent structure which at best simply tolerates the teacher and her/his students as temporary intrusions in their well-ordered working life.

In a traditional management structure, the individuals involved in permanent systems have well-defined tasks and roles which utilize the skills and attributes of each worker. These conditions are absent in a temporary system. The clinical teacher's skills as an educator are generally viewed as pointless and somewhat burdensome by the nursing staff in the clinical area. The teacher in this structure becomes "a part in search of the whole" (Slater, 1969 p.81), struggling to maintain a differentiated identity within the permanent system, while at the same time seeking a sense of collegiality and belonging. This leads paradoxically to the teacher's cry for acknowledgement of the clinical teacher's uniqueness and to the exacerbation of the division between the permanent and temporary system. The primary consequences of temporary systems are individuation, the separation of the individual from a permanent group from which he/she derives a sense of identity, and a feeling of loneliness, meaninglessness and alienation (Slater, 1969). Goodman and Goodman (1976) suggest that temporary systems receive little attention or study within a profession because of their lack of permanence. The focus becomes the task assigned to the temporary system (e.g., providing a clinical learning

experience for students) and little is learned about the management and coping strategies necessary for the "turbulent field" (Emery & Trist, 1965) of temporary systems.

A secondary consequence of temporary systems is that both the permanent and temporary systems establish their territory as exclusive from that of the other (Slater, 1969). Territoriality ranged in degree for the teachers who participated in the research. A number of mediating factors (e.g., length of time teacher had taught in the clinical area; the head nurse's personal philosophy about nursing education; the workload of the nursing staff) influenced the extent of territoriality experienced by a clinical teacher and the nursing staff in the clinical area in which she taught. In general, the greater the psychological distance experienced by the two groups, the greater was the extent of territoriality demonstrated by them. Territoriality was minimized by the degree to which each group perceived the other to share similar interests, particularly their common interest in and commitment to patient care.

#### Territoriality

Five of the six clinical teachers in the research intimately experienced the boundaries of the ward staff's territory. The notable exception was Teacher #4 who was a nurse on the ward on which she taught students. Some aspects of temporary systems did exist for her and her students. However, her experience was so unlike that of the others that it will be discussed separately in detail later in this section of the report.

Although formal rules were rarely articulated, the teachers knew when they had trespassed into the nursing staff's territory by the verbal and nonverbal feedback they or the students received. New clinical teachers learned to identify the nursing staff's territory

by changes in the staff's behaviour toward the students and themselves when they transgressed these unspoken rules. Often the exact nature of the transgression was never identified but the teacher received the underlying message.

To researcher: The nurses on the evening shift just freaked about the students going off the ward to watch the interactive video program even though the students had their treatments done. They couldn't handle students reporting off and then coming back on the ward. First they complained to the students. At the end of the evening, they complained to me. The evening staff can't handle any changes in their routine. They pour all their meds for the evening shift at noon and unless I've made the assignment the day before, they get really annoyed if the students want to give the meds. (Fieldnotes: March 22, 1990)

The more experienced teachers in the research had learned over the years to function on the ward as a "guest": i.e, never assuming that the host's home and all its contents was yours; always asking permission before you altered the host's routine; occasionally suggesting alterations in the functioning of the host's home but always accepting the host's answer as final; and remaining pleasant and grateful at all times.

To researcher: I see that someone brought cookies to the ward today. I'd love one but I dare not have one . No one's offered so I dare not touch. (Fieldnotes: October 27, 1989)

Students were taught these social amenities by their clinical teachers.

To students in orientation to clinical area: You go through me if you have any complaints about the staff. I don't want you to try and handle it on your own. The patient care responsibility is 100% yours. Don't expect the nurses to help you. Some nurses will just let you stand back and let you do everything. (Fieldnotes: March 6, 1990)

A new staff nurse was being orientated to the ward. The head nurse asked the teacher if the nurse could have many of the students' skills that day because she needed to assess this nurses' capabilities. When a student complained later that she had lost an opportunity to do a catheterization because of this, the teacher replied: I'm afraid the head nurse has first dibs here. (Fieldnotes: May 16, 1990)

It was understood by students as well as by the teachers that patients were ultimately the "property of the staff"; students belonged to the teacher.

The semantical practices of both the ward staff and the clinical teachers were revealing in their relegation of territory. For example, teachers referred to patients on the ward in conversations with students as "our patients". When interacting with the nursing staff in the area, the clinical teachers referred to patients only by name. The nursing staff commonly referred to "our patients". Students, however, were referred to by the staff in discussions with the teacher as "your students". The teacher, in turn, talked about "my students". Teachers and students termed areas on the ward as "the staff washroom"; "the staff conference room"; and the "ward medication room", although they utilized these areas as much as the staff in their clinical experiences.

The clinical teachers identified their territory as their students. This was most often revealed when a staff member was harsh with or negatively critical of a student the teacher had assessed differently.

To researcher: Staff tend to give positive feedback to me regarding students rather quickly. If it's negative, I see them talking quietly in a corner. If they're (students) not doing well, I don't need the staff's feedback to know about it. I can see it myself. (Fieldnotes: March 13, 1990)

The teacher commented that she has asked the head nurse for feedback regarding her clinical teaching. There apparently is no problem with the teacher but there have been with some of her students.

To researcher: Some of them (the staff) worry about what kind of nurse they are going to be. One nurse asked me, 'Are these students new?' --- like they were brand new. I think I said something to her like, 'Oh, I think they are doing OK'. (Fieldnotes: March 27, 1990)

The teacher asked the night nurse how a student had done. The nurse said that she was "OK" but she had expected "more initiative" from the student

when a patient died. Apparently, the student did not ask questions regarding the documentation of the death and "showed no interest in talking to the family". In the conversation, the nurse said that it was the student's first death. The teacher asked the nurse: So how did she do with the others? The ones who managed to stay alive? (Fieldnotes: May 17, 1990)

### Patient Care

It was in the arena of patient care in which the territory of the nursing staff was most apparent. The teachers were generally reluctant to interfere with or to suggest alternate methods of the patient care on the ward. However, they were often directly affected by the nature and quality of the nursing care delivered by the nursing staff to the patients in the clinical area.

To researcher: X (student) is supposed to go to the OR with her patient. Yesterday, I went in to talk to him with X and he told us that if the ileostomy was to be permanent, he was going to refuse to have the surgery. There was no one else around but us. The patient had normal concerns about the surgery. Like could he ever go swimming again? He had not been seen by the enterostomal therapist yet. I resented that the staff had not talked to him about any of these things and it was left up to the student and myself to talk to him. (Fieldnotes: February 22, 1990)

The clinical teachers were witnesses to many dark facts concerning the care of patients in the clinical area. However, they were critically aware that to make these public was to transgress the rules of "guest" etiquette. They were conscious of the possibility that the staff may view such public acclamations as "being a traitor".

One "property" of the nursing staff related to patient care was the written documentation of the patient's progress and management (e.g., the patient's chart; the Kardex; the computer printout of the patient's care plan). The message that teachers and students were visitors in the clinical area was very clearly transmitted by the common

practice of all staff to expect teachers and students to "give up" the patient's chart if a nurse on the ward or a physician requested it.

The ward clerk asked for chart which teacher and student were reviewing. The teacher said : Suggest to Dr. X. that he'll be really quick with it. Later, she left the student in the conference room to locate the chart at the nurses' station. She said to the physician who was putting the chart back in the shelf: Oh, I see it's been done. Thank you for getting it back so quickly. (Fieldnotes: October 11, 1989)

Staff nurses complained to the teacher that there were too many students around the desk charting. She replied: If they chart in there (conference room), you guys will be wanting the charts all the time. This way works best. (Fieldnotes: February 7, 1990)

It was a common occurrence to observe the clinical teacher or her students waiting for a staff member to be finished with the chart or care plan. Only rarely did the teacher or student assert that their need for the chart/care plan was equal to that of the staff's.

### Separateness

Although the teachers frequently encouraged the students to utilize the nursing staff on the ward as resources, it was not uncommon for both the nurses and the students to avoid this practice.

A student indicated she had waited 20 minutes for the teacher to countersign a narcotic.

The teacher said: One thing -- X (staff nurse) over here is a very capable nurse. She could countersign this for you in situations like this. (Fieldnotes: March 9, 1990)

The head nurse told the teacher that an ambulance was ready for a comatose patient to transfer him to a rural facility. The staff nurse had forgotten to communicate this information to either the teacher or the student caring for the patient. The teacher told the head nurse that she was "very busy" but would get the patient ready. She and the student had to collect his clothes, empty his urine bag and clamp his NG (nasogastric) tube. They discontinued his IV (intravenous). Then they transferred the patient from the bed to the stretcher. Although several nurses stood at the

nurses station and watched this process, no one offered to help.  
(Fieldnotes: February 9, 1990)

Staff nurses on one ward refused to sign students' narcotics because "the teacher might like you to do it her way". One nurse stated that her head nurse had given directions to the staff that they should avoid "having anything to do with the students because that's the teacher's job". Staff who questioned a teacher's activities with students on the ward rarely pursued the subject if the teacher indicated disagreement with their point of view.

The head nurse brought the student assignment to the teacher and said, "This looks crazy. Some people have really heavy assignments and others don't have anything to do".

Later the teacher said to the researcher: I explained that I wanted to see how they'd (students) do. But other students with less to do could help them. She seemed to accept that. As long as you can give them (the staff) a reason, they'll accept it. (Fieldnotes: March 27, 1990)

The clinical teachers frequently referred to the differing perspectives of the staff and the teacher as justification for the territoriality teachers maintained in regard to their students.

To researcher: Staff think service when they see students. The students and I think learning experience. I think about service as well. It's rare to have a nurse who sees having a student as an opportunity to teach and learn, instead of just some help with her workload. (Fieldnotes: March 22, 1990)

To researcher: The staff still makes comments when I have a long weekend or, like in term X when I take the students off on Wednesdays for conference, they'll make comments about how nice it is to go off at 1300. I think it's because they see the students as being there to provide service. Also, I think with many head nurses, it's a power thing. (Fieldnotes: April 2, 1990)

The teachers frequently emphasized the distance between students and staff by referring to the less than ideal practices of some of the nurses on the ward, suggesting that the students, by their affiliation with the staff, may become contaminated in their practice of

the profession.

A student repeated the advice given to her by the staff nurse to the teacher. The teacher had given the student advice which was directly opposite to that of the nurse's. The teacher said: Who told you that? I don't agree. If it was some nurse with 20 years experience here then maybe I'm wrong. (Fieldnotes: October 25, 1989)

A student said she had prepared a medication ticket, according to a staff nurse's instructions, on a piece of paper torn from her notebook. The teacher said: I'm going to show you something. This is an addressograph. Your med (medication) ticket should be stamped with your patient's addressograph. There may be two patients with the same name on the ward and you have to be able to distinguish between them. Also some teachers absolutely insist on it. (Fieldnotes: November 30, 1989)

The clinical teachers and their students frequently assisted the ward staff in many nursing activities, particularly if their own work was complete. However, rarely was this contribution acknowledged by the nursing staff. One teacher coordinated a complex resuscitation on the ward. The head nurse was away and the nurses appeared confused about what they were to do. Only one of the staff commented that they had appreciated her help. The head nurse, upon hearing about the incident later, remarked to the teacher that emergencies no longer impressed her.

To researcher: X (staff nurse) told me that last Wednesday morning was just fine but all of a sudden in the afternoon they were so busy they filed an unsafe working condition report. It never seemed to occur to her that the reason the morning was fine was because the students had been there. (Fieldnotes: November 29, 1990)

Although the clinical teachers regularly demonstrated their commitment to the patient care given in the clinical area and they were often helpful to the nursing staff, they at the same time communicated to the staff that their "hearts were elsewhere" (Ashworth & Morrison, 1989, p.1013). The teachers were able to leave the ward with their students

in the middle of the day to attend a conference or class, no matter what was happening on the ward at the time. The teachers could arbitrarily assign and take away patients from students; nurses in the clinical area do not have such freedom. The teachers could decide to leave the ward earlier than scheduled and decrease their workload under the auspices of the students' learning needs. From the staff's perspective, it is not surprising that the teachers in the study reported that staff nurses who know little of the teacher's activities outside the clinical area often view clinical teaching as "an easy job" with little accountability.

Teachers who were employed by hospital-based schools of nursing and taught in areas within that hospital met other faculty regularly for lunch and coffee breaks. The purpose of these meetings was described by one teacher as "a meeting of like minds". These were regarded as occasions for the teacher to contact the members of her permanent system. It was implied that the faculty of the school were the only individuals in the hospital who could truly understand the clinical teacher's role.

To researcher: We try to meet each other around the same time each day. That way we can talk about how our day is going and what we are having trouble with. (Fieldnotes: October 11, 1989)

It is significant that none of these teachers ate lunch or had coffee with the nursing staff during the course of the research. This was explainable, in part, because the teacher often used these breaks to discuss clinical teaching with the researcher. However, all acknowledged that they rarely joined the nursing staff from the clinical area for meals or coffee breaks.

The teachers who affiliated from the university to an urban hospital were less

likely to experience a unity with other faculty members because they seldom interacted with them except at monthly meetings. Teacher #4 did arrange to meet with and discuss clinical teaching with two teachers from the university program who were also teaching in the same hospital. Teacher #6 did not express a desire to meet with other teachers who were teaching as affiliates from the university in the hospital.

To researcher: I've avoided forming an armed camp with the other instructors. I hated that as a student, so I wouldn't do that now. The students against the teachers. I only phone X (other university teacher) if it's very important. Mostly I've tried to figure things out on my own. (Fieldnotes: February 1, 1990)

### Communication

A consequence of temporary systems within permanent systems is that the parties involved communicate poorly or not at all about matters which they consider to be part of their territory (Slater, 1969). Accordingly, the nursing staff often forgot to give the teacher and the students information which was not written on the patient's care plan or in the chart about patients. This regularly caused the clinical teachers frustration and additional energy expenditure.

The teacher had assigned a student to one patient. No one had told the teacher that the patient's husband had died unexpectedly the night before, although the staff was aware that the teacher had made this assignment. The teacher discovered the information "by accident" immediately before the student was to care for the patient.

To researcher: So we (student and teacher) did a quick assessment and I decided that she (patient) should not have a student. (Fieldnotes: November 16, 1989)

The head nurse was at a conference. The teacher told the researcher that yesterday she had not received report (the head nurse tells the teacher about any relevant information concerning the patients assigned to the students), as was her usual practice, from the head nurse because of the conference and that this had proven to be confusing for her and the

students because they had information about the patients only from the Kardex which was not current. (Fieldnotes: November 17, 1990)

The communication of information between teacher and staff was often a problem; omissions were common and written communications frequently proved inadequate. Three of the teachers regularly attended physician or interdisciplinary rounds on the ward in order to clarify many aspects which remained inarticulate in the staff's formal documentation of patient care.

To researcher: I usually attend discharge rounds every week when I'm making out my assignment. It helps me a lot. This week I learned that one of the patients has developed a respiratory infection. We're doing respiration in class this week. I'll assign the person doing respiratory assessment in postconference this week to this patient. (Fieldnotes: January 24, 1990)

The clinical teachers in the research often assumed that posting the students' assignment on the ward was enough to communicate what the students would be doing during their clinical learning experience. Nursing staff frequently expressed their confusion about the aspects of care for which the student was responsible. At least once in every clinical day, the teacher was required to clarify the students' roles and responsibilities, in addition to the written notification she had previously provided.

A student reported that the nurse had not seen the assignment sheet and had washed the student's patient.

To researcher: Makes you wonder why you bother making out an assignment sheet. No one ever reads it. Now I'll have to check with her that she knows about the other students who have her patients this morning. (November 3, 1989)

At times, the clinical teachers expressed to the researcher the desire that the nursing staff would assist them with the students' learning, especially when the teacher was busy with other students. This expectation was never stated to the nursing staff

during the course of the research, although occasionally the teacher commented to the staff that she was having to "be in ten places at once". The teachers' expectations in this regard were for the most part disappointed. The teachers often expressed their frustrations on clinical days in which they were unable to "juggle" the needs of all of the students and their patients.

To researcher: I realize that the reason we're doing so poorly today is that I usually assign only the patients we can manage ourselves without help from the staff. Today I went for the skills and the staff hasn't helped one bit. It seems unfair to me that they would react that way because we do things all the time to help them on the ward. Last week, everyone had gone for lunch and X (head nurse) asked me to man the desk while she went to the office for a minute. It was only five minutes or so but I was happy to help out. They only seem to talk to me if they want something from me. It's pretty one-sided. (Fieldnotes: March 9, 1990)

### Defensiveness

Another consequence of temporary systems is defensiveness of its members in relation to those of the permanent system. This was particularly apparent in the interactions of teachers who were teaching in a clinical area for the first or second time.

The teacher found an envelope containing a narcotic medication stapled to the narcotic book in the medication room on the counter.

To researcher: It's the same one I took so much trouble to lock up. They are going to have someone help themselves to it and then they'll phone and ask me where it is. (Fieldnotes: February 9, 1990)

The teachers who had established some degree of permanence in a clinical area, by nature of their annual assignment to the ward, were far less defensive than those teachers who were less familiar to the staff in the clinical area.

The affective responses of the five clinical teachers to their temporary status in the clinical area varied according to the length of their assignment in a particular area; their

personal sense of competence both as a teacher and a nurse; and their ability to receive support and derive an identity from their own permanent system, the school of nursing. Another factor which affected the teacher's reaction to the temporary structure of clinical teaching was her perception of "spatial discrepancy" (Ashworth & Morrison, 1989, p.1013). Clinical teachers who worked in schools of nursing which regularly moved teachers from one clinical area to another, under the assumption that in order for teachers to teach in a generalist program they must be generalists, expressed discouragement, frustration and alienation. They stated that such a practice resulted in their "never feeling settled in one area" and "never feeling like you belong".

#### Courting the Staff

Clinical teachers who initially experienced great alienation and loneliness in a clinical area attempted to alleviate their separateness from the ward staff by becoming extremely sensitive and responsive to the staff's norms. The experienced clinical teachers in the study referred to this as "courting" the staff. It was not until they believed they had been largely accepted by the staff as credible clinicians and teachers that they permitted themselves the luxury of suggesting changes and offering constructive criticism to the head nurse. The teachers in the research stated that they experienced less territoriality in the clinical area if the staff accepted them as credible. Teachers #2 and #6 frequently analyzed their interactions with the nursing staff in order to assess how "accepted" they were.

A nurse said to the teacher: Y (the teacher) if you want to go with your students, I'll stay here and help X (student). I saw one of your students waiting for you with the narcotic keys.

Teacher to researcher me later: That was nice, wasn't it? That's how you

know they accept you. When they offer to help you with the students.  
(Fieldnotes: November 16, 1989)

These less experienced teachers tended to avoid confronting the staff with obvious aberrations of the staff's nursing care. They frequently made references to their "guest in the house" status when making decisions about how and when to discuss these "delicate" issues with the head nurse.

To researcher: X (head nurse) doesn't have her BN and I think that she feels insecure about that. She's always trying to keep everyone happy on her staff. It's very frustrating when she doesn't want to listen to my ideas. I have to be careful as an outsider. I tell her, "I've noticed this and it's not working for me. How's it for you?" (Fieldnotes: November 17, 1990)

They most often chose to discuss these situations with the students as a learning experience, rather than discuss them with the ward staff.

The teacher discussed with students at post-conference an incident on the ward in which a "placement patient" had become loud and aggressive because she did not want to change her room.

To students: They (the staff) are talking about restraining her now. I don't know if I feel too good about that. We heard the head nurse say she was going to get her a valium order. Why don't you agree with giving her valium? You have to do something if the patient is hitting out at people. So what do you do other than restraints? It was kind of pitiful actually - listening to her. Do you get a feeling for patient rights here? Have any of you been in situations in which you have been the patient's advocate?  
(Fieldnotes: January 17, 1990)

Teachers #3 and #5 often confronted both medical and nursing staff about the patient care on the ward. These teachers agreed that they were able to do so because they had been assigned to the same ward for a few years and the staff had come to know and respect them. Teacher #1 stated that her recent experience as a clinician had given her the confidence to challenge the quality of patient care given by the staff.

To researcher: It took me three years to achieve credibility with the staff

on this ward. You have to demonstrate your credibility. It's what you do with the students that they watch. And how you react to what the staff does. They watch you like a hawk when you're new. (Fieldnotes: October 25, 1989)

To researcher: For the first three years, I barely got a hello from X (head nurse). And the ward staff weren't as good then. The IV's (intravenous) were four hours late when we came on in the mornings. Now I've established some credibility on the ward with X and her staff. But teachers who come onto the ward for short periods would find that they (the staff) are slow to warm up to them. (Fieldnotes: April 2, 1990)

Teacher #5 stated that she had an added advantage in that she taught in a small hospital which emphasized that teachers were part of the nursing staff of the institution.

To researcher: I think she (head nurse) values my opinion about things because this is a small hospital. All the teachers have taught here for quite awhile and the wards know us. I'm often asked to join in the ward's social events like showers and parties. (Fieldnotes: March 14, 1990)

However, even these teachers carefully considered the consequences before confronting the staff and when they disagreed with the staff's response to their suggestions/concerns, they generally did not discuss the matter further.

To researcher about a patient on the ward: Notice his footdrop. Isn't that disgusting? (regarding one of the patients not assigned to students) There's no excuse for that to happen. And he's not the only one who's had it. I have told X (head nurse) and any of the nurses that would listen that wearing sneakers will prevent foot drop. I'm tired of mentioning it. No one seems to listen. (Fieldnotes: February 9, 1990)

The head nurse told the student that her patient had complained of a pulled back. She told her to write out an incident report on what the patient had told the head nurse. The teacher told the head nurse that she should do it. "The person who heard it should write it." The head nurse repeated that the student should do it. Later, the teacher said to the student: I don't really see why you have to do it but you need to do one. When you're ready, I'll help you with it.

Later to researcher: I didn't win that round. I'll save my energy for the major battles. (Fieldnotes: May 8, 1990)

Patient's complaints, communicated by patients to the teacher or the students about the nursing care given on the ward, were generally handled in a similar manner.

The teacher talked to one student about her patient. The patient had confided in the student that the nurses on the ward were not answering her light at night. The teacher listened and then countered with a story of how patients had complimented one nurse on the ward for her readiness to respond to patients' needs at night. (Fieldnotes: October 18, 1989)

To researcher: When a student says a patient has complained about the care on the ward I usually react by asking them to step into the other person's shoes and see what might be going on for them. Usually I bring it up in conference and we decide as a group how we are going to handle it. If its a complaint I've heard before about a particular staff member, I usually let a word fall into the head nurse's ear and let her handle it. (Fieldnotes: January 8, 1990)

The clinical teachers at times attempted to "maintain the peace" between themselves and the ward staff by compromising some of the idealistic practices taught to students in the curriculum and by adopting the pragmatic practices of the staff. Such compromise was not without personal conflict for the teachers, particularly those who taught beginning students and believed that the students should be protected from the ideal-reality dichotomy in the profession. These teachers always explained their decision to the students by discussing their impotence to change the staff's practice.

To researcher: On this ward if you have a 0800 med (medication) and you have to wait for whatever reason and give it at 0900, you still chart it at 0800. It's hard for the students to understand when they've learned how important it is to chart the time accurately. X (Student) said to me that we have to chart the time we actually gave the med and not when it says on the ticket. I didn't really know how to explain to her that the ward has chosen not to follow that policy. (November 2, 1989)

Those teachers who espoused the value of teaching students that some revisions to ideal practice do not constitute unsafe practice, taught students to adopt the staff's practices if

the students evaluated them as "safe" for themselves and patients.

The clinical teachers communicated to the students on a regular basis that they were the ambassadors of the school of nursing to the clinical area. The teachers often gave "pep talks" to students before the clinical day began, referring to specific errors students commonly made which were aggravating to the staff and which reflected poorly on the quality of teaching provided by the faculty. They often monitored the students for these transgressions, halting the error before it became noticeable and a problem to the staff.

To students at pre-conference: Some of you have four patients today. Don't forget to check for bowel day (the day the patient usually received suppositories) for your patients. Also check the teaching sheet to see if any teaching has been done and what is left to be taught. (Fieldnotes: January 17, 1990)

To researcher: I check the Intakes and Outputs's first thing in the morning because students often forget to do it and then they're lost when they try and figure it out later. (Fieldnotes: January 8, 1990)

Three of the clinical teachers communicated to the staff when students were considered by them to be performing badly in the clinical area. They stated at these times that they were aware of the student's shortcomings, they were handling these concerns appropriately and the student would not be allowed to proceed in the program.

The teacher told a staff nurse: Can you keep an eye on X (student)? She is quite weak. I can't see her doing well in the program. It's so hard to have students like this but you have to do your best with them before you can decide they're not right for nursing. (Fieldnotes: November 10, 1990)

This practice was remarkable in that at no other time did the teachers discuss the limitations of students' clinical performance with the nursing staff, unless the staff specifically requested clarification about something which they had observed about a

student.

### Unique experience

Teacher #4 experienced entirely different aspects of the temporary system of clinical teaching than those experienced by the five other teachers in the research. Her usual role as a staff member on the ward in which she taught students was a decided advantage in minimizing the occurrence of territoriality and defensiveness. Because she knew the staff and the patients, she was able to provide learning experiences for the students which were the most appropriate to meet their learning needs. She also was granted access to the backstage realities and unspoken, unwritten information which was necessary truly to function as a team member in the clinical area. At the end of her first clinical teaching experience, Teacher #4 concluded that she would not have been able to teach effectively without these advantages.

To researcher: I think one of my strengths as a clinical teacher has been my relationship with the staff. Because of that relationship they have gone out of their way to help the students and to try and give them more experiences. I need to be better at telling the staff exactly what I am doing when I'm teaching. Sometimes I gave them and the students mixed messages because I acted as a patient's nurse sometimes and other times, I said I was the teacher and referred the patient to the nurse. I do think though that my relationship with the ward helped me to provide creative assignments for the students. I was able to match them with patients who were most appropriate to meet their individual learning needs. I also could identify the staff who were most appropriate to buddy with the individual students. (Interview: December 14, 1989)

She frequently reflected on the experience of most clinical teachers who were not members of the nursing staff in the clinical area.

To researcher: How do other teachers do it when they aren't a member of

the ward staff? They wouldn't know the patients or who to buddy the students with. Or all the thousands of things that aren't written down anywhere about the way we do things on the ward. (Fieldnotes: October 24, 1989)

Students in this clinical area were encouraged by Teacher #4 to study the profession of nursing by working and socializing with the nursing staff.

To students: In a couple of weeks, I'll be wanting you to have breaks with the staff. You'll have an opportunity then to learn more about your profession. (Fieldnotes: October 24, 1990)

Although this teacher experienced unity with the staff in the clinical area, she experienced other consequences of a temporary system. Patients and staff who were aware that she was teaching for a temporary period often requested that she carry out nursing activities in addition to her teaching. As well, she worked different shifts than she did in her regular schedule. This caused her to work with staff she had not known previously and to discover aspects of the ward's functioning with which she had been largely unfamiliar.

Teacher #4 entered the room to attend the change of shift report and discovered that the evening staff had interrupted the report to meet with the head nurse to complain about a recent ruling on the ward. She listened for a few minutes and then left the room without saying anything. Later she told the researcher that the experience had made her feel uncomfortable. (Fieldnotes: October 23, 1989)

Teacher #4 went into the conference room with student to look for the student's buddy nurse. The nurse had not been seen on unit for some time. She was sitting on a chair with her feet elevated, reading a newspaper. #4 said: I'm sorry, X (the nurse). I know you're on your break but the student has a question. (Fieldnotes: October 23, 1989)

This teacher also recognized that, although the staff were skilled clinicians, not all were adept at teaching the students.

To researcher: I'm seeing our ward through the eyes of the students now. I see that the prime focus of the staff is the patient's care. That's not

always the best for the students' learning. (Fieldnotes: October 31, 1990)

In addition, despite the staff's willingness to participate in teaching the students, delineation about what the staff nurse's role was and how it differed from that of the teacher's was often problematic. This was in part due to Teacher #4's inexperience with the role and her difficulties in defining it.

Nurse to Teacher #4 ; "Do you have a student assigned to that patient?"

"Yes."

"Well her bathroom light is on and I didn't want to answer it if it wasn't OK. I didn't know whether the student should do it or not". (Fieldnotes: October 24, 1989)

The clinical teachers and their students represent a temporary system which, although it emerges from the same profession as the permanent system, differs in orientation toward both the employing institution and the profession. It is difficult to maintain this state of marginality without negative consequences for the individuals involved and for the roles they wish to enact (Guy, 1985). In order to survive as a member of a temporary system, the clinical teacher engages in rational decision-making which often includes personal and professional compromises. This generally involves a staking out of territory and an exacerbation of the "us against them" phenomenon. The degree to which this results in personal, professional and organizational trade-offs is dependent on a number of mediating variables.

### **Mediating Variables**

Clinical teachers intend to teach according to their individual perspectives about clinical teaching. However, they must adapt what they wish to do, according to the

realities of the clinical teaching experience. A number of variables influence how clinical teachers will mediate these realities. The mediating variables identified in the research are setting, personal and history. The boundaries of the mediating variables are not entirely distinct and they overlap with one another. For example, the educational background of the clinical teacher is both a historical and a personal characteristic. However, as the educational qualifications of the faculty of a school of nursing impact upon the practices and philosophy of that program, it can also be said that the education of a clinical teacher is a setting characteristic.

### Setting Variables

#### Curriculum

Setting variables in clinical teaching include the content and organization of the school of nursing's curriculum. Each of the clinical teachers in the study made adaptations to the clinical component of the curriculum "because what looks great on paper doesn't always work in practice".

To researcher: Last year, we (the faculty) covered one need at a time. This year, we decided to do it cumulatively. I think right now the students are having a hard time figuring out Level I and II data. So for now, I'm going to cover just one need area at a time. This is a hard model to understand. I think we need to do anything we can to help them handle it better.  
(Fieldnotes: October 26, 1989)

An interesting facet of this observation is that the teachers rarely shared these revisions with the individuals in the school who could effect necessary changes in the curriculum. The teachers gave several explanations for this practice: (1) there are faculty with "louder voices" who would "out vote" them if they were to address this issue formally; (2) the curriculum looked "tidy" on paper, satisfying the needs of administrators and accreditors

and, therefore, should not be changed; (3) if the administration of the school became aware that the teacher is making changes, the teacher may be told that she is to adhere to the curriculum or she may be disciplined; and (4) it would require "more effort than it was worth" to change the curriculum.

The teacher stated to the researcher that the students are taught the head-to-toe assessment on their first month in the program and then expected "to dissect out the need areas one by one throughout term X." She said she finds this to be confusing to students and often alters what she is actually supposed to emphasize to students because "it doesn't work". She said there is some pressure from other teachers to conform to this way of teaching so "you just don't advertise what you're doing any more than you have to". Discussions with faculty about this in formal meetings have proved fruitless: "I've heard it said that teachers who leave school to work in the real world and who can't take the reality of it, return to teaching to reinforce the ideal -- how they think the real world should operate. I know at least two of this type on our faculty and they do everything they can to keep things the way they think it should be." (Fieldnotes: November 22, 1989)

Clinical teachers who taught beginning students and the those who were teaching for the first time appeared to be far more focused on the need to integrate the formal curriculum into the clinical teaching experience than did the other participants. These teachers regularly discussed with their students how they intended to integrate aspects of the curriculum. They developed post-conference themes to reflect the classroom theory which had been presented to the students. They were also more likely than the other teachers to assign students to patients who would represent the curriculum content presented at that time.

The curriculum influenced clinical teaching in another way. Students who were "overwhelmed by the demands" of tests and assignments required in the program were frequently distracted and, at times, more error-prone because their attention was not solely

on their clinical learning experience. Some written assignments were viewed as "the bane of a clinical teacher's existence" because the students became preoccupied with obtaining data for the assignment, rather than learning in the clinical area.

To researcher: The students are concentrating on their ethics assignment so much that they jump on just about any issue just to get their assignment done. (Fieldnotes: February 13, 1990)

To researcher: Assigning patients is a balancing out of who needs to get challenged and who doesn't. I'm frustrated that so many of these students can't think about what they may learn with a particular patient --they're too busy thinking about writing their paper and if the patient meets the criteria in the syllabus. (Fieldnotes: February 6, 1990)

The conceptual framework of the school of nursing's curriculum had little impact upon the clinical teacher's teaching. Although the three schools involved taught according to different nursing models, this was only apparent in some of the terminology used by the teachers and students. One of the teachers, who had taught in other model-directed curricula, agreed that her teaching in the clinical area was not affected to any significant extent by this variable. She proposed that the reason the conceptual framework does not influence clinical teaching is that current nursing models are not utilized in the practice of the profession; they are "simply tools to structure a school of nursing curriculum".

To researcher: I have to sort out what is important for the students in regard to collecting Level I and II data. Like is it important for them to write it all down? I learned to assess patients that way as a student and now I no longer assess that way. Is it right to teach our students something this complicated that they won't even use? (Fieldnotes: October 26, 1989)

To researcher: I see her (student) standing there hating all of this (Placing data into categories). We take some one who thinks as well as she does and we make her learn to put the things she sees in boxes. What does it matter if she can't figure out how to relate her data to the theoretical framework if she knows the data? (Fieldnotes: October 27, 1989)

It had been anticipated at the onset of the research that the mission and philosophy of the diploma versus the baccalaureate programs in nursing would influence the clinical teacher's teaching. This supposition was not testable in the research because both university program teachers were new to the faculty and had little prior experience with the curriculum. By their own admission, these teachers tended to teach as they had been taught in their diploma basic education program.

### Resources

The resources available to the clinical teacher affected her ability to teach in the clinical area in an often dramatic manner. For example, the physical resources in the clinical area regularly determined the teacher's workload, as well as how the teacher could implement her perspective of clinical teaching.

To students: The conference room is all torn up during the renovations. So we can use the goldfish room (a recreation area for patients) during this time. (November 2, 1989)

When she arrived on the unit, the teacher discovered that the ward's medication room would be closed for a time due to renovations. She discussed her concerns with the researcher about this. Her students were expected according to the curriculum to administer medications in the next clinical week: Each student will have to be supervised by me as they prepare their meds (medications) and it is preferable that they learn in as similar a setting as they will encounter in practice elsewhere.

The teacher later discussed this with her colleagues at coffee and decided that her students would not give medications until the room was renovated. (Fieldnotes: November 17, 1989)

Wards which were long and narrow meant that the clinical teacher experienced difficulty observing her students, other than directly in the patient's room. They also resulted in the teacher walking long distances to locate individuals or equipment. Clinical areas with a chronic lack of operational or appropriate equipment required that students be taught

compensatory measures.

To student: You should save this linen (taken off patient's bed) because linen is at a premium right now until the cart comes up. (Fieldnotes: October 19, 1989)

To students: These are the old activity sheets. In seminar last week you heard about the new activity flow sheets. They aren't coming out until November 1. I know you didn't learn this one but we'll just have to fill it in because the new ones aren't ready yet. (Fieldnotes: October 26, 1989)

Most clinical areas suffered from an appalling lack of space in which the teacher could discuss matters with students in private. Consequently, teachers addressed sensitive and emotionally-laden topics with students in rooms piled with dirty laundry and equipment, in the cleaning person's closet filled with cleaning supplies and in patient's bathrooms.

The teacher talked to one student about her patient in the clean supply room on the ward. The teacher referred to this as her "office". (Fieldnotes: October 19, 1989)

The lack of conference space on most wards required that clinical teachers leave the ward in order to meet with the students as a group.

Another resource in the clinical area available to the clinical teacher was the nursing staff. The primary resource in this regard was identified by the teachers to be the head nurse. The six clinical teachers perceived the head nurse's commitment to nursing education and her/his behaviour toward the teacher and students as greatly influencing the clinical teaching experience.

To researcher: I decided to talk to X (head nurse) about all the things that have been happening with the staff lately. She had been a resource nurse last week for one of the students because they were short of staff. I saw that she knew how to be a good resource nurse so I knew she would probably expect that her staff were functioning in the same way. After I talked to X, Y (staff nurse) has been much nicer to us. W (staff nurse) is

trying more but she's still pretty inconsistent. It's very disheartening that four core members of the staff are leaving shortly. It makes me concerned about who will be left. (Fieldnotes: April 12, 1990)

One teacher referred to the head nurse as the "tone setter" for the ward. For example, a head nurse was reputed to dislike baccalaureate students, believing their program to be too theoretical and not pragmatic enough. She had never hired a graduate of the university program on her ward. The clinical teacher stated that the head nurse's attitude had resulted in the staff's general animosity toward university program nursing students. The teachers in the study also reported that the composition of the general nursing staff and the practices of the staff in the clinical area affected their clinical teaching.

The ward was staffed primarily by float nurses today. The teacher told a student about her buddy nurse who was a nurse from a casual employing agency: You're probably going to know more about the patient than she does.

This was to prove correct as the float nurse later told the student that she could not give her any information about the patient as she did not know him herself. (Fieldnotes: November 17, 1989)

To researcher: One disadvantage of the 12 hour shift is that the team leader can be off for more than a week and when she comes back, the students and I know the patients better than she does. (Fieldnotes: February 7, 1990)

The two teachers of first year diploma students in the field study suggested that nursing staff were perhaps less supportive of first year students than they were of second year students.

To researcher: If a ward has second year students as well as first years they often have a problem figuring out what students can and cannot do. They usually can't understand why first years can't do certain things and they get ticked off when they discover that a first year student won't do the entire care for the patient. The first year student is often made to apologize for not being a second year student. (Fieldnotes: October 18, 1989)

Patients were viewed by all the clinical teachers as a resource for the students' clinical learning experience.

To researcher: Students don't often think that patients know anything and they think I know everything. One patient won an award from an organization and the student came out of her room to ask me what it was. I said, "How would I know about it? Ask the patient. She's the one who received it." The student was surprised. She went back in and the patient told her all about it. (Fieldnotes: October 26, 1989)

To students: Don't be in such a hurry to ask the nurses all the questions. Patients know quite a bit about their conditions too, you know. (Fieldnotes: November 16, 1989)

The teacher's relationship with patients in the clinical area was considered to be a particularly significant mediating variable by Teachers #1, #2 and #6. These teachers consciously maintained relationships with long term patients in the clinical area in order to ensure that the patients would agree to be assigned to students week after week.

The teacher stopped by a patient's room; the patient was not assigned to students. She spent several minutes conversing with the patient about her condition and welfare. When we left the room, the teacher said to the researcher: I like to spend some time with the ones we aren't using this week because I may wish to use her again next week. (Fieldnotes: November 22, 1989)

They also utilized patients to teach the students. For example, Teacher #6 often asked patients to "play a detective game" with the students. The students were sent into the patient's room in small groups and told to "assess the patient". They then met with Teacher #6 to discuss their findings and to compare these with the information Teacher #6 had already compiled about the patient.

Because patients were identified as a teaching resource by the six teachers in the study, changes in patient acuity in the clinical area were often regarded as critical to their

ability to teach effectively. The teachers often expressed their concern about the number of "placement patients" (those awaiting discharge to a nursing home) in the clinical area. Their concern arose from the perception that these patients offered "no valuable experience for students".

To researcher: I don't usually choose the placement patients because the students are up here to learn acute medicine skills. (Fieldnotes: January 7, 1990)

### Personal supports

A resource external to the clinical area which was perceived by the six clinical teachers to be integral to the nature of the teacher's clinical teaching was a support person or group. Each of the teachers defined their personal supports in different ways. Some discussed issues in relation to clinical teaching with a administrative individual at the school of nursing; others discussed these matters with a few select faculty members who were known to share like ideas and philosophies regarding teaching; and others chose to share their concerns and fears with individuals outside of their employing institution. Four of the teachers expressed a desire for more formal sharing of the faculty in regard to teaching strategies and the major issues of clinical teaching.

Three of the teachers were occasionally provided by the administration of their school of nursing with another teacher who was assigned to assist them to supervise clinical skills or to provide individual attention to a student who was experiencing difficulties in the clinical area. These teachers expressed great appreciation for this resource.

To researcher: I'll need roller skates today. I made the assignment this heavy because yesterday X (lab teacher) was here to help me and we were

able to provide the students with a lot of skills. (Fieldnotes: March 9, 1990)

### Norms and standards of school

Each school of nursing was characterized by certain norms and standards which influenced the clinical teacher's teaching. The schools of nursing were described in various ways by the individual participants: "having a work ethic"; focusing "on the negative"; valuing "assertiveness"; valuing "people who do their job silently"; "valuing book learning more than clinical experience"; and believing "that all students are meant to be nurses". The six teachers reported that the characteristics of the schools were changeable, affected by such variables as accreditation reports, new personnel, organizational policy and trends in the profession. For example, one school had apparently reacted to a number of student appeals in the past year by requiring all clinical teachers to document comprehensively students' clinical performance. This requirement resulted in the clinical teacher focusing a great deal of her time with students on incidents which she could observe and measure. Such a practice was so incongruent with one of the teacher's perspective of clinical teaching that she ultimately abandoned it. She chose instead not to evaluate any students as clinically unsatisfactory "because as long as they (students) are all doing fine, no one asks you to justify your evaluation".

During the research, the diploma programs were affected by plans formulated by their directors in relation to the development of a baccalaureate nursing program, in collaboration with the university. The diploma teachers in the research were often deeply affected by the rumours which arose concerning this plan. A rumour which circulated for several weeks in one school was that only half of the faculty would be required in the

new program. Hospital staff regularly confronted the teachers about the future collaborative program. One head nurse stated that her staff had told her that the clinical teacher was planning to assume her position because the teacher had a baccalaureate degree and the head nurse did not. The researcher observed in these times that the creativity, spontaneity and enthusiasm of these clinical teachers appeared to be largely influenced by the amount of direct and clear communication they perceived they had received from their directors in this regard.

To researcher: I have felt the impact of the uncertainty of the future of the school this year. It's such a big question mark in all of our (the faculty's) lives. What will I be doing next year? Will they (administration) still need me to teach if I don't have my master's degree? It's been hard to stay motivated and creative because of the apathy which all of us have experienced as a direct result of not knowing what will happen. (Interview: January 8, 1990)

The perceived status of clinical teaching in the school of nursing was identified as a mediating variable by the two university program teachers. These teachers were employed on a part-time basis and were aware that their salary was "at the low end of the totem pole" at the university. They perceived that the university administration values academic pursuits more than it does the practice of the profession. One of these teachers admitted it was "demoralizing to realize you're working so hard and they (the university) don't even seem to think it's (clinical teaching) all that important". The diploma teachers did not identify this variable. They stated that clinical teaching is valued as an integral aspect of the diploma programs. However, they also stated that "it is assumed everyone knows how to teach clinically" .

#### Clinical Setting as Place to Teach

Another factor which influenced clinical teaching was the teacher's perception of the clinical area as a context in which to teach. Teachers who ascribed to an ability-evaluative or a task-mastery orientation were often disturbed by changes in the ward practices which resulted in "less experience" for their students.

To researcher: I will not select patients unless they provide the skills the students need. I don't just choose patients to give the staff an easy day. A lot of patients on this ward are on self drugs. They don't provide much experience for a student who wants to give meds (medications). (Fieldnotes: November 22, 1989)

When these teachers were assigned to areas which required few psychomotor skills in patient care, they expressed restlessness and frustration. Teachers with a moral-responsibility orientation were less likely to be affected by the number of "skills" the clinical area offered but were influenced in their clinical teaching by their perception of how willing and able the nursing staff were to assist and to teach the students.

### Characteristics of Students

The characteristics of the students influenced clinical teaching. The teachers stated that groups of students develop characteristics over time which influence how a clinical teacher relates to them.

To researcher: Student groups often seem to be either weak or strong generally. It seems as if the more motivated, strong students establish the group behaviour and standards. (Fieldnotes: February 22, 1990)

To researcher: The last group had 0 sick days. It's interesting how a group establishes a group norm for things like that. (Fieldnotes: April 2, 1990)

The teachers recognized that there are differences in teaching students who know each other versus students who have never worked together before their clinical experience.

To researcher: You can see the difference in students who have been

together for some time and those who don't know each other very well. These students feel free to ask one another for help and to talk about things that are bothering them. (Fieldnotes: February 27, 1990)

Four of the teachers commented that they must at times adapt their clinical teaching to meet the needs of students who are adjusting to a new clinical teacher or the needs of students who are "restless to finish a clinical rotation".

To researcher: Today's their last day on the ward so I have closed my eyes to a lot. It always seems as if funny things happen on their last day. (Fieldnotes: April 19, 1990)

To researcher: Whenever students have a new teacher, they tend to regress a bit. They are so busy trying to figure out what a teacher wants. They are afraid to do what they know without asking the teacher's permission. (Fieldnotes: February 15, 1990)

They also acknowledged that students "are different" whenever they have been away from the clinical area for any length of time (e.g., for Christmas vacation). They stated that students who had a hiatus from the clinical area tended to experience difficulties in the areas of organization and decision-making until they were re-adjusted to the clinical area.

To researcher: This group of students was not here last week and things get quite hectic at first because they are being re-oriented to clinical again. (Fieldnotes: October 18, 1989)

Two of the diploma teachers expressed some envy of the university program because of the nature of students that program supposedly attracted.

To researcher: If I had the intelligence pool of the university students, clinical teaching would be great. But we have mature students who never made it through high school and now because they're 25, they're socially accepted into the program. (Fieldnotes: November 16, 1989)

However, one university teacher in the study discovered that some nursing staff are not as supportive and helpful of baccalaureate nursing students as they are with diploma

students.

To researcher: Some nurses seem to resent BN students' knowledge. One nurse yesterday challenged a student about something and the student gave her the rationale dead on. That stopped the conversation dead in its tracks. (Fieldnotes: March 22, 1990)

The level of the student was identified as a powerful motivating variable by the clinical teachers, particularly by the two teachers who taught beginning diploma nursing students. These clinical teachers identified a need to become "far less directing" and "less mothering" in the second half of the students' first academic year in the program. One of the teachers stated, "We feel we have to get them (the students) ready for second year and second year means they have to be able to stand on their own". Both teachers commented that other faculty members are often critical of teachers who do not adequately prepare their students for all necessary clinical skills.

The teacher explained to the researcher that there is a "pressure to make sure that your students will meet the expectations of their new teacher at the end of the term". Last year, a teacher "complained" that her students did not know how to place patients on a bedpan. She "announced it in the coffee room". My students were used to orthopaedic patients and they had difficulty adapting to other patients for this procedure. (Fieldnotes: November 22, 1989)

To researcher: I totally exhausted myself last year. I made sure that all the students in the second term did all the dressings they could. The second year teachers were saying that the students were coming to them and their dressing technique was terrible. Some of the second year teachers even check the students all over again, even though they (the students) have been checked off (passed as satisfactory in their performance of a skill) in first year. (Interview: January 8, 1990)

A similar preoccupation with nursing skill readiness was observed in those clinical teachers who were preparing students for graduation from the program. These teachers

often commented that senior nursing students "must demonstrate that they can function independently on a ward before they graduate". They indicated that, although task mastery was contradictory to their teaching perspective, they "felt forced" by the expectations of the administration of the school "to produce graduates who don't embarrass the school".

The model of teaching for the clinical teachers in the research did not differ dramatically with the level of student except in the teacher's emphasis of priorities. For example, Teacher #3 taught second year diploma students until the end of the academic year when she taught first year students. Her style and practice of teaching remained the same in the two experiences. However, she emphasized priority-setting and decision-making more with the second year students; she emphasized skill acquisition and assessment more with the first year students.

All of the teachers discussed differences in teaching novice students versus students who were more expert in the practice of the profession. They defined novice as a student who entered an unfamiliar situation in the clinical area and who, because of this unfamiliarity, was unable to interpret accurately and manage the situation.

To researcher: Whenever they have a new skill to do, they forget all about the patient. They get tunnel vision. The patient gets reduced to a one inch square. (Fieldnotes: February 27, 1990)

To researcher: Students have no time perspective. The first day post-op (following surgery) is the same to them as the seventh day. Like X who didn't think of questioning why her patient was having spirometry on his 14th day. (Fieldnotes: February 13, 1990)

Consequently, the clinical teachers identified students as novices if they were assigned for the first time to a medical or surgical area, even if they were in the last months of the program. The teachers stated that novices need more direction and coaching than do more

expert students. They described novice students as focused on one aspect of nursing at a time and experiencing difficulty "making connections" between concepts in the profession. The teachers identified that as the student reaches the end of the program, the time it takes for him/her to develop expertise in a clinical rotation is greatly reduced.

Other student characteristics identified by the participants as affecting clinical teaching were the student's locus of control and the student's personality. If a student was perceived as internally controlled, the teacher tended to emphasize task achievement and personal growth. Externally controlled students were perceived as requiring more directive teaching. Three teachers identified students with an external locus of control as being their "least favourite" students to teach. These teachers stated that students with external loci of control depend excessively on the teacher for feedback about their performance and are reluctant to make independent decisions. Two teachers implied that students became more internally controlled as a natural progression in the program.

While walking to the unit, the teacher said to the researcher: I really hate term 1 (first term in the program). They have no confidence in their ability at this stage. They depend on you constantly. It's much better in terms two and three when you start to see them being able to make decisions for themselves and they have some degree of confidence in what they can do. (Fieldnotes: October 27, 1990)

The variable of locus of control was closely related to student personality. Two teachers described their "least favourite" student as similar to the descriptions given regarding students with external loci of control; i.e., "dependent" and "clingy". Other personality characteristics which were cited as "irritants" to the clinical teacher were "students who try to manipulate" the teacher; "students who know it all"; "students who have no regard for anyone but themselves"; "students who can't be trusted to tell the

truth"; and "students who are lazy". In contrast, the teachers stated "it is easy and a pleasure to teach" students who are "self-directed", "prepared for their clinical experience", "motivated to learn", "sensitive to the feelings of others", and "caring".

To researcher: X is delightful. You start explaining things and the lights go on. She jumps two steps ahead of me. I could spend a whole posting with students like that. (Fieldnotes: January 23, 1990)

Although all the teachers stated they preferred self-directed, internally controlled students, behaviours of these students which occurred at the expense of the teacher's control of the clinical teaching experience were frequently regarded as negative.

To researcher: X (student) is a very bright student but she doesn't know her boundaries. She changed her patient assignment last night and chose someone else. When I asked her about it, she said she wanted more of a challenge. I told her that I might have had something special in mind for her with the patient I gave her. For all she knew, maybe I wanted to give her a special experience with a patient who won't talk. I let her get away with it this once but I let her know that she'll never survive (in the program) if she insists on doing everything her own way. (Fieldnotes: March 21, 1991)

Although the variables of locus of control and personality were identified as influencing clinical teaching, the teachers denied that they had a significant impact. One teacher stated, "You have to teach everyone the same way." However, in practice, it was observed that the teachers avoided certain students more than others. At times, their behaviour toward specific students they identified as "annoying" or "aggravating" was more curt and perfunctory than was their usual behaviour.

The teacher and researcher returned from coffee. The students greeted her with "Can you help me? I have lots of questions" Some students were unable to articulate questions but said they were "confused" and "overwhelmed" by the information in the chart. One student could not read the doctor's writing. She gave loud groans and sighs. "I'll never get this". When the researcher later asked why the teacher did not seem to pay

attention to the student's pleas, she stated: I did that deliberately. I ignored her on purpose. If she can structure a question to me, fine. But if she just moans, I'll ignore her. She'll get the idea. (Fieldnotes: November 22, 1989)

### Personal Variables

A number of variables which relate to the clinical teacher's personal makeup influence her/his ability to teach in the clinical area. For example, the teachers reported that the teacher's ability to interact in an interpersonal relationship with students, staff and patients affects the quality of experiences provided for the students. Teacher #5 stated in her concept map (see Appendix 5) that positive relationships with the staff provide the clinical teacher with the information and co-operation she/he needs to teach effectively in the clinical area. Likewise, strained relationships with the staff will cause the staff to withhold information and to "make things difficult for the teacher and the students".

A nurse interrupted the teacher's conversation with a student to seek clarification about an intravenous order. The teacher left the student and looked with the nurse through the patient's chart. Later to researcher: I need to respond to requests like this in terms of achieving credibility with the staff. It means a lot in the long run as to how they will deal with my students. One nurse has some quirks about what she likes done. I always tell the students about them because if I don't, she'll be miserable to them when they're on the ward. Students get a better experience if they are not viewed as a nuisance by staff. I sense that if you got on her shit list that your students would suffer. (Fieldnotes: November 30, 1989)

### Knowledge of clinical teaching

The clinical teacher's knowledge of effective clinical teaching methods and concepts was identified by the participants to be a major variable affecting clinical teaching. They differentiated between a teacher's generalized ability to teach in any

clinical area and a domain-specific ability to teach in specific clinical areas (e.g., acute gastrointestinal surgery). All of the teachers stated they desired more interaction with other faculty regarding the teaching strategies and principles of clinical teaching. Three of the teachers stated that this interaction should be formally scheduled by the administration of the school of nursing.

To researcher: Once we had a group at the school who would meet over coffee and discuss what was happening in their clinical teaching. I found it very intellectually stimulating and I learned a lot about how different people handle different situations on the ward. But not all people want to talk about their teaching. (Fieldnotes: January 23, 1990)

The teachers were aware of what other teachers did in the clinical area only so far as what other faculty shared at school meetings and at coffee and meal breaks. They often expressed a desire to "work with another clinical teacher for a day" in order to evaluate their own clinical teaching and to "know what clinical teachers are really supposed to do". The six teachers agreed that "there is little in the literature to guide clinical teachers". None of the teachers stated that she had been taught the skills of clinical teaching in her basic education program or in her orientation as new faculty. The more experienced clinical teachers in the research acknowledged that they had learned how to teach in the clinical area by "trial and error". All of the teachers expressed some degree of lack of confidence that they were implementing clinical teaching in the correct and most effective manner.

#### Structure of clinical teaching

The teachers in the research study frequently made reference to their lack of time to teach effectively, because of the many demands on their time in the clinical area. Each

of the six clinical teachers structured the clinical teaching experience in the traditional manner, wherein each student is assigned to one or two patients and the clinical teacher assumes responsibility for both students and patients, as well as for the communication to and from the nursing staff in the area. In such a system, the clinical teachers were forced to respond to the most pressing need at any one time. They often reported feeling "stretched beyond belief" by the strain of attempting to meet the needs of so many individuals. The teachers stressed that clinical teachers need to be adaptable to cope with these constant demands. Four teachers referred to former colleagues who were not adaptable and who consequently "had to leave" clinical teaching. Each teacher in the field study adopted specific behaviours to organize their response to the demands of clinical teaching.

To students after change of shift report: All right, everyone. If you need me for (supervising) skills today, let me know now. X (student), I know you have that dressing to do at 1000. Let's do it at 1030. I'm going to be busy with the other students doing IV meds (intravenous medications) from 0930 to 1030. I'll go for lunch around 1130 so I can be back to help those of you who have IV medications. Is there anything else I need to schedule? (Fieldnotes: October 27, 1989)

However, circumstances beyond the teacher's control arose continually in the clinical area which greatly affected her ability to enact these behaviours. For example, a teacher went into a patient's room to find a student and discovered the patient was haemorrhaging. Although the patient was not assigned to a student, she chose to take the patient's vital signs, calm the patient and locate his nurse. This took several minutes. She forgot why she had wanted to speak to the student by the time she was finished caring for this patient. Those teachers in the research with an ability-evaluative or task-mastery

orientation tended to organize their activities around nursing skills performed by students. Those with a moral-responsibility or mentoring-professional identity orientation organized their time in order to discuss aspects of patients' care with individual students.

### Clinical Skill

The teacher's level of skill as a clinician in the particular clinical area on which she taught was also considered to be a mediating variable.

To researcher: I feel that because X (clinical area) is not my area I'm not offering the students all I could in the area. I try to read all I can and to get resources for the students. But it doesn't seem like enough. (Fieldnotes: October 26, 1989)

This variable was cited as a concern to four of the teachers because they believed it to be critical to their ability to teach effectively. However, they were unsure how they could maintain their skills as a clinician, as well as teach, in the present structure of clinical education in nursing education. Teachers #4 and #6 are practising clinicians, teaching only on a part-time term basis, and did not consider this to be a difficulty they faced. The type of the clinical teacher's experience in nursing affected her teaching in the clinical area. Teachers with a working background in critical care nursing admitted that they tended to emphasize assessment more than other teachers.

In a patient's room as she does her 'rounds' in the early morning, the teacher makes note of the patient's vital signs record, his intake and output, his urinary drainage, his oxygen level and his operative dressing. Later to researcher: It's my ICU background. Unfortunately, students don't seem to notice what I do. (Fieldnotes: November 21, 1989)

One teacher who had been a nursing administrator stated that her style of clinical teaching was derived from her experience of "what worked and what didn't work" in management.

Teachers who received their basic education more than five years ago occasionally commented that it was difficult for them to "keep up" with the many changes in the profession, particularly when the changes contradicted the traditional primary concepts of nursing.

To researcher: You know you're getting old when you can't get used to people putting gloves on for everything. (Fieldnotes: March 13, 1990)

### Education

The educational level of the clinical teacher was identified by the participants as a moderately significant mediating variable. One teacher suggested that clinical teaching is affected not only by the educational qualification a teacher has achieved but also by the nature of the education program she attended.

To researcher: I find there is a difference between the teachers who are generic BN grads and the diploma post-RN grads. The teachers who went through the BN program think it's OK not to know everything but that nurses should know how to assess and to obtain the information they need. The diploma people think that they and the students have to know everything. (Fieldnotes: October 26, 1989)

Two teachers stated that whether a clinical teacher is prepared at a baccalaureate or masters degree is not important; it is more significant to note the number of courses taken by the teacher which directly relate to the principles of clinical teaching. However, two of the teachers expressed some pessimism about their ability to implement the content of such courses, considering the present structure of clinical education in nursing.

To researcher: Here I am taking a course in education and would love to apply the things I'm learning. But with the limited exposure and so much for the students to learn, all I can do with some students is to say this is what you do because I say so. There is no time to teach them to think. (Fieldnotes: November 16, 1989)

## History

### Student experience

One of the most significant variables affecting clinical teaching was identified by the participants as the teacher's own experience as a student. The teachers commonly asserted that they imitated or chose to behave oppositely to teachers they had in their personal education experience.

To researcher: I usually allow them a time or two with grace. Until then, I don't expect them to do it perfectly. A lot of how I teach relates to how I was taught. I had a teacher who terrified students. I swore that if I ever went into teaching I would not do what she did. Students have often communicated to me that I'm very laid back. It's because I don't want them to feel like I'm always over their shoulder. (Fieldnotes: January 17, 1990)

### Clinical teaching experience

The six teachers did not identify length of experience as a clinical teacher to be a significant variable which influences clinical teaching. This premise was difficult to validate in the research as the most inexperienced participants, with the exception of Teacher #6, were also the teachers of beginning students. It is difficult to decipher whether some of their teaching practices reflect inexperience or their adaptations to the needs of beginning students. The participants referred to individuals in their experience who "have remained stagnant as clinical teachers" despite many years of teaching. They attributed development as a clinical teacher primarily to the teacher's ability to reflect actively on his/her practice as a clinical teacher and to learn from this reflection. The clinical teachers did, however, indicate that first-time teachers demonstrate some characteristic novice behaviours which affect their clinical teaching.

The teacher commented about a teacher with no previous teaching experience in the school: She'll do what we all did at first and overachieve. When asked why this occurs with first-time teachers, she answered: Well, for one thing, there are very few definite expectations that are defined for new teachers. You learn what you're really supposed to be doing by making lots of mistakes. You say something at coffee and someone else with more experience asks you why on earth you're doing that. You begin to have a better idea of what you're supposed to do by listening and getting feedback from the other teachers. (Fieldnotes: November 22, 1989)

Teachers' previous experience with "types of students" often affected the way in which they interacted with and assessed certain students in the clinical area. The teachers often made references to student behaviours which were perceived as characteristic of problems which the teacher had previously encountered.

At coffee, the teacher discussed another teacher's student as "a recovered alcoholic with a motivational problem who hasn't looked at her nursing or med-sci content yet and who develops a new personal problem each week." She describes the student as "a combination of X and Y (students from last year who were unsuccessful in completing the program)". The other teachers at the table nodded in agreement. (Fieldnotes: October 27, 1989)

To researcher: I'm not sure but she may be an example of a student who's trying to sabotage herself. I had a student like that last year. There's nothing much you can do. They're so unaware of what they're doing they can't even hear you when you tell them what you see. (Fieldnotes: April 2, 1990)

If the past experience had been extremely negative, the teacher admitted that she tended to enter the next clinical teaching experience somewhat defensively. Teachers who had experienced "putting a lot of energy into helping a student" who later failed the program stated they frequently had "to fight a detachment reaction" in their clinical teaching. They acknowledged that the temptation in these situations was to assume a comfortable and safe affective orientation in their future relationships with students. Three of the clinical

teachers openly chastised themselves for "prolonging the agony" of a student in the past by continuing to help her, despite indications that the student "was hopeless". These teachers indicated that, because of this history, they had resolved "only to help students as long it will mean they will be successful".

### Experience with evaluation

Three of the teachers in the study mentioned experiences which had "devastated" them in relation to student evaluations. These teachers stated that they would avoid evaluating a student as unsatisfactory in the future because the incident had been "so traumatic". Teachers who had failed a student in a previous clinical rotation expected that their reputation as a "hit man" would affect the responses of students to them in future rotations.

To researcher: It's unfortunate that if a teacher has to fail a couple of students, the students start reacting by coming to that teacher expecting to fail the term. It's happened to lots of really good teachers. (Fieldnotes: February 15, 1990)

### Students

The history of specific students or student groups was frequently communicated to the clinical teacher in an informal manner by other faculty members or in a formal way by summative evaluations. Whether or not this affected the teacher's response to the student(s) depended on the clinical teacher's perception of the value of this information.

To researcher: There's benefits to conferring with one another about students. Like X (teacher) told me what Y (student) was doing with her and I told her, "She did that in Term I". I told her what I had done about it and what had worked and what hadn't. She said she was glad to have that information so that she knew where to start with Y. (Fieldnotes: February 8, 1990)

To researcher: If a teacher I respect says something about a student, I listen. I believe it to be true. New teachers who have not achieved credibility among the rest of the staff and who do not know the rest of the faculty need very supportive coordinators. (Fieldnotes: February 13, 1990)

Students come to nursing education programs with a variety of personal and professional experiences which influence how the clinical teacher interacts with them. The teachers expressed considerable concern about students who had a history of emotional and/or social problems which compromised their ability to perform well in the program. A particular challenge to three clinical teachers were students who were licensed practical nurses (LPN) or nursing assistants prior to entering the program.

The teacher said that one of the students had been an aide before coming into the program. This student had apparently told the teacher, "I hope what I know doesn't get in the way of what I need to know."

To researcher: I think that's great because so many of these students with aide or orderly experience think they know everything and don't want to learn new ways of doing things. (Fieldnotes: October 19, 1989)

To researcher: X (a student) is a LPN who seems to have reached her potential. She can be counted on to let someone know if something untoward happens. However, I worry about six months from now when she's required to make more independent decisions. (Fieldnotes: March 28, 1990)

Students frequently entered a clinical rotation with perceptions, derived from their past experiences with teachers in the program, about correct and expected behaviour which at times differed from the expectations of their current clinical teacher. The clinical teacher was required on these occasions to identify first that these conflicting perceptions existed and then to explicate her personal expectations for the student.

To researcher: Once there was a head nurse on X (ward) who wouldn't let the students carry the narcotic keys. So the students would come to me from that ward and they were forever leaving the keys in the drawer. They would countersign with a nurse and then assume that she would take the

keys. (Fieldnotes: April 13, 1990)

### The clinical area

Teachers were often informed about the history of a clinical area by other teachers who had taught there in previous years and by faculty who had heard rumours about the ward's functioning. This history frequently affected the teacher's ability to effect her perspective of clinical teaching. For example, according to the participants, teachers who taught on wards in which the majority of senior staff were discontented with their working conditions faced the staff's increasing intolerance of students and, ultimately, a large degree of staff turnover.

To researcher: There's been a lot of turnover this year. I've noticed a lot of float nurses. They tend not to know things and to miss things. That makes the staff tense and they seem more impatient with the students than usual. (Fieldnotes: February 9, 1990)

Teachers who taught in areas which had a previous negative experience with another clinical teacher reported that they were "tested" and "watched under a microscope" for most of the first year in the area. Conversely, wards who had viewed the previous clinical teacher in a positive manner communicated their expectations of similar performance to a newly-assigned teacher.

To researcher: I was kind of nervous about coming with my beginning students to this ward. In term three and four last year, they had X (another teacher) who knows everything about this ward and, of course, her students could do more than my first term students. But I felt really good when they (the staff) were so receptive about my coming back this year. I don't have the clinical background in (the specific area of nursing) but it doesn't seem to matter to them. (Fieldnotes: November 22, 1989)

The six clinical teachers in the research communicated profiles of the area to other teachers at coffee breaks, focusing on the interpersonal relationships they had with the

staff, particularly the head nurse, and the nature of learning experiences available on the ward. If the teacher had taught in the area previously, she tended to assume that the staff's practices and norms had remained the same. These teachers stated that they became "far more comfortable" each year they were assigned to teach on the same ward.

### Personal history

The personal history of the clinical teacher occasionally affected her clinical teaching during the course of the research. For example, one teacher assigned a patient to a student and then discovered that the patient and she had a previous altercation as members of the same residential community. The teacher avoided entering this patient's room.

### Patients

Patients' histories were also a factor which at times affected clinical teaching. Patients who had been assigned to many students in their hospital stay, occasionally became reluctant to be nursed by a novice and refused to have a student care for them.

The teacher told two students that she was going to be doing foot care on another student's patient and suggested they watch the procedure. "I'm sure she won't mind if you watch and it will be good experience for you." Later the patient refused saying she had "enough of students" in her hospital stay and that in fact her one student was causing her to feel uncomfortable by "watching" her all the time. The patient said: "She sat down beside me and watched me eat supper. In all my life I never had anyone stare at me while I ate. I felt very anxious." (Fieldnotes: October 23, 1989)

Other patients who were used to students caring for them every week at times became "annoyed" or "hurt" that the teacher decided not to assign them to a student for one week.

To researcher: We had a couple of irate patients on the unit today. They somehow got the idea that students were supposed to be there (on the unit) today and we're not. A couple (of patients) who had students last week are really put off that they don't get students this week. (Fieldnotes: November 22, 1989)

At times, patients agreed to be cared for by students because of the attention they would receive from the clinical teacher.

The teacher told the researcher about a patient who had initially refused to have students but when she observed the teacher talking to her roommate, "wanted the attention of the teacher". "I told her that she could only have me if she agreed to have students. Since then she's had students." (Fieldnotes: November 3, 1989)

Pugh (1980) suggests in her research that clinical teachers act in congruence with their perspective of clinical teaching when the teacher's role identification is representative of her/his role preparation. The six clinical teachers who participated in this research study did not demonstrate this finding. Each teacher at times acted in ways which were contradictory to her perspective of clinical teaching because of the multiple variables which influenced the clinical teaching experience. Although the teachers often acknowledged that they would have preferred to behave differently in the clinical area, they generally expressed feelings of "having to compromise" what they believed because of the perceived priority of the needs of others (i.e., students, staff, patients, the school of nursing). The teachers also indicated that without definite guidelines to structure and implement clinical teaching, the clinical teacher in nursing education will "never know what is right in clinical teaching" and, therefore, will "never have the confidence that their way of teaching is appropriate".

### Summary

In this chapter, the individual perspectives regarding clinical teaching of the six teacher participants in the research have been described. The elements of their perspectives (e.g., goal orientation; primary focus) were identified, compared and contrasted. Three variables were identified as providing the context of all clinical teaching activities: caring, professional identity, and temporary systems. The research findings demonstrated that clinical teachers in nursing teach in accordance with the basic precepts of nursing. A number of factors were detailed which impacted upon the clinical teachers' ability to teach as they intended. The list of mediating variables which influence clinical teaching has not been exhausted in the preceding discussion. However, the major influences affecting the clinical teacher's ability to teach as she/he intends have been identified. This section of the report also depicts the number of variables in the present structure of clinical education in the nursing profession which remain beyond the teacher's control, yet dramatically affect the teacher's ability to enact his/her perspective regarding clinical teaching.

## **CHAPTER FIVE**

### **THE EXPERIENCE OF CLINICAL TEACHING**

In this chapter the experience of clinical teaching as it was enacted by the six clinical teachers in the research is discussed. It begins with a description of what actually happens in the interactive phases of clinical teaching: the transmission of practice; assessment of student learning needs; the responses of the teacher; helping; crystallization; development of a plan; and evaluation. This chapter includes the identification of the various ways in which a clinical teacher determines whether a student should be helped to succeed in the clinical rotation or encouraged to withdraw from the program. The factors pertaining to the clinical teacher's final evaluation of a student's clinical performance, before, during and after the formal evaluation process, are also presented. The focus in this chapter is the teachers' interactions with their students in the clinical teaching experience. Notwithstanding the significance of the clinical teacher's relationships with others (e.g., staff, patients, faculty), the teacher participants in the research considered these to be variables which mediated the reality of the clinical teaching experience, not the essence of clinical teaching.

#### **Crystallization Model of Clinical Teaching**

A schematic representation of the clinical teaching experience, including the context and the experience of clinical teaching is presented in Figure 2.

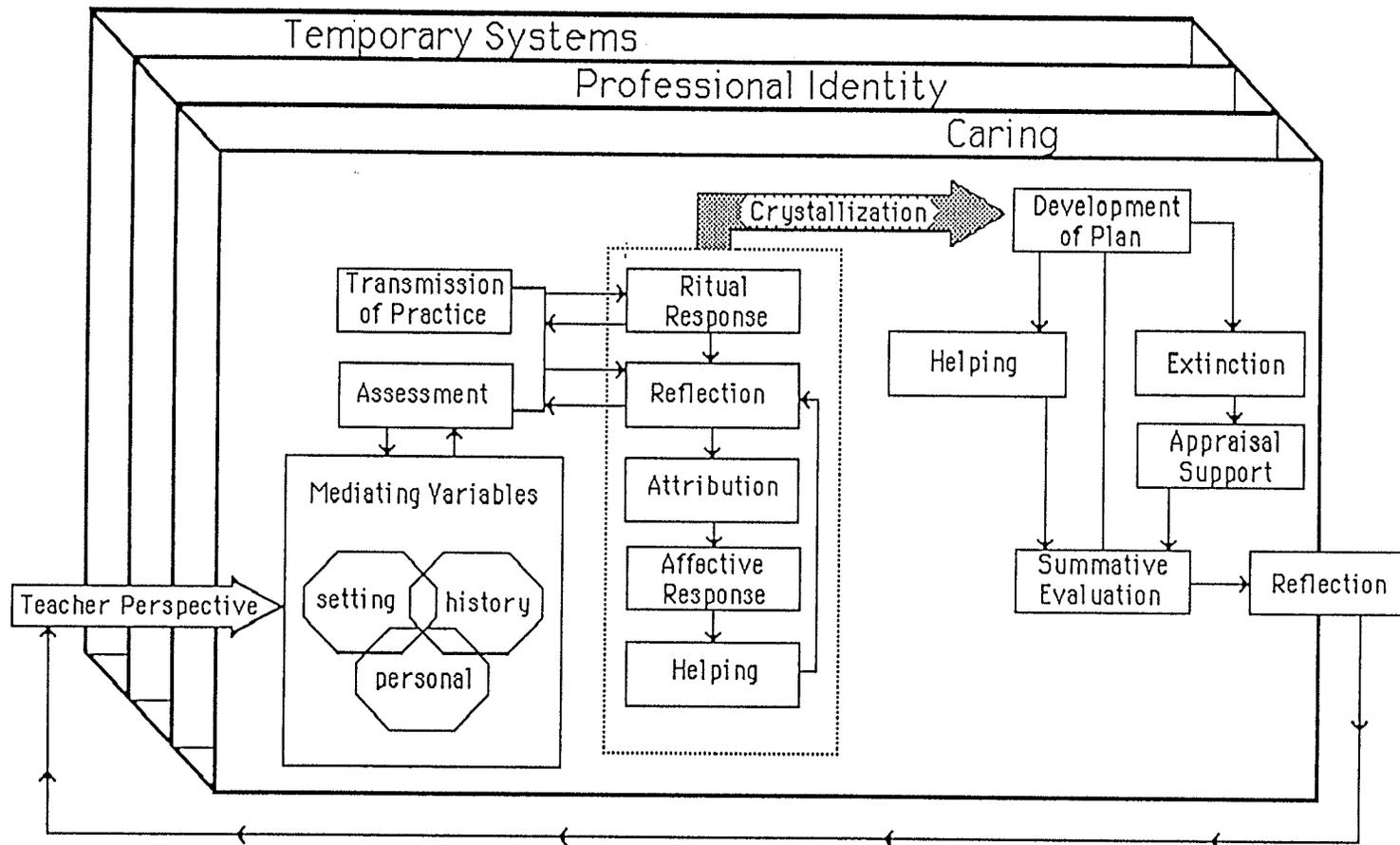


Figure 2. Crystallization Model of Clinical Teaching

The schematic design was suggested, in part, by the Hymovich model for family assessment in chronic childhood illness (Hymovich, 1985). Specifically, the way in which Hymovich represented the contextual and mediating variables was incorporated in the schematic design of the Crystallization Model of Clinical Teaching. Although no linear schematic can adequately represent the dynamic processes and interactions of clinical teaching, the model presents many of the elements of the substantive theory which have arisen from the research findings.

The Crystallization Model of Clinical teaching purports that the clinical teacher brings to the teaching experience his/her unique perspective of clinical teaching. This perspective is the sum of the teacher's beliefs and values concerning clinical teaching. It is representative of what the teacher intends to do. The clinical teacher's ability to behave as he/she intends is mediated by the context in which clinical teaching occurs; the contextual and mediating variables discussed in the previous chapter. According to the Crystallization Model, the clinical teacher attempts to carry out two major elements of clinical teaching within this context: the transmission of the practice of the profession to students, and the assessment of students' learning needs and clinical competence. These elements are implemented concurrently.

The model suggests that the transmission of practice entails a number of ritual responses, ways of responding and behaving which the teacher has amassed in his/her past experience. If the ritual responses do not achieve their usual result or if a situation arises which the clinical teacher deems is unique, the teacher searches for explanations (attributions) concerning the student outcome. This reflective search often produces

affective reactions in the teacher, as well as new strategies to help and teach the student. The process of transmitting the practice of the profession, assessing student competence, searching for attributions and developing helping strategies continues in a cyclical and concurrent fashion until the clinical teacher crystallizes a judgement about the student's clinical ability.

The model proposes that the crystallization process results in the development of a plan to assist the student to resolve clinical difficulties, the completion of a written summative evaluation, or to the extinction (removal) of the student from the program. Clinical teachers may seek further support (i.e., personal support; further evidence) in this process for their appraisal of students. Following the evaluation and/or extinction of a student, particularly when teachers receive data which contradicts their crystallized judgement of a student, they may reflect on their perspective of clinical teaching. They may revise this perspective accordingly.

### **Transmission of Practice**

The six clinical teachers agreed that the essential function of a clinical teacher is to transmit the practice of the profession to students. They did not necessarily concur as to the methods by which this transmission could be achieved; nor did they always agree as to the essential elements of professional practice to be transmitted. Transmission of the practice of the profession occurred concurrently with the assessment of the students' learning needs. However, for the purposes of clarification of the category and because the six clinical teachers viewed this as an unique entity in clinical teaching, "Transmission

of Practice" will be discussed separately from "Assessment" in this chapter.

In general, the six teachers in the study transmitted a "model of and for reality" (Benner, 1987) to their students. They attempted in their clinical teaching to socialize the students to the values, norms and the practices of the profession. Transmission of the practice of the profession included assisting students to learn and perform the skill competencies, as well as assisting students to identify significant patterns and to develop the skill of problem representation in the profession. It emphasized the "connoisseurship" (Whitman & Gasper, 1989) of the profession: i.e., knowing and appreciating what is clinically significant and appropriate in the nursing care of patients. For four of the six clinical teachers in the study, "Transmission of Practice" also entailed fostering the students' ability to reflect on their performance and the performance of others in the clinical area.

The clinical teachers transmitted the practice of the profession in both the pre-active (planning) and the interactive (implementation) stages of clinical teaching. The teachers' planning activities were minimal. Most were focused on matching the numbers and experience levels of students with the available patients in the clinical area. The exception was Teacher #3 who spent considerable time prior to the clinical learning experience formulating contracts with students and determining how best to meet the student's identified learning needs. The absence of the pre-active planning of the clinical teaching experience occurred in part due to the perception of the clinical teachers that "clinical teaching is almost totally beyond (the teacher's) control" and "cannot be planned for".

### The Teacher's Perspective

The six clinical teachers presented the ideal and the actual practice of the profession to their students, in accordance with their perspective of clinical teaching. Those teachers who attested to a primary goal orientation which emphasized task achievement and evaluation tended to focus their efforts on the students' skill acquisition. Those with a moral-responsibility or mentoring orientation fostered decision-making and problem-solving. Teacher #3, who attested to a mentoring orientation of clinical teaching, also emphasized the development of the student's individual conception of the role of a professional nurse.

The teachers, who believed their role as a clinical teacher was to teach, emphasized strategies which were largely directive and supervisory in nature (e.g., feedback; rehearsal; cuing). The teachers, who advocated a teacher-nurse or nurse-teacher role as a clinical teacher, concentrated on activities which entailed student participation in the learning (e.g., contracting; discussion; nursing with the student). Teachers who described their role as shaping students, or transferring their knowledge to students, were the directors of the clinical learning experience. They determined what students needed to know and how they would achieve this knowledge. Student input in this process was generally minimal. Teachers who described clinical teaching as helping students to grow professionally, advocated a more participative orientation. For example, students were encouraged by Teacher #4 to compose a "wish list" identifying what they wished to accomplish and how they wished to learn in the clinical area. Students included items on their "wish lists" such as the way in which they preferred to receive feedback from the

clinical teacher and their definition of a "challenging" experience in the clinical area.

Going over the students' wish list in post-conference: A co-operative relaxed learning environment. Are we achieving that? A student replied: "Well, it's not too relaxed for me." Is there anything we can do about it? "Not much. There's only one of you to go between us and so many other people on the ward." (Fieldnotes: November 13, 1989)

Teacher #3 formulated individual contracts with students which were revised throughout the clinical rotation to reflect changes in the student's learning goals. Teacher #3 contracted with students to provide specific learning experiences. This often entailed detailed negotiation between herself and the student as to what each believed was necessary and beneficial in the transmission of practice.

#### Real Versus Ideal

The six teachers differed as to the degree to which they acknowledged and made visible to students the dichotomy which exists between ideal and the actual practices of the profession. The teachers of beginning diploma nursing students were particularly affected by situations in which they were required to function as a buffer between the ideals taught in the program and the reality of the work setting. These teachers stated that it is necessary for beginning students to "master the ideal before they cope with the shortcuts and the compromises" which exist in the profession. Beginning students were viewed by these teachers as being so focused on the exact performance of the skill, as they had learned it, that they were unable to tolerate any suggestions of change in the procedure.

To researcher: I'd like to do a lot of incidental teaching during procedures. But students at this stage can't seem to tolerate the distraction. One little thing throws them off and they start making a series of mistakes. (Fieldnotes: October 27, 1989)

These teachers frequently responded to students' discovery of such discrepancies by ignoring the issue, by intimating that the observed practices were incorrect or by stating that "only nurses with a great deal of experience" can make decisions to revise ideal practices.

A student said: "The nurses on the ward don't make tickets for their narcotic meds (medications)".

To the student: Nurses have a great deal of experience. You can be assured that nurses have their own safe way of doing things.

Student: "Well, my nurse brought a patient the wrong med. The patient had to tell her that it wasn't the right pill."

What did you learn from that experience, X? You learned that nurses make medication errors. You also learned that it is important to teach patients about their meds so they can recognize them. (Fieldnotes: November 16, 1989)

Student, referring to staff's practice of preparing all medications several hours before they were scheduled to administer them: "Can they (the staff) do that? Get all their meds together and leave them on a tray?"

To student: Well, no. But this is the real world. By the time nurses do this, they know about the preparation of oral meds (medications). They also make sure they close the door to the med room so the patients don't walk in and take some. (Fieldnotes: November 22, 1989)

Despite their personal inclinations at times to abandon the ideals of the profession, these teachers staunchly advocated ideal practices to the students. The exception was when the situation involved a decision to be made between ideal practices as taught in the program and cost-containment measures. However, even in these situations, the teacher justified the decision to the students in such a way as to suggest that the ideal practice was preferable.

A student stated: "I found this pile of blue pads on the floor. Should I throw them out as we've been taught?"

To student: Well---in the real world? I guess the best thing you could do is to only throw out the ones which were facing the floor directly on the side that would touch the patient. That is an awful lot of pads to throw

out. They are quite expensive.

"But they were all on the floor on that side."

I guess you better throw them all out then.

The teacher sighed audibly. (Fieldnotes: October 12, 1989)

To student: You can use pre-cut sponges for the drain.

The student replied: "You mean we can use them? Aren't they too expensive? They told us in the lab that they're too expensive."

The pre-cut drain sponges are more absorbent. The reason you were taught how to make your own is that the pre-cut ones are not always available to you. (Fieldnotes: February 8, 1990)

The teachers who were practising clinicians as well as teachers (#4 & #6) were more likely than any of the other teachers to address these dichotomies and, at times, to encourage the students to adopt the practices of the staff which differed from what had been taught in the classroom/laboratory.

To researcher: I find it very hard to teach by the books. It's uncomfortable for me. One thing is that I don't know the books any longer. I graduated X years ago. I suppose that students have to learn the ideal to become competent nurses. But when they're challenged on the ward, how do they make sense of what they see as reality which is so different from what they learned in their textbooks? (Fieldnotes: December 7, 1989)

Teachers #3 and #5 often used ideal versus reality situations as topics for discussion by the student group. They generally presented these situations as having no right or wrong answer; students were encouraged to explore the situation and to determine the consequences of adopting these practices in their role as a nurse. They also deliberately introduced students to situations in which the student was required to confront the realities of a nurse's workload.

A student told the teacher that her patients had required much more care than their Kardexes (care plans) had indicated. One patient was supposed to be "assist bath" (the patient was able to bathe himself with minimal assistance) when in fact he was a "complete" (the patient was unable to bathe himself and required the nurse to do so) and quite confused. One

patient had become suddenly quite ill and was requiring a great deal of supportive care. The teacher did not intervene except to comment that the baths "might not be a priority" in this situation and to give mouth care and reposition the patients in the morning. "

Later to researcher: Students just have to cope with these things. As new grads they need to be able to care for seven completes (complete bed baths) on this ward. Generally I don't interfere unless I see they're really drowning. This is reality for them.

The teacher observed the student from the hallway for most of day and asked her four times if she needed any assistance. Once, she went in and helped the student reposition her patient. (Fieldnotes: February 7, 1990)

### Communicating Expectations

The clinical teachers stated that they transmitted the practice of the profession to students by identifying what was appropriate and what was not appropriate in the students' nursing care of patients assigned to them. Expectations of students by their clinical teachers were transmitted in a variety of ways, both direct and subtle. The six teachers communicated formal expectations to the students in the orientation to the clinical area and whenever they met with the students as a group.

To students after change of shift report in morning: Some of the rest of you have people to be weighed today or tomorrow. Check your people and see if they have a weight on their chart. For many of them their weight is extremely significant. Also they may not have been capable of doing a weight on admission and one might never have been done. (Fieldnotes: January 4, 1990)

In preconference, the teacher discussed in detail the students' responsibilities for the next clinical day. She told them her expectations as well as when she would help them (e.g., "I'll help you locate the fluid balance sheet in your patient's room this afternoon." "

She asked the students: What time are we going to do this tomorrow morning?

Students:"0745"

Good answer. What then?

"Say good morning?"

Do you think you might want to hear how he (patient) did the night before?

All the students nodded.  
Right. And remember --- at 0800, everyone waits to receive report in the goldfish room. (Fieldnotes: October 18, 1989)

Students received direct and immediate verbal positive feedback from their clinical teacher when the teacher perceived that the student had cared for her/his patient in an exemplary manner. The positive feedback given by the teachers in the field study was generally brief and undetailed (e.g., "Great job"; "You did fine"). Negative feedback was usually more detailed and it was preceded by one or two positive comments. Feedback was perceived by the teachers to have both a motivating and directing function in clinical teaching. All but Teachers #3 and #5 valued immediate feedback as a teaching strategy. Teachers #3 and #5 stated that there were times when it "is best to let the student cool off and get some perspective before you try teaching her what went wrong".

The teachers also communicated expectations of exemplary performance by referring to past or present students who had exceeded the teacher's expectations. At times, they referred to their own errors as students or as clinicians.

To student preparing parenteral medication: I think you need to get rid of some air. I did that once as a student and I pulled the plunger right out. I lost all my medication. My teacher was not happy. (Fieldnotes: October 25, 1989)

The clinical teachers in the study conveyed transgressions of practice by direct feedback and by other indirect means, such as change in voice tone, change in facial expression and proxemic changes. For example, a commonly observed incident in the fieldwork study involved teachers who supervised a student in the performance of a psychomotor skill at the patient's bedside. The teacher usually began the supervisory process on the side of the patient's bed, opposite to the student. The teacher generally assumed the role of talking

to the patient throughout the procedure. If the student made an error or was about to make an error, the teacher stated the nature of the aberration and walked around the bed to assume a position at the student's side. The teacher then focused her attention on the student's performance, observing the student closely. Often, the teacher's voice became monotone and softer as she coached the student through each step of the procedure. The conversation with the patient became non-existent or minimal.

A student contaminated the iodine cup during a dressing change. After the contamination, the teacher moved from the opposite side of the patient's bed to beside the student's elbow.

The teacher went down the hall to get another sterile container and when she returned, she whispered to the student: Slow down. You're doing fine. The teacher then directed the student until the completion of the procedure. [e.g., "Support it with your other instrument. Put your forceps on next to his skin. Now you've got it. OK Put the pin in."] (Fieldnotes: February 27, 1990)

Teachers #3, #4 and #5 permitted students to make errors, provided these did not compromise the patient's safety or welfare, because they identified errors as a method of learning.

To researcher referring to a student's removal of a nasogastric tube: I had no idea where it was going to land. I just let her cope. It's one way to learn. (Fieldnotes: February 27, 1990)

The clinical teachers occasionally used sarcasm, gestures or humour to indicate expectations of the profession to students.

A student said she had forgotten her scissors at home. The teacher made a motion in the air to indicate a spanking. The student responded, "I'll borrow a pair from X". (Fieldnotes: April 15, 1990)

Students in conference room were sucking on lollipops.

To students: Very dignified. Very dignified.

The students quickly finished their candy. (Fieldnotes: April 11, 1990)

Restating students' comments was a common strategy used by the teachers to communicate the terminology and accepted phraseology in the profession.

A student told the teacher that her patient had "a bit of bleeding from his penis".

To student: A clot? A stream? A scant amount? What? (Fieldnotes: March 28, 1990)

The student said to the teacher, "You could raise the head of the bed so that his upper lungs would be clear to breathe".

The teacher replied: Right. So you could raise the head of the bed to cause pooling of the secretions in the lower lobes and increase the vital capacity of the upper lobes. (Fieldnotes: February 6, 1990)

Another strategy used by the clinical teachers was what one teacher referred to as "nagging". In this strategy, the clinical teacher would refer to one of her "pet quirks" in the nursing profession and regularly remind students that she was observing their performance for evidence that this aberration existed in their practice.

To students: You don't know about my call bell rounds. You haven't seen me yet go from bed to bed checking the call bells. (Fieldnotes: October 12, 1989)

The individual teachers "nagged" about students who forgot to provide for their patient's privacy, students who charted incorrectly, students who ignored the psychosocial needs of their patients, and students who failed to implement appropriate safety measures for patients. The teachers agreed that each clinical teacher emphasizes different "quirks" and that students learn to "keep the teacher happy by not doing it".

The beginning clinical teachers in the study occasionally experienced difficulty making their expectations clear to students. At times, they were misunderstood by their students because they failed to communicate their expectations, assuming that the students would know these from prior experience.

To researcher: The students in the last group -- a couple of them at least - - evaluated me as unapproachable and unavailable. I think it was the two stars of the group who I left alone a lot. I realize now that they didn't know that I wasn't seeing them because I felt perfectly confident they were doing OK. Now I know they need feedback too. One of the students I think evaluated me like this was obviously stunned when I told her on her evaluation that she was absolutely excellent. (Fieldnotes: March 15, 1990)

The experienced clinical teachers in the research did not demonstrate difficulty communicating their expectations of practice to students. They did, however, express the concern that students learn to meet the teacher's expectations ("learning the student game") and do not necessarily relate these to the standards of the profession.

#### Teaching Strategies

A number of strategies were utilized by the teachers to transmit the nature of the profession to students in the clinical area. The majority of these were intended to assist the student to retrieve theoretical knowledge they had learned in the classroom/nursing laboratory and to integrate this content with their practice in the clinical area. Some were designed to generate self-reflection by the student or to communicate the affective and attitudinal attributes of the profession. Many incorporated elements of discovery and innovation. It is significant that although the teachers implemented many teaching strategies in the clinical area, they were generally surprised that the researcher had identified these as remarkable.

To researcher: I read that you had found that I did all sorts of things, like cuing, for instance, and at first, I was really amazed. I thought I didn't do anything that sophisticated. But then I thought about it and I realized that all of this (clinical teaching) has become so second nature to me that I don't even realize I'm doing these things. No one ever taught me how to cue students. I guess I just learned from trying out what works and what doesn't work. I felt better about myself as a clinical teacher when I saw

that list (of teaching strategies used). I could see that what I do is based on actual rationale. (Interview: June 22, 1990)

### Attending

Because the clinical teachers were generally required to conduct their teaching in crowded rooms in the clinical area, it was necessary for them to adopt a variety of ways of ensuring that a student be able to attend to what the clinical teacher was saying. Humour was utilized a great deal in this regard and the teachers often varied their tone of voice and facial expression for this purpose. If the student appeared to be distracted, the teacher touched a student on the arm or shoulder and faced the student directly before continuing to speak. At times, the teacher placed both her hands on the student's shoulders. Teachers #4 and #6, as inexperienced clinical teachers, were initially unsure of how to obtain a student's attention in the clinical area, particularly when the student was so focused on her patient's care that she did not appear to hear or see the teacher. Both expressed reluctance to startle the student or to "yell down the hall after her". At the end of the academic year, both teachers had adopted attention-seeking behaviours through a trial and error learning. The clinical teacher's expressiveness behaviours (e.g., tone of voice; gestures) were also utilized to indicate priorities in the practice of the profession. Teachers regularly stressed certain words or phrases which revealed the values and the norms of the profession.

A student asked the teacher to supervise insulin preparation.

To student: What's his blood sugar?

"I don't know. I'll check."

Later when student returned with the information: Never, ever give insulin unless you know the sugar. (Fieldnotes: April 19, 1990)

### Cuing

The six teachers in the research study frequently cued the students regarding aspects of nursing care, in order to promote the student's recall of previously learned information. Generally, cuing occurred by means of questioning.

A student said that the patient's bladder was distended and when he got up to void, he only voided 50 cc.

To student: Does that make sense to you? His bladder was distended and he only voids 50cc?

"Well, no".

Did you check the level of his bladder distention after he voided?

(Fieldnotes: January 23, 1990)

However, by the end of the clinical rotation, the students were often so familiar with the teacher's mannerisms that the teacher could cue the students with gestures and facial expressions. One situation which was repeated on several occasions in the fieldwork was when the clinical teacher "coached" the student through each step of an unfamiliar skill. Frequently, students appeared to rely on the teacher's coaching to the extent that, if the teacher omitted a step in the procedure, the student also omitted it. The teachers often commented on this phenomenon, but were unable to analyze why it occurs.

### Questioning

The teachers maintained individual styles of questioning students. These questioning practices reflected the teacher's interests and perception of significant concepts in the profession. For example, Teacher #6 questioned students about the pharmacologic action of medications; Teacher #2 questioned students about intravenous orders; Teacher #5 asked students about the patients' discharge plans. The teachers also responded to students' answers to their questions with specific standard phrases. The

students knew immediately if their answer was correct or deficient.

To student: What is the normal theophylline level?

Student: "11 to 14?"

Really? Are you sure?

"I'll look it up". (Fieldnotes: May 16, 1990)

The teachers also maintained individual rituals about how they answered students questions. Teachers #4 and #6 tended to answer students' questions directly. Teachers #1 and #2 answered beginning students' questions but, when the students neared the end of their second year, they often referred the student to other resources or asked the student "to think harder" about the answer.

A student asked, "Do I need an alcohol swab?"

To student: I don't know. Do you need one?

To researcher later: At this stage, I feel I can redirect the questions back to them. They need to start asking themselves first before they automatically ask me. (Fieldnotes: April 12, 1990)

Teacher #3 and #5 re-directed students' questions about procedures and practices which the students had learned previously in the program. They directly answered those questions referring to concepts or information which they knew to be unfamiliar to students.

### Rehearsal

A teaching strategy which was utilized by all six teachers was rehearsal.

To student doing dressing change: You're having a lot of trouble manipulating those forceps. That's OK. I do too. You might consider stopping by the lab and asking for a pair to take home for the weekend to practice. (Fieldnotes: February 8, 1990)

The teachers often encouraged students to "walk me through" a nursing procedure, prior to performing the skill. Rehearsal was generally verbal. However, at times, the teacher

reinforced the separate steps of a procedure by asking the student to "write it down in the order you would do it and number each step". Rehearsal was often utilized as an opportunity for the teacher to insert some additional information about the procedure or to acquaint the student about how the reality of the situation differed from the "textbook picture".

The teacher rehearsed a shortening of a Penrose drain with a student.  
To student: Where students usually go wrong is they put on their sterile gloves and then they touch their instruments. They've handled them with their hands before.

The student replied, "Don't do it. Right?" (Fieldnotes: November 21, 1989)

Rehearsal for beginning students and for students new to a particular clinical area often occurred in groups. The "football huddle" strategy was utilized to identify the major components of a student's typical day in the clinical area. Teachers #1, #3 and #5 often utilized the strategy of rehearsal to inspire confidence in the student's ability to handle sensitive interpersonal situations which arose in the clinical area.

#### Repetition

Practice and repetition were highly valued as a learning strategy by the six teachers in the research.

A student had not given intramuscular injection in several months and admitted she was nervous about giving one.

The teacher told her to practise giving one to a styrofoam cup. To student: Pretty good. Do it again until you get the feel of it down pat. (Fieldnotes: October 25, 1989)

Patients were generally chosen who provided the student with the opportunity to practise nursing skills and decision making. Teachers of beginning students emphasized practice as necessary for novice students to "master" certain skills in the profession. They

indicated that beginning students have a need for inflexible structure in the "how to's" of the profession. They stated that beginning students "need to know something backwards and forwards before they can start experimenting with changes". Teachers of more senior students, however, provided practice opportunities for students in order to assist the student to draw comparisons between situations and experiences. Repetition for these students was intended to provide them with an opportunity to develop broad concepts and to develop the skills of classification and discrimination.

### Compartmentalization

Compartmentalizing was a teaching strategy most often employed by the teachers of beginning students in the research study. These teachers frequently assisted the students to "break down the larger picture into smaller parts", in order to facilitate the beginning student's processing of specific information.

A student asked: What does polyarthritis mean?"

To student: OK, now. Let's dissect this. What does "poly" mean?  
(Fieldnotes: October 12, 1989)

To student: It's very important that you learn the importance of staging. You can never do it all in nursing. Learn to break down the tasks before you into small manageable pieces. (Fieldnotes: December 7, 1989)

### Role Modelling and Mentoring

Role modelling was cited by Teachers #3, #4 and #5 to be a significant clinical teaching strategy. These teachers stated that students often assume the clinical teacher's nursing attitudes and behaviours by means of identification. The imitation of the clinical teacher was expected to result in a behavioral and/or attitudinal change for the student. Although these teachers modelled the practice of the profession a great deal, students

frequently appeared unaware of the intention of this strategy. It was not uncommon for the researcher to witness the teacher nursing the patient, while the student took this as an opportunity to leave the patient's room and complete other aspects of her work.

A student asked the teacher to talk to her patient who was crying. The teacher spent several minutes talking to him in front of the student. The patient said he felt much better after the talk.

Later to researcher: I don't think they really see the creative things I and the other nurses do. It's because they are novices and they only see what they have to in order to survive. But I keep hoping some of what I do they'll remember. (Fieldnotes: November 13, 1989)

A student was talking to an elderly patient in the hallway. She stopped the teacher who was walking down the hall and said, "I don't think she knows what she's saying. She keeps talking about a puppy".

The teacher crouched down beside the patient's wheelchair and asked her if she'd ever had a puppy. She told the patient to close her eyes, imagine the puppy and to describe it. The patient did so and expressed her pleasure about remembering the dog she had owned before her hospitalization. When the teacher finished her conversation with the patient, she looked around and said to the researcher, "Now where did that student go? Do you mean that when I sat down to talk to X (patient), she just left? She didn't hear anything? Showing students how to communicate with the elderly is part of what I'm trying to do here. They have to watch to learn". (Fieldnotes: October 23, 1989)

At times, the teachers' role modelling produced other unintended effects.

To researcher: Last week I thought I'd demonstrate some therapeutic communication to my students so I talked to a patient in the hall with my students watching. The patient finally said, "Have you any more goldarn questions?" and all the students giggled. (Fieldnotes: November 3, 1989)

Teacher #3 chose mentoring strategies as an alternate to the traditional role modelling approach in clinical teaching. Mentoring differed from role modelling in its directive nature and in its inclusion of the student as a critical analyst of the teacher's behaviour. Whenever Teacher #3 demonstrated an aspect of nursing care to a student, she discussed what she was about to do beforehand and directed the student to observe

specific aspects of her performance. These were discussed with the student following the observation. The student was invited by Teacher #3 to analyze and criticize the teacher's performance in relation to the student's view of ideal professional practice.

#### Learning from others

All the teachers encouraged students to observe and learn from the practice of nurses they considered to be "good practitioners" in the clinical area. However, only Teachers #2, #3, #4 and #5 actually arranged for individual students to schedule time in order to observe a staff nurse perform aspects of nursing care. Teachers #3, #4 and #5 regularly "nursed patients" with students in order to demonstrate aspects of patient care.

Patients were utilized by all of the clinical teachers to provide "bedside teaching" to students. The teachers occasionally encouraged patients to discuss with her and a student an aspect of their illness or hospital experience. Generally, however, the patient did not participate in bedside teaching. Patients were frequently used to demonstrate differences between concepts which the student had learned in the classroom but was unable to differentiate in practice.

A student said her patient's pulse was "bounding".

To the student: Let's go take it together. Later to same student outside of the patient's room: No, that's not bounding. Bounding is much stronger. That pulse was perfectly normal. (Fieldnotes: November 19, 1989)

To student at patient's bedside, in hushed tone: You see how her fingers are cyanotic. That's because of her poor peripheral circulation.

Later at the nurses station, the teacher discussed the seriousness of patient's condition with the student. (Fieldnotes: October 26, 1989)

#### Chunking

The teachers assisted students to relate "chunks" of information in the profession

by their exploration with students of the exemplars of specific concepts, extracting the unique attributes of that concept. For example, the teachers frequently told "horror stories" from their past which illustrated negative aberrations of a concept.

The teacher asked student what was under patient's dressing. Student replied she did not know. The teacher told her to "remove the dressing and see even if the staff nurse had said only to remove it when soiled". Later she said to the student: There once was a patient - a lady - who came up to the ward from Emergency. She'd been there for some time and for some reason they had put an eye patch on. For whatever reason it was not taken off on the ward for a long time. By the time someone looked at it the patient had developed an infection and a corneal abrasion. Whenever I see a dressing that has not been removed, I think of her. (Fieldnotes: January 4, 1990)

Students whose clinical performance was judged by the teacher to be exceptional were often asked to relate to the student group how they had responded to specific clinical situations in the post-conference. The teacher utilized these situations as examples of positive exemplars. As one "chunk" of a concept was recalled by the student or the teacher, the student often recalled other related "chunks" of information. In addition, the teachers frequently shared with the students incidents which had occurred in the clinical day which the teacher regarded as "a learning experience".

To researcher: X (student) aspirated the needle last week and the syringe filled with blood. I have never seen that happen in all my years in nursing. I showed all the students the syringe as an example of why it is important to aspirate before you give the medication. I couldn't believe it this week when X forgot to aspirate with Mrs. Y's (patient) IM (intramuscular injection). (Fieldnotes: February 22, 1990)

#### Providing Perspective

The clinical teachers in the research indicated that a significant portion of concept attainment in clinical teaching involves helping the students to attain an accurate

perspective of a clinical situation. They stated that students, because of their inexperience and narrow focus as novice learners, tend to assume that minor details are more important than they truly are. They also tend to "focus on the negative" in their clinical performance. As one teacher stated, "This is something you can't teach them in a book".

To researcher: Students don't often know how to roll with the punches. Their idea of a bad day is when everything doesn't go as planned. They tell me they've had a horrible day and I tell them, 'Well, nobody died, did they?' If everybody survived they couldn't have had such a terrible day. Something must have gone OK. (Fieldnotes: January 5, 1990)

Assisting students "to gain proper perspective" often entailed the clinical teacher communicating her faith in the student's ability to practise the profession appropriately.

To student at the patient's bedside: Tell me what you've done so far today. The student replied, "I can tell you what I haven't done".  
Let's be positive --- what have you done?  
The student replied that she had given all her medications but had not begun her bed baths.  
So you've given all your meds on time. Good. Making sure your meds are on time is probably more important for these patients than their baths. If you have to, there is no reason why you can't give them a bath in the afternoon. (Fieldnotes: March 22, 1990)

A student gave the teacher a prolonged explanation of why she thought her patient needed the larger dose of analgesic.  
To student: Hold it. You worry too much. You have the necessary data. Now go for it. (Fieldnotes: October 25, 1989)

### Imagery

The teachers in the study utilized a variety of strategies to provide visual imagery for their students, including drawing pictures, and metaphors.

The student said she had never had a patient with an abdominal perineal resection and was "a little hysterical" about changing the dressing the next day.  
To student: Here let me draw you a picture of what you can expect to see tomorrow when you take off her dressing. (Fieldnotes: April 11, 1990)

To student, explaining how to recognize coarse lung sounds: Coarse is like rubbing your hair in front of your ear. (Fieldnotes: February 6, 1990)

The teacher drew a basic sketch of a chest tube for student after change of shift report. "

To student: You don't seal it.

Student asked: "Why? Is it like a Foley bag?"

It's more like a sandwich bag. (Fieldnotes: October 25, 1989)

### Mnemonics

The teachers in the field study also utilized mnemonic techniques to assist the student to recall and retain theoretical concepts. For example, Teachers #1 and #5 often related clinical incidents to situations in the student's personal experience as a student, a spouse or a parent in order to improve the student's understanding of a concept.

A student reported that her patient had an infected intravenous site and the nurse had recommended hot fomentations. The student was concerned because there was no doctor's order.

To the student: It's an independent nursing action. So how would you do it?

"I don't know. I looked in the procedure manual and I couldn't find it".

If you were at home with one of your kids and they had an infected scratch on their arm, what would you do? (Fieldnotes: April 19, 1990)

Teacher #6 used acronyms for the same purpose.

The teacher gave a student a hint to remember side effects of atropine: "mad as a hatter, dry as a bone". (Fieldnotes: February 6, 1990)

These strategies were designed to connect unfamiliar with familiar concepts for the students and to facilitate their learning of new concepts.

### Postconferences

A strategy which five of the teachers in the study stated was of dubious value to the students' learning was the concept of postconference. The teachers in the research stated that the hour-long conference session is intended to occur immediately following

a clinical day "so that the students can discuss their experiences and learn from one another". However, in practice, the teachers and the students often found it difficult to be free to leave the clinical area for conference at the scheduled time. Some teachers were required by the curriculum of the program to discuss specific topics in the conference period. As these topics were often unfamiliar to the students, bearing little if any relation to the day's clinical experience, the teachers generally lectured during the conference time. Another factor which minimized the effectiveness of the postconference was that the teachers and the students were frequently fatigued and eager to complete the day when the postconference time arrived.

To researcher: Postconferences are often scheduled at a time when I'm not at my best. Students usually get off the ward late. They usually are finishing their charting when we're supposed to be off. I have to check their charts before I can leave. It doesn't leave much time for a post-conference. (Fieldnotes: April 15, 1990)

Three of the teachers in the research study regularly shortened or cancelled their postconferences. One teacher reported that, in her school of nursing, this practice is "well known but never talked about". Teachers #4 and #6 expressed some reservations as novice clinical teachers about the postconference concept but were reluctant to revise this practice because of their concern to adhere to the school's expectations.

To researcher: Next time, I'm going to let go of some of my own agendas. Because of my own insecurities -- I was afraid to do anything they hadn't told me I could do -- I sometimes compromised their needs for mine or the school's. Like postconferences -- next time I'm not going to insist we cover certain things and do it the way I think it should be done. Often they were too tired to listen or they had something far more pressing in their minds to discuss. (Interview: December 14, 1989)

Teacher #3 scheduled the postconferences for her students in the middle of the

clinical day. She explained to the researcher that this afforded the opportunity for the students to discuss problematic issues in the clinical area and then to return to the ward to implement what had been advised by the group. Teacher #3 considered postconferences to be essential in order to assist students with pattern recognition and problem representation.

In postconference, the teacher and students discussed X's (student) concern regarding her patient's medication order. They advised X to talk to the doctor about the questionable order. The student stated that she would ask her buddy nurse to communicate the information to the physician. The teacher replied that X was to do this herself and to report back to the group about the experience. The student later reported that the experience had been a "major accomplishment" for her as she had "been petrified" of doctors until this time.

Later to researcher: Yesterday, I looked at the (teacher-student) contracts and I said, "Oh, yeah. I need to give her that experience". (Fieldnotes: October 25, 1989)

#### Patient Assignment

A teaching strategy utilized by four of the teachers in the research was entitled the "sink or swim" method of clinical teaching by one of the participants. This strategy of assigning one or more critically ill or heavy care patient(s) to a student was both an assessment and a teaching strategy.

To researcher: I believe in the 'sink or swim' method. Throw them in deep water and watch what they can do. I've given some of them very heavy patients and they have done well. Once I know they can cope with such a heavy assignment I know they can be more independent. They don't need me to be checking up on them all the time. (Fieldnotes: March 15, 1990)

Although these patients may have been assigned previously to other students in the teacher's clinical group, they were perceived by the teachers as the "heaviest" patients (those requiring the most care) which could be assigned to this level of student. The

strategy was generally intended to introduce the student to the "real world of nursing". It was reasoned that this type of experience would either challenge the student and motivate her/him to do well in the future, or it would result in the student's realizing that nursing was too difficult for him/her. The student's passing of this 'test of their ability' was frequently viewed as critical to the teacher's assessment of the student's total clinical performance.

#### Promoting Reflection

Teacher #3, #4 and #5 utilized several teaching strategies in order to foster self-disclosure and self-reflection by students regarding their clinical practice. Teacher #4 requested that the students complete a journal following each clinical day. The journal was confidential, seen only by the student, and it was intended to assist the student to vent and analyze her affective reactions to the experiences of the day. Teachers #3 and #5 frequently asked students in their post-conferences to reflect upon incidents they had experienced or observed in the clinical area, particularly those entailing ethical dilemmas. The questioning of students by these three teachers was frequently intended "to make the student think" about her performance or attitudes.

#### Decision Processing

A significant finding in the research is that the clinical teachers in the research utilized the majority of their teaching strategies in order to facilitate student's information processing and decision-making. The goals of information processing and decision-making were perceived by the teachers as overlapping and related concepts in the transmission of practice. The teachers stated that decision analysis was necessary in clinical teaching

in order to assist students to identify and interpret cues in their clinical experience. A major emphasis in decision analysis was upon the recognition by students of both relevant and irrelevant cues and linking cues in a clinical situation. Decision analysis was utilized to some degree by all of the clinical teachers but it was a particularly distinctive strategy utilized by Teacher #3. She stated that problem representation was a major area of deficit for many diploma nursing students.

To researcher: Students who are good clinicians often have trouble with data analysis. They often think a patient has one nursing diagnosis or another. But not both. They have trouble defining what they're really looking at. (Fieldnotes: October 25, 1989)

This teacher frequently "thought aloud" a decision with students. This procedure enabled students to determine the essential elements of the decision making process in nursing. She also directed students, by means of sequencing questions, to identify the information they needed to make an appropriate decision, as well as the consequences of various decisions.

To student: Why is the Foley discontinued?

Student: "Because the doctor ordered it".

Bang! (made a gun motion with her hand) That's a lousy answer.

"OK. But I'm not finished".

What other data do you have?

"I don't have any other data".

Yes, you do. What are you concerned about if you take the Foley out?

"Renal failure?"

Well, that's not the first thing that comes to mind. (other student came to ask for assistance) You figure this out and I'll be back.

(later) "I still don't see what you're getting at. I'm lost".

The teacher wrote out the data and the steps of the decision for her.

So now what's your decision? (Fieldnotes: November 21, 1989)

## Assessment

At the same time as the clinical teachers in the research transmitted the practice of the profession, they also assessed the student's learning needs and abilities. The teachers observed the students during the transmission of practice for clues as to the student's comprehension and analysis of the aspects of nursing which were being transmitted by the clinical teacher. Assessment in clinical teaching entailed a number of processes including supervision, intuition, patient assignment, feedback from others and written assignments.

## Supervision

### Assessment of Skill Performance

Supervision encompassed the majority of assessment strategies employed by the six clinical teachers. The inexperienced clinical teachers (Teachers #4 and #6) in the sample population initially emphasized to a great degree the necessity of supervising students' in the performance of unfamiliar skills/procedures. However, as they discovered that it was physically impossible for them to supervise all students at once, they began to prioritize students' need for supervision according to the complexity of the skill to be performed by the student and their judgement, based on prior experience with the individual, of the trustworthiness of the student. Teacher #4, as a first time clinical teacher, commented that supervising students tends to focus on the supervision of psychomotor skills to the exclusion of all other aspects of nursing.

To researcher: I often felt as if I were riding the crest of a wave. Like I was skirting things, instead of examining them in depth. I went from one crisis or need to the next. The time for reflection and planning just wasn't there. (Interview: December 14, 1989)

The less experienced teachers (Teachers #2, #4 & #6) supervised students directly during the course of the fieldwork study. They also communicated to students the expectation that students be supervised until the teacher judged them to be competent enough to perform the specific procedure independently.

Two students approached the teacher: "Can we do vital signs on our own?"

To students: "Sure. You guys did a lot last week. Just call me if you have any difficulty."

A student who was standing beside these two asked, "Can I do my vital signs?"

To student: Well, you're a little uncertain about some things. I'd better come with you. (Fieldnotes: October 11, 1989)

These teachers generally conveyed to students that a major role of the clinical teacher is to prevent the student from making errors and to protect them from the consequences of those errors.

A student told the teacher that her patient usually got dressed at 0730. She asked if she could come to the ward earlier the next day in order to assist her patient and to further assess her mobility.

To student: It's not that I don't think you can do it but who will you use as a resource if I'm not there and you run into difficulty? (Fieldnotes: October 12, 1989)

Teachers #2, #4, and #6 were often uncertain about the legal responsibilities associated with determining that a student no longer required teacher supervision in the performance of specific skills. They were also unclear as to the criteria to be utilized to determine that a student was able to perform a skill independently. They relied to a great degree on tools such as "skills checklists" provided by the school or their personally devised tools to "keep track of how many times a student did a particular skill and whether you can trust them to do it well on their own".

The teacher commented to the researcher that she has not given any

student a score of 10 in her personal coding system of medication knowledge. To researcher: If they got 10 (out of a possible score of ten), how could they improve? That would mean they know everything. (Fieldnotes: February 1, 1990)

Consequently, these teachers were generally reluctant to assess a student as capable of functioning independently, without teacher supervision. The more experienced teachers in the study did not depend upon tools or checklists to determine a student's ability to function independently in aspects of their nursing care; they made their assessments based on prior experience and knowledge of the curriculum.

The teacher explained why she does not use checklists to determine students' competency in skill performance. To researcher: Some teachers think that just because there are eight slots to fill out that a student performed a skill, that they should watch the student eight times. Not me. I watch the student until I'm satisfied that they know how. I think checklists are for teachers who need them to feel comfortable in their decisions about students. (Fieldnotes: October 12, 1990)

To researcher: You give students the wrong message with check-offs. You suggest to them that if the teacher has signed them off, they'll be perfect and never make mistakes. (Interview: June 26, 1990)

In contrast to Teachers #2, #4 and #6, Teachers #1, #3 and #5 supervised students indirectly as well as directly.

The teacher was standing outside a patient's room listening to student's conversation. To researcher: I find I can assess a lot about how a student relates to her patient without even going in the room. (Fieldnotes: February 13, 1990)

They were more inclined than the less experienced teachers to acknowledge that students were capable of functioning without teacher supervision. They also identified certain skills/procedures as requiring less teacher concern and supervision than others, based on the severity of errors the student could commit.

To researcher: I'll give X (student) a check-off for her IVAC maintenance. It's not a skill I get too concerned about. She still hasn't come to tell me about what the "1" (on the infusion pump scale) means but she knew how to clear it and when the alarm went off, she played with it until it went off. (Fieldnotes: May 8, 1990)

Another differentiating practice between these two groups of teachers was that the experienced teachers tended to tell students that they were "checked off" (judged as performing the skill satisfactorily) immediately after supervising their performance of a newly learned skill. The less experienced teachers required the student to demonstrate proficiency, while being directly supervised by the teacher, on more than one occasion. They often omitted to tell the student when the student no longer required teacher supervision in the performance of that skill, leading to much confusion and misunderstanding at times.

#### Assessment of Affective Dimensions

The six clinical teachers identified that supervision of students enabled them to assess more than the performance of clinical procedures in nursing. They stated that supervision enables them to assess the student's interpersonal skills with patients and staff, the student's organizational skills and the student's affective/caring response to her patient.

To researcher: I find with both X and Y (students) that communicating with them is often very difficult. I don't know what they're talking about sometimes. They seem to have trouble saying what they really mean. It's good they have lots of skills to do today because now I can watch how they interact with their patients. (Fieldnotes: January 17, 1990)

The teachers reported that they became "naturally suspicious" of students who appeared to avoid supervision by the clinical teacher.

### Defining Appropriate Expectations

The teachers relied on various strategies to determine appropriate expectations for students in the clinical area. These expectations determined their response to students' behaviour. The experienced teachers in the research study were able to utilize the curricular expectations for student clinical performance, as well as their own experience with students in the past, as their primary guidelines in this regard.

To researcher: X (student) - remember she was the one who impressed me so much because she had been so kind to Mr. Y (patient)? -- well, she showed me her SOAP note (charting). Her mastectomy patient had sat in a chair all morning. She had not coughed or done DB & C (deep breathing and coughing exercises). No leg exercises. No analgesics. You'd think at this stage you could at least expect them to do the basics in post-op (following surgery) care. (Fieldnotes: February 27, 1990)

To researcher: X (student) tends to drink in everything and think about things a whole lot more than some of the others. She always wants to be right so her risk taking is pretty low. But she's not at all bad for this level. (Fieldnotes: March 13, 1990)

Teachers #4 and 6 were unable to utilize this strategy effectively in their assessments of students because of their own unfamiliarity with the curriculum and their inexperience as clinical teachers.

To students: My expectations of you aren't for you to know EKG cardiology. I don't know what the school has as its expectations but I don't expect you to know this now. (Fieldnotes: February 1, 1990)

Consequently, they relied on methods such as comparing students with one another to establish a uniform standard. Teacher #4 sought counsel from experienced clinical teachers in the university program. These methods were often deemed unsatisfactory and confusing by these teachers.

To researcher: I was surprised about the amount of peer pressure from the

other teachers. At coffee, they would often speak about students so negatively that I would go back to the ward and try to figure out whether I was being too easy on my students or whether I had missed something. (Fieldnotes: December 7, 1989)

### Student Dependency

Although each of the teachers employed supervision as their main assessment strategy, not all of the teachers were convinced that direct supervision was beneficial to students' learning or performance. Teachers #2, #3 and #5 discussed with the researcher their concerns that direct supervision often results in student dependency on the teacher and more student errors. Two teachers identified that students tended to depend excessively on the teacher for direction whenever the clinical teacher supervises the student in the performance of an unfamiliar procedure.

To researcher: She's a student who wants to be told everything. The trouble is that when I tell her what to do, she stops thinking for herself. She actually did much better yesterday when I had to do two dressings at once and I could only pop in to see how she was doing and leave. (Fieldnotes: February 9, 1990)

Teachers #1, #3 and #5 also identified that students often became more anxious when the teacher supervised them, resulting in the student making mistakes.

To researcher: Sometimes I think over supervision results in more errors. The students are so aware of you being there they forget what they have to do. (Fieldnotes: February 13, 1990)

To researcher: I had a student who had to give an IM (intramuscular injection) to each of the patients in the same room. She had asked me to supervise her mapping. I saw that she had mapped OK with the first patient and then I started chatting to the patient. Then we went to the next patient and the same thing. I was talking to the patient and I heard her gasp. She had given him the other patient's needle. The one that had just come out of the other patient. When we reported it to the charge nurse, we had to tell both patients what happened and take blood from the first patient. The staff were really annoyed that they had to do all the

paperwork. That incident proved my theory that over supervision results in mistakes. The student thought I would prevent her from making mistakes. She transferred the accountability to me. When the rest of the faculty heard about that, some completely missed the point. They felt that from then on you needed to watch everything students do. (Fieldnotes: February 20, 1990)

On six occasions during the research, a student made an error of substantial proportions while being directly observed by the clinical teacher. These incidents appeared to have occurred, in part, because the student was anxious about performing the procedure under the teacher's supervision and because the student appeared to depend on the clinical teacher to prevent all errors.

The teacher came for coffee with other teachers and said that she was supervising a student giving insulin and was checking the patient's pedal pulses before they began.

To teachers: Before I noticed, she had given the insulin already. I asked her if she checked the arm band. She said, "No". Later we discovered she had given the wrong amount to the patient. When we talked about it later, she said she was nervous and had gone too fast. (Fieldnotes: April 19, 1990)

The clinical teachers frequently left a student to continue with a procedure/skill alone when they recognized that the student was becoming increasingly anxious in their presence.

The teacher was supervising a student preparing an intravenous medication.

To student: So what's the story?

Student: "I hate it when you ask me questions I don't know what you're asking. What do you mean 'the story'?"

The student then bent her needle in the vial and the cap of the needle fell to the floor.

"Oh, shit".

The teacher talked very quietly and slowly: OK, now. Just remove the needle. It's all right.

Later, she went away from the student to the nurses station.

To researcher: I thought if I left her alone she wouldn't flap as much. (Fieldnotes: May 17, 1990)

To researcher: It looks like X (student) managed OK when we were at coffee. She would have done a lot worse if I'd stayed around and nagged her. (Fieldnotes: May 16, 1990)

They also recognized their own tendency to supervise "just to keep busy".

To researcher: I'm so tempted to go into their rooms and push a few buttons on their TPN's. But I know they don't need that now and I'm forcing myself to stay out. (Fieldnotes: April 12, 1990)

To researcher: I tend to be well organized and I like to keep students that way. Sometimes I find that I interfere with them just because I want to be busy. I hate just standing around. (Fieldnotes: January 17, 1990)

### Trusting the Student

The need for supervision by the clinical teachers in the research was largely determined by the teacher's trust of the student's ability to perform aspects of nursing care safely. The teachers occasionally discussed with the researcher their concerns about the consequences of emphasizing supervision for the students who are experiencing the most clinical difficulties. Students who were perceived by the teacher to be a problem and to be untrustworthy received more teacher attention than those students who were able to function well in the clinical area.

To researcher: I don't worry too much about X (student). She does what she's supposed to do. She comes to get me if she doesn't know something. I don't worry about Y either. Those students have their act together. I worry about neglecting them though. They don't get as much of my attention as the students who are having more difficulty. (Fieldnotes: February 15, 1990)

To researcher: The problem students are the ones that take up most of your time. You want to give them the benefit of the doubt. You don't want to be unnecessarily severe. That takes time away from the students who aren't having major problems but who would like to learn more. (Fieldnotes: February 28, 1990)

### Determining the Amount of Supervision

The decision about how much supervision was good and right for students was an individual one. The teachers reported that they arrived at this decision with many misgivings. Teachers, such as Teachers #3 and #5, who had decided not to function as gatekeepers to the profession and to trust most students, were temporarily shaken and confused when a student they had not supervised made a serious error.

To researcher: X (student) in the last group was about to give 10.5 cc of insulin instead of 0.5 in the sage (infusion pump) the last week she was with me. I knew I'd missed her in the rotation. I'd been so concerned with Y (other student) that I hadn't checked her enough. The last teacher -- she'd had told me the same thing. I knew it and I let her slip through. (Fieldnotes: November 21, 1989)

Teachers such as Teacher #1 and #2, who were primarily concerned with the safety of student's nursing care, recognized that supervision at times resulted in unintended and negative consequences for students. These teachers occasionally explored the appropriateness of the amount of their student supervision in the clinical area.

To researcher: The question I ask myself all the time in this term is am I helping the students enough? I want to give them some space to be independent of me but I don't want them to feel abandoned either. (Fieldnotes: November 30, 1989)

All of the teachers identified specific cues which indicated to them that a student required more frequent and intensive teacher supervision.

To researcher: If they do things that get my attention, I start watching them more. (Fieldnotes: January 5, 1990)

To researcher: I don't know how I decide who to hover over and who to leave alone. I guess it's a matter of trust. If I can trust them to get me if they have a problem or they don't know something and I feel my presence is making them flap, I will allow them to be on their own and come and get me when they need me. But there are some students I wouldn't turn my back on. Like the students who at the end of the day you realize you haven't seen all day and you don't really know what they've been doing.

You start to wonder why it has been necessary for them to keep such a low profile. Then I start watching them to see what they're really doing. (Fieldnotes: May 16, 1990)

For example, students who finished their work earlier than the rest of the students and spent the latter part of the clinical day in the conference room or talking to the nursing staff were generally regarded as "hiding something" from the teacher. Students who rarely requested a teacher's assistance and students who spent a great deal of energy attracting the teacher's attention to themselves were regarded with equal suspicion.

To researcher: X (student) gives me a very uncomfortable feeling. There's too much swashbuckling about how smart she is. (Fieldnotes: March 22, 1990)

To researcher: If students don't come and get me for help, I find I don't see what they are doing. So I like to make regular rounds just to see how they're doing. (Fieldnotes: January 5, 1990)

The teacher checked the student's charting and discovered she had not charted on the flow sheet.

To researcher: Somehow I knew that. With all the free time she seems to have, she still doesn't get around to things like this. (Fieldnotes: March 9, 1990)

At times, the teachers deliberately withdrew from their usual supervisory role in order to assess the student's ability to function independently of the clinical teacher.

To the researcher: "I stay with them for awhile but then I deliberately leave them on their own. That way they are forced to sort things out for themselves. (Fieldnotes: October 11, 1989)

Outside of patient's room, to researcher: X (student) was doing a good job so far of that dressing. I thought I'd leave her and see how she does on her own. (Fieldnotes: November 21, 1989)

Teachers #2, #4 and #6 also utilized this strategy to communicate to students their trust in the student's ability and to increase the student's self-confidence.

X (student) called to the teacher from the other end of hall. The teacher replied: I'm busy right now.

X said "OK" and went into her patient's room.

Later to researcher: I knew that X was calling for me because she wanted me to tell her that a decision she had made was correct. She needs to develop some confidence that she doesn't need my assurances all the time. She has to start making decisions on her own. (Fieldnotes: February 22, 1990)

However, Teachers #4 and #6 identified at the end of their first clinical teaching term that students did not always recognize the teacher's intentions in these situations.

#### Patient Assignment

The six teachers utilized patient assignments in order to determine a student's capabilities and limitations. Teachers #1, #2 and #6 utilized this assessment strategy primarily for students whom they perceived as functioning exceptionally well in the clinical area and for students who were perceived as having "one last chance to demonstrate that they can be successful". Teachers #3, #4 and #5 used the strategy largely to "challenge" a student who had requested additional experience. However, they also assessed "weak" students' clinical abilities in this manner.

A student's patient was unexpectedly discharged and she was left with only one patient who required minimal care. To student: OK. Just cruise around (the ward) and help people out.

Later the teacher told the researcher that she had deliberately chosen the assignment for this student because she had suspected that she would not cope well with a heavier patient load.

To researcher: It's always that way. You choose patients that are really going to challenge them and you get on the ward and discover that they've been transferred or gone home or something. You never get to find out what the student would have done if she'd had these kind of patients. (Fieldnotes: October 25, 1989)

#### Assessment of Students' Knowledge

One common assessment strategy which often proved to be difficult for the clinical teachers in the research was questioning, particularly when the clinical teacher questioned students about related theoretical content during, or immediately before, the student performed a nursing skill. The students generally became visibly flustered and did not execute the skill correctly if questioned intensely by their clinical teacher. Another consequence of this method of questioning was that students appeared to learn the questions teachers commonly asked. One teacher, who questioned students at length about the action and side effects of medications, stated that she was "amazed" that at the end of the clinical rotation students were giving her "the right information about their medications" before she had asked them a question. This method of questioning, termed "drill by fire" by one of the participants, appears to be a hallmark of some inexperienced clinical teachers. The clinical teachers with prior teaching experience stated they had abandoned this strategy in earlier years when they discovered "it was teaching students nothing but how to be petrified". They also discovered that this assessment strategy is extremely time-consuming.

To researcher: I don't think it's important to know if the students know all about their medications. I don't ask them questions about their meds(medications). If they know their five rights and they give it appropriately, that's OK with me. I'll spot check them if I want to test their knowledge. Otherwise, I don't. With all their oral meds, if I asked them about each one, that's all I'd do until the end of time. (Fieldnotes: February 8, 1990)

Teacher #6 discovered the effects of questioning about medications as producing fear and anxiety in her students. She subsequently omitted this strategy in the last weeks of her clinical teaching term.

Teachers #1, #2, #3 and #5 relied on the students' charting of the nursing care they had given to determine areas of understanding which the student lacked/had attained, as well as what the student had actually done for her/his patient that day.

To researcher: I evaluate how well they have assessed their patients by reviewing their charting. For example, you can see by X's charting that although she seems to do well on the ward she has trouble tying it in with theory. She doesn't do well in tests either. She's a nice girl but sometimes the correlation (of practice with theory) isn't there. (Fieldnotes: January 17, 1990)

A student had charted that she was unable to get a blood pressure in either of the patient's arms.

To researcher: I don't think she got any one to help her with the BP. She certainly didn't mention it to me. I'll have to talk to her about what to do in cases like this. It's not enough to simply not chart a BP. (Fieldnotes: February 28, 1990)

To researcher: X (student) undermedicated her patient by giving her 75 of demerol when 75-100 was ordered because only 75's were in the drawer. That's the stupidest reason I've ever heard for medicating someone. And we had been to a pain control inservice just that morning. I found out about it when she wrote a SOAP note which said the patient had good air entry. She (the patient) had a total lung capacity of 500cc. and she had not coughed all day. Even physio had not got her to cough all day. (Fieldnotes: February 27, 1990)

All of the teacher participants checked the students' charting, but only these teachers concentrated on the assessment of the students' nursing knowledge and practice. The other teachers focused on the charting skills of the students.

Another assessment strategy employed by the clinical teachers in the research was to "set the student up to see if they discover some vital information and make the right decisions with it". The teachers would often know something about a student's patient or the patient's treatment regimen but would not reveal these data to the student. They then assessed the student's ability to discover this information and to utilize it in an

appropriate manner in their nursing care.

To student: Did you realize that a contraindication of this drug is that it shouldn't be given to a patient who is allergic to aspirin? I was all ready to explain to you why your patient was receiving it even though she is allergic to ASA. It's a matter of the good outweighing the evil. I had expected you to refuse to give this medication. It would have demonstrated to me that you had researched your meds (medications) well. (Fieldnotes: November 16, 1989)

A student came to the teacher to say that she was having difficulty counting her patient's pulse. The teacher asked: Is it regular?

The student said it was irregular. The conversation continued : To student: It is irregular. So what should we do?

Student: "What should we do?"

Yes.

"Take it bilaterally? No? Well, I don't know."

Later the teacher told the researcher that she had been aware that the patient's pulse was irregular beforehand but she "just wanted to see how she'd do". (Fieldnotes: October 19, 1989)

Another version of this strategy was "try to see what's missing in this picture".

To student: Did you notice anything different about your IV?

"No".

Well, it isn't a ball valve. It is easy to run dry without one. If his IV continues, I'd change it if I were you. It's safer. (Fieldnotes: November 29, 1989)

The teacher went into a patient's room and observed that Oxygen was not connected to nasal cannula although the patient was dyspneic.

To researcher: I wonder if there's a reason for that. Later when the student came into the room, the teacher asked her: There is something wrong with the oxygen. See if you can find out. (Fieldnotes: March 27, 1990)

### Information from Others

#### Patients

All of the teachers attempted to see the patients assigned to students on a daily basis. Termed "rounds" by the teachers, these visits enabled the clinical teachers to obtain current information from the patients and to inquire about the quality of care the patient

was receiving from the student. Questioning of patients for the purpose of assessing students was generally subtle and oblique, disguising the true intent of the teacher's questions.

The teacher visited a student's patient when the student was away from the room. She asked him about his angiogram.

To patient: Did X (student) take a look at it (the angiogram site)?

She looked at the site herself and then discussed with the patient what he knew to be the physician's plans for his future. Later to researcher: I often find out information when I talk to patients so that I can compare it later with what the student knows. I also like to get in my nursing licks from time to time. (Fieldnotes: April 11, 1990)

### Nursing Staff

The teachers at times received feedback from the nursing staff regarding student's performance in the clinical area. In three of the six teachers' clinical areas, the nursing staff generally gave only negative feedback concerning students to the clinical teacher. In Teachers #3 and #5's areas, the staff gave the teacher both negative and positive feedback about students. Staff feedback in these areas was not frequent. It is significant that only in Teacher #4's area did the staff give the teacher regular daily feedback. This was also the only nursing staff in the research which assumed responsibility for assisting the teacher and the student to identify any problems they identified in the student's clinical performance.

A nurse commented to the teacher that a student had given her an excellent report at the end of the shift.

To nurse: Thank you for telling me this. We've been learning a lot about communication in the last week. (Fieldnotes: November 30, 1989)

The teachers valued feedback from nurses who were generally more positive with students. They often ignored feedback from nurses who were usually negative about

students.

To researcher: That nurse is very kind to students. Some of them are ready to find fault with students. I don't pay as much attention to what one of them says about a student as I would when someone like X (the nurse) tells me something. (Fieldnotes: May 8, 1990)

### Faculty

The teachers also relied at times on feedback from other faculty members regarding the students' clinical performance and other related information, in order to provide a historical context to their assessments of students in the clinical area. This feedback was provided formally, by means of evaluation records and committee meetings at the school of nursing, and informally in group discussions. All of the clinical teachers expressed much ambivalence about utilizing the formal student evaluations as a basis for their own assessment of students. They stated that they were concerned that "seeing the evaluation before you meet a student might prejudice you about them". As well, the teachers identified several problems with the criteria used to evaluate students and the diversity of teachers' interpretations of the various categories in the evaluation record.

To researcher: Written feedback about students from teachers is usually not too revealing. The Term 1 criterion we use is crap. Everyone passes. All of these students will pass. (Fieldnotes: November 16, 1990)

To researcher: I tend to write a lot because I believe in positive feedback. Outstanding is a very difficult category (in the evaluation form) because does it mean that they've done everything or does it mean that they walk on water? (Fieldnotes: January 4, 1990)

To researcher regarding the evaluation form: In the form we use, one incident can be represented under several different criteria. It depends how serious it is but I tend not to use the same incidents. It looks like you're beating them to death with the same mistake. (Fieldnotes: March 14, 1990)

The general tendency of the six teachers in the study was to avoid reading these unless

a problem developed with a specific student which they felt unable to manage.

To researcher: X (student) told me that she was very angry about her last rotation. She doesn't think she was treated fairly. I'll wait a couple of weeks and see how she's doing. If she's not doing well, I'll check the last teacher's documentation. (Fieldnotes: February 20, 1990)

The informal network about students was actively utilized by all of the clinical teachers in the study.

The teacher asked the lab teacher at coffee if X (student) had a sight problem or was it her knowledge base which was weak?

To teacher: She seems to hesitate so much before she does anything.

The lab teacher replied that her assessment was the student had a poor knowledge base. (Fieldnotes: February 15, 1990)

Teachers #3 and #5 noted that teachers in schools of nursing at times communicate information to other faculty about students which does not appear in the formal evaluation record and may never have been communicated to the student.

To researcher: I find it really maddening when a teacher tells me that a certain student is weak, but there's nothing written in the evaluation summary about it. I don't think that's fair to the student or to me. (Fieldnotes: October 25, 1989)

Four of the teachers commented that the informal feedback of teachers tends to be in reference only to the negative or exemplary aspects of a student's performance. It was the observation of the researcher during the clinical teachers' coffee and meal breaks with their colleagues, that teachers learned much about students in this informal communication network.

To researcher: X (the lab teacher) has given me some feedback about my group. She feels that Y (student) acts as if she knows everything. She's not very impressed with the others either. Its discouraging to me that some of the teachers who have been with them hate them. W (teacher) said to me, "You have a really weird group there". (Fieldnotes: November 2, 1989)

To researcher: Other teachers warned me about X and Y (students). They were satisfactory, but they didn't always make the connections with the theory. When I started thinking about that, I thought that students who perceive that their teachers are thinking negatively about them will be aware of the expectation that they will make mistakes and consequently will make mistakes. I met with X and I asked her how she thought she was doing. She said she thought she was doing well because I didn't act as if I thought she was dangerous. She said that when teachers watch her she gets anxious if she figures they don't trust her. She also withdraws. I've decided that I'm going to say to her, "Great. You think you can do this. So let's see you do it". (Fieldnotes: March 15, 1990)

### Intuition

Teachers #1, #3 and #5 frequently referred to their "intuition" about students in the clinical area. They spoke of "hunches" and "ideas" they had concerning specific students which later were validated by other assessment strategies.

The teacher asked a student if her patient was ready for the operating room. She asked the student if the patient's valuables had been collected. The student then revealed that the patient's diamond rings had been placed in the bedside table and not the locked valuables cupboard as required by hospital policy.

Later to researcher: A lot of clinical teaching is asking the right questions. (Fieldnotes: February 22, 1990)

A student said what the patient's chemstrip reading had been. To student: Really? That's pretty low for him, isn't it?

The teacher retrieved the strip from the patient's garbage to re-read it. She deduced that it had not been read accurately because she obtained another reading. (Fieldnotes: April 11, 1990)

Teachers #2, #4 and #6 also utilized intuition in their assessments of students. However, they expressed less confidence than the other group of teachers in their ability to perceive situations accurately by means of intuition.

To researcher: I thought she (student) was quiet and shy, but when I asked her, she said it was because she had a philosophy that the best way to learn is to listen. I said to her 'so if that's been your philosophy, what have you learned so far?' I was really surprised -- she learned a lot. I

wonder now if I may have misjudged some of the other students.  
(Fieldnotes: March 22, 1990)

The intuitive signals received by the clinical teachers were transmitted in the form of emotions or as a pattern of seemingly unrelated facts or visual clues.

To researcher: Sometimes I don't like students and I don't know why I feel that way. It later turns out that I don't like their care. I think I know intuitively they don't like their patients. (Fieldnotes: November 21, 1989)

The teachers implied that their intuitions were processes operating independently of analysis.

To researcher: Sometimes you get hunches about students and you sort of hold them to the side and then things happen that give you more information to reinforce what you initially perceived. Like a teacher in X (clinical area) had a student going through a follow through. The teacher doesn't have much to do with students there. It's supposed to be more of an observational learning experience. Anyway, a nurse said to the teacher, "Aren't students supposed to be with their patients in this experience? Because that student just sat in the coffee room most of the time drinking coffee and reading magazines." The teacher knew then that her hunch about the student being lazy was correct. (Fieldnotes: March 28, 1990)

However, upon reflection, the teachers would generally determine that they had seen or perceived something which evoked past memories and experiences.

To researcher: When I get back from coffee I'll check X's (student) charting to see if everything is ready to go on her patient's graphic sheet for him to go to the operating room. Ordinarily, I wouldn't. But something about her body posture --- she looked really ticked off when I was talking to her. I'll check and see if she knows what she's doing. (Fieldnotes: April 17, 1990)

This led to a seemingly irrational conclusion, an intuition. For example, a teacher was speaking to the researcher in the clinical area and she saw a student carrying a tray of medications. She called out to the student and asked to see the medications. She discovered that the student was about to administer the wrong form of morphine to the

patient. Later, she attributed this discovery to "an intuition" she had about the student. However, several days following the incident, she concluded that she had known the student to possess a "weak knowledge base". When she heard at the change of shift report that morning that the patient's morphine had been changed from pill to elixir, the teacher was aware from her previous experience with students that the student would probably not recognize the significance of the change.

To researcher: I thought it was intuition. But I really did know that she (the student) would probably not know the difference when she prepared his (the patient's) morphine. I had stored it up in my subconscious but when I saw her with the tray, I remembered. (Interview: August 23, 1990)

The teachers reported that intuition often led them to "seek a validation of what might be true" and to increase the amount of direct supervision of a particular student. The possibility of this leading to a self-fulfilling prophecy, resulting in the very behaviour which they were attempting to validate, was not identified as a concern by the participants.

The teachers in the research study often interpreted students' gestures, facial expressions and interpersonal behaviours as indicative of learning and/or personal difficulties. They applied this strategy when they knew the student well enough to be able to detect changes in the student's usual behaviour pattern. The teacher generally attempted to validate her interpretations in these situations, using additional assessment methods.

The teacher commented at coffee to her colleagues from the school that "the strongest student in the group" had sat behind the other students at preconference. She interpreted this to mean that the student had recognized that the rest of the group were relying on her for the answers to the teacher's questions and it "was her way of saying that she would prefer a more peripheral role in the group." (Fieldnotes: October 18, 1989)

### Academic Performance

Three clinical teachers in the study utilized students' written assignments as indicators of the student's ability to practise the elements of the profession. Teachers #1, #2 and #6 frequently altered their initial assessments of a student's ability because of contradictory information received in the student's written assignment.

To researcher: I was really surprised when X (student) handed in an assignment that was really quite good. She was my biggest concern. Now I see she has the potential. Maybe she's been too anxious to do well. (Fieldnotes: November 3, 1989)

They made similar adjustments when a student gave an oral presentation which differed from the teacher's assessment of the student's nursing practice or when a student experiencing clinical difficulties achieved high academic grades.

To researcher: X (student) is a sleeper. I mean that literally. She often looks tired and bored and disinterested. But she did postconference yesterday and you wouldn't have believed it. I'd given her an article on thoracotomies and she told us all about everything her patient had done and all about his care. (Fieldnotes: February 9, 1990)

To researcher: X (student) scored Y (marks) on her midterm. It's the highest mark we've ever had. She didn't articulate well a minute ago when I asked her to explain about the chest drainage -- but I know that the wheels are always turning. (Fieldnotes: February 13, 1990)

To researcher: I am concerned about X (student). She keeps making mistakes. Her eye-hand coordination isn't the best and she can't seem to memorize her meds (medications). She can read them but she can't seem to commit them to memory. But she gave this presentation on Mr. Y (patient). It was so fine. She had included research about his coping mechanisms and it was so thorough. In my two groups so far, this was the best presentation yet. She won me over with that. I knew she wasn't incompetent then. She knew how to do something well. So we can work on her problems. She can learn. (Fieldnotes: March 1, 1990)

Teachers #3 and #5 stated that students utilize different skills in their written and practical

work. They were less likely than the preceding group of teachers to negate their assessment of a student's clinical practice because of contradictory evidence in written assignments.

### Other Assessment Strategies

The more experienced teachers in the study (Teachers #1, #3 and #5) utilized several creative methods of assessing students' ability. For example, Teacher #3 assessed a student's ability to communicate with the nursing staff in the clinical area by observing how the student managed to locate and request the narcotic keys.

To researcher: The best test of a student's assertiveness is to see how long it takes her to get the narcotic keys. (Fieldnotes: October 25, 1989)

However, the traditional assessment techniques of supervision and questioning were the most commonly utilized by all of the teacher participants in the study.

### **The Teacher's Response**

During the transmission of practice/assessment phase of clinical teaching, the teacher receives and processes a variety of cues about individual students. The student's learning problems/needs in the clinical area are identified. This phase is followed by the clinical teacher's attempt to understand the situation, to develop various ways of framing the problem/task and to propose strategies to resolve the problem and/or meet the student's need.

The clinical teachers in the research study considered various alternatives in their responses to specific student problems/needs. These alternatives were identified by means

of heuristics the teachers had developed to sift through possible solutions and to decide which was the most expedient in the particular situation. When the teacher participants were in the clinical area with students, they did what made sense to them in the circumstances. What had worked in the past and what seemed likely to be effective, given the specific context, are among the criteria which guided the clinical teacher's response.

### Rituals

Each teacher maintained a repertoire of responses to be used in typical situations which arose in their relationship with students in the clinical area. Simple, ritualistic responses were selected before the teachers enacted their search for more complex solutions. For example, the teachers spontaneously responded to students' questions about nursing procedure or hospital policy by referring them to procedure/policy reference manuals in the clinical area. Immediate feedback regarding student's performance of an unfamiliar procedure was another ritual practised by all but Teachers #3 and #5. One teacher in the study referred to these rituals as "scripts" of clinical teaching.

The teacher's rituals were generally straight-forward, delineating clear courses of action to be implemented by the teacher when she received certain cues about students (e.g., if a student has not researched her patient assignment, she should be made accountable for her behaviour by sending her off the ward). Rituals generally led to transmission of practice strategies (e.g., feedback often included rehearsal of the "correct" way to perform an aspect of nursing care) and, concurrently, to further assessment of the student's needs and abilities. Occasionally, rituals were disciplinary in nature. If the teacher were uncertain about the student's response to the ritual, she generally engaged

in further assessment strategies to test the validity of the initial cues she had received.

To researcher: I have to give X (student) another day and see if what she's been doing is just the result of being in a new area. But she can't get away with being cute. It seems like she's used to being babysat and being prevented from making mistakes. Next week I'll give her heavier patients. We'll see if she gets the message that she has to think. (Fieldnotes: January 23, 1990)

The clinical teachers selected specific responses as rituals on the basis of their past experience as students and teachers and of their knowledge base regarding clinical teaching. Novice teachers assumed clinical teacher rituals they had learned primarily in their experience as students. These teachers frequently referred to more experienced teachers' "bag of tricks" which novices did not possess. They expressed regret and consternation that their responses were necessarily limited to the extent of their experience and knowledge in the field of clinical teaching. They often discussed situations, which more experienced teachers in the study referred to as "typical" in the clinical teaching experience, as unique and surprising.

To researcher: Last term people (students) were hanging around the desk. I didn't know if they were avoiding patients or they just didn't know what to do next. This time in orientation I made the comment that it is important that if they have spare time they should spend it with their patients. (Fieldnotes: February 1, 1990)

When a situation arose which presented itself to the clinical teacher as a unique case, the teacher was unable to treat it as a problem or task to be solved by applying one of the rules in her store of professional and personal knowledge and experience. She was forced to deal with it by exploring and testing newly designed strategies and approaches. Generally, these unique situations were problematic in a number of ways. For example, one of the teachers in the study taught a student who made several inaccurate decisions

about the priorities in her patient care. The student intimated that her personal problems were so extensive that she could not concentrate in the clinical area. The clinical teacher admitted that she possessed no satisfactory model of how to proceed in such a situation. The teacher also received pressure from the other faculty to "clean up this student's act before she is allowed to go on in the program". Although these atypical situations generally pertained to clinical problems, they occasionally related to students who were performing well in the clinical area who were requiring additional "challenge" or supplementary learning experiences.

When the clinical teacher's ritual responses were perceived by the teachers to be effective in resolving students' learning difficulties and meeting student's learning needs, the tendency of the teachers was not to analyze the clinical teaching experience in a serious way. The teachers' ritual responses yielded intended outcomes as long as the situation to be addressed by the teacher fell within the boundaries of what the teacher had learned to treat as normal. Unexpected and inconsistent outcomes led the clinical teacher to question the assumptions of her usual patterns and to explore the newly observed phenomenon in an intensive and introspective manner.

To researcher: I am confused about her. She writes excellent assignments. But the person who writes the assignments doesn't seem to be the same person who answers my questions so poorly and performs so badly clinically. (Fieldnotes: February 15, 1990)

### Reflection

Reflection by the clinical teacher was initiated because a situation was out of the bounds of the clinical teacher's experience and knowledge or because the teachers' ritual responses did not yield the intended outcomes. Reflection entailed tying a variety of

fragments of information concerning the situation together, so as to be able to describe the elements of the situation and to draw inferences about the appropriate response required of the teacher.

The teacher told the researcher that she once gave a clinical unsatisfactory grade to a student who told a patient that "if she pooped the bed, she'd have to clean it up herself." The teacher said she had to consider that the nursing team leader who had discussed patient's need to be more continent may have communicated it to the student in this manner. "But it concerned me that she didn't have better judgement." (Fieldnotes: January 4, 1990)

The clinical teachers' reflections revealed much about their beliefs regarding clinical teaching because, in this process, they were required to rely on what they knew and felt about clinical teaching. At times, particularly when the teacher determined that the situation was too complex for her accurate interpretation, other faculty were asked their opinions about the situation. This most often occurred at coffee and meal breaks. Frequently the situation was presented to the faculty as if the teacher had already analyzed the circumstances and was merely reporting the situation to her colleagues. However, the teachers frequently implemented the suggestions and intimations of their colleagues immediately following these discussions.

The teacher walked down the hall of the School of Nursing with the researcher and another faculty member. She told her colleague of a student who was "so stressed with personal problems, it would make you sick". She related several instances which had occurred that morning to illustrate her statement (e.g., "She came to the ward without an organizational plan because she had cried all night"). The other teacher listened and commented that the student should be asked to withdraw from the program.

Later to researcher: I am glad she (the other teacher) agrees with me. I was a little worried that I was being too harsh. X (student) has so many personal problems. Sometimes I don't know if I have a right to push her to do the same things as the other students on the ward. Y (the other teacher) helped me to see that I have to be more forceful with her. She

either improves or she's out (of the program). (Fieldnotes: October 27, 1989)

At times, the clinical teachers concluded that they required additional data to reflect accurately upon the situation as it had been presented to them. This most often occurred in cases when the student's clinical performance had been inconsistent. The teachers were generally reluctant to acknowledge that a student had a clinical problem if the student had been able to implement the specific aspect of nursing care beforehand at least once in the clinical rotation. They were also reluctant to view the situation as a problem if the student's performance in other aspects of her clinical performance were exemplary. The teachers often concluded in their reflections of problematic situations that the student required additional transmission of practice strategies in order to resolve the problem effectively or meet the identified need.

### Attributions

#### Attributional Search

The clinical teachers in the research initiated an attributional search during the reflection period when their intentions (i.e., the expected outcome) did not match the student's cognitive, behavioral or affective outcomes. According to Weiner's theory of motivation and emotion (1985,1986), people attempt to ascertain the cause of outcomes in their experience, particularly those which are aversive, unexpected and important. This causal search elicits attributions which in turn influence the individual's cognitive, behavioral and affective response. Weiner classifies causal attributions according to three dimensions: locus, stability and controllability.

The clinical teachers engaged in attributional searches when a student performed

better or worse than the teacher had expected, when the outcome was unexpected, and when the outcome was incongruent with the teacher's previous assessment of the student. Teachers who attested to an ability-evaluative or task-mastery goal orientation as a clinical teacher, generally concluded that the student's lack of effort or ability was the cause of the student's failure to meet a specific learning goal; student success was attributed to the teacher's interventions. Those teachers with a moral-responsibility or mentoring orientation were more likely than the other teachers to determine initially that it was their teaching style/methods which resulted in the student's clinical difficulty. However, if they instituted new strategies and methods and the student's difficulties remained unresolved, these teachers later revised their attribution to indicate the student's responsibility for the problem. Student success was attributed to the student's ability and effort in the clinical area. Attributional searches by clinical teachers occurred most often in response to an aversive student outcome. Positive outcomes were rarely the object of an attributional search. For this reason, the following discussion refers only to negative outcome causal attribution searches by clinical teachers.

### Attributional Dimensions

The teachers identified a number of dimensions of the attributions they made about student outcomes in the clinical area, which in turn determined the intensity and perseverance of the teacher's affective response to these attributions. The dimensions included locus (internal or external), controllability (uncontrollable or controllable), stability (stable or unstable), and globality (global or specific). Intent of the student was not perceived as an attributional dimension because, as one teacher stated, "Often the

student has the best intentions in the world but just can't make it happen".

Internal attributions made by the clinical teachers in the research study refer to those inherent to the student: lack of ability; lack of effort; inadequate learning strategies; anxiety; inadequate knowledge base; lack of sensitivity; inadequate interpersonal skills; lack of caring about patients and/or the profession; fatigue; personality; lack of accountability; lack of moral integrity; and poor motor co-ordination. External attributions refer to those causes outside of the student, such as family demands, "overload" of unfamiliar stimuli in the clinical area, the complexities of and unfamiliarity with the task assigned to the student, the nursing staff's responses to the student, and the teacher's inability to intervene effectively as a clinical teacher. The teachers sometimes identified causes, generally attributed to be internal, as external, particularly if they knew and were closely involved with the student. For example, anxiety was identified as having an internal cause if the teacher did not know the student well; as having an external cause ("It's because of the messages we give in this program"; "I've been watching her too closely. She needs more space") if the teacher knew the student well, particularly if the student had visited the teacher on several occasions to request help in dealing with personal and school-related concerns.

To researcher: X (a student the teacher had labelled in the previous week as lacking in ability to succeed in the program) came to see me yesterday. She said she goes home every weekend and her parents tell her every week that she'll never make it. Every time she makes a mistake, she thinks they are right. They want her to stay home and get married. Poor her. This program is hard enough without that. (Fieldnotes: January 24, 1990)

The clinical teachers differentiated between teacher controllability and student controllability in making attributions about student outcomes. Outcomes which were

perceived by the teachers to have resulted from within the student were identified as controllable by the student. However, outcomes which were external to the student were identified as either student or teacher-controllable. For example, teachers who believed that students, adversely affected by the attitudes and behaviour of staff nurses in the clinical area, should address these issues themselves, regarded these situations as controllable by the student. Teachers, who believed that it was the teacher who should address all interpersonal problems which arose within students' relations with the ward staff, viewed these situations as controllable by the teacher, uncontrollable by the student. However, situations in which the teacher discovered that a student was experiencing difficulties in the clinical area but had not informed the teacher were viewed as within the student's control.

The attribution of stability, or the duration of the cause, was affected by the clinical teacher's perspective of clinical teaching, as well as by her previous experience and her knowledge in the field of clinical education. For example, novice teachers in the sample population tended to attribute certain characteristics as inevitable throughout the student's educational program.

To researcher: They respond to a challenge. They generally won't challenge themselves. If they do, they generally don't know how to go about it. (Fieldnotes: March 1, 1990)

More experienced teachers had learned that students were unique in their responses to the clinical learning experience. They tended to perceive causal attributions as traits rather than states. The attributional dimension of stability also determined the teacher's expectancy for the student's eventual success; the more stable the causal attribution, the

less the teacher predicted the student would be successful in the program and in the clinical area.

To researcher: I think X (student) is going to get into trouble farther into the program. She thinks by rote. But she doesn't always know why she's doing things. (Fieldnotes: April 12, 1990)

Teachers who taught students who had performed poorly in the preceding clinical rotation, attempted to "treat the student just like all the others" until unique problem situations arose or until the teacher's ritual responses did not achieve the intended outcomes. In these situations, the teachers frequently made attributions to the student's lack of ability, a stable attribute, and their expectancy for success by the student was low.

Globality, the generalizability of a cause (Abrahamson, Seligman & Teasedale, 1978), was a significant attributional dimension for the novice teachers. It was less so for the more experienced clinical teachers in the study. Beginning teachers frequently assumed a student's error in one aspect of their nursing practice to be indicative of a global characteristic. For example, students who did not answer the novice clinical teacher's questions about medications correctly were subsequently questioned about their knowledge concerning additional aspects of their patient's care. These teachers also tended to assume that a student who had demonstrated insensitivity and uncaring to one patient would nurse all patients in that manner. Teachers #3 and #5 suggested to the researcher that globality is often assumed by beginning teachers because of the short period of time in which a teacher is required to collect data to formulate judgement about the student's clinical performance during a clinical rotation.

To researcher: You have about six hours a day on the ward, three days a week for six weeks. You spent about one and a half of those hours at

coffee or lunch. You spend another two seeing patients, reading charts and coordinating everybody. You have eight to ten students a time. You're lucky if you see them for half an hour each. In that short time, you're supposed to see them enough to be able to write a final evaluation which tells the world if they can go on in the program or not. You may have only seen them when they're having bad days. But you have to write the evaluation based on what you saw. Their whole future rests on you seeing them for maybe eight hours in a rotation. (Interview: June 24, 1990)

### Affective Response

The clinical teachers in the research responded with a variety of emotions to their perceptions of causality of student outcomes. The most highly valued student outcomes were identified by the six teachers as patients' welfare and/or safety and caring. Students who did not effect these outcomes because they risked the patient's safety, disregarded the patient's welfare or demonstrated uncaring behaviours were subject to the most intensive, negative affective response by their clinical teachers. The teachers agreed that some incidents are less of a concern to clinical teachers than others, based on the consequences of the outcome to patients assigned to the specific student. The teachers' affective responses associated with student outcomes were determined by the degree to which the teacher perceived the outcome to have compromised the patient's well-being.

The clinical teachers experienced a variety of affective responses to attributions they ascribed to student outcomes. The most intense emotions were associated with attributions of internal, stable, global and student controllable causes. The teachers expressed concern if a student demonstrated anxiety, lack of ability, poor motor coordination, or inadequate learning strategies in their clinical practice. They expressed displeasure and, at times, frustration and anger, when the student demonstrated lack of effort, lack of caring, lack of accountability, lack of moral integrity, lack of sensitivity

and a difficult personality.

To researcher: The littlest things throw X (student). She came to my office at 1600 yesterday and said, "My patient's supposed to have 100mg and they have only been giving him 50". I told her there was nothing we could do about that then and we'd deal with it when we got on the ward the next day. But she just wouldn't let it go. She has so many personal problems. She was supposed to hand in a practice assignment and didn't. When I asked her about it, she said she had difficulty getting the information from Y (another student) but now she had it and she would hand it in on Tuesday. Tuesday came and went and still no assignment. Finally on Friday I talked to her and she said her daughter had thrown it out in the garbage. I said, "Why don't you start taking responsibility for your own things. You're always blaming someone else". (Fieldnotes: April 12, 1990)

Students who had appeared to disregard the needs of patients in the clinical area were generally defined as uncaring. Teachers #3, #4 and #5 stated that they experienced difficulty labelling any student as uncaring and only did so after an intensive search for other possible causal attributions (e.g., anxiety). Students who were unprepared for their clinical assignment and the responsibilities inherent in it were identified as lazy and not caring about the profession. These attributions elicited anger, frustration and impatience in the teachers. If a student's poor nursing knowledge base was perceived to be due to uncontrollable factors (e.g., low intelligence), the teacher offered expressions of support and understanding.

To researcher: It's really too bad when a not too bright student gets not so good advice from a nurse. They don't have the insight or knowledge base to evaluate what they've been told. (Fieldnotes: October 25, 1989)

If, however, this was perceived to have resulted from laziness or a lack of effort, the teachers responded angrily and in a punitive manner.

To researcher: One kind of student that's always difficult is the one who is lazy and only gets their act together when you've given them a kick in

the ass or threaten to fail them. They pass only because they've learned the game. If you fail them, they come back and pass because all you have done is to teach them the game. (Fieldnotes: October 25, 1989)

A student had put a restraint jacket on a patient but it was too large. The head nurse told the teacher about the incident. When the teacher confronted the student, the student said she had put it on because the jacket had been in the patient's drawer.

Later to researcher: I asked some other teachers about her. Some say she's anxious but Y (other teacher) said that she's lazy and won't do it until she gets the boot a bit. That's all very well but you shouldn't have to scare them to make them do things at this stage. (Fieldnotes: April 17, 1990)

Anger was elicited by mostly internal causal attributions. Student outcomes which were thought by the teachers to result from internal, stable and uncontrollable causes were generally paired with low expectations for success.

To researcher: X (student) is still not taking responsibility for her med (medication) error last week. She keeps saying that I set her up because I handed her the ticket and told her to give the med. She lied about it to the lab teacher. She said that she'd never had a chance to research the skill before she gave the med because it was a new order. I had to be blunt with her. I said if she didn't get her personal problems resolved she'd never be successful in this term. (Fieldnotes: February 22, 1990)

Causes of aversive student outcomes which were identified by the teacher participants as stable, global and controllable by the student generated affective responses of resignation and hopelessness. Causes perceived as being beyond the control of students elicited a response of pity and sympathy from the clinical teachers. If the teachers perceived that an outcome was beyond the control of both the student and themselves, they generally expressed feelings of futility, frustration and confusion. If the outcome was defined as teacher-controllable, the teachers responded with statements of personal guilt. However, if the teachers perceived that the student was critical of the teacher's inability to intervene in order to effect positive student outcomes in the clinical area, the teacher

often responded in anger and defensiveness.

To researcher: In the last term's evaluations, one student wrote that I wasn't available enough. You work your butt off for them and then they say you weren't there for them. What do they want from us? (Fieldnotes: February 15, 1990)

### Helping

Following the teacher's attributional determination of a particular student outcome and the resultant affective response, the clinical teachers engaged in helping behaviours. The helping activities in clinical teaching were both informal and formal; personal and professional. Many of the informal helping behaviours have been articulated previously in this report in the section entitled "Caring". Formal helping activities included mentoring strategies (e.g., guiding, advising, supporting), attributional retraining (Weiner, 1986), counselling, teaching of appropriate learning strategies, and questioning.

To researcher: X (student) had U's (unsatisfactory) and I's (incomplete) in her last rotation. She came to see me this morning and said she had difficulty in articulating her (nursing) diagnosis. I said I would keep hounding her. I told her the questions she could expect to be asked. (Fieldnotes: April 11, 1990)

### Goal of Helping

All helping strategies, whether informal or formal, were intended to effect one, some or all of the following: (1) to promote the student's exploration of her feelings/attitudes which were contrary to the basic tenets of the profession; (2) to increase the student's understanding/knowledge of aspects of the practice of the profession; (3) to determine the course of action which the teacher, student or others should take to resolve the problem or meet the student's need; and (4) to assist the student to develop means of coping with similar situations in her future practice. Helping strategies often revealed the

need for the teacher to reflect further upon the situation. This, in turn, led to further assessment/transmission of practice or to additional/revised attributions made about student outcomes. The cyclical process entailed assessment/transmission of practice, reflection, attribution, affective response and helping. This cycle was interrupted only when the teacher decided to terminate the helping relationship.

To researcher: I was really surprised when X (student) handed in an assignment that was really quite good. She was my biggest concern. Now I see she has the potential. Maybe she's been too anxious to do well. (Fieldnotes: November 3, 1989)

Helping in the teacher-student relationship of clinical teaching occurred within the context of the teacher's caring and concern. However, the focus of the teacher-student interactions was based, not on friendship and reciprocity, but on the needs of the student. Although this did not preclude the clinical teachers in the study from being friendly with the students, the goal of the clinical teacher in this relationship was not friendliness but objectivity. A concern expressed by all the teachers in the research was that clinical teachers should be able to remain professionally detached enough to ensure the teacher's objectivity in the helping relationship. Consequently, the teachers initially offered their help to all students, despite attributions which suggested that the teacher might withhold her helping behaviours because she was angry or displeased with a student's behaviour.

### Individual Differences

The teachers in the research study differed as to their expressions of their role in the helping relationship. Each brought her unique personality to this relationship. Some teachers were, therefore, more friendly and involved with students than were others. Some were more direct and prescriptive in their helping responses. Teachers #1, #2 and #6

fostered the student's independence in skill performance in their helping relationships. Teachers # 4 and #5 promoted the independence of students in problem-solving in their nursing practice. Teacher #3 emphasized independence in decision-making and establishing a unique professional identity with students in the helping relationship.

#### Expectations of Helping Relationship

The helping relationship in clinical teaching was based on a number of assumptions which guided the teachers' activities in this process. The time constraints of the helping relationship were established as the duration of the clinical rotation. Although students frequently visited the offices of clinical teachers they had in the past, the teachers expressed reluctance to offer advice or assistance to students once the rotation was finished. If students requested help from a past teacher, the teacher generally referred them to their current clinical teacher or to an administrator of the program. Another requirement of helping was that the student assume responsibility for implementing the changes/practices recommended by the clinical teacher. Students who disregarded the teacher's advice were viewed as contravening the unwritten contract of the helping relationship.

To researcher: The thing that is usually the end of a student with me is when they've been given guidelines and they don't bother following through with them. Like X not going to a counsellor when we had recommended it to her. Or doing things the same way as she always had even though I had told her how to correct her mistakes. (Fieldnotes: February 15, 1990)

Students were also expected to demonstrate the resolution of problems and/or the achievement of specific learning goals in the helping relationship. Helping was expected to result in some tangible gain for the recipient. Helping was terminated by the clinical

teachers in the research if the student did not fulfil the expectations of his/her role.

### Offering/Withholding Help

The offering or withholding of help by the clinical teachers was influenced by the causal attributions they had made concerning student outcomes. The teachers offered every student help at least initially in the clinical rotation. Even students who entered the clinical area with a past history of poor clinical performance were offered help by the clinical teachers. However, the teacher generally had little expectancy for the student's success in these situations. One or two indications that the assessment of the prior clinical teacher had been correct resulted in the teacher terminating the helping relationship.

To researcher: X (another teacher) was unable to fail her (student) because with our criteria, anyone passes. It's up to me now to see if she can make it in Term Y. I'm going to give her a fair chance. I've already met with her and told her I'll help her as much as she needs. But if I start to see the same things that X saw --- she's out. I won't waste my time with someone who doesn't have a chance. The other students who are doing well will benefit more than she will. (Interview: January 10, 1990)

The clinical teachers in the research were most likely to offer their help to students when the following conditions were met: 1) the student requested help from the teacher; (2) the student's need for help was perceived by the teacher to have resulted from uncontrollable, rather than controllable (by the student), factors; and (3) the student's need for help was perceived by the teacher to have resulted from external, rather than internal, factors. The stability and globality of the causal attributions did not influence the clinical teachers' helping judgements. Students who did not request a teacher's help, particularly when they were experiencing major clinical difficulties, were generally perceived as lacking insight into their problems and/or unwilling to expend effort to resolve the difficulties. The

teachers in the study were more likely to help students whom they perceived as lacking in intelligence or clinical ability than they were students perceived as uncaring or lazy.

### Attributional Retraining

One helping strategy employed by the clinical teachers in the study was attributional retraining, the induction of specific causal attributions in order to increase the student's desire to strive for achievement (Foersterling, 1985). This entailed assisting students to alter their attributions regarding their performance in the clinical area to external rather than internal causes; to unstable rather than stable causes; and to controllable rather than uncontrollable causes.

The teacher was giving feedback to a student about an intramuscular injection the student had just given.

To student: It's not too good to say, "Oh" before you inject the needle. You make the patient anxious when she thinks you are nervous. I had to guide your hand to put the needle in. I think what you did is panic when you saw the needle by the skin. Not to worry. Take some deep breaths next time and you'll find it will be easier. Tomorrow you have a chance to do it again and you'll find it'll be much better. (Fieldnotes: February 22, 1990)

For example, a common attributional retraining strategy was to imply that if the students practised, they would be able to overcome all clinical difficulties. This strategy altered the student's attribution for clinical problems from the internal, uncontrollable cause of lack of ability to the internal, controllable cause of lack of practice. Another strategy was to imply that task difficulty was an unstable rather than a stable characteristic.

To students: At Christmas time, you'll be laughing at yourself for how you've reacted today. By then, you'll be giving medications and doing lots of things. This data base will seem mickey mouse to you then. (Fieldnotes: October 11, 1989)

Attributional retraining was not utilized by the six teachers with students whom the

teacher had identified as hopeless. It is significant that, although the teachers stated they were unaware of attributional retraining as a formal helping technique, they asserted that "if you tell a student it's only a matter of time before they get it right, they will believe you".

### Fostering Self Esteem

Many of the teachers' helping behaviours were directed to the affirmation of students and the enhancement of their self-esteem. The teachers stated that students "who feel good about themselves are more likely to be successful" in the clinical area.

To researcher: I'm going to get X (student) to do something else before she has the time to get anxious about it. If she does several things in a row well, maybe she'll have more confidence in herself.

The teacher then asked the student to do a dressing change on a patient not assigned to her (the student). (Fieldnotes: February 22, 1990)

Again, it is significant that these helping strategies were not employed for students whose possibility for success appeared minimal to the teacher.

### Choosing Helping Strategies

Much of the clinical teacher's decision-making concerning how to help a student was based on their personal judgements about what would be best for the student. At times, the teacher relied on her past experience, her knowledge of nursing and teaching, and the advice of colleagues to determine the most appropriate helping strategies. However, the teacher participants frequently reported that they were forced to use a variety of "hit and miss" techniques in order to help students with clinical problems beyond their experience and knowledge base. These techniques often produced helpful results but in a time-consuming and generally frustrating manner.

### Dependency

A difficulty encountered by the less experienced clinical teachers in the study (Teachers #2, #4 and #6) was that their helping often appeared to result in student dependency on the teacher. Although each of these teachers expressed concern about this phenomenon, they were unable to effectively determine why it occurred and what could be done to prevent this from happening.

To researcher: X (student) does well if she is not supervised. But if I'm with her and start asking questions--- last week she was starting an IV (intravenous). I know it was her first time so I wasn't expecting her to be perfect but I was so impatient that day with her always asking me, "What should I do now?" I'd answer, "Well, what do you think you should do?" and she'd come back with, "What do you think I should do?" It almost drove me crazy. Finally I told her, "just go ahead and do what you think is right". (Fieldnotes: March 1, 1990)

To researcher: I want to help X (student) today but I found out that if I'm in there the student backs off and lets me do everything. I find it better to encourage the students to help each other than my going in. (Fieldnotes: March 27, 1990)

### Hopelessness

The six clinical teachers expressed sadness and frustration whenever they were unable to help students who had requested their assistance. A common example of such a situation was when the teacher had attributed a student's clinical problems to lack of ability. The teachers often recognized their helping in these situations as a "hopeless cause". They frequently expressed anger and frustration about the school's admission policies at these times, stating that students with such low ability "should never have been allowed to enter the program". Another common situation was when students' personal problems were so overwhelming that the student was unable to benefit from the help

which was offered.

To researcher: I figure out how much help I'll give a student by asking myself: "Why are they asking for help? Is it a knowledge gap or too much pressure or they just want some positive feedback from the teacher?" One student told me she had no self esteem and never had. In one rotation, I can't make up for all the lacks in her life. If I have patience, I can sometimes help these students to be weaned off needing so much support from the teacher. I can point out to them when they have known what to do but were not confident in their ability. I can say, "Next week I want you to go one step further". (Fieldnotes: January 8, 1990)

One teacher in the study referred to this situation as "watching a person drown as you stood helpless by the river bank". Student anxiety and defensiveness were challenges to all of the clinical teachers in the study. The novice teachers reported that their helping strategies frequently appeared "to make student more anxious". Defensive students were frequently perceived as uncaring and "hiding something" from the clinical teacher.

To researcher: X (student) is very defensive. I ask her a simple question and she thinks you want complex answers. She has no evidence of having a heart. Defensiveness makes her so preoccupied with herself, she doesn't even see the patient and his needs. (Fieldnotes: March 13, 1990)

### Termination of Helping

The teachers in the study identified limits to their helping. One teacher referred to this as "drawing a cut-off line where you say that's enough help". The clinical teachers terminated a helping relationship when (1) the student had resolved her clinical difficulties or achieved all of the learning goals; (2) the clinical rotation had come to an end; and (3) the teacher became unwilling to offer her help. When a student failed to resolve the clinical problem(s) despite the efforts of both the student and the teacher, the clinical teacher acknowledged the situation as hopeless and terminated the helping relationship.

To researcher: When I run out of ideas or when I become convinced that

a situation is hopeless and a student is never going to improve, I stop helping them. It's usually hard to have any perspective at that point. Usually I try to figure out where I have gone wrong. Like with X (student). Her (evaluation) file didn't fit what I saw on the ward. I had to wrestle with was I being unfair or did she actually do things as badly as I perceived she had. (Fieldnotes: January 8, 1990)

Other situations which commonly resulted in the termination of the helping relationship were those in which the student contravened the expectations of the helping process (e.g., the student did not try to resolve the difficulties; the student failed to follow the teacher's advice).

To student: What did you find when you listened to his chest?

Student: "Well, there were some peculiar chest sounds."

What were they? Whistles, crackles or what?

Later to researcher: I went with her to do a chest assessment. She had been listening to his (patient's) heart, not his chest. There were crackles all over which she didn't even hear. She hadn't looked up anything I had told her to specifically yesterday. I told her what to look up and she didn't even do it. This is hopeless. (Fieldnotes: February 15, 1990)

The termination of the helping relationship led to the crystallization phase of the clinical teaching experience.

### Crystallization

The crystallization of the clinical teacher's judgements about students generally occurred in the final weeks of the clinical rotation. The crystallized judgement influenced the various ways in which a clinical teacher determined whether the student should be helped to succeed in the clinical rotation or encouraged to withdraw from the program.

To researcher: X (student) has several areas to work on. She has had long-standing problems in the areas of medical asepsis, psychomotor skills and expected outcomes. I don't think we'll change her at this stage. She wants a high fluting, high tech area. She'll never be convinced to put in the

necessary effort until she gets to one of those wards. (Fieldnotes: February 5, 1990)

### Crystallizing a Judgement

The clinical teachers were expected to crystallize their judgements about students within the time span of the clinical rotation. Formal written evaluations were required by the schools of nursing at the end of each clinical rotation. This requirement often caused the clinical teachers to focus in the clinical teaching experience on the collection of sufficient data to complete the detailed evaluation forms. The clinical teachers in the study generally arrived at a crystallized judgement of a student's ability within the last two weeks of the rotation. The crystallized judgement referred to a generalized assessment, such as whether the student should pass or fail the clinical rotation and whether the student was caring or uncaring toward patients.

To researcher: X (student) has too many thoughts on her mind. She has so much information she doesn't know what to pick. She knows her pathology but she doesn't differentiate at times. She's very bright, very conscientious. And she cares about her patients. (Fieldnotes: March 1, 1990)

Following the crystallization of the clinical teacher's judgements about a student, all data received concerning the student's clinical performance were utilized to reinforce that judgement. This practice was termed "building your case" by one of the teachers in the field study. Although the teachers occasionally received information which contradicted their crystallized judgement, they did not revise the general assessment to reflect this. Consequently, when a student made a critical medication error in the last clinical week of the rotation, after the teacher had determined that the student should pass the rotation,

the teacher noted the incident on the student's evaluation form but gave her a satisfactory grade in the clinical rotation.

### Early/Late Crystallization

At times, the crystallization experience occurred earlier or later than the last two weeks of a clinical rotation. For example, the teachers were generally reluctant to judge a student as incapable of passing the rotation, if the student had demonstrated motivation to learn in the clinical area. Teachers #3 and #5 acknowledged that they had sometimes "worked too long" with a student who lacked the ability to succeed in the program, because the student "wanted so desperately to be a nurse". They had learned in their years of clinical teaching experience that persistence in the face of failure was maladaptive for the student but they found it difficult to "give up on the student".

Failing a student takes its toll on teachers. I tend to stick it out longer than I should with some students just because I hate failing them so much. After I fail someone, it's the informal discussions with the coordinator and the other teachers that gets me through the experience. (Fieldnotes: January 8, 1990)

In these situations, the clinical teacher continually revised her initial assessments of the student's ability, listing the positive and negative incidents in the student's clinical performance until the last clinical day in the rotation. Although the teachers often began writing other students' clinical evaluations prior to the last clinical week, they generally postponed writing until the last possible minute the evaluations of students who had demonstrated effort but questionable ability. They often requested the help of an administrative person or a colleague in the school of nursing to crystallize their judgments concerning these students.

The teachers of beginning students stated they postponed their crystallizations of novice students because the criteria for evaluation were often tenuous and because the students "haven't done enough by this stage to determine if they've got what it takes to make it" in the program. They also indicated that it occasionally takes students an entire first clinical rotation to "relax enough so they can learn". Teachers of graduating students also frequently delayed the crystallization process because their decision about whether a student should pass or fail the rotation determined whether the student would be able to graduate with their classmates. Three of the clinical teachers in the field study expressed their abhorrence of the practice of some teachers "to push students with problems through the program because they don't like to fail students". According to these teachers, this practice occasionally resulted in their "having to fail someone in their last rotation in the program, right before graduation".

Crystallization occurred earlier than usual if the teacher determined that the student had contravened the principles of the helping relationship; i.e., the student had ignored the teacher's advice or demonstrated lack of effort or disinterest in resolving their clinical difficulties. It also occurred early in the rotation if a student had a previous history of "borderline" clinical performance and continued to experience similar clinical difficulties in the new rotation. Teacher #6 crystallized her judgements of students who performed in an exemplary manner in the clinical area early in the rotation, in order to concentrate most of her time with the students who were experiencing difficulties.

#### Ignoring Contrary Information

It is significant that everything the clinical teacher did following crystallization

was intended to reinforce the judgements she had formulated in the crystallization process. For example, if a student was judged as unable to succeed in the rotation, the teacher did not offer helping strategies to the student. It is also significant that two of the teachers always crystallized students as able to succeed, although they acknowledged grave concerns about some students' ability and trustworthiness. Teachers who were reluctant to evaluate students negatively, attributed this practice to prior negative experiences with the evaluation process and to their unwillingness to make decisions which would result in anticipated "devastation" for students. An additional concern in this regard was the other students' reaction to the teacher if her reputation as one who fails students became known.

To researcher: I don't know what the impact on the students will be if we ask X (student) to leave. It may get around that I throw people off the ward and get them kicked out of the school. They may be scared to come to me. I don't know how I should handle it. If I bring up the topic of students having to leave the program in post-conference, the group will know who we're talking about. I don't think it's fair to X to discuss her with other students. But if I don't, they may believe that I was cruel and unfair. (Fieldnotes: November 2, 1989)

## **Development of a Plan**

### Evaluation

The clinical teachers in the research developed a plan of action immediately following their crystallization of their judgements about students. If the student was perceived by the teacher to be either exemplary or performing at an average level of expected performance, the clinical teachers tended to decide to proceed to the formal written evaluation stage. Evaluations for these students were sometimes written in advance

of the actual evaluation meeting. One teacher in the field study stated, "With mediocre students or students who are stars, you know that they won't change much from week to week".

Students who were expected to succeed in the clinical rotation and who had demonstrated motivation to succeed, but who continued to experience clinical difficulties, were generally offered help by the clinical teacher. These helping activities were similar to those enacted prior to the crystallization phase of clinical teaching. However, this helping relationship was only terminated because the clinical rotation had ended. Students who did not adhere to the terms of the helping relationship (see Chapter Five - Helping) in this stage were not neglected by the teacher. The clinical teachers often expressed doubt about the student's future success in the program but the helping relationship was not terminated. These students were generally "passed onto another teacher" with the hope that the next clinical teacher would "make them (the students) shape up or ship out".

To researcher: X (student) met with Y (coordinator) and me this week. We tried to convince her to withdraw. She refused. Y said, "Don't worry. Pass her in this rotation and she'll fail out in X (next term of program)". It makes me feel badly to do that. (Fieldnotes: April 12, 1990)

Her next rotation is X. It's not routine and it's busy. It will be the ultimate test for her. I know that another teacher may be saying that right now about another student coming to Y (her clinical area). I've played the bad guy role in the last rotation before and I'm just not prepared to do it any more. (Fieldnotes: November 29, 1989)

### Extinction

If a student were judged by the clinical teacher as unable to succeed in the rotation

and/or unwilling to expend the necessary effort to succeed, the clinical teacher engaged in extinction strategies. These activities were intended to give the student the message that she was unlikely to succeed in the program. Four of the teachers in the field study enacted a variety of extinction strategies when they judged a student as incapable of succeeding in the rotation. The two other teachers in the research did not assess any students as performing in an unsatisfactory manner in the clinical area.

The most commonly observed extinction strategy in the field study was when the teacher increased her direct supervision of the student's clinical performance. This was usually preceded by a formal meeting with the student and generally an administrator from the school of nursing, in order to explain to the student that his/her future in the program was in jeopardy. The student was given a list of requirements to be achieved in order to ensure his/her eventual success in the clinical rotation.

To researcher: It's sink or swim for X (student) today. We've had about ten major confrontations this week. She knows that if anything goes wrong, we'll call a special promotions meeting (a committee to determine whether the student should withdraw from the program, based on the teacher's recommendation). (Fieldnotes: February 15, 1990)

Other extinction strategies employed by the clinical teachers were extensive questioning of the student about aspects of their patient's care; giving the student predominantly negative feedback concerning their clinical performance; meeting with the student to discuss the possibility of her withdrawal from the program before formal evaluation proceedings were initiated; assigning the student to a particularly complex patient "to see how (the student) does" in the situation; and questioning the student's choice of profession. During the course of the research, five students were the subjects of the

extinction process. None of these students successfully completed her clinical rotation.

It is significant that extinction strategies were enacted within a context of caring for the student. The clinical teachers who implemented extinction strategies frequently expressed to the failing student that they were concerned for his/her welfare. They often stated at the completion of the extinction process, when the student either withdrew or failed the rotation, that it was "for the good of" the student that they "forced the decision" of the student to recognize that he/she lacked ability and/or was "not suited to nursing". They also stated that the other students in the clinical group had benefitted from the student's expulsion.

#### Appraisal Support

The search for alternative actions continued after the clinical teacher had decided to fail a student in the clinical area. The teacher justified her decision by comparing it to the most attractive of the alternatives for the purpose of identifying its deficiencies.

To researcher: She could receive a satisfactory evaluation but it would just be postponing the inevitable. She would just have to wait longer before she made other career choices. (Fieldnotes: April 30, 1990)

Clinical teachers, who felt impelled to fail a student because of perceived clinical incompetence, expressed great interpersonal conflict concerning this decision. Although they did not revise their crystallized judgement, they often questioned the "fairness" of their decision. Consequently, they engaged in various forms of appraisal support, in order to justify their decision further. They observed the student's clinical performance for signs of incompetence, identifying each incident as further proof of their assessment. They occasionally read evaluations which had been given to the student in past clinical

rotations, noting trends and incidents in the student's performance which reflected their judgement. They met with other faculty in informal discussions, presenting the student for their analysis. It was common in these presentations that the teacher presented the circumstances of the student's performance in an entirely negative light. The faculty were always supportive of the teacher's decision to fail the student. Following such a discussion with other faculty, the clinical teacher generally confided to the researcher that she was not entirely confident that she had made the right decision. She often indicated that she was aware of extraneous variables (e.g., problems in the student's home life) which had resulted in some of the student's behaviour. The teachers did not identify these variables or their self-doubt to the other faculty in the researcher's presence.

### **Summative Evaluation**

The formal summative evaluation process was a procedure which was remarkably similar among all of the teachers in the study. Each teacher indicated on a standard scaled form her judgement of how a student had performed in the identified aspects of nursing care. Data for the form were collected and annotated for the entire duration of the curriculum. Consequently, the teacher's assessment of the student's ability to communicate with his/her patients was annotated with incidents which had occurred at the beginning, middle and/or end of the clinical rotation. Conspicuously absent in the evaluation forms was a measurement of the affective elements of nursing, particularly caring, although the categories "attitude" and "professionalism" were expected to include these. The form required both the student's and the teacher's signatures. Consequently,

the teachers scheduled times for individual students to read what the teacher had written. Although there was space on the form for students to comment on the contents, the teachers in the study stated that students tended to make general, unrevealing statements if they wrote anything at all.

### Teacher Stress

The evaluation process was cited as the most stressful aspect of clinical teaching by five of the six clinical teachers. The difficulties they experienced in the evaluation arose from the following aspects inherent in the process: 1) criteria to be utilized in grading students' clinical performance were frequently unclear and open to individual teachers' interpretation;

To researcher: Often students who have received "Outstanding" in several categories come to me expecting the same. The trouble is I have a different opinion about "outstanding" than some teachers. I tend to think it should be given very rarely and only for students who are exceptional in certain areas. Some teachers see it differently. They believe it will motivate students if they think they're outstanding in lots of areas. Students who are used to that system of marking are annoyed when I don't give them any "outstandings". (Interview: May 18, 1990)

(2) the teacher must base her/his evaluation on data she/he has observed. This may not be representative of the student's clinical performance; (3) an unsatisfactory (failing) student evaluation results in the teacher "having to justify her/his decision" to the faculty and/or to an appeal board. The four teachers who had experienced this process reported that it was intimidating and stressful;

To researcher: Last year I had a student who left after she had not done well with me. It had been very stressful. X (the coordinator) asked me to write a summary for her (the student's) file. I tried and tried to do it but it was so fresh in my mind and I couldn't do it in June. So I waited until I came back after the summer and I wrote and wrote. When I finished, I gave it to X to read to see if it was OK. I

asked her if this was what it was like to get ready for Y (appeals committee). She said yes. I never want to go to Y. It was such a lot of work getting the summary ready. And it was so stressful dredging up all the dirt and anxiety I had about that student when she was with me. (Interview: August 8, 1990)

To researcher: I felt so awful in X (internal appeals committee). I thought I was going crazy at one point. My gut feeling was that she should have failed but people (other faculty) said we don't fail anyone in Term Y. They always reverse clinical failures in appeals. (Interview: January 8, 1990)

and (4) other faculty "hold the teacher accountable" for her/his evaluation of the student until the student graduates.

To researcher: I understand that X (student) is not doing so well right now with Y (other teacher). Y came to me and asked me about her. She asked me how she could have possibly received such a glowing evaluation from me when she was such a disaster now. I told her I had X in the first term. She looked OK then but that was because the first term doesn't demand too much of students. Everyone passes. Y looked at me like I had let X through just to get rid of her. Some teachers do that, you know. (Fieldnotes: April 19, 1990)

The beginning teachers in the research were particularly concerned about the evaluation process. They frequently asked their coordinator and other faculty for advice about how to phrase certain statements and the amount of substantiating data required to justify specific grading. Each of these teachers stated that they would have preferred to learn more about the evaluation process before they were required to write summative evaluations.

To researcher: I found when I came to do the students' final evaluations that I lacked the knowledge and skill to be able to know how to effectively evaluate someone. I wonder if that shouldn't be included in new teachers' orientation. I found it to be a huge paper mill and I was never sure if I was putting enough down or whether my judgments were accurate. When I saw how thick the others (faculty) evaluations were, I was worried that I had forgotten something. (Fieldnotes: December 7, 1989)

Because of the difficulties for the clinical teacher associated with the summative

evaluation, the teachers in the research stated it is preferable to "convince a student to withdraw before the evaluation". Student withdrawal prior to the summative evaluation resulted in less paperwork than writing an unsatisfactory evaluation; the teacher was not expected to defend her decision to the student or the faculty; and the teacher was not required to face the student again (e.g., at an appeals meeting).

### The Student Game

Four of the clinical teachers identified that the emphasis of schools of nursing on evaluation results in a phenomenon they referred to as the "student learning the game". These teachers implied that students expend the majority of their energies determining what will satisfy the expectations of the clinical teacher, rather than developing their individual identity as professionals. The teachers stated that the preoccupation with what the teacher wants, rather than what is best for the student, patient and the profession, results in students who receive top academic and clinical grades in the program but who are unable to cope with the demands of actual practice as a graduate of the program. According to these teachers, students who choose not to play the "student game" or lack the ability to identify the unwritten rules of the "student game" often receive low clinical grades, but are known in their work setting as superb practitioners when they graduate.

To researcher: Once I believed it was important to keep anyone out of the profession who wouldn't be a good nurse. I no longer believe that. It's impossible. Plus I've seen students who have won awards from us who have just bombed on the wards when they graduated. I've also seen students who struggled through our program and became stars after graduation. I think that many times we award the students who have learned how to be good students but do not necessarily know how to function on their own. (Fieldnotes: April 2, 1990)

### Reflection

Following the summative evaluation, the clinical teachers in the field study reported that they frequently engaged in a period of self-reflection. The impetus for their reflection was generally some information which suggested that the teacher's assessment of the student had been inaccurate or unfair. For example, teachers whose summative evaluation was challenged by a student in an appeals committee meeting often reflected about their decision after they had heard the response of the student and the committee members to the data provided in the evaluation form. The teachers' reflections at this time generally influenced their practice in the following clinical rotation.

To researcher: I took her (student's) case to X (internal appeals committee). Y (the student) was there. I had to present what had happened and why I thought she should leave the program. Y kept staring at me all the time. I was pretty confident when I went in there but some of the teachers, like W and Z, were really snotty. They intimated that I had ridden her (student) and that I was being unfair. And P (coordinator), I don't know what was wrong with her, she kept asking me questions like I was the one on trial. I tell you one thing --- that was my first time at one of those and I don't intend to ever go back. (Interview: June 22, 1990)

### **Summary**

This chapter has focused on the interactive stage of clinical teaching. It has emphasized the teacher-student relationship in clinical teaching. A highly significant finding in this chapter is the identification of sophisticated, often innovative, strategies which the clinical teachers utilized in the transmission of practice/assessment and helping phases of clinical teaching. The clinical teachers generally selected specific routine responses to meet students' learning needs in the clinical area. However, certain clinical

teaching situations were deemed beyond the response capabilities of the teacher's rituals. At other times, the rituals did not exact the outcomes intended by the clinical teacher. Both of these scenarios caused the clinical teachers to reflect upon the problem situation and to describe and analyze it. Reflection often led to further assessment of the student's practice and to the transmission of the practice of the profession. At times, it led to the teacher's search for the reason for the particular student outcome. The attributional search was conducted according to four attributional dimensions. The interpretations of causal attributions according to their dimensional properties varied considerably between the novice and the more experienced teachers. Attributional searches by the clinical teachers in the research were generally initiated in response to aversive and unexpected student outcomes. However, they were occasionally conducted when a student achieved an exceptional, unexpected and positive outcome in the clinical area. The teachers experienced affective responses to causal attributions. The intensity and perseverance of these responses were dependent on the dimensional properties of the causal attribution, on the value of the outcome by the clinical teacher and the degree of involvement the teacher maintained with the student. The clinical teachers crystallized their judgments about students in response to the time constraints of the clinical rotation and when they perceived that their helping a student was no longer effective or appropriate. A number of factors which influence how clinical teachers crystallize their judgments about students' clinical performance were identified in this chapter. The teachers' responses to their crystallized judgments (i.e., helping, extinction or evaluation) were identified and described. The process of summative evaluation and the resultant reflections of the

clinical teacher were also detailed.

## **CHAPTER SIX**

### **DISCUSSION**

An analysis of the findings identified in Chapters Four and Five of this report are presented in this chapter. The discussion focuses on the major issues which are evident in the findings, suggesting implications for education, research and practice in the nursing profession. The analysis occurs within the framework of symbolic interaction, focusing on the meanings which the six teachers in the field study shared in their clinical teaching experiences. The theoretical propositions which emerged from the findings of the study are analyzed as to their implications for the practice and research of clinical teaching in nursing education.

#### **The Role of the Clinical Teacher**

##### Preparation for the Role

The clinical teacher in nursing education faces a number of role conflicts and ambiguities in the enactment of his/her role. Perhaps the most significant factor contributing to this role confusion is the lack of specific expectations and directives regarding what it is that a clinical teacher is to do. It was striking that each of the six participants was virtually unaware of what other clinical teachers did in regard to clinical teaching strategies. They were also unaware of many of the strategies which they intuitively employed to effect their teaching goals. Because much of the clinical teaching

role in nursing is learned by trial and error and because there appears to be so little direction about teaching strategies which teachers could implement to assist students to learn in the clinical area, it is not surprising that all of the teachers expressed some degree of uncertainty as to whether they were meeting the expectations of their role.

The need for clinical teachers to be prepared for their role by studying theories of instruction which are applicable to the clinical area is indicated by the research findings. A number of elements (e.g., teaching strategies; teacher perspective) which may be incorporated in the development of theories of clinical teaching have been identified in this study. These theories must be necessarily based on sound theories in teaching and learning, where the essential ingredients would be an in-depth knowledge base in regard to the practice of nursing and clinical teaching. The knowledge base of clinical teaching must be composed of more than teacher behaviours; it must encompass the cognitive processes of teachers and students (Zeichner, 1990). It must include dimensions such as the teaching strategies which are associated with specific student outcomes; the cognitive dimensions of clinical teachers' planning and decision making; and how students learn the practice of the profession.

The teacher's perspectives of clinical teaching were found to predict to a considerable extent how the teacher intended to structure and prioritize her clinical teaching. The consequences of teacher's value and knowledge claims should be explored with all clinical teachers, particularly novice teachers. If teachers were assisted to recognize the intended and unintended consequences of their perspectives on student learning, they could teach in a more enlightened and reflective manner in the clinical area.

The teacher's professional role identification also influenced the degree of role conflict experienced by the clinical teachers in the research. Those individuals who attested to primarily a teacher role identity were continually tested in the clinical area as to their adherence to this role orientation. Because they were nurses before they were teachers, these clinical teachers experienced great difficulty neglecting a patient's needs or assigning a "weak" student to an acutely ill patient. These teachers believed that clinical teachers are to avoid nursing patients; it is the learning needs of the student which should be the clinical teacher's primary responsibility. They constantly encountered crises in the clinical area in which they were forced to intervene as nurses, not teachers. They expressed guilt and reservation about these incidents. In contrast, the two teachers who espoused a nurse-teacher role orientation believed that nursing with students was essential to the transmission of the practice of the profession. These teachers welcomed opportunities to nurse patients in order to convey the values and the skills of problem analysis and representation to students. Another important facet of nursing with students is that its underlying message appears to be that these teachers are nurses and enjoy nursing. A particularly poignant incident which occurred in the course of the research was when a group of beginning students expressed surprise that their clinical teacher was a nurse. The teacher was considerably amused by this incident, indicating that novice students occasionally do not understand that their teachers are nurses. However, as this teacher consciously avoided nursing during her clinical teaching, it is perhaps not surprising that the students maintained this misperception.

### Novice Teachers

The research findings suggest that novice teachers do not possess the cognitive or experiential frameworks necessary to interpret accurately and to intercede in the situations which arise in the teacher-student relationship in the clinical area. Many of the behaviours of the novice teachers in the study reflect those of novice nurses, as identified by Benner (1984). The novice teachers who were subjects in the research were more hesitant than the others in their descriptions of the instruction and management of clinical teaching. They were able to describe what they observed and often used vocabulary similar to that utilized by the more experienced teachers in the field study. However, they did not appear to be able to supply the multiple and complex interpretations of situations that were common to the more experienced teachers. Consequently, novice teachers tended to rely on the feedback of others and the concrete expectations of the program (e.g., evaluation) to structure their clinical teaching. Experience alone did not appear to result in the teacher's ability to integrate related concepts in clinical teaching, or to synthesize her personal definition of the clinical teacher's role.

The key to the development of expertise in clinical teaching appears to be the ability to reflect upon one's experience. The teachers differed in their ability to infer unconsciously (i.e., their level of intuitive ability) and it seems likely from the findings of the research that these differences are significant determinants in the development of expertise in clinical teaching. How to teach individuals to become more intuitive remains a topic for further investigation. It is possible to teach novice clinical teachers to develop reflective skills (Zeichner, 1990) and this research suggests the benefits of doing so.

There is little need for novice teachers to learn from trial and error in their clinical teaching. It is apparent from this research that clinical teaching entails a number of specific teaching strategies, designed to facilitate the information processing and decision making abilities of students. Although the effectiveness of these strategies has not yet been evaluated in clinical teaching, some have been extensively researched in classroom teaching (e.g., expressiveness). It is feasible that these strategies could be taught to novice clinical teachers in order to provide them with more teaching tools than their personal experience as students identified and in order to assist them to explore the meanings which the novice encounters in her/his teaching experience.

#### Powerlessness

All of the clinical teachers in the study expressed varying degrees of powerlessness as clinical teachers. They had learned that their perspective of clinical teaching was generally compromised by myriad factors beyond their personal control. The experience of powerlessness was particularly poignant for the novice teachers in the research study. They were continually confronted with outcomes which were not contingent on their responses (e.g., a student who became anxious when the teacher believed she was being caring and supportive). These teachers tended to respond to such inconsistencies by generalizing the perception of uncontrollability to other situations in their clinical teaching. It would appear that novice clinical teachers in nursing may benefit from a relationship with a mentor, an experienced clinical teacher who has studied educational theory and research, and who would offer guidance and direction to the inexperienced teacher.

### Clinical Teaching Behaviours

It is significant that the transmission of practice and concurrent assessment of students' learning needs were identified as the essence of clinical teaching. This conclusion directs the teaching behaviours which are most applicable to clinical teaching as unique to the clinical area (e.g., nursing with the student). Classroom teaching behaviours such as expressiveness, decision analysis and overlearning cannot be exactly replicated in the clinical area. Although the information processing functions of these teaching strategies remain the same, the unique structure and functioning of the clinical setting demand some adaptations to their usual classroom application. For example, obtaining a student's attention must necessarily be different in a clinical area where the space to conduct teaching is extensive, and occupied by many individuals who are not involved in the teaching relationship. Another factor which differentiates clinical and classroom teaching strategies is the decision processing function of most clinical teaching strategies. The transmission of the practice of the profession entails assisting students to develop skills in making decisions and solving problems which arise in their practice. Retrieving facts and storing new information (i.e., information processing) in a student's memory are not sufficient to transmit the practice of the profession in the clinical arena.

Despite the differences between clinical and classroom teaching, there is much to be learned from the research previously conducted in regard to teaching effectiveness in the classroom. For example, the effect of specific classroom teaching strategies has been extensively studied by Perry and his associates (Magnusson & Perry, 1989; Perry & Dickens, 1984; Perry & Dickens, 1988; Perry, Magnusson, Parsonson & Dickens, 1986;

Perry & Tunna, 1988). The conclusions from this research suggest several implications for clinical teaching, particularly in regard to the effectiveness of specific behaviours for assisting externally and internally controlled students. The clinical teachers in the research were largely unaware of this research. They tended to describe clinical teaching as lacking a theory of instruction. Therefore, they tended to teach as they had been taught and to rely on speculation and hunches in their decisions about appropriate teaching behaviours.

The research findings suggest some implications in regard to the evaluation of teacher's ability to teach in the clinical area. Teaching behaviours have been identified which appear to effect desired student outcomes. Although the clinical teaching behaviours identified in this study may be taught to nursing educators, the ability to implement these strategies does not represent the totality of the clinical teaching experience; i.e., they are not a whole index of clinical teacher competency. The clinical teaching behaviours which are readily observable (e.g., rehearsal) represent only a fraction of elements of the transmission of practice in the profession. An evaluation of clinical teaching effectiveness which does not account for the less tangible, but equally important, dimensions of clinical teaching (e.g., caring) will not capture all of the artistic as well as the scientific dimensions of the teacher's teaching. In addition, the research findings suggest that an evaluation of clinical teaching effectiveness cannot occur by means of an isolated event or observation. If, for example, a clinical teacher were to be observed only as she/he enacted extinction strategies with a student, the evaluator would receive no data regarding this teacher's abilities to assess, help, and teach students in the clinical area.

### The Teacher's Attributions

Many of the findings from this research study confirm Weiner's (1985, 1986) theory of attribution and motivation. The attributions made by the clinical teachers about students were identified. The majority of research pertaining to Weiner's theory has investigated students' attributions concerning their own outcomes. Although many of the study's findings replicate those detailed in Weiner's (1986) analysis of his theory, there are some notable differences. For example, the participants identified another dimension to the causal attributions, globality. Although Weiner (1986) mentions this dimension as a possibility, it is not part of his basic model.

#### Controllability

Weiner (1986) has suggested that the perceived importance of an outcome may affect an individual's response to it. The teachers in the research study indicated that their response to a student outcome is, in part, mediated by the perceived risk of the action to a patient's safety or welfare. The most important outcomes (i.e., those which severely compromised a patient's welfare or safety) were generally perceived as being caused by controllable factors. The teachers' response in these situations was usually anger.

The teacher participants made an interesting distinction between student and teacher controllability. Weiner (1986) has indicated in his personal analysis and critique of his theory that controllability may refer to control by other than the student. However, the basic model of his theory refers to the personal controllability of the student. The distinction of the clinical teachers in the study is significant in that it implies a shared responsibility between teacher and student of specific student outcomes in the clinical

area. It supposes that teachers influence student outcomes in the clinical learning experience. Teacher controllability was only applied by the participants in the analysis of student outcomes ascribed as external. Thus, it may be postulated that the clinical teachers did not believe they were able to influence internal attributions such as the student's lack of ability or effort.

#### Attributional Style

The clinical teachers in the study appeared to maintain an attributional style which influenced their expectancies for individual students' success. The existence of an attributional style, or a tendency to bias attributions in a particular direction, has been widely debated (Cutrona, Russell & Jones, 1985). As of yet, the issue remains unresolved. The manifestation of an attributional style was particularly true of the novice teachers who tended to attribute globality, stability and controllability to the causes of aversive student outcomes. This is, in part, representative of the lack of schemata possessed by the novice teacher in order to explain and analyze specific student problems. For example, the novice teachers tended to attribute negative student outcomes to lack of ability or lack of effort; whereas the more experienced teachers in the study identified a number of possible attributions (e.g., student anxiety; overload of extraneous stimuli; personal problems which interfere with learning) to account for similar outcomes. Another factor which influenced the clinical teacher's attributional style was the teacher's past experience with evaluations of students who had not succeeded in the program. If a teacher had a particularly negative experience and consequently determined to "never fail a student again", the teacher tended to ascribe attributions to student outcomes which were external,

uncontrollable, specific and unstable.

### Helping

Weiner's theory states that help is unlikely when the cause of an aversive outcome is ascribed to be internal and controllable by the student. The teachers in the field study demonstrated a tendency to help least students they believed to lack the willingness to expend effort in the clinical area (internal, controllable). However, contrary to Weiner's postulations, even these students were offered help by the clinical teacher. This appears to have occurred because the six teachers viewed helping students as their professional obligation. Tollefson and Chen (1988) found in their study of high school teachers' attributions that teachers expressed a willingness to help all students, despite the perceived cause of the student's failure. However, their subjects reported that they would enjoy most helping those students they believed lacked the ability to succeed in school. Students who were perceived as lazy or unwilling to expend the necessary effort elicited anger, and eventually the withdrawal of help from their teacher subjects. The researchers postulate that students who are perceived as being lazy may, in fact, believe that they lack the ability to succeed without the teacher's help. When the teacher becomes angry that the student is not expending effort and withholds help, the student determines that he/she will fail and gives up trying to succeed. This, in turn, elicits the teacher's anger and the continued withholding of help. The cyclical process continues until the student fails or leaves the school.

Helping students was perceived by the six participants in the research to be a caring act. The helping relationship in clinical teaching was presented by the participants

as a socially binding process which was based on the expectation that the student would follow the teacher's advice and do well. An interesting finding of the research related to the clinical teacher's initial willingness to help all students. This appears to be congruent with the teachers' caring orientation and their interpretation of professional and personal obligation in their role as a clinical teacher. Amato and his colleagues (1984) determined in their investigation of helping behaviours of 372 Australian subjects that the amount of help given to victims of bush fires was mediated by their feelings of personal obligation. The findings of this research study would appear to concur with the conclusions of Amato and his colleagues. The consensus among the six teachers that helping was an expected behaviour of clinical teachers appears to have determined their initial helping behaviour with students. The teachers in the field study identified that the student's potential for success as perceived by the teacher was less of an impetus to their helping behaviour than was the teacher's sense of the role obligations associated with the clinical teacher's role. Although all students were offered help from the clinical teacher initially, students who were perceived as having contravened the terms of the helping relationship were denied further help. Termination of the helping relationship also occurred when the solution to resolve a student's difficulties appeared intractable.

The role of the clinical teacher as a helper was particularly revealing of the teacher who functions within the context of the caring inherent in the nursing profession. The six clinical teachers demonstrated myriad caring behaviours with their students. The degree of involvement they perceived they had with students was a predictor of the teacher's willingness to persevere in helping the student to resolve clinical difficulties, as well as

the teacher's expectancy of the student's success. Involvement also decreased the clinical teacher's perceptions of the controllability of specific student outcomes. An interesting facet of the helping relationship in clinical teaching is that the teachers expected students to request their help. They regarded with suspicion any student who did not ask for their assistance. Little (1990) in her review of research pertaining to helping in a mentoring relationship states that help is more often and more favourably accepted when it is offered than when the individual feels he/she must request it. She also suggests that the very act of requesting help may prompt an internal attribution of lack of ability for the student. Graham and Baker (1990) suggest that helping may inadvertently function as a low ability cue for students: if students need the teacher's help, they must lack ability.

Weiner (1986) makes the point that attribution theory cannot encompass all the facets of the helping process. However, it proved to be a suitable framework within which to explain and interpret the helping behaviours of the teacher participants. He suggested in his analysis of the theory (1986) that there may exist a direct pathway from the eliciting stimuli to help-giving. The research findings suggest that the teachers' ritual responses may represent such a situation, as these appeared to override their usual attributional paths. They responded to specific cues and perceptions of students' needs with a spontaneous response, apparently without engaging in a causal search.

The teachers were unable to offer feasible and effective helping solutions to many students who experienced clinical difficulties. One reason for this occurrence was that the teachers experienced difficulty recognizing and processing certain cues concerning students' problems. For example, the teachers often appeared to be unaware of the

manifestations of student anxiety, other than the most observable (e.g., shaking, appearing nervous). They frequently assessed a student's apparent disinterest (e.g., "hiding out" in the conference room, away from his/her patients) as an indication that the student was lazy or unwilling to expend effort in the clinical area. They generally became angry and frustrated with such a student, occasionally implementing punitive measures in response. Not surprisingly, such a response generally effected an exacerbation of the initially observed behaviour. Students who appeared uncaring about their patients often manifested signs of anxiety (e.g., staying away from the patient; communicating to the patient in a terse, superficial manner) which were interpreted by the clinical teacher as an indication that the student was not suited to the profession.

If attributional retraining has proven to be effective in the changing of attributions of students, it must also be possible to change the attributions of clinical teachers about their students. Perhaps, preparation for the role of clinical teacher should include attributional retraining, changing attributions of lack of effort to anxiety, or to the novice stage of professional competence. This may have the effect of increasing the teacher's willingness to continue helping students in the clinical area.

#### Learned Helplessness

Another student problem which was often misinterpreted was a student's experience of learned helplessness. Learned helplessness is a phenomenon characterized by motivational, cognitive, and emotional deficits, which occurs when an individual perceives that outcomes (e.g., performing a clinical skill satisfactorily) are not within his/her personal control (Weiner, 1986). The teachers expressed great concern about a few

students who appeared to function less effectively each clinical week. They often commented to the researcher that the decline in the student's functioning was also evident in the student's academic grades and in her relationships with her peers. "She gets more and more spaced out every week". The teachers stated that the student appeared to want the teacher's help to improve his/her clinical performance but appeared unable to effect the necessary changes. They generally concluded that the student lacked the ability to succeed in the program. Abrahamson, Garber and Seligman (1980) refer to such a student as having experienced negative, aversive outcomes (e.g., being unable to achieve a nursing skill) which are not contingent on their actions (e.g., the student practises a skill in the laboratory but is unable to perform it in the clinical area). This condition, termed learned helplessness, results in a perception of uncontrollability which is generalized to other achievement-related situations. The individual reacts to learned helplessness with cognitive, motivational and emotional withdrawal. Helping strategies for learned helpless students include attributional retraining (i.e., altering attributions from uncontrollable to controllable causes), a strategy intuitively practised by some of the teacher participants. However, these teachers did not generally employ attributional retraining for students who appeared to match the learned helpless description. Learned helpless students were often regarded as beyond the teacher's help. This was just one of the examples in the research findings which suggest that the teacher's expectancy of a student's success sometimes produced a self-fulfilling prophecy. The teachers, particularly the novice teachers, demonstrated a tendency to perceive, remember and explain students' actions in ways consistent with their expectations. The clinical teachers in the field study were largely

unaware of theories such as learned helplessness and, consequently, were unable to employ a theoretical base in making sense of specific student problems.

If a student were believed to be lacking sufficient effort to succeed in the clinical rotation, the clinical teachers in the study tended to respond to the student in frustration and, sometimes, hostility. Covington and Omelich (1979) suggest that students may adopt the strategy of disinterest and lack of effort because they cannot face the psychological and motivational messages inherent in accepting an attribution of lack of ability. The teachers who were normally kind and caring to students were often curt and prescriptive with these students. They do not appear to have considered that a student's apathy in the clinical area may have been related to other than laziness.

The clinical teachers reported feelings of hopelessness when they ascribed a student's failure in the clinical area to the student's lack of ability. Attributional retraining was a strategy often employed with these students as a means of helping them to increase their motivation to succeed. However, another benefit of this strategy is that it often appeared to enhance the teacher's motivation to help; i.e., the teacher seemed to believe her own message. When the clinical teacher became convinced that the cause of the aversive outcome was external, unstable or uncontrollable, she appeared to experience renewed hope that the student could succeed.

### **The Structure Of Clinical Education**

The teachers in the research, with the exception of Teacher #4, maintained the traditional structure of clinical education wherein the teacher and his/her students assume

a marginal role in the work setting. The teacher assigned students to the available patients in the clinical area and functioned more like the choreographer than the facilitator of the clinical experience for students, running between the needs of students, patients and staff. The teachers' complaints of fragmented observations of students' practice, heavy workload, lack of time for meaningful teaching, lack of personal satisfaction and the stressors related to communication with the nursing staff in the clinical area were largely a result of this traditional structure. Because they are detached geographically and in allegiance, the teachers are not accountable to the practice setting for their behaviour and actions. However, because they need the services of the hospital staff to provide necessary information and teaching support to the teachers and students, the clinical teachers in nursing education must spend considerable energy convincing the staff of their credibility as teachers and clinicians.

#### Temporary Versus Permanent Systems

Because clinical teachers and their students represent a temporary system within a permanent system (the service agency), the clinical teaching experience is characterized by some degree of territoriality and defensiveness. The experience of clinical teachers as a temporary system may be analyzed from the perspective of negotiated order (Strauss, 1978). According to Strauss, all social interactions take place within a negotiation context which may serve to constrain the interactions which take place. Therefore, clinical teaching occurs as part of an immediate (temporary system) and a larger structural (permanent system) context. A number of elements (mediating variables) were identified as characteristic of the transcending social environment which constrained the setting

where the negotiations took place.

Each process of negotiation has the potential to alter and to constrain the larger contexts of which it is a part. Negotiation within the contexts of clinical teaching were ordered by means of establishing territory, symbolic language, and restrictions to the extent and type of communication which occurred between the members of the permanent and temporary systems. The clinical teacher often feels alone and abandoned in the clinical area, away from the school of nursing. This results in the teacher and students experiencing a cohesiveness as a group, excluding the nursing staff from many of their activities. The teacher is more likely to criticize freely a nurse whom she regards as a member outside of the temporary system, particularly one who has criticized the teacher and the students equally as freely. Because the teacher is generally not a clinician and because student interactions with staff are often restricted, the student nurse receives a view of the practice of the profession from an individual who is detached from the practice setting and who, because of that detachment, may present an unrealistic portrayal of the profession. As well, the traditional practice of assigning students to one or two patients whose care is carefully monitored by the clinical teacher, results in the student rarely experiencing the teamwork concept which is so essential to the interdisciplinary functioning of health care.

#### Assignment of Patients

The practice of assigning patients to students is fraught with difficulties. First, the teacher must depend on the patient census on the ward to develop the assignment. If there is a drastic change in patient numbers or acuity, the clinical learning experience is

compromised. Second, students are often assigned patients who require aspects of care which are unfamiliar to students at that level of the program. The clinical teacher's response in such situations was generally that the student was only responsible for what she/he knew; the buddy nurse was responsible for the rest. However, students regularly reported considerable anxiety about caring for a patient who had equipment and apparatuses with which they were unfamiliar. They also reported that frequently the staff nurse did not check on the student or the patient because she/he assumed the student was caring for the patient independently. The third major difficulty associated with assigning students to patients was that the effective care of these patients depended upon the caregiver possessing the current and relevant data concerning the patient's health status. As members of a temporary system, the teachers and the students often encountered difficulties related to misinformation or lack of information in this regard. This occurred largely because the nursing staff knew much about the patients in the clinical area which was never written or communicated in any other manner to the students. Melia (1987) refers to this phenomenon as "nursing in the dark".

The students in the study often asked a teacher how they would "ever cope with more than two patients". The teachers tended to respond in these occasions by stating that the care of four patients was simply the care of two multiplied by two and that the students would learn organizational skills with experience after graduation. The students rarely appeared satisfied with this response. In fact, if a student never has the opportunity to observe how a nurse organizes and prioritizes the care of several patients, can we safely assume that the student will understand these concepts upon graduation? It has been

traditionally believed that the care of one or two patients allows a student to provide many aspects of patient care which would be considered luxuries in the real world of nursing (e.g., foot care). It has been assumed that the student would recognize these practices as ideal and would strive to maintain these in their role as a practitioner in the profession.

Although such practices are indeed important in patient care, we must begin to consider how we can teach students to incorporate these in the real workload of today's nurse. For example, students caring for one patient usually give the patient a bath and then sit down to talk to the patient about his/her concerns. It remains to be determined how students learn in the present structure of clinical teaching to combine these activities, without compromising the benefits of either.

Furthermore, if a student's conception of nursing is that an individual, analogous to the teacher, is always available to assist the nurse and to prevent her/him from making errors, how does she/he adapt to the harsher realities of the profession upon graduation? If their student experience has included minimal interactions with the nursing staff and an implication that nurses practise in less than the ideal manner, how do graduates of the schools of nursing become effective members of the nursing team in a clinical area? In no other profession does the basic education experience protect students so much from the realities of the workplace. Nursing education's adherence to the "teaching the ideal" of the profession seems to imply a basic distrust of practitioner's ability to care for patients effectively in accordance with the precepts of the profession.

### Skills Preoccupation

The clinical teachers in the research occasionally commented on the skills preoccupation of student nurses. They were perplexed about the origins of this phenomenon. This was particularly true of those teachers who ascribed to a non-skill mastery perspective of clinical teaching. This is an example of one of the many double-barrelled messages inherent in the traditional clinical teaching structure in nursing education. Teachers tell their students that there "is so much more to nursing than doing a lot of skills". Despite the teachers' attempts to diminish the importance of skill acquisition in nursing, the students were also made aware that they can fail the program if they did not acquire the necessary clinical skills within a specific time period. Two of the schools of nursing in this study required that teachers maintain complex lists of skills students had performed. All of the six clinical teachers in the study spent considerable time in their clinical days supervising students' performance of skills and giving them corrective feedback about their performance.

If nursing is truly "more than skills", the performance of psychomotor skills in the profession must be placed in proper perspective. If overlearning of psychomotor skills is required, perhaps it would be best to request that a student do nothing but injections in a clinical day. The argument against this practice has been that it separates the skill from the totality of patient care, implying that a nurse cannot give an injection unless she/he knows the patient. However, an advantage of the practice is that it promotes overlearning of the skill and, most importantly, it permits the teacher and the student to focus at other times on the synthesizing and analytical processes which are essential to

the transmission of practice.

### Evaluation

Another concern of the clinical teachers in the research was the student's greatly magnified apprehension in relation to clinical evaluations. The teachers often stated to the researcher that they did not understand why students appeared to distrust their teachers and to be overly anxious about the summative evaluations. In the past two decades, nursing education has responded to the rights-consciousness of the population by developing evaluation forms and records which detail how a teacher has made a decision about a student's clinical performance. Students receive regular written feedback about what they have done correctly and incorrectly in the clinical area. Evaluations are given to students at the end of the clinical rotation. An unintended consequence of frequent written feedback is that students appear to interpret this to mean that success in the clinical area is learning how to keep the clinical teacher happy. This phenomenon was frequently demonstrated by the students being unwilling to act independently of their clinical teacher. The students' dependency on their clinical teacher was apparently exacerbated by the serious consequences of failing a clinical rotation. Generally, failing a clinical rotation meant expulsion from the program. Research pertaining to college students, such as that cited by Tschikota (1990), indicates that students in nursing education may become increasingly externalized in their locus of control as they proceed through their basic education program. The findings of this research provide a context in which to explain such a phenomenon. Students who learn that they are continually evaluated in the clinical area will be inclined to act in accordance with the assumption

that it is the teacher (external) who determines the student's outcomes. Consequently, the student learns that the teacher's comments and behaviours toward him/her are indications of the student's ability.

The emphasis on evaluation of a student's clinical competence results in the development of a performance, rather than a mastery, orientation among student nurses. It also enhances the competitive structure of clinical education. The proliferation of externally controlled students in nursing education is of considerable concern when considered in the light of research findings by Perry and Penner (1990). These researchers determined that when external controlled students experience a transitory or permanent sense of loss of control, they are unable to learn, despite effective instruction by their teacher. In contrast, internally controlled students react to incidents of loss of control by increasing their efforts to cope with the situation, continuing to benefit from effective instruction. It would appear that the possibilities for students to experience loss of control in the current structure of clinical education are abundant. Strategies to promote the mastery orientation of students, which would serve to increase students' sense of personal control, should be included in teaching nurse educators to assume a clinical teaching role.

Other unintended consequences of the evaluatory focus of schools of nursing include the fact that the teachers must obtain the necessary amount of data to complete the forms and retain the semblance of objectivity in the evaluation process. This resulted in the teacher's emphasis on evaluatory techniques such as direct supervision of students and questioning to determine the student's knowledge base. The teachers were forced to observe and maintain records about aspects of the student's clinical performance which

were directly observable and measurable. For those teachers who viewed themselves as the gatekeepers to the profession, it also resulted in the teacher's focus on the "weakest" students in a clinical group, often excluding self-directed, independent students.

Another factor which has resulted from the emphasis on evaluation in clinical education is teacher role confusion. The teachers' role as caregivers and evaluators of students is contradictory, resulting in the teacher making sense of her/his evaluatory role by emphasizing that it is "good" for the student. Asking a clinical teacher to evaluate students every six-eight weeks is analogous to requesting that a nurse decide which patients are deserving of treatment. The research findings suggest that clinical teachers intend to teach as they nurse; in a caring, nurturing manner. However, the teachers are required by their schools of nursing to complete weekly records concerning students' clinical performance; to give students continual verbal feedback about their clinical performance; to attend regular faculty meetings at which students' clinical performance is discussed and analyzed; and to complete a summative evaluation on each student.

The clinical teacher is expected to carry out simultaneously the incompatible roles of coach and referee (Stroble & Cooper, 1988). Because of the documentation and evaluation requirements of schools of nursing, the teacher must necessarily focus on the evaluatory role in her/his clinical teaching. In the conflict between evaluator and teacher/helper roles in clinical teaching, it appears as if the most beneficial aspects of the teacher-student relationship are necessarily strained. The goals of evaluation are antithetical to those of the transmission of the practice of the profession. The confusion which arises because of these disparate goals places considerable demands on the clinical

teacher and contributes greatly to the teacher's experience of role confusion in the clinical area.

The goal of frequent and detailed evaluation in nursing education was to provide students with corrective feedback; to analyze objectively their clinical strengths and limitations. The objectivity of the current evaluation process is most assuredly questionable. The clinical teachers in the research reported that they felt often required to make premature judgments about students, based on inadequate and selectively sampled data. Some of the teachers did not make the judgments which they believed were correct because of factors external to the clinical learning experience (e.g., the appeals procedure; the expectations of other faculty). As well, the evaluation process resulted in several aversive and unintended outcomes which interfered with the students' ability to learn and the teachers' ability to teach in the clinical area.

One may question why evaluation must occur so often in nursing education. Why must evaluation of a student's clinical competence be conducted by the clinical teacher? Why are all data collected throughout the clinical rotation considered as part of the summative evaluation? Surely, students would be expected to make errors and to lack proficiency until the end of their clinical rotation. Why do evaluations focus on the behaviouristic paradigm in nursing when the affective elements of the profession are equally, if not more, important? Why must each clinical rotation be a potential termination point for students? Could schools of nursing not incorporate the mastery concepts which have proven so effective in other areas of higher education? It appears that nursing education would do well to learn from the evaluation techniques of other

professional programs. For example, teacher education has utilized videotaping to compare the student's and the teacher's evaluation of classroom teaching (Nelson, 1988). Medical education has employed patient simulations (Schnabel, 1989), as well as oral exams, and structured clinical examinations in order to assess the clinical performance of medical students (Swanson, 1990). Kane (1990) asserts that, although the implementation of alternative evaluation methods is not without problems (see Chapter Two), assessing the competence of students by means of direct observation in the clinical area introduces a number of extraneous variables which may influence an individual's performance and the outcome of the assessment.

Another concern in regard to the evaluation of students' clinical competency is the criteria which are used to assess their performance. The nursing profession must question if educators are evaluating what the profession truly values as the essential dimensions of nursing. The written evaluation forms in most schools of nursing reflect only the cognitive and psychomotor ability of the student (Andrusyszyn, 1989). The attitudinal and emotional elements of the profession are largely neglected. If affective ability is considered paramount to the quality of nursing care given by a nurse, it would appear that the current methods of clinical evaluation of students require considerable refinement in order to reflect adequately the affective dimension of the practice of the profession.

#### Questions to be Answered

It is time for the nursing profession to reconsider the structure of clinical teaching. This research study has indicated that the current structure results in teacher powerlessness, an over-emphasis on evaluation and skills performance, and student

dependency. Teacher #4's unique situation was particularly indicative of a need for substantial changes in the structure of clinical education. She functioned as part of the nursing staff and, consequently, was able to offer her students a wider, more supportive, and more individualized clinical experience than were the other five teachers in the study.

A number of questions concerning the present structure of clinical education in nursing arise from this research study. Why, for example, must students be assigned to patients? Why are they not assigned to nurses? Nursing is the only profession which continues to segregate students from practitioners in this manner. Assigning students to nurses would permit the student to internalize the elements of the profession (e.g., prioritizing; organization; teamwork; communication with physicians, family members and auxiliary staff) which have remained hidden and inaccessible to students in the current structure of clinical education. It would also provide an individual mentoring system for students. Students would be able to learn from the practitioner and, at the same time, implement the aspects of nursing care for which they are prepared. Assigning to nurses would also permit the schools of nursing to co-ordinate clinical learning experiences more effectively with the classroom curriculum. Students could care for patients with nurses in a variety of clinical areas during one clinical rotation. This would occur instead of, as is the current practice, caring for whoever is available on the ward.

Teacher education reformers have used the term "cognitive apprenticeship" for the carefully structured experience of students which aims to teach them the relevant concepts of the profession by involvement with a practitioner in actual practice (Brown, Collins & Duguid, 1989). This differs from the traditional practice of preceptorship in nursing,

where a nurse is given the responsibility of teaching a student in the clinical area, with minimal preparation for the responsibility of her/his preceptor role (Griep, 1989). The cognitive apprenticeship is structured and coordinated by a faculty member. It is characterized by the collaborative, social interaction of the student, practitioner and faculty member. Each learns from the experience and knowledge of one another. Another advantage to this system of clinical education is that it enables students to have access to the thinking of practitioners. Practitioners in this system focus much more than is traditional on helping students to alter their cognitive and behavioral dispositions (Zeichner, 1990).

A number of arguments have been raised concerning the preceding recommendation (see Chapter Two in regard to the issues associated with who should teach in the clinical area). The most prevalent of these has been that nurses are not teachers and will therefore neglect the learning needs of the student in order to provide service to patients. If the clinical teacher were part of the staff of a clinical area, many of these arguments would be abated. At present, clinical teachers are neither expert in their clinical field nor are they able to plan and implement clinical teaching according to what they intend. The clinical teachers in the research viewed their role as impotent, subject to the whims of many individuals. A great deal of this impotence occurs because of the structure of temporary versus permanent systems in clinical education. If teachers were part of the staff, they would be members of the permanent system with access to the unwritten information and backstage realities in the clinical area. They would also be recognized for their expertise as teachers, providing guidance and support to nurses who

are required to teach students, new graduates or patients. Integrating education and service in this manner would require a curriculum reform in nursing education. It would necessarily mean that both service and education would be required to expand the horizons of their territory to adopt an integrative curriculum. The pragmatic details of such a change are yet to be determined.

The clinical teaching associate model (Phillips & Kaempfer, 1987; del Bueno, Griffin, Burke & Foley, 1990), in which nurses employed by a health care agency participate in the clinical instruction of students in collaboration with faculty, may provide some guidelines in this direction. Some nursing educators (e.g., Infante) have already made several advances in this regard. Surely, the first step in relation to the re-structuring of the clinical teaching experience is to recognize the need and to state our intention to "re-vision" (Allen, 1990) the structure of clinical education in nursing. Nursing education must continue to strive to conceive clinical learning experiences for students which effectively connect caring and learning with evaluation.

### **Implications for Future Research**

A number of implications for future research have emerged in the analysis of the research findings. The following research questions are not an exhaustive list. They do, however, indicate the extent of research yet to be conducted in the area of clinical education in the professions.

- 1) There is evidence in this research that the varying perspectives of clinical teaching result in different teacher behaviours, which in turn influence specific learning by

students. The teachers who attested to a task-mastery orientation suggested that they maintained that perspective because it was most applicable to the unique learning needs of beginning students. Are some perspectives of clinical teaching more applicable to certain student populations than others? Are some more applicable in certain settings than others? For example, is a task-mastery goal orientation more suited to a highly technical clinical area? Is the mentoring orientation more suited to a clinical area, such as community health, where the issues and concepts of nursing are more the focus than are nursing skills? Do the perspectives described by the six teachers represent the developmental levels of expertise in clinical teaching? If so, are there more levels which have not been identified in the research? What student behaviours are enhanced or minimized by each of the four perspectives?

- 2) The novice teachers in the research demonstrated tendencies to regard situations in the clinical area as novel. They possessed fewer rituals of response than did the more experienced participants. What situations/incidents in clinical teaching do expert teachers consider as typical and worthy of a spontaneous response? If these were identified and the responses described, perhaps novice teachers could be taught what to expect in their role as a clinical teacher, as well as some of the ways in which they might respond to typical situations. Are the ritual responses of expert clinical teachers accurate and appropriate (i.e., do they effect the intended outcome?) or do they merely appear effective because the teacher is expecting them to produce the desired outcome?

- 3) The research findings indicate that any investigation of the nature of clinical teaching in nursing education must incorporate not only disciplined inquiry but also nursing education's commitment to practice. Theory construction in this regard is necessary to develop clinical teaching strategies which are effective in the transmission of the practice of the profession. Further exploration is needed to determine the implications of the caring context of clinical teaching in regard the transmission of practice by clinical teachers.
- 4) The research study has proposed several essential elements of clinical teaching as it exists in its current North American structure. Further research is necessary to determine how these factors relate to one another in the complex environment of clinical education. For example, how do a teacher's attributions about helping a student influence a clinical teacher's evaluation of the student?
- 5) Further investigation is needed to determine how a teacher develops his/her professional role identity as a clinical teacher. It must still be determined what role identity is preferable for clinical teachers to develop in order to meet effectively the learning needs of students and to transmit the practice of the profession.
- 6) The clinical teachers in the research expressed their desire to teach internally controlled students. However, many of their practices appear to have inadvertently resulted in external locus of control in student nurses. Tschikota (1990) suggests that teachers may be taught strategies to empower students and to minimize the performance orientation which results in students perceiving a loss of control in

the clinical area. Which empowering strategies indicated in the research conducted in the classroom arena are applicable in clinical teaching in this regard? What are the implications to nursing education and the profession at large if all students are encouraged to become internally controlled?

- 7) The research identified a number of elements of clinical teaching (e.g., helping) which could be included in an assessment of a clinical teacher's teaching. What is the most effective method or combination of methods of assessing clinical instruction in order to improve it? What low inference teaching behaviours can be identified in order to facilitate evaluation of clinical teaching effectiveness? Can the elements of clinical teaching be linked to specific student outcomes (e.g., does direct supervision of students in the clinical area enhance the student's learning?)
- 8) The accuracy of the clinical teachers' attributions about students was not measured in this research. However, it would appear that these were not always as the teacher perceived. The teachers utilized extinction strategies for some students whom they perceived to have no chance of success in the program. How many students who are extinguished by a school of nursing later enrolled in another or the same nursing program and were subsequently successful? What are the cognitive and affective responses of a student during and immediately following the extinction process? Do the attributions of clinical teachers differ with length of teaching experience? How do teachers measure their degree of involvement with students and how does involvement affect their attributions of student outcomes?

- 9) Perry (in press) states that classroom teachers could improve the effectiveness of their teaching if their perceived control were enhanced. The perceived control of the clinical teachers was not directly studied in this research. However, the findings suggest that clinical teachers often experience a perceived loss of control and resultant powerlessness. How does the teacher's perceived control influence student performance in the clinical area? What strategies do clinical teachers employ to regain and maintain a sense of control in clinical teaching?
- 10) The research identified a number of teaching strategies used by the participants to facilitate the students' information processing and decision making. Which of these strategies best enhances mastery orientation and internality among the students?
- 11) How may the research findings be applied to the study and analysis of other professions? What are the differences and commonalities between the experience of the nursing clinical educators and clinical teachers in other professions? How does each profession identify the essence of its practice to be transmitted in clinical education?

### **Summary**

This chapter has included a discussion of the major issues arising from the findings of the research study. The issues have centred on the lack of teacher preparation and the lack of clinical teaching theory to guide and direct the role of the clinical teacher, as well as the problems which have arisen in the current structure of clinical education.

It has proposed recommendations for the future of clinical education in nursing and raised some questions which must be answered before these can be effectively realized. None of the recommendations proposed is in itself a panacea for the many problems which plaque clinical teaching in nursing today. However, the solution to these problems lies in the willingness of nurse educators to effect a "re-vision" of the current practice of clinical teaching. The nursing profession must continue to strive to attain a quality of clinical education in which clinical teachers are able to make decisions based on choices of the means and ends of teaching, as well as being informed by a relevant knowledge base, intuition, self-reflection and value claims which are congruent with the philosophical underpinnings of clinical teaching.

## CHAPTER SEVEN

### SUMMARY AND CONCLUSION

#### Summary

The research presented in this report was a qualitative investigation of the experience of six clinical teachers in nursing education during the course of one academic year. The study focused on uncovering the meaning of these experiences for the six teachers. This entailed the research methods of interview, participant observation, document analysis and concept mapping. The practice propositions which were formulated by the teachers to guide their practice as clinical teachers were grounded in the theoretical description of their lived experience.

#### The Teacher's Perspective

The world of the clinical teacher in nursing education was discovered to be a dynamic reality, in which the teachers interacted with a number of individuals and a variety of constantly-changing environmental, personal and historical variables. The clinical teachers brought to each of these interactions a perspective of clinical teaching. This perspective encompassed their knowledge and value claims about clinical teaching. It detailed how the teacher intended to teach in the clinical area, as well as how she/he perceived and responded to situations which arose in the teacher-student, the teacher-staff and the teacher-patient relationship.

The clinical teachers in the research study attested to a narrow or a broad applied

science perspective of clinical teaching. In both orientations, the role of the clinical teacher was perceived to be to train students. In the narrow view, the teacher's role focused on reproducing behaviours and patterns of thought which were believed to be appropriate to the practice of the profession. The broader version fostered the capability of students to make decisions in the practice of the profession. Those with an ability-evaluative or task mastery perspective focused on the gatekeeper functions of the clinical teacher. Those who attested to a moral-responsibility or professional identity-mentoring perspective emphasized the professional development of students. There was evidence that clinical teachers may assume various perspectives at specific stages of their professional development. However, these changes were related to the reflective ability of the teacher, not length of clinical teaching experience.

#### Variables

There was a striking discrepancy between the teachers' intentions and their actual practice as clinical teachers. The contextual variables which accounted for this occurrence were identified and described in the report. The extent of the impact of these variables was so significant that it dramatically influenced the clinical teachers' ability to teach as they intended. The resultant dissonance between a teacher's intentions and her/his teaching activities caused the teachers to experience a sense of being unable to control what occurred in the clinical learning experience. The teachers reported feelings of powerlessness and, at times, resignation. Planning activities were minimal because clinical teaching was perceived as beyond the teacher's control to plan. The teachers had received minimal education about the role of a clinical teacher. They had learned the role largely

from trial and error, consulting with colleagues and their reflections on their own experience as students.

A significant contextual variable was found to be the structure of clinical education as a temporary system (the teacher and students) within a larger permanent system (the clinical setting). Because of the unique nature of such a structure, the clinical teachers were required to engage in courting and negotiating behaviours to ensure the nursing staff's co-operation in the clinical teaching experience. The consequences of the temporary system structure to the teacher's ability to execute her/his perspective of clinical teaching were generally the teacher's compromise of her/his clinical teaching perspective, as well as territoriality and defensiveness.

#### Relationships in Clinical Teaching

The research findings revealed that the essence of clinical teaching, according to the participants, is the primacy of the teacher-student relationship. The teachers perceived that their relationships with others (e.g., nursing staff, patients) in the clinical area were not their primary focus. They maintained their relationships with these individuals largely to effect positive learning experiences for their students. Although the teachers intended to demonstrate caring to the students, their practices (e.g, evaluation) were not always interpreted by the students as evidence of the teacher's concern for students' welfare. The teachers demonstrated a caring and support for other clinical teachers in their faculty. The benefits of such a support group were perceived by the participants to be cathartic, as well as educative.

### Role Identification

The findings also revealed that clinical teachers in nursing teach as nurses, not as teachers (i.e., in teacher education). The participants' practice as clinical teachers was characterized by the same elements which denote the profession of nursing: caring; assessment; decision making; and evaluation. The teachers' role identity was discovered to have been largely influenced by their self-reflections about their professional experience. Ability-evaluative or task-mastery teachers tended to ascribe to a teacher role, consciously restricting their nursing activities during the teaching experience. Those with a moral-responsibility or mentoring perspective consciously nursed patients in front of and with their students. No relationship was identified between the teacher's professional role identity and her/his educational preparation for the role.

### Transmission of Practice/Assessment

The transmission of the practice of the profession was the central element of clinical teaching identified by the six teachers in the field study. The participants identified a number of creative and sophisticated teaching strategies which they utilized to effect this purpose. Many of these strategies were designed to facilitate the student's cognitive processing of the concepts of the profession, as well as to assist the students to develop problem-solving and decision-making skills in the practice of the profession. The teachers often functioned as explorers of meaning with the students.

Assessment of the student's clinical performance occurred concurrently with the transmission of practice activities of the clinical teachers in the research. Supervision was the most common assessment strategy utilized by the teachers. Direct supervision and

questioning were the assessment strategies most frequently utilized by the novice teachers in the study. The more experienced teachers in the research employed less intrusive strategies (e.g., indirect supervision).

The six clinical teachers were found to practise specific ritual responses in regard to cues given to them by students, patients or nursing staff. These ritual responses bypassed an attributional search. The teachers responded spontaneously and without reflection when they encountered situations which they regarded as typical. Novice teachers maintained fewer ritual responses than the other participants. They were more likely than the others to regard situations in clinical teaching as unique and novel.

#### Attributional Search

When the clinical teachers in the study were confronted with a situation/incident which was not resolved by the teacher's ritual response, she/he reflected upon the reason for this occurrence. Reflection also occurred whenever the teacher encountered a unique or unexpected student outcome. If the student outcome were unexpected or unintended, the teacher engaged in an attributional search, searching for a cause of the outcome. Attributional searches were generally conducted by the teachers in response to negative, aversive student outcomes, rather than positive outcomes.

The clinical teachers in the research identified four dimensions of the attributions they ascribed to specific student outcomes: locus; stability; globality; and controllability. They demonstrated specific attributional styles which appeared to be related to their level of development as a clinical teacher. The affective responses of the participants were dependent on the importance of the outcome, as it related to the risk it posed to patients'

safety or welfare. Causal attributions which were perceived by the participants to be internal, controllable and stable elicited anger and frustration. Those believed to be internal, uncontrollable and stable resulted in an affective response of hopelessness and resignation.

Attributional searches led the clinical teachers to enact helping behaviours. The teachers offered students their help, regardless of the attributions they had made regarding the cause of the student's outcome and despite their affective response to their attributional ascriptions. Helping students was viewed by the participants as a professional obligation and an act of caring. Helping in clinical teaching was perceived by the clinical teachers as a social process, entailing expected student behaviours. Helping was terminated by the clinical teacher when the student's clinical problems were perceived as intractable, when the student did not meet the expectations of the socially-binding helping relationship, and when crystallization occurred.

#### Crystallization

Crystallization of the teacher's generalized judgement about students' clinical ability was frequently prompted by the time span of the clinical rotation and the requirement that the teacher be prepared to evaluate the student's clinical performance. The evaluatory focus of the clinical learning experience at times resulted in premature closure; i. e., crystallization. Early crystallization occurred when a student entered the clinical rotation with a previous history of poor clinical performance or when a student appeared to be disinterested in learning or to be lazy in the clinical area. Crystallization was delayed for beginning and graduating students.

The clinical teachers in the field study developed specific plans in relation to their crystallized judgments about students. Some students received their summative evaluations immediately following the crystallization process. Others were offered help from the clinical teacher, with the anticipation that the student would succeed in the clinical rotation. Extinction strategies were employed for students who were perceived by the clinical teachers to have no chance for success.

The summative evaluation is a formal process in nursing education, involving detailed, comprehensive written information concerning a student's clinical performance. The clinical teachers expressed considerable ambivalence about this process, particularly concerning the discrepancy between their helping and evaluatory roles. The evaluation was occasionally the impetus for the teacher to reflect upon her practice as a clinical teacher and to revise her/his practice in the following clinical rotation.

### **Conclusion**

The findings and analysis of a ten month qualitative investigation of the experience of clinical teaching in nursing education have been detailed in this report. The implications of the research findings were analyzed in the research report in regard to the role of the clinical teacher, the clinical teacher's attributions and the structure of clinical education in nursing. A number of recommendations were identified for the resolution of the myriad problems and inadequacies which plague clinical teaching in nursing education today. Several topics for future research projects in regard to clinical teaching in the professions were postulated.

Messer (cited in MacKenzie, 1988) raised a question about clinical teaching in the professions which is particularly relevant, considering the findings from this research. He asked, "Does fulfilling requirements constitute an education? (p.35)" Clinical teaching in nursing education as observed in this study appears to be largely "training", the preparation of functional, proficient practitioners. The production model of clinical education is no longer appropriate if the aspirations of the profession to educate autonomous, critical thinking practitioners are to be met. The educative goals of clinical teaching, such as assisting students to develop their critical thinking abilities, were often compromised in the course of the research by the needs of the agency staff, the structure of the clinical curriculum and the lack of theory in regard to clinical teaching. The teachers who participated in the research continually demonstrated their commitment to the students and to the nursing profession. However, they were often disabled in their intentions to effect quality clinical education by several factors beyond their control. Despite the handicaps to their role, these teachers managed to implement innovative and sophisticated teaching strategies, as well as to demonstrate the caring which epitomizes the nursing profession.

The research has contributed to a more complex understanding of what actually occurs in clinical teaching. The findings of the study may be utilized to identify the constituents of effective teaching in the clinical area. Many of the aspects of the clinical environment which affect clinical teaching have also been identified in this research. An unexpected contribution of the research is that it has provided an attributional analysis of clinical teachers' judgments and helping behaviour in the clinical area. It has also tested

Weiner's theory of attribution and motivation in the arena of the actual experience of the participants. Weiner (1986) has indicated that a deficiency in the research which has previously tested his theory is that causal dimensions were largely derived from theorists, not the subjects. This research study has presented the subjects' analysis of attributional dimensions.

It is apparent from the research findings presented in this report that it is now time for the members of the nursing profession to engage themselves actively in the challenge of dealing with the many problematic issues in the current system of clinical education. Educators and practitioners in the profession have for too long assumed that the chaotic structure of clinical teaching necessarily requires them to respond passively in a survival mode to the inefficiencies and limitations of the present system. This structure is no longer feasible or appropriate. It has resulted in a situation in which the teachers teach as outsiders in their own profession.

Clearly, a clinical teacher cannot control all the variables in the complex clinical environment which might negatively affect clinical teaching. The emerging paradigm of clinical instruction should be one in which the teacher is able to attend to the multiple dimensions of clinical teaching, equipped with a sound and relevant theoretical basis. Clinical teaching should include specifically designed strategies which enhance students' self-esteem and perceived control, in order that they be able to maximize the benefits of their clinical education. The nursing profession clearly requires an alternative to the traditional paradigm of clinical teaching; one in which the relationships between faculty, students and staff are characterized by reciprocity and collaboration and where education,

not training, is the goal.

### **BIBLIOGRAPHY**

- Aamodt, A. M. (1982). Examining ethnography for nurse researchers. Western Journal of Nursing Research, 4(2), 209-221.
- Abrahamson, L.Y., Seligman, M.E.P., & Teasdale, J. (1978). Learned helplessness in humans: Critique and reformulation. Journal of Abnormal Psychology, 87, 49-74.
- Abramson, L. Y., Garber, J., & Seligman, M. (1980). Learned helplessness in humans: An attributional analysis. In J. Garber & M. Seligman (Eds.), Human helplessness: Theory and applications (pp. 3-34). New York: Academic.
- Acheson, K., and Gall, M. (1980). Techniques in the clinical supervision of teachers: Preservice and inservice applications. New York: Longman.
- Adams, W. R. (1974). Research in self-education for clinical teachers. Journal of Medical Education, 49, 1166-1173.
- Agar, M. H. (1986). Speaking of Ethnography. Beverly Hills, Calif.: Sage.
- Agor, W. H. (1989). Intuition in organizations. Newbury Park, CA: Sage.
- Albas, D. C., & Albas, C. M. (1988). Student life and exams: Stresses and coping strategies. Dubuque, Iowa: Kendall/Hunt.
- Alfonso, R. J., Firth, G., & Neville, R. (1984). The supervisory skill mix. Educational Leadership, 41(7), 16-18.
- Allen, D. G. (1990). The curriculum revolution: Radical re-visioning of nursing education. Journal of Nursing Education, 29(7), 312-316.
- Amato, P. R., Ho, R., & Partridge, S. (1984). Responsibility attributions and helping behaviours in the Ash Wednesday bushfires. Australian Journal of Psychology, 36(2), 191-203.
- Ames, C., & Ames, R. (1984). Systems of student and teacher motivation: Toward a qualitative definition. Journal of Educational Psychology, 76(4), 535-556.

- Ames, C., & Archer, J. (1988). Achievement goals in the classroom: Students' learning strategies and motivation processes. Journal of Educational Psychology, 80(3), 260-267.
- Andrusyszyn, M. A. (1989). Clinical evaluation of the affective domain. Nurse Education Today, 9, 75-81.
- Applegate, J. H. (1985). Early field experience: recurring dilemmas. Journal of Teacher Education, 36(2), 60-63.
- Applegate, J. H., & Lasley, T. J. (1982). Cooperating teachers' problems with preservice field experience students. Journal of Teacher Education, 33(2), 15-18.
- Applegate, J. H., & Lasley, T. J. (1984). What cooperating teachers expect from preservice field experience students. Teacher Education, 24, 70-82.
- Archbold, P. G. (1986). Ethical issues in qualitative research. In W. C. Chenitz & J. M. Swanson (Eds.), From practice to grounded theory (pp. 155-167). Menlo Park, CA: Addison-Wesley.
- Archer, S. E., & Fleshman, R. P. (1981). Faculty role modeling. Nursing Outlook, 29(10), 586-589.
- Ardery, G. (1990). Mentors and proteges: From ideology to knowledge. In J. C. McCloskey & H. K. Grace (Eds.), Current Issues in Nursing, 3rd ed. St. Louis: C. V. Mosby.
- Argyris, C. (1952). Diagnosing defenses against the outsider. Journal of Social Issues, 8(3), 24-34.
- Argyris, C., & Schon, D. A. (1974). Theory in practice: Increasing professional effectiveness. San Francisco: Jossey Bass.
- Armaline, W. D., & Hoover, R. L. (1989). Field experience as a vehicle for transformation: Ideology, education and reflective practice. Journal of Teacher Education, 40(2), 42-48.
- Artinian, B. M. (1982). Conceptual mapping: Development of a strategy. Western Journal of Nursing Research, 4(4), 379-393.
- Ashley, J. (1975). Hospitals, paternalism and the role of the nurse. New York: Teachers College Press.

- Ashton, P. T. (1985). Motivation and a teacher's sense of efficacy. In C. Ames & R. Ames (Eds.), Research on Motivation in Education: Vol. 2. The classroom milieu (141-174).
- Ashworth, P., & Morrison, P. (1989). Some ambiguities of the student nurse's role in undergraduate nurse training. Journal of Advanced Nursing, 14, 1009-1015.
- Atwood, A. H. (1979). The mentor in clinical practice. Nursing Outlook, 27, 714-717.
- Atwood, J. R., & Hinds, P. (1986). Heuristic heresy: Application of reliability and validity criteria to products of grounded theory. Western Journal of Nursing Research, 8(2), 135-154.
- Avant, K. C., & Walker, L. O. (1988) Strategies for theory construction in nursing (2nd ed.). Norwalk, CO:Appleton & Lange.
- Bandler, L. S. (1982). Reflections on psychodynamic clinical social work perspective: An historical perspective. In L. Bandler (Ed.), Education for clinical social work practice: Continuity and change (pp. 11-29). New York: Pergamon Press.
- Barnes, R. D., Ickes, W., & Kidd, R. F. (1979). Effects of the perceived intentionality and stability of another's dependency on helping behavior. Psychology and Social Psychology Bulletin, 5(3), 367-372.
- Barnham, V. A. (1965). Identifying effective behaviours of nursing instructors through critical incidents. Nursing Research, 14, 65-69.
- Barr, F. (1980). Are your students positive about their experience in the clinical area? The Canadian Nurse, 79(9),48-50.
- Barrows, H. S. (1985). Springer Series on Medical Education/Volume 8: How to Design a Problem-based Curriculum for the Preclinical Years. New York, New York: Springer Publishing Company.
- Barrows, H. S. (1986). A taxonomy of problem-based learning methods. Medical Education, 20, 481-486.
- Barrows, H. S. (1987). The scope of clinical education. Journal of Medical Education, 62, 23-34.
- Barrows, H. S., & Peters, M. J. (Eds.). (1984). How to begin reforming the medical curriculum. Springfield, Illinois: Southern Illinois University School of Medicine.

- Barrows, H. S., & Tamblyn, R. M. (1980a). Springer Series on Medical Education/Volume 1: Problem-based Learning - An Approach to Medical Education. New York, New York: Springer Publishing Company.
- Barrows, H., & Tamblyn, R. (1980b). A problem-based learning: An approach to medical education. Springer Publishing: New York.
- Batterson, G. E. (1966). Inservice teacher training. Journal of Dental Education, 30, 34-36.
- Baxuin, C. H., & Yonke, A. M. (1978). Improvement of teaching skills in a clinical setting. Journal of Medical Education, 53, 377-382.
- Becher, R. M., & Ade, W. (1982). The relationship of field placement characteristics and students' potential field performance abilities to clinical experience performance ratings. Journal of Teacher Education, 33(2), 24-30.
- Becker, H. S. (1962). The nature of a profession. In N. B. Henry (Ed.), Education for the professions. Chicago: National Society for the Study of Education.
- Becker, H. S., & Geer, B. (1969). Participant observation and interviewing. In G. J. McCall & J. L. Simmons (Eds.), Issues in participant observation: A text and reader. Reading, Mass: Addison-Wesley.
- Becker, H., Geer, B., Hughes, E., & Strauss, A. (1961). Boys in white: Social culture in medical school. Chicago: University of Chicago Press.
- Behling, J., Curtis, C., & Forster, S. A. (1982). Impact of sex-role combinations on student performance in field instruction. Journal of Education for Social Work, 18(2), 93-98.
- Benne, K. D. (1976). Educational field experience as the negotiation of different cognitive worlds. In W. G. Gennis, K. D. Benne, R. Chinn & K. E. Correy (Eds.). The planning of a change (pp. 102-122). New York: Holt, Rinehart & Winston.
- Benner, P. (1984). From novice to expert. Menlo Park, Calif.: Addison-Wesley.
- Benner, P. (1990). Celebrating nursing: Valuing nursing. Keynote address, Paper presented at the Celebrations 90 Conference, Winnipeg, Manitoba.
- Bennis, W. G. (1969). Beyond bureaucracy. Trans Actions, 2(5), 31-35.

- Bennis, W. G., & Slater, P. E. (1969). The temporary society. New York: Harper & Row.
- Bentler, P. M., & Speckart, G. (1979). Models of attitude--Behavior relations. Psychological Review, 86, 452-464.
- Benyamink, K., Kedar, H. S., & Raveh, I. (1987). How do supervising doctors construe the medical student in clinical training? Medical Education, 21, 410-418.
- Bereiter, C., & Scarmadalia, M. (1986). Educational relevance of the study of expertise. Interchange, 17(2), 10-19.
- Berg, B. L. (1989). Qualitative research methods. Boston: Allyn & Bacon.
- Bergman, K., & Gaitskill, T. (1990). Faculty and student perceptions of effective clinical teaching: An extension study. Journal of Professional Nursing, 6(1), 33-44.
- Berliner, D. C. (1989). If the metaphor fits, why not wear it? The teacher as executive. Theory into Practice, XXIX(2), 85-93.
- Bernard, J. M. (1979). Supervisor training: A discrimination model. Counselor Education and Supervision, 19, 60-68.
- Bevil, C. W., & Gross, L. C. (1981). Assessing the adequacy of clinical learning settings. Nursing Outlook, 79, 658-661.
- Beyer, J., & Marshall, J. (1981). The interpersonal dimension of collegiality. Nursing Outlook, 29(11), 662-665.
- Bichard, S. H. (1986). Field-placement and supervision: A comparison of the Tavistock model with other fieldwork models. Education and Child Psychology, 3(2), 22-25.
- Bidwell, A. S., & Brasler, M. L. (1989). Role modeling versus mentoring in nursing education. Image, 21(1), 23-25.
- Bienha, R. A., Bienha, R. H., & Mendleson, M. A. (1987). Computer-assisted general medicine clerkship evaluation. Medical Education, 21, 138-142.
- Binger, J. L., & Huntsman, A. J. (1988). Coaching: A technique to increase employee performance. AORN, 47(1), 229-237.
- Bischoff, J., Farris, P., & Henninger, M. (1988). Student perceptions of early clinical experiences. Action in Teacher Education, X(3), 22-25.

- Bland, C. J., Houge, D. R., Hofstrand, H. F., Filiatrault, L. J., & Gunkler, J. W. (1977). Developing an objective based curriculum for a family medicine residency. Journal of Family Practice, 4, 103-110.
- Blane, S. M. (1968). Immediate effect of supervisory experience on counselor candidates. Counselor Education Supervision, 8, 39-44.
- Blauch, L. E. (1962). A century of the professional school. In W. W. Brickman & S. Leherer (Eds.), A century of higher education. New York: Society for the Advancement of Education.
- Blease, D. (1983). Observer effects on teachers and pupils in classroom research. Educational Review, 35(3), 213-217.
- Blumberg, A. (1968). Supervisory behavior and interpersonal relations. Educational Administration Quarterly, 4(2), 34-45.
- Blumer, H. (1967). Society as symbolic interaction. In J. Manis & B. Meltzer (Eds.), Symbolic interaction: A reader in social psychology. Boston: Allyn & Bacon.
- Blumer, H. (1969). Symbolic interactionism: Perspective and method. Englewood Cliffs, N.J.: Prentice-Hall.
- Bolin, F. S. (1988). Helping student teachers think about teaching. Journal of Teacher Education, 39(2), 48-54.
- Bolton, N. (1984). Educating professional nurses for clinical practice. Nursing and Health Care, 3(7), 384-389.
- Bondy, K. N. (1984). Clinical evaluation of student performance: The effects of criteria on accuracy and reliability. Research in Nursing and Health, 7, 25-33.
- Borrowman, M. L. (1960). Thee liberal and technical in teacher education: A historical survey of American thought. New York: Teachers College Bureau of Publications.
- Bosk, C. L. (1979). Forgive and remember: Managing medical failure. Chicago, Illinois: University of Chicago Press.
- Bowen, J. (1981). A history of western education. London: Methuen.
- Bowers, B. J. (1986). Grounded theory. In B. Sarter (Ed.), Paths to knowledge: Innovative research methods for nursing, pp. 33-54. New York:NLN.

- Boyd, W. (1961). The history of western education. London. Adam & Charles Black.
- Bramadat, I. J., & Chalmers, K. I. (1989). Nursing education in Canada: Historical 'progress' -contemporary issues. Journal of Advanced Nursing, 14(9), 719-726.
- Bridgman, M. (1983). Collegiate Education for Nursing. New York: Foundation.
- Brimfield, R., & Leonard, R. (1983). The student teaching experience: A time to consolidate one's perceptions. College Student Journal, 17, 401-406.
- Brook, P., Ingleby, D., & Wakeford, R. (1986). Students' attitudes to psychiatry: A study of first-and-final-year clinical students' attitudes in six medical schools. Journal of Psychiatric Education, 10, 151-169.
- Brown, E. L. (1948). Nursing for the future. New York: Russell Sage Foundation.
- Brown, F. (1949). Clinical Instruction. Philadelphia: W. B. Saunders.
- Brown, J. S., Collins, A., & Duguid, P. (1989). Situated cognition and the culture of learning. Educational Researcher, 18(1), 32-42.
- Brown, L. A. (1981). Innovative diffusions: A new perspective. New York: Methuen & Company.
- Brown, R. S. (1970). House staff attitudes toward teaching. Journal of Medical Education, 45, 156-159.
- Brown, S. T. (1981). Faculty and student perceptions of effective clinical teachers. Journal of Nursing Education, 20(9), 4-15.
- Bruner, J. S. (1975). Toward a theory of instruction. Cambridge, Massachusetts: Belcamp.
- Bryman, A. (1988). Quantity and quality in social research. London: Unwin Hyman Ltd.
- Buchanan, M. (1989). The careful vision: How practical is contemplation in teaching? American Journal of Education, 98(1), 35-61.
- Burgess, R. G. (1985). The whole truth? Some ethical problems of research in a comprehensive school. In R. G. Burgess (Ed.), Field methods: The study of education (pp. 139-162). Lewes: Falmer Press.
- Burgess, R. G. (Ed.) (1989). The ethics of educational research. Philadelphia: The Falmer Press.

- Burke, S. (1985). Reporting on qualitative and quantitative research: Evolving issues and criteria. Nursing Papers, 17(2), 69-71.
- Burns, N. (1989). Standards for qualitative research. Nursing Science Quarterly, 2(1), 44-52.
- Burns, N., & Grove, S. (1987). The practice of nursing research: Conduct, critique, utilization. Philadelphia: Saunders.
- Burr, W., Leigh, G., Day, R., & Constantine, J. (1979). Symbolic interaction and the family. In W. Burr, R. Hill, F. Nye, & I. Reiss (Eds.), Contemporary theories about the family: Vol.II (pp.41-111). New York: Free Press.
- Bursl, L. D. (1981). The teacher as a manager of the learning environment. Journal of Nursing Education, 20(5), 42-47.
- Bush, R. N. (1977). We know how to train teachers: Why not do so? Journal of Teacher Education, 28(6), 5-9.
- Bush, R. N. (1987). Teacher education reform: Lessons from the past half century. Journal of Teacher Education, 38(3), 13-18.
- Butler, B., & Elliot, D. (1985). Teaching and learning for practice. Aldershot, England: Gower.
- Byrd, P., & Garofalo, J. (1982). Issues in conducting a pre-student teaching field experience. Journal of Research and Development in Education, 15(4), 45-52.
- Byrne, C., McKnight, J., Roberts, J., & Rankin, J. (1989). Learning clinical teaching skills at the baccalaureate level. Journal of Advanced Nursing, 14, 678-685.
- Byrne, N., & Cohen, R. (1973). Observational study of clinical clerkship activities. Journal of Medical Education, 48, 919-927.
- Byrne, P. S., Harris, C. M., & Long, B. E. (1972). Teaching the teachers. Journal of Medical Education, 6, 37-43.
- Calderhead, J. (1987). Introduction. In J. Calderhead (Ed.), Exploring teachers' thinking (pp. 84-103). London: Cassell.
- Calderhead, J. (1988). The contribution of field experiences to student primary teachers' professional learning. Research in Education, 49, 33-50.

- Cambone, J. (1990). Teachers and thinking. Harvard Educational Review, 60(2), 217-236.
- Camp, M. G., Hoban, J. D., & Katz, P. A. (1985). A course on teaching for house officers. Journal of Medical Education, 60, 140-142.
- Campbell, J. L. (1985). What do freshmen medical students get from their first clinical experience in psychiatry? Journal of Psychiatric Education, 9, 73-76.
- Campbell-Heider, N. (1986). Do nurses need mentors? Image, 18(3), 110-113.
- Cantrell, T. (1973). How do medical school staff learn to teach? Lancet, ii, 724-727.
- Capers, C. F. (1986). Some basic facts about models, nursing conceptualizations and nursing theories. Journal of Continuing Education in Nursing, 16(5), 149-154.
- Carifio, M. S., & Hess, A. K. (1987). Who is the ideal supervisor? Professional Psychology, Research and Practice, 18, 244-250.
- Carkhuff, R. R. (1969). Critical variables in effective counselor training. Journal of Counseling Psychology, 16, 241-246.
- Carney, M. K., & Kein, S. T. (1978). Cost to a hospital of a clinical training program. Journal of Allied Health, 7, 187-191.
- Carpenito, L. J., & Duespohl, T. A. (1985). A guide for effective clinical instruction (2nd ed.). Rockville, MD: Aspen.
- Carr, A. M. (1983). Towards a theory of clinical teaching in nursing. (Doctoral dissertation, Boston University School of Education, 1983). Dissertation Abstracts International, 44, 1430 A. (University Microfilms No. 8319875).
- Carter, K. (1989). Meaning and metaphor: Case knowledge in teaching. Theory into Practice, XXIX(2), 109-115.
- Carter, K., Cushing, K., Sabers, D., Stein, P., & Berliner, D. (1988). Expert-novice differences in perceiving and processing visual classroom information. Journal of Teacher Education, 39, 25-32.
- Cassell, J. (1980). Ethical principles for conducting field work. American Anthropologist, 82(1), 28-41.

- Cassell, J. (1982). Harms, benefits, wrongs and rights in fieldwork. In J. E. Sieber (Ed.), The ethics of social research: Fieldwork, regulation and publication. New York: Springer Verlag.
- Centra, J. A. (1973). Self ratings of college teachers: A comparison with student ratings. Journal of Educational Measurement, 10, 287-295.
- Chandler, P., Robinson, W. P., & Noyes, P. (1990). Is initial training nurturing proactive teachers? Educational Research, 32(2), 130-139.
- Chandlet, T. A. (1982). Can Theory Z be applied to the public schools? Education, 104, 343-345.
- Chaska, N. L. (Ed.). (1990). The nursing profession: Turning points. St. Louis: C. V. Mosby.
- Chenault, T., & Brownford, F. (1978). Human services professional education: Future directions. New York: McGraw Hill.
- Chenitz, W. C., & Swanson, J. M. (1986). Qualitative research using grounded theory. In W. C. Chenitz, & J. M. Swanson (Eds.), From practice to grounded theory (pp. 3-15). Menlo Park, CA: Addison Wesley.
- Cherulnik, P. D. (1983). Behavioral Research. New York: Harper and Row.
- Christie, B. A., Jowycy, P. C., & Moeller, P. L. (1985). Fieldwork experience part 2: The supervisor's dilemma. American Journal of Occupational Therapy, 39, 675-681.
- Christman, J. B. (1988). Working in the field as a female friend. Anthropology & Education Quarterly, 19, 70-85.
- Christy, T. E. (1980). Clinical practice as a function of nursing education: A historical analysis. Nursing Outlook, 28, 493-497.
- Chung, Y. I., Spelbring, L. M., Boissoneau, R. (1980). A cost benefit analysis of fieldwork education in occupational therapy. Inquiry, 17(3), 216-219.
- Clark, C.M., & Peterson, P.L. (1986). Teachers' thought processes. In Wittrock, M. C. (Ed.), Handbook of research on teaching, pp. 255-296. New York: Macmillan Pub. Co.
- Clifton, R. A. (1977). The effects of an experimental program on the performance and self-concept of student teachers. Canadian Journal of Education, 2, 23-28.

- Clifton, R. A. (1979). Survival in a marginal situation. Canadian Journal of Education, 4(3), 60-74.
- Cohn, M. M. (1981). A new supervision model for linking theory and practice. Journal of Teacher Education, 32(3), 26-30.
- Cohn, M. M. (1983). Using motivation theory as a framework for teacher education. Journal of Teacher Education, 34, 10-13.
- Cohn, M. M., & Gellman, V. C. (1988). Supervision: A developmental approach for fostering inquiry in preservice teacher education. Journal of Teacher Education, 39, 2-8.
- Coleman, J. S., Livingston, S.A., Fennessey, G. M., Edwards, S. A., & Kidder, S. J. (1973). The Hopkins Game Program: Conclusions from seven years of research. Education Researcher, 2, 3-7.
- Coles, J., Dobbyn, M., & Print, C. (1981). Nursing students' perceptions of teaching in the clinical area. Australian Nurses' Journal, 11(1), 47-49.
- Collins, G. F., Cassie, J. M., & Daggett, C. J. (1978). The role of the attending physician in clinical training. Journal of Medical Education, 53, 429-431.
- Conant, J. B. (1963). The education of American teachers. New York: McGraw-Hill.
- Condon, E. H. (1986). Theory derivation: Application to nursing. Journal of Nursing Education, 24:4, 156-159.
- Connors, V. L. (1979). Teaching affective behaviours. Journal of Nursing Education, 18, 33-39.
- Connors, D. D. (1988). A continuum of researcher-participant relationships: An analysis and critique. Applied Nursing Science, 10(4), 32-42.
- Copeland, W. D. (1982). Student teachers' preferences for supervisory approach. Journal of Teacher Education, 33(2), 32-36.
- Copeland, W. D., & Atkinson, D. R. (1978). Student teachers' perceptions of directive and nondirective supervisory behavior. Journal of Educational Research, 71, 123-126.
- Corcoran, S. A. (1977). Should a service setting be used as a learning laboratory? An ethical question. Nursing Outlook, 25, 771-776.

- Corcoran, S. A. (1986). Planning by expert and novice nurses in cases of varying complexity. Research in Nursing and Health, 9, 155-162.
- Cotanch, P. H. (1981). Self-actualization and professional socialization of nursing students in the clinical laboratory experience. Journal of Nursing Education, 20:8, 4-14.
- Covington, M. V., & Omelich, C. L. (1979). It's best to be able and virtuous too: Student and teacher evaluative responses to successful effort. Journal of Educational Psychology, 71(5), 688-700.
- Covington, M. V., & Omelich, C. L. (1984). Task-oriented versus competitive learning structures: Motivational and performance consequences. Journal of Educational Psychology, 76(6), 1038-1050.
- Covington, M. V., Spratt, M. F., & Omelich, C. L. (1980). Is effort enough or does diligence count too? Student and teacher reactions to effort stability in failure. Journal of Educational Psychology, 72(6), 717-729.
- Cowles, K. V. (1988). Personal word expansion for survivors of murder victims. Western Journal of Nursing Research, 10(6), 702-704.
- Cronin-Stubbs, D., & Mathews, J. G. (1982). A clinical performance evaluation tool for a process-oriented nursing curriculum. Nurse Educator, 7(4), 24-29.
- Cruickshank, D. R. (1984). Toward a model to guide inquiry in preservice teacher education. Journal of Teacher Education, 35, 43-48.
- Cutrona, C. E., Russell, D., & Jones, R. D. (1985). Cross-situational consistency in causal attributions. Does attributional style exist? Journal of Personality and Social Psychology, 47, 1043-1058.
- Dachelet, C. (1981). The critical incident technique applied to the evaluation of the clinical practicum setting. Journal of Nursing Education, 20, 15-31.
- Daggett, C. J., Cassie, J. M., & Collins, G. F. (1979). Research on clinical teaching. Review of Educational Research, 49(1), 151-169.
- Daloz, L. A. (1987). Effective teaching and mentoring. San Francisco: Jossey-Bass.
- Danby, M., & Bernard, G. (1990). Concept formation and the improvement of reading comprehension. Paper presented at AMTEC Annual Conference, June 10, 1990.

- DaRosa, D. A., Dawson-Saunders, B., & Folsie, R. (1985). A comparison of objective and subjective measures of clinical competence. Evaluation and Program Planning, 8, 327-330.
- Davidhizar, R. E. (1988). Mentoring in doctoral education. Journal of Advanced Nursing, 13, 775-781.
- Davies, D., & Amershek, K. (1969). Student teaching. In R. Ebel (Ed.), The Encyclopedia of Educational Research, 49, 151-169.
- Davis, L., & Tomney, P. (1982). The best of two worlds. The Canadian Nurse, 78, 34-37.
- Davis, M. Z. (1986). Observation in natural settings. In W. C. Chenitz, & J. M. Swanson (Eds.), From practice to grounded theory (pp. 48-65). Menlo Park, CA: Addison Wesley.
- Degner, L. F., Beaton, J. L., and Glass, H. P. (1981). Life-death decision-making in health care: A descriptive study. Winnipeg: University of Manitoba.
- Delaney, D. J., & Moore, J. C. (1966). Students' expectations of the role of the practicum supervisor. Counsellor Education and Supervision, 6, 11-17.
- del Bueno, D. J., Griffin, L. R., Burke, S. M., & Foley, M. A. (1990). The clinical teacher: A critical link in competence development. Journal of Nursing Staff Development, 5, 135-138.
- de Tornyay, R. & Thompson, M. (1982). Strategies for teaching nursing, 2nd ed. New York: John Wiley.
- Denzin, N. K. (1970). The Research Act. Chicago: Aldine Publishing Co.
- Denzin, N. K. (1989). Interpretative interactionism. Newbury Park, Calif.: SAGE Publishing Co.
- De Voogd, R., & Salbenblatt, C. (1989). The clinical teaching associate model: Advantages and disadvantages in practice. Journal of Nursing Education, 28(6), 276-277.
- Dexter, P. A., & Laidig, J. (1980). Breaking the education/service barrier. Nursing Outlook, 78, 179-182.
- Dickens, M. R. (1983). Faculty practice and social support. Nursing Leadership, 6, 121-127.

- Diekelmann, N.L. (1988). The nursing curriculum: Lived experience of students. In NLN (Ed.), Curriculum revolution: Reconceptualizing nursing education, pp. 25-42. New York: NLN.
- Diekelmann, N.L. (1990a). Preserving the practice of teaching in nursing [Guest editorial]. Journal of Nursing Education, 29(5), 195.
- Diekelmann, N. (1990b). Nursing education: Caring, dialogue and practice. Journal of Nursing Education, 29(7), 300-305.
- Diekelmann, N., Allen, D., & Tanner, C. (Eds.) (1989). The NLN criteria for appraisal of baccalaureate programs: A critical hermeneutic analysis. New York: NLN.
- Dillon, R. F., & Sternberg, R. J. (Eds.) (1986). Cognition and instruction. Orlando, Florida: Academic Press Inc.
- Dinham, S. M., & Stritter, F. T. (1986). Research on professional education. In Wittrock, M. C. (Ed.), Handbook of research on teaching (3rd ed.), pp. 952-970. New York: Macmillan Pub. Co.
- Dobson, S. (1986). Ethnography: A tool for learning. Nurse Education Today, 6, 76-79.
- Doyal, G. T., & Forsyth, R. A. (1973). The relationship between teacher and student anxiety levels. Psychology in the Schools, 10, 231-233.
- Drew, N. (1989). The interview experience as data in phenomenological research. Western Journal of Nursing Research, 11(4), 431-439.
- Duffy, B. S. C. (1986). Learning theories and the ward tutorial. Nurse Education Today, 6:1, 23-27.
- Duffy, M. E. (1985). Designing nursing research: The qualitative-quantitative debate. Journal of Advanced Nursing, 10, 225-232.
- Dunkin, M. J., & Biddle, B. J. (1974). The study of teaching. New York: Holt, Rinehart & Winston.
- Dutton, W. H. (1962). Attitude change of elementary school student teachers and anxiety. Journal of Educational Research, 55:8, 380-382.

- Eisenberg, J. M. (1983). Development of attitudes about sharing decision-making: A comparison of medical and surgical residents. Journal of Health and Social Behavior, 24, 85-90.
- Eisner, E.W. (1982). An artistic approach to supervision. In T.J. Sergiovanni (Ed.), Supervision of teaching, pp. 53-66. Alexandria, VA: Association for Supervision and Curriculum Development.
- Eisner, E. I. (1985). Can educational research inform educational practice? Phi Delta Kappan, 65, 447-502.
- Ellen, R. F. (1984). Ethnographic research. London: Academic Press.
- Elliot, E. S., & Dueck, C. S. (1988). Goals: An approach to motivation and achievement. Journal of Personality and Social Psychology, 54(1), 5-12.
- Emery, F. E., & Trist, E. (1965). The causal text of the environment. Human Relations, 18(2), 21-37.
- Emmerson, R. M. (1987). Four ways to improve the craft of fieldwork. Journal of Contemporary Ethnography, 16(1), 69-89.
- Erickson, D. A. (1979). Research on educational administration: The state of the art. Educational Researcher, 26, 9-14.
- Erickson, F. (1986). Qualitative methods in research on teaching. In M. Wittrock (Ed.), Handbook of Research on Teaching (3rd ed.), pp. 119-161. New York: MacMillan Publishing Co.
- Evans, R. K., & Rozelle, R. M. (1973). Social Psychology in Life. Boston: Allyn and Bacon Inc.
- Evaneshko, V. (1985). Entree strategies for nursing field research studies. In M. M. Leininger (Ed.), Qualitative research methods in nursing (pp. 133-137). Orlando, FL: Grune & Stratton.
- Evaneshko, V., & Kay, M. A. (1982). The ethnoscience research technique. Western Journal of Nursing Research, 4, 49-64.
- Fagan, M., & Fagan, P. (1983). Mentoring among nurses. Nursing and Health Care, 4, 77-82.

- Fairweather, J. S. (1989). Academic research and instruction: The industrial connection. The Journal of Higher Education, 60(4), 388-407.
- Faria, G., Brownstein, C., & Smith, H. Y. (1988). A survey of field instructors' perceptions of the liaison role. Journal of Social Work Education, 24, 135-144.
- Fetterman, D. M. (1990). Ethnography step by step. Newbury Park, NJ: SAGE.
- Field, P. A. (1980). An ethnography: Four nurses' perspectives of nursing in a community setting. Unpublished doctoral dissertation, University of Alberta, Edmonton.
- Field, P. A. (1981). A phenomenological look at giving an injection. Journal of Advanced Nursing, 6, 291-296.
- Field, P. A. (1983). An ethnography: Four public health nurses' perspectives of nursing. Journal of Advanced Nursing, 8, 3-12.
- Field, P. A., & Morse, J. M. (1985). Nursing research: The application of qualitative approaches. Rockville, Maryland: Aspen Publishers Inc.
- Fisher, M. (1983). The issue: Faculty practice. Journal of Nursing Education, 22(5), 207-210.
- Fitzpatrick, J. L., & Taunton, R. L. (1987). Annual Review of Nursing Research. Vol. 6. New York: Springer Publishing Co.
- Flagler, S., Loper-Powers, S., & Spitzer, A. (1989). Clinical teaching is more than evaluation alone. Journal of Nursing Education, 27(8), 342-346.
- Floden, R. E., & Klinzing, H. G. (1990). What can research on teacher thinking contribute to teacher preparation? A second opinion. Educational Researcher, 19(4), 15-20.
- Foersterling, F. (1985). Attributional retraining: A review. Psychological Bulletin, 98, 495-512.
- Frumppkin, M. L. (1980). Social work education and the professional commitment fallacy: A practice guide to field school relations. Journal of Education for Social Work, 16(2), 91-99.
- Fuller, F. F. (1969). Concerns of teachers: A developmental conceptualization. Educational Research Journal, 6, 207-226.

- Fuller, F. F. (1970). Personalized teacher education for teachers: An introduction for teacher educators. Austin: University of Texas, Research and Development Centre for Teacher Education. (ERIC Document Reproduction Service No. ED 208 487).
- Galbo, J. J. (1983). Teacher anxiety and student achievement. Educational Research Quarterly, 7:4, 44-49.
- Gans, H. J. (1982). Observations on the personal aspects of fieldwork. In R. G. Burgess (Ed.), Field research: A sourcebook and field manual (pp. 53-61). Lewes: Falmer Press.
- Gardner, J. M. (1981). Characteristics of effective teaching. Radiologic Technology, 52:6, 607-609.
- Gaut, D. A. (1986). Evaluating caring competencies in nursing practice. Topics in Clinical Nursing, 8(2), 77-83.
- Gehnke, N. J. (1988). On preserving the essence of mentoring as one form of teacher leadership. Journal of Teacher Education, 39(1), 43-45.
- Gillis, C. L. (1985). Faculty practice in primary care. Journal of Professional Nursing, 1, 256.
- Gitlin, A., Ogawa, R. T., & Rose, E. (1984). Supervision, reflection and understanding: A case for horizontal evaluation. Journal of Teacher Education, 35(3), 46-50.
- Glaser, B. (1978). Theoretical Sensitivity. Mill Valley, California: The Social Press.
- Glaser, B. G. (1982). Generating formal theory. In R. G. Burgess (Ed.), Field research: A sourcebook and field manual (pp. 53-61). Lewes: Falmer Press.
- Glaser, B., & Strauss, A. (1966). The purpose and credibility of qualitative research. Nursing Research, 15:1, 56-62.
- Glaser, B., & Strauss, A. (1967). Discovery of Grounded Theory. Chicago: Aldine Publishing Co.
- Glaser, B., & Strauss, A. L. (1985). Discovery of a substantive theory: A basic strategy underlying qualitative research. American Behavioral Sociologist, 8, 5-12.
- Glaser, R. (1988). On the nature of expertise. In C. Schooler & W. Schaie (Eds.), Cognitive functioning and social structure over the life course. Norwood, NJ: Ablex.

- Glass, H. P. (1971). Teaching behavior in the nursing laboratory in selected baccalaureate nursing programs in Canada. Unpublished doctoral dissertation, Teachers College, Columbia University, New York.
- Glazer, M. (1982). The threat of the stranger: Vulnerability, reciprocity, and fieldwork. In J. E. Sieber (Ed.), The ethics of social research: Fieldwork, regulation and publication. New York: Springer Verlag.
- Glickman, C. D. (1981). Developmental supervision: Alternative practices for helping teachers improve instruction. Alexandria, VA: Association for Supervision and Curriculum Development.
- Golden, M. P. (Ed.) (1976). The research experience. Itasca, Ill.: F. E. Peacock Pub.
- Goldenberg, D., & Waddell, J. (1990). Occupational stress and coping strategies among female baccalaureate nursing faculty. Journal of Advanced Nursing, 15, 531-543.
- Goodman, R. A. (1971). Socio-technological systems: An action-oriented, organizational vantage point. Los Angeles: University of California.
- Goodman, R. A. (1976). Some managerial issues in temporary systems: A study of professional development and manpower - the theatre case. Administrative Science Quarterly, 21, 494-501.
- Goodman, R. A., & Goodman, L. P. (1972). Theatre as a temporary system. California Management Review, 15(2), 103-108.
- Goodyear, R. K., & Robyak, J. E. (1982). Supervisors' theory and experience in supervisory focus. Psychological Report, 51, 978.
- Gormisch, D. S., Banford, J. C., Rous, S. N., Sall, S., & Rubin, S. (1972). A comparison of student and department chairmen evaluation of teaching performances. Journal of Medical Education, 47, 281-4.
- Gowin, D. B., & Novak, J. D. (1984). Learning how to learn. Cambridge: Cambridge University.
- Grace, H. (1983). Nursing. In C. H. McGuire, R. P. Foley, A. Gorr, & R. W. Richards (Eds.), Handbook of health professions education. San Francisco: Jossey-Bass Inc.
- Graham, S. & Baker, G. (1990). The down side of help: An attributional-developmental analysis of helping behavior as a low ability cue. Journal of Educational Psychology, 82(1), 7-14.

- Granger, J. M., & Starnes, S. (1982). Field Instruction Model for Baccalaureate Social Work. New York: Syracuse University School of Social Work.
- Green, J. L., & Harker, J. O. (Eds.) (1988). Multiple perspective analyses of classroom discourse. Norwood, N.J.: Ablex Publishing Co.
- Greenberg, L., Goldberg, R., & Hewett, P. (1984). Teaching in the clinical setting: Factors influencing residents' perceptions. Confidence and Behavior. Medical Education, 18, 360-365.
- Griep, M. E. (1989). Nursing preceptorship-Looking back, looking ahead. Journal of Nursing Staff Development, 14, 269-272.
- Griffith, J. W., & Bakanauskas, A. J. (1983). Student-instructor relationships in nursing. Journal of Nursing Education, 22(3), 104-107.
- Guistra, L. (1985). Training issues in the treatment of severely disturbed patients. American Journal of Psychotherapy, 34:1, 95-107.
- Guy, M. E. (1985). Professions in organizations. New York: Praeger.
- Guzzetta, G., Katz, A. J., & English, R. A. (Eds.). (1982). Education for social work practice: Selected international models. Brighton, Eng.: Council on Social Work Education.
- Gypbers, N. (1965). Strategies for practicum supervision. Counselor Education and Supervision, 3, 149-152.
- Hageman, P. A. (1979). Ratings of clinical clerkship feedback by allied health faculty and students. Journal of Allied Health, 17, 115-121.
- Hagerty, B. (1986). A second look at mentors. Nursing Outlook, 34(1), 16-19, 24.
- Hall, G. E. (1983). Clinical supervision in teacher education as a research topic. Journal of Teacher Education, 34(4), 56-58.
- Hames, C. C. & Joseph, D. H. (1986). Basic concepts of helping: A holistic approach. Norwalk, Conn.: Appleton-Century Crofts.
- Hamilton, J. D. (1976). The McMaster curriculum: A critique. British Medical Journal, 1, 1191-1196.

- Hamilton, M. S. (1981). Mentorhood: A key to nursing leadership. Nursing Leadership, 4(1), 4-13.
- Hamilton, M. S. (1986). Mentorhood: A key to nursing leadership. In E. C. Hein & M. J. Nicholson (Eds.), Contemporary leadership behavior: Selected readings, 2nd ed. Boston: Little, Brown.
- Handley, P. (1982). Relationship between supervisors' and trainees' cognitive styles and the supervision process. Journal of Counseling Psychology, 29, 508-515.
- Hansen, J. C., & Baker, E. N. (1964). Experiencing the supervisory relationship. Journal Counseling Psychology, 11, 107-111.
- Hansen, J. C., Pound, R., & Petro, C. (1976). Review of research on practicum supervision. Counselor Education and Supervision, 16, 107-116.
- Hardy, L. K. (1980). Keeping up with 'Mrs. Chase': An analysis of nursing skill-learning. Journal of Advanced Nursing, 5, 321-327.
- Harootuhian, B., & Koon, J. R. (1970). The reinforcement behaviours of teachers in training. Paper presented at the meeting of the American Educational Research Association, Minneapolis. (ERIC Microfiche No. ED 040 941).
- Harrison, L. L. (1990). Maintaining the ethic of caring in nursing. Journal of Advanced Nursing, 15, 125-127.
- Harrison, M. A. (1987). Conspectus '87. Physiotherapy, 73(12), 640-647.
- Hayter, J. (1973). An approach to laboratory evaluation. Journal of Nursing Education, 12, 17-22.
- Hearn, G. (1958). Theory building in social work. Toronto: University of Toronto Press.
- Heppner, P. P., & Handley, P. G. (1981). A study of the interpersonal influence process in supervision. Journal of Counseling Psychology, 28, 437-444.
- Heppner, P. P., & Roehkle, H. J. (1984). Differences among supervisors at different levels of training: Implications for a developmental level of supervision. Journal of Counseling Psychology, 31, 76-90.
- Hess, A. K. (1987). Advances in psychotherapy supervision. Professional Psychology, Research and Practice, 18, 187-188.

- Hildebrand, M. (1973). The character and skills of the effective professor. Journal of Higher Education, 54:1, 41-50.
- Hill, A. S. (1989). Precepting the clinical nurse specialist student. Clinical nurse Specialist, 3(2), 71-75.
- Hill, J.C. (1985). The teacher as artist: A case for peripheral supervision. Educational Forum, 49, 183-187.
- Hinkleman, K. W., & Long, N. K. (1973). Method for decreasing subjective evaluation in preclinical restorative dentistry. Journal of Dental Education, 10, 13-18.
- Hitchings, K. S. (1989). Preceptors promote competence and retention: Strategies to achieve success. Journal of Continuing Education, 20(6), 255-260.
- Hodge, E. A., Payne, P. A., & Wheeler, D. D. (1978). Approaches to empathy training: Programmed methods versus individual supervision and professional versus peer supervisors. Journal of Counseling Psychology, 25, 449-453.
- Hogan, P. (1983). The central place of prejudice in the supervision of student teachers. Journal of Education for Teaching, 9, 30-45.
- Holloway, E. (1987). Developmental models of supervision: Is it development? Professional Psychology, Research and Practice, 18, 209-216.
- Holloway, I., & Penson, J. (1987). Nurse education as social control. Nurse Education Today, 7, 235-241.
- Holm, K. (1981). Faculty practice: Noble intensions gone away? Nursing Outlook, 29, 655-657.
- Holonen, R. J., Fitzgerald, J., Simmons, K. (1976). Measuring the costs of clinical education in departments utilizing allied health in professionals. Journal of Allied Health, 5, 5-12.
- Hook, C. M., & Rosenshine, B. V. (1979). Accuracy of teacher reports of their classroom behavior. Review of Educational Research, 49(1), 1-12.
- Hooper, D., & Johnston, I. (1973). Teaching practice: Training or social control. Education for Teaching, 92, 25-30.

- Hoover, N. L., O'Shea, L. J., & Carroll, R. G. (1988). The supervisor-intern relationship and effective interpersonal communication skills. Journal of Teacher Education, 39, 22-27.
- Horowitz, J. A., & Olivieri, R. (1985). Preparing nurse-educators: Who should teach undergraduates? Journal of Psychosocial Nursing and Mental Health Service, 23(2), 36-38.
- Houle, C. O., Cyphert, F., & Boggs, D. (1986). Education for the professions. Theory into Practice, XXVI(2), 87-93.
- Housego, B. E. J. (1987). Critical incidents in the supervision of student teaching in an extended practicum. Alberta Journal of Educational Research, XXIII(4), 247-259.
- Housego, B. E. J., & Boldt, W. B. (1985). Critical incidents in the supervision of student teaching. Alberta Journal of Educational Research, XXXI(2), 113-124.
- Housego, B. E., & Grimett, P. P. (1983). The performance-based/developmental debate about student teaching supervision.: A typology and temporary resolution. Alberta Journal of Educational Research, 29(4), 319-337.
- Houston, W. R., Haberman, M., & Sikula, J. (1989). Teacher education as a field of scholarly inquiry. Action in Teacher Education, XI(2), 19-24.
- Howey, K. (1977). Preservice teacher education: Lost in the shuffle? Journal of Teacher Education, 28(2), 26-28.
- Hoy, W. K., & Woolfolk, A. E. (1990). Socialization of student teachers. American Educational Research Journal, 28(2), 279-300.
- Hughes, C. (1985). Supervising clinical practice in psychosocial nursing. Journal of Psychosocial Nursing, 23, 27-32.
- Hunnskaar, S., & Seim, S. (1984). The effect of a checklist on medical students' exposures to practice skills. Medical Education, 18, 439-442.
- Hunt, D. D., Carline, J., Tonesk, X., Yergan, J., Siever, M., & Loebel, J. P. (1989). Types of problem students encountered by clinical teachers on clerkships. Medical Education, 23, 14-18.
- Hutchinson, S. A. (1984). Creating meaning out of horror. Nursing Outlook, 32(2), 86-90.

- Hutchinson, S. A. (1986). Creating meaning: Grounded theory of NICU nurses. In W. C. Chenitz, & J. M. Swanson (Eds.), From practice to grounded theory (pp. 191-204). Menlo Park, CA: Addison Wesley.
- Hymovich, D. P. (1984). Development of the chronicity impact and coping instrument: Parent questionnaire. Nursing Research, 33, 218-222.
- Infante, M. S. (1981). Toward effective and efficient use of the clinical laboratory. Nurse Educator, 6(1), 16-19.
- Infante, M. S. (1985). The clinical laboratory in nurse education (2nd ed.) New York: John Wiley & Sons.
- Infante, M. S. (1986). The conflicting roles of nurse and nurse educator. Nursing Outlook, 34, 94-96.
- Infante, M. S., Forbes, E. J., Houldin, A.D., & Naylor, M. D. (1989). A clinical teaching project: Examination of a clinical teaching model. Journal of Professional Nursing, 5(3), 132-139.
- Irby, D. M. (1977). Evaluating teaching skills. The Diabetes Educator, 52, 155-157.
- Irby, D. M., (1978a). Clinical faculty development. In L. E. Ford (Ed.), Clinical Education for the Allied Health Professions (pp. 95-105). St. Louis, Missouri: Mosby.
- Irby, D. M. (1978b). Clinical teacher effectiveness in medicine. Journal of Medical Education, 53, 808-814.
- Irby, D. M. (1983). Evaluating instruction in medical education. Journal of Medical Education, 58, 844-849.
- Irby, D. M. (1987). Clinical teaching and the clinical teacher. Journal of Medical Education, 62, 34-45.
- Irby, D. M., DeMers, J., Scher, M., & Matthews, D. (1976). A model for the improvement of medical faculty lecturing. Journal Medical Education, 51, 403-409.
- Irby, D., & Rakestraw, P. (1981). Evaluating clinical teaching in medicine. Journal of Medical Education, 56, 181-186.
- Irion, A. L. (1965). A brief history of research on the acquisition of skills. New York: Academic Press.

- Jackson, P. (1968). Life in classrooms. New York: Holt, Rinehart & Winston.
- Jacobson, B.S., & Meninger, J. C. (1985). The designs and methods of published nursing research: 1956-1983. Nursing Research, 34, 306-312.
- Jagasinski, C. M., & Nicholls, J. G. (1990). Reducing effort to protect perceived ability: "They'd do it but I wouldn't." Journal of Educational Psychology, 68(1), 15-21.
- Janesick, V. J. (1977). An ethnographic study of a teacher's classroom perspective. Unpublished doctoral dissertation, Michigan State University.
- Jason, H. (1978). Is faculty development necessary? In fact, what is it? Journal of Medical Education, 53, 42.
- Jewett, L. S., Greenberg, L. W., & Goldberg, R. M. (1982). Teaching residents how to teach: A one-year study. Journal of Education, 57, 361-366.
- Joachin, G. (1982). Head nurse and clinical instructor. The Canadian Nurse, 78, 26-29.
- Johnson, D. M., & Wilhite, M. J. (1973). Reliability and validity of subjective evaluation of baccalaureate program nursing students. Nursing Research, 22, 257-262.
- Johnson, J. (1969). Changes in student teacher dogmatism. Journal of Educational Research, 62, 224-226.
- Johnson, L., & Gueldner, S. H. (1989). Remember when...? Using mnemonics to boost memory in the elderly. Journal of Gerontological Nursing, 15(8), 22-26.
- Jorgensen, D. L. (1989). Participant observation: A methodology for human studies. Newbury Park, Calif.: SAGE Publications Inc.
- Joyce, B., & Weil, M. (1980). Models of teaching (2nd ed.). Englewood Cliffs, New Jersey: Prentice Hall.
- Just, G., Adams, E., & de Young, S. (1989). Faculty practice: Nurse educators' views and proposed models. Journal of Nursing Education, 28(4), 161-167.
- Kadushin, A. (1976). Supervision in Social Work. New York: Columbia University Press.
- Kagan, D. M. (1987). Cognitive level of student teachers and their perceptions of cooperating teachers. Alberta Journal of Educational Research, 33, 180-190.

- Kagan, D. M. (1988a). Research on the supervision of counselors- and teachers-in-training: Linking two bodies of literature. Review of Educational Research, 58(1), 1-24.
- Kagan, D. M. (1988b). Teaching as clinical problem solving: A critical examination of the analogy and its implications. Review of Educational Research, 58(40), 482-505.
- Kaltsounis, T., & Nelson, J. L. (1968). The mythology of student teaching. Journal of Teacher Education, 19(3), 277-281.
- Kanter, R. M. (1983). The changemasters: Innovation for productivity in America. New York: Simon and Schuster.
- Kapinus, B. (1981). Role shifts and role strains entailed in moving from participant to observer. Paper presented at the Annual Meeting of the Eastern Educational Research Association, Philadelphia, ED 209 244.
- Kaplan, D. M. (1983). Current trends in practicum supervision research, Counselor Education and Supervision, 22, 215-226.
- Karmos, A. H., & Jacko, C. M. (1977). The role of significant others during the student teaching experience. Journal of Teacher Education, 28(5), 51-55.
- Karuhije, H. F. (1986). Educational preparation for clinical teaching: Perceptions of the nurse educators. Journal of Nursing Education, 25, 137-144.
- Katz, L. G., & Raths, J. D. (1985). A framework for research on teacher education programs. Journal of Teacher Education, 36, 9-15.
- Kaufman, M. (1976). American medical education: The formative years, 1765-1910. Westport, Conn.: Greenwood Press.
- Keenan, T., Aiken, L., & Cluff, L. E. (Eds.). (1981). Nurses and Doctors: Their Education and Practice. Cambridge, Mass.: Olegeschlager, Gunn and Hain.
- Kellmer, D. M. (1982). The lack of effective faculty role models within professional schools. Nursing and Health Care, 54, 44-45.
- Kelly, L. Y. (1987). The nursing experience: Trends, challenges and transitions. New York: MacMillan Publishing Co.
- Kelly, R. L. (1973). Evaluation is more than measurement. American Journal of Nursing, 73, 114-116.

- Knaack, P. (1984). Phenomenological research. Western Journal of Nursing Research, 6:1, 107-114.
- Knapfl, K., & Burkett, G. (1975). Professional socialization in a surgical specialty: Acquiring medical judgement. Sociology, Science and Medicine, 9, 397-404.
- Knafl, K. A., & Howard, M. J. (1984). Interpreting and reporting qualitative research. Research in Nursing and in Health, 7, 17-24.
- Knafl, K. A., & Webster, D. C. (1988). Managing and analyzing qualitative data: A description of tasks, techniques and materials. Western Journal of Nursing Research, 10:2, 195-218.
- Koehler, V. (1984). University supervision of student teaching (Report No. 9061). Austin: University of Texas, Research and Development Center for Teacher Education. (ERIC Document Reproduction No. ED 270439).
- Koehler, V. (1985). Research on preservice teacher education. Journal of Teacher Education, 36(1), 23-30.
- Koehler-Richardson, V. (1988). Barriers to the effective supervision of student teaching: A field study. Journal of Teacher Education, 39, 28-34.
- Kohn, S. D. (1970). Paolo Soleri thinks very big. New York Times Magazine, July 26, p. 30.
- Kracht, C. R., & Casey, J. P. (1968). Attitudes, anxieties and student teaching performance. Peabody Journal of Education, 45, 214-217.
- Kramer, M. (1968). Role models, role conceptions and role deprivation. Nursing Research, 17(2), 115-120.
- Kramer, M. (1979). Educational preparation for nurse roles. In J. Williamson (Ed.), Current perspectives in nursing education. St. Louis: C. V. Mosby.
- Kramer, M., Polifroni, E. C., & Organek, N. (1986). Effects of faculty practice on student learning outcomes. Journal of Professional Nursing, 289-301.
- Kuhn, T. S. (1970). The Structure of Scientific Revolutions. Chicago, Illinois: University of Chicago Press.

- Kulik, J. A., & McKeachie, W. J. (1975). The evaluation of teachers in higher education. In F. N. Kerlinger (Ed.), Review of Research in Education, Vol. 3, pp. 210-240. Peacock, Itaska, Illinois.
- Kus, R. J. (1985). Stages of coming out: An ethnographic approach. Western Journal of Nursing Research, 7:2, 177-198.
- Kushnir, T. (1986). Stress and social facilitation: The effects of the presence of an instructor on student nurses' behaviour. Journal of Advanced Nursing, 11, 13-19.
- Lambert, M. J., & Arnold, R. C. (1987). Research and the supervisory process. Professional Psychology, Research and Practice, 18, 217-224.
- Lampert, M., & Clark, C. M. (1990). Expert knowledge and expert thinking in teaching: A response to Floden and Klinzing. Educational Researcher, 19(4), 21-23.
- Lampert, M. (1990). When the problem is not the question and the solution is not the answer: Mathematical knowing and teaching. American Educational Research Journal, 27(1), 29-63.
- La Monica, E. L. (1976). Empathy training as the major thrust of a staff development program. Nursing Research, 36:6, 447-451
- Lanier, J.E., & Little, J.W. (1986). Research on teacher education. In Wittrock, M. C. (Ed.), Handbook of research on teaching (3rd ed.), pp. 527-569. New York: Macmillan Pub.
- Lanzilotti, S. (1986). The practice integrated learning sequence: Linking education with the practice of medicine. Adult Education Quarterly, 37:1, 38-47.
- Lawrence, P. F. (1983). Determining the content of a surgical curriculum. Surgery, 94, 309-317.
- Lawrence, P. F. (1987). The clinical education of medical students: A perspective from surgery. Journal of Medical Education, 62, 67-74.
- Lawson, B. K., & Harvill, L. M. (1980). The evaluation of a training program for improving residents' teaching skills. Journal of Medical Education, 55, 1000-1005.
- Layton, M. M. (1969). How instructors' attitudes affect students. Nursing Outlook, 17(1), 27-29.

- Le Breck, D. B. (1989). Clinical judgement: A comparison of theoretical perspectives. In W. Holzemer (Ed.), Review of research in nursing education. Vol. II. New York: NLN.
- Leiken, A. M. (1983). Method to determine the effect of clinical education on productivity in a health care facility. Physical Therapy, 63(1), 56-59.
- Leinhardt, G., & Greeno, J.G. (1986). The cognitive skill of teachers. Journal of Educational Psychology, 78, 75-95.
- Leinhardt, G., & Smith, D.A. (1985). Expertise in mathematical instruction: Subject matter knowledge. Journal of Educational Psychology, 77, 247-271.
- Leininger, M. (1980). Caring: A central focus of nursing and health care services. Nursing and Health Care, 1(3), 135-143, 176.
- Leininger, M. (1984). Transcultural nursing: An overview. Nursing Outlook, 32(2), 72-73.
- Leininger, M. (Ed.) (1985). Qualitative research methods in nursing. London:Grune & Stratton Inc.
- Leino-Kilpi, H. (1989). Learning to care: A qualitative perspective of student evaluation. Journal of Nursing Education, 28(2), 61-66.
- Leino-Kilpi, H. (1990). Self-reflection in nursing teacher education. Journal of Advanced Nursing, 15, 192-195.
- Lenburg, C. B. (1979). The Clinical Performance Examination. Appleton-Century-Crofts, New York.
- Lenz, E. R., et al. (1986). Clinical specialty preparation and nurses' interpretation of client situations. Western Journal of Nursing Research, 8:4, 431-444.
- Lernau, O. Z. (1989). Problem-solving instruction during the clinical clerkship: Description and preliminary evaluation of a programme. Medical Education, 23, 179-183.
- Levinson-Rose, J., & Menges, R. J. (1981). Improving college teaching: A critical review of the research. Review of Educational Research, 51, 403-434.
- Lewin, D. C., & Leach, J. (1982). Factors influencing the quality of wards as learning environments for student nurses. International Journal of Nursing Studies, 19:3, 125-137.

- Lewis, J. M., & Kappelman, M. M. (1984). Teaching styles: An introductory program for residents. Journal Medical Education, 59, 355.
- Lewis, W. W., Newell, J. M., & Withall, J. (1961). An analysis of classroom patterns of communication. Psychological Reports, 9(2), 211-219.
- L'Hommedieu, R., Menges, R., & Brinko, B. J. (1990). Methodological explanations for the modest effects of feedback from student ratings. Journal of Educational Psychology, 82(2), 232-241.
- Light, D. (1979). Uncertainty and control in professional training. Journal of Health and Social Behavior, 20, 310-322.
- Lillard, J. (1982). The socialization process: A student's viewpoint. Nurse Educator, 7, 11-12.
- Lincoln, Y. S. (1985). Organizational Theory and Inquiry: The Paradigm Revolution. Beverly Hills: Sage.
- Lindeman, C.A. (1988). Clinical teaching: Paradoxes and paradigms. In NLN (Ed.), Curriculum revolution: Reconceptualizing nursing education, pp.55-70. New York: NLN.
- Little, J. W. (1990). The mentor phenomenon and the social organization of teaching. Review of Research in Education, 16, 297-351.
- Little, D., & Carnevali, D. (1972). Complexities of teaching in the clinical laboratory. Journal of Nursing Education, 11, 15-22.
- Lofland, J. (1976). Doing social life: The qualitative study of human interaction in natural settings. New York: John Wiley.
- Loganbill, C., Hardy, E., & Delworth, U. (1982). Supervision: A conceptual model. The Counseling Psychologist, 10(1), 3-42.
- Lopez, K. A. (1983). Role modelling interpersonal skills with beginning nursing students: Gestalt techniques. Journal of Nursing Education, 22(3), 119-122.
- Lortie, D. C. (1975). Schoolteacher: A sociological study. Chicago: University of Chicago Press.
- Lowe, C., & Kassin, S. M. (1977). On the use of consensus: Prediction, attribution and evaluation. Psychology and Social Psychology Bulletin, 3(4), 616-619.

- Lowry, E. (1986). The impact of the nursing process on the role and function of the clinical teacher. Nurse Education Today, 6, 60-63.
- Lowry, Louis. (1983). Social work supervision: From models toward theory. Journal for Social Work, 19(2), 55-58.
- Ludmerer, K. M. (1985). The Development of American Medical Education. New York: Basic Books, Inc.
- Lundstreen, S. W. (1983). The evaluative role of participant observation. Paper presented at the Annual Meeting of the Professional Training Institute, ED. 229 306.
- MacKenzie, R. S. (1988). The applied science of clinical teaching in dentistry. Gainseville, Fla.:RSM Press.
- MacKinnon, J. R., & Page, G. C. (1986). An analysis and comparison of the educational costs of clinical placement for occupational therapy, physical therapy, speech pathology and audiology students. Journal of Allied Health, 16, 225-236.
- Mahler, S., & Benor, D. E. (1984). Short and long term effects of a teacher-training workshop in medical school. Higher Education, 13, 265-273.
- Mangione, C. M. (1987). How medical school did and did not prepare me for graduate medical education. Journal of Medical Education, 62, 3-10.
- Manis, J., & Meltzer, B. (Eds.). (1967). Symbolic interaction: A reader in social psychology. Boston: Allyn & Bacon.
- Manning, D. T. (1987). Historical lessons for teacher education. Journal of Teacher Education, 38, 20-24.
- Marakis, D. A., Russell, R. K., & Dell, D. M. (1985). Effects of supervisor experience level on planning and in-session supervisor verbal behavior. Journal of Counseling Psychology, 32, 410-416.
- Marcoux, B., & Pinkston, D. (1984). Clinical experience and cognition of a physical therapy procedure. Physiotherapy, 64(7), 1545-1548.
- Marsick, V. J. (1988). Learning in the workplace: The case for reflectivity and critical reflectivity. Adult Education Quarterly, 38, 187-198.

- Marson, S. N. (1982). Ward sister-teacher or facilitator? An investigation into the behavioral characteristics of effective ward teachers. Journal of Advanced Nursing, 7, 347-357.
- Martenson, D., & Nystrup, J. (1984a). Evaluation and consequences of teaching competence: Scandinavian developments. Medical Education, 18, 394-400.
- Martenson, D., & Nystrup, J. (1984b). Evaluating competence of medical teachers. Medical Education, 18, 125.
- Martin, Y. M., Harris, D. L., & Karg, M. B. (1985). Clinical competence of graduating medical students. Journal of Medical Education, 60, 919-934.
- Mattern, W. D., Weinholtz, D., & Friedman, C. P. (1983). The attending physician as teacher. New England Journal of Medicine, 308, 1129-1132.
- Mattinson, J. (1975). The Reflection Process in Casework Supervision. London: The Tavistock Institute of Human Relations.
- Mawardi, B. H. (1965). A career study of physicians. Journal of Medical Education, 40, 658-666.
- McAulay, J. D. (1960). How much influence has a cooperating teacher? Journal of Teacher Education, 11(1), 79-83.
- McAulay, R. G., & Woodward, C. W. (1984). Faculty perception of the McMaster MD program. Journal of Medical Education, 59, 842-843.
- McBride, H., Littlefield, J., & Garman, R. E. (1981). A simulation method measuring psychomotor skills. Evaluation and the Health Profession, 4, 295-305.
- McCabe, B. W. (1985). The improvement of instruction in the clinical area: A challenge waiting to be met. Journal of Nursing Education, 24, 255-257.
- McCall, G. J., & Simmons, J. L. (1969). Issues in Participant Observation. Menlo Park, California: Addison-Wesley Publishing Co.
- McCloskey, J. C., & Grace, H. K. (Eds.). (1985). Current Issues in Nursing, 2nd Edition. Boston: Blackwell Scientific Publications.
- McColley, S. H., & Baker, E. L. (1982). Training activities and styles of beginning supervisors: A survey. Professional Psychology, 13, 283-292.

- McDonald, F. J., Allen, D. W., & Orme, M. E. J. (1965). The effects of self-feedback and reinforcement on the acquisition of a teaching skill. Unpublished manuscript. Stanford University, Stanford, CA.
- McFaul, S. A., & Cooper, J. M. (1982). Peer clinical supervision in an urban elementary school. Journal of Teacher Education, 33(1), 34-38.
- McGrath, J. E., & Altman, I. (1966). Small Group Research. New York: Holt, Rinehart and Winston, Inc.
- McKenna, E. K. (1987). Psychology in business. Hillsdale, N.J.: Lawrence Erlbaum.
- McKenna, M. (1986). Anthropology and nursing - The interaction between two fields of inquiry. Western Journal of Nursing Research, 6:4, 423-431.
- McMillan, M. A., & Dwyer, J. (1989). Changing times changing paradigm: From hospital training and college education in Australia. Nurse Education Today, 9, 13-18.
- McNamara, D. (1990). Research on teachers' thinking: Its contribution to educating student teachers to think critically. Journal of Education for Teaching, 16(2), 147-159.
- Meleca, C. B., Schimphauser, F. T., Witteman, J. K., & Sachs, L. A. (1981). Clinical instruction in nursing: A national survey. Journal of Nursing Education, 20:8, 32-40.
- Melia, K. M. (1982). Tell it as it is - qualitative methodology and nursing research: Understanding the student nurses' world. Journal of Advanced Nursing, 7(3), 327-335.
- Melia, K. M. (1987). Learning and working: Occupational socialization of nurses. London: Tavistock.
- Melnick, D. (1990). Computer-based clinical simulation: State of the art. Evaluation and the Health Professions, 13, 104-120.
- Meltzer, B. N., Petras, J., & Reynolds, L. T. (1975). Symbolic interaction, genesis, varieties and criticisms. Boston: Routledge & Kegan Paul.
- Menges, R. J., & Brinko, K. T. (1986). Effects of student evaluation feedback; A meta-analysis of higher education research. Paper presented at the American Educational Research Association, San Francisco, Calif., April, 1986.
- Merriam, S., & Simpson, E. (1984). A guide to research for educators and trainers of adults. Malabar, Fl: Robert E. Krieger.

- Mesler, M. A. (1989). Negotiated order and the clinical pharmacist: The ongoing process of structure. Symbolic Interaction, 12(1), 139-157.
- Messick, S. (1989). Assessing readiness for professional practice. In R. L. Linn (Ed.), Educational measurement (3rd ed., pp 13-103). New York: American Council on Education & MacMillan.
- Mezirow, J. (1981). A critical theory of adult learning and education. Adult Education, 32(1), 3-24.
- Mezirow, J. (1985). A critical theory of self-directed learning. In S. Brookfield (Ed.), Self-directed learning: From theory to practice (pp. 17-30). San Francisco: Jossey-Bass.
- Miles, M. B., & Huberman, A. M. (1984). Qualitative data analysis: A source book of new methods. Beverly Hills, California: Sage.
- Mitchell, J., & Marland, P. (1989). Research on teacher thinking: The next phase. Teaching and Teacher Education, 5(2), 115-128.
- Monke, R. (1971). Effect of systematic desensitization on the training of counselors. Journal of Counselling Psychology, 18, 320-323.
- Mooney, T., & Carlson, W. (1976). Counselor trainee emotional responses to initial counselling interview stress. Journal of Counselling Psychology, 23, 557-559.
- Moore, J. T., & Bovula, J. A. (1980). A conceptual framework for teaching geriatrics in a family medicine residency. Journal of Medical Education, 55(4), 339-344.
- Morgan, J. (1983). Students' perceptions of clinical teaching. Nursing Papers, 15, 4-20.
- Morgan, J., & Knox, J. E. (1987). Characteristics of best and worst clinical teachers as perceived by university nursing faculty and students. Journal of Advanced Nursing, 12, 331-337.
- Morgan, M. K., & Irby, D. M. (1978). Evaluating Clinical Competence in the Health Professions. St. Louis: C. V. Mosby.
- Morgan, W. L. (1987). The environment for general clinical education. Journal of Medical Education, 62, 47-58.

- Morley, I. (1984). Bargaining and negotiation. In C. L. Cooper & P. Makin (Eds.), Psychology for managers. Basingstoke, Hants: British Psychological Society/Macmillan Publishers.
- Morse, J. M. (Ed.). (1989). Qualitative nursing research: Contemporary dialogue. Rockville, Maryland: Aspen Publishers Inc.
- Mosher, R., & Purpel, D. (1972). Supervision: The reluctant profession. Boston: Houghton Mifflin.
- Mullen, P. D., & Iverson, D. (1982). Qualitative methods for evaluative research in health education programs. Health Education, 13:3, 11-18.
- Muller, S. (Chairman). (1984). Physicians for the twenty-first century: Report of the project panel on the general professional education of the physician and college preparation for medicine. Journal of Medical Education, 59, Part 2.
- Munhall, P. L. (1988). Ethical considerations in qualitative research. Western Journal of Nursing Research, 10:2, 150-162.
- Munhall, P. L., & Oiler, C. J. (1986). Nursing Research: A Qualitative Perspective. Norwalk, Connecticut: Appleton-Century-Crofts.
- Munson, C. E. (Ed.). (1979). Social Work Supervision. New York: Free Press.
- Murden, R., Galloway, G. M., Reid, J. C., & Colwill, J. M. (1978). Academic and personal predictors of clinical success in medical school. Journal of Medical Education, 53, 711-719.
- Muslin, H. L., & Thurnbald, J. P. (1974). Supervision as an evaluative mechanism. In H. L. Muslin, R. J. Thurnbald, B. Templeton, and C. H. McGuire (Eds.), Evaluative Methods in Psychiatric Education. Washington, D.C.: American Psychiatric Association.
- Meyer, J. P., & Mulherin, A. (1990). From attribution to helping: An analysis of the mediating effects of affect on expectancy. Journal of Personality and Social Psychology, 39, 201-210.
- Nadler, D. (1977). Feedback and organization development: Using data-based methods. Reading, Mass.: Addison-Wesley.
- National Center for Research on Teacher Education. (1988). Teacher education and learning to teach: A research agenda. Journal of Teacher Education, 39(6), 27-32.

- Nelson, B. L. (1989). Mentor teachers' thinking about teaching and mentoring. Unpublished Report, University of Manitoba.
- Nelson, B., Jansson, L., & Slentz, K. (1987). Supervision not a luxury in teacher preparation. The Manitoba Teacher, 66, 2-4.
- Newman, L. F. (1986). Premature infant behavior: An ethological study in a special care nursery. Human Organization, 45:4, 327-333.
- No author. (1986). Patterns in Specialization: Challenge to the Curriculum. New York: NLN.
- No author. (1987). Patterns in Nursing: Strategic Planning for Nursing Education. New York: NLN.
- O'Shea, H. S. (1982). Role orientation and role strain of clinical nurse faculty in baccalaureate programs. Nursing Research, 31:5, 306-310.
- O'Shea, H.S., & Parsons, M.K. (1979). Clinical instruction: Effective and ineffective teacher behaviours. Nursing Outlook, 27, 411-415.
- Oleson, V. L., & Whittaker, E. W. (1968). The silent dialogue. San Francisco: Jossey Bass.
- Orban, D. A., & Bahl, S. M. (1987). A structured approach to clinical education in a dietetic curriculum. Journal of the American Dietetic Association, 87:1, 57-60.
- Oskamp, S. (1984). Applied Social Psychology. Englewood Cliffs, New Jersey: Prentice-Hall Inc.
- Overhold, G. E., & Stallings, W. I. (1976). Ethnographic and experimental hypothesis. Educational Research, 5:8, 10-14.
- Pagana, K. D. (1988). Stresses and threats reported by baccalaureate students in relation to an initial clinical experience. Journal of Nursing Education, 27(9), 418-423.
- Parfitt, B. (1989). A practical approach to creative teaching: An experiment. Journal of Advanced Nursing, 14, 665-677.
- Park, C. L. (1982). A clinical instruction observation tool. Nursing Papers, 14:3, 7-15.
- Patton, M. Q. (1980). Qualitative evaluation methods. Beverly Hills: SAGE.

- Perry, E. L. (1968). Ward Administration and Teaching: The Work of the Ward Sister. London: Baillere, Tindall and Cassell.
- Perry, J. F. (1981). A model for designing clinical education. Physical Therapy, 61:10, 1427-1432.
- Perry, R. P. (in press). Perceived control in college students: Implications for instruction in higher education. In J. Smart (Ed.), Higher education: A handbook of theory and research. (Vol. 7). New York: Agathon.
- Perry, R. P., & Leventhal, L. (1980). Learned helplessness in the classroom: Are teacher behaviours involved? Proceedings, XXII International Congress of Psychology, Leipzig, GDR.
- Perry, R. P., & Magnusson, J. L. (1989). Causal attributions and perceived performance: Consequences for college students' achievement and perceived control in different instructional conditions. Journal of Educational Psychology, 81, 164-172.
- Perry, R. P., Magnusson, J. L., Parsonson, K. & Dickens, W. J., (1986). Perceived control in the college classroom: Limitations in instructor expressiveness due to noncontingent feedback and lecture content. Journal of Educational Psychology, 78, 98-107.
- Perry, R. P., & Penner, K. S. (1990). Enhancing academic achievement in college students through attributional retraining and instruction. Journal of Educational Psychology, 82, 112-121.
- Perry, R. P., & Tunna, K. (1988). Perceived control, Type A/B behavior, and quality of instruction. Journal of Educational Psychology, 80, 102-110.
- Peters, T. J., & Waterman, R. H. (1982). In search of excellence: Lessons from America's best-run companies. New York: Warner Books.
- Phillips, J. R. (1989). Qualitative research: A process of discovery. Nursing Science Quarterly, 2(1), 5-6.
- Phillips, S. J., & Kaempfer, S. H. (1987). Clinical teaching associate model: Implementation in a community hospital setting. Journal of Professional Nursing, 5, 165-175.
- Powell, J. H. (1989). The reflective practitioner in nursing. Journal of Advanced Nursing Studies, 14, 824-832.

- Preston, R., & Baker, R. (1985). An exploratory study of the clinical observation system: A systematic approach to student teacher observations during field experience. The South Pacific Journal of Teacher Education, 13(1), 29-43.
- Pruitt, D. B., McColgan, E. B., Pugh, R. L., & Kiser, L. J. (1986). Approaches to psychotherapy supervision. Journal of Psychiatric Education, 10, 129-147.
- Pugh, E. J. (1980). Factors influencing congruence between beliefs, intentions, and behavior in the clinical teaching of nursing. (Doctoral dissertation, University of California). Dissertation Abstracts International, 41, 2521A-2522A. (Microfiles No. 802902).
- Pugh, E. J. (1983). Research on clinical teaching. In W. Holzemer (Ed.), Review of research in nursing education. Thorofare, N.J.:SLACK Inc.
- Quinn, F. M. (1980). The principles and practice of nurse education. London: Croom Helm.
- Rabinowitz, F. E., Heppner, P. P., & Roehkle, H. J. (1986). Descriptive study of process and outcome variables of supervision over time. Journal of Counseling Psychology, 33, 292-300.
- Rauen, K. C. (1974). The clinical instructor as role model. Journal of Nursing Education, 13, 33-40.
- Redland, A. R. (1989). Mentors and preceptors as models for professional development. Clinical Nurse Specialist, 3(4), 70.
- Reed, P. G. (1986). A model for constructing a conceptual framework for education in the clinical specialty. Journal of Nursing Education, 25:7, 295-299.
- Reischman, R., Browning, F. G., & Hinshaw, J. R. (1964). Observations of undergraduate clinical teaching in action. Journal of Medical Evaluation, 39, 147-168.
- Reising, G. N., & Daniels, M. H. (1983). A study of Hogan's model of counselor development and supervision. Journal of Counseling Psychology, 30, 235-244.
- Rew, L. (1988). Intuition in decision-making. Image, 20(3), 150-154.
- Rew, L. (1990). Intuition in critical care nursing practice. Dimensions of Critical Care Nursing, 9(1), 30-37.

- Reynolds, W. (1985). Issues arising from teaching interpersonal skills in psychiatric nurse training. In C. Kagan (Ed.), Nursing education research and developments. London: Croom Helm.
- Reynolds, W., & Cormack, D. (1982). Clinical teaching: An evaluation of a problem-oriented approach to psychiatric nursing education. Journal of Advanced Nursing, *7*, 231-237.
- Reynolds, W., & Cormack, D. F. S. (1985). Clinical teaching of group dynamics: An evaluation of a trial clinical teaching program. Nurse Education Today, *5*(3), 101-108.
- Reynolds, W., & Cormack, D. (1987). Teaching psychiatric nursing: Interpersonal skills. In B. Davis (Ed.), Nursing education: Research and development. London: Croom Helm.
- Richardson, J. T. E., Eyseneck, M. E., & Piper, D. W. (Eds.). (1987). From student learning: Research in educational and cognitive psychology. Stony Stratford, England: SHRE/Open University Press.
- Riesman, D., & Jencks, C. (1968). The academic revolution. New York: Doubleday.
- Riley, W. (1975). The Peer-model Paradigm as a Pre-practicum Approach. (Doctoral Dissertation, University of Missouri-Columbia). Dissertation Abstracts International, *36* 6486A.
- Ripley, D. M. (1986). Invitational teaching behaviours in the associate degree clinical setting. Journal of Nursing Education, *25*, 240-246.
- Rippy, R. M. (1981). The evaluation of teaching in medical schools. New York: Springer.
- Roach, S. M. (1987). The human act of caring. Ottawa: Canadian Hospital Association.
- Roberts, J., & Akinsanya, S. (Eds.). (1976). Schooling in the Cultural Context. New York: David McKay Co.
- Robertson, C. M. (1986). Clinical teaching: An historical perspective. Nurse Education Today, *6*, 97-102.
- Robertson, M. H. B., & Boyle, J. S. (1984). Ethnography: Contributions to nursing research. Journal of Advanced Nursing, *9*, 43-49.
- Robinson, C.A., & Thorne, S.E. (1989). Reciprocal trust in health care relations. Journal of Advanced Nursing, *13*(6), 782-789.

- Rodgers, J. (1985). An examination of research priorities in nurse education. Journal of Advanced Nursing, 10, 233-236.
- Rogers, C. (1959). On Becoming a Person. Boston: Houghton Mifflin.
- Rogers, C. (1965). Client-centered Therapy. Boston: Houghton Mifflin.
- Rolfe, G. (1990). The role of clinical supervision in the education of student psychiatric nurses: A theoretical approach. Nurse Education Today, 10, 193-197.
- Romberg, E. (1984). A factor analysis of students' ratings of clinical teaching. Journal of Dental Education, 48(5), 258-262.
- Rosenthal, T. T. (1987). The clinical teaching experience of two psychiatric nursing instructors. Unpublished doctoral dissertation, Virginia Commonwealth University.
- Rosenthal, T.T. (1989). Using ethnography to study nursing education. Western Journal of Nursing Research, 11(1), 115-127.
- Russell, R. L. (1980). Conceptual models for teaching: A current examination. The Australian Nurses' Journal, 10:2, 38-42.
- Ryan, K. (1986). The induction of new teachers. Phi Delta Kappa Fastback No. 237. Bloomington, IN: Phi Delta Kappa Educational Foundation.
- Sandelowski, M. (1986). The problem of rigor in qualitative research. Advances in Nursing Science, 8(3), 27-37.
- Sarter, B. (1988). (Ed.). Paths to knowledge: Innovative research methods for nursing. New York: NLN.
- Schaefer, K. M., & Lucke, K. T. (1990). Caring - The work of the clinical nurse specialist. Clinical Nurse Specialist, 4(2), 87-92.
- Schauer, A. H., Seymour, W. R., & Geen, R. G. (1985). Effects of observation and evaluation on anxiety in beginning counselors: A social facilitation analysis. Journal of Counselling and Development, 63, 279-285.
- Schein, E. (1978). Career dynamics: Matching individual and organizational needs. Reading, MA: Addison-Wesley.
- Schensul, J. J., Borrers, M. G., & Garcia, R. (1985). Applying ethnography in educational change. Anthropology and Education Quarterly, 16, 149-164.

- Schnabel, G. K. (1989). Interpersonal skills competency of graduating medical students. Unpublished master's thesis, University of Manitoba, Winnipeg, Manitoba.
- Schon, A. (1987). The reflective practitioner. San Francisco: Jossey Bass.
- Schueler, R., Gold, B., & Mitzel, H. (1962). Improvement of student teaching. Washington, DC.: American Association of Colleges for Teacher Education.
- Shuell, T. J. (1990). Phases of meaningful learning. Review of Educational Research, 60(4), 531-547.
- Schwartz, H., & Jacobs, J. (1979). Qualitative sociology: A method to the madness. New York: Free Press.
- Schwebel, M. (1985). The clash of cultures in academics: The university and the education faculty. Journal of Teacher Education, 36(4), 2-7.
- Schweer, J. E. (1972). Creative teaching in clinical nursing, (2nd ed.). St. Louis: C. V. Mosby.
- Schweer, J., & Gebbie, K. (1976). Creative Teaching in Clinical Nursing, 3rd ed. St. Louis: C. V. Mosby Co.
- Scully, R. M. (1974). Clinical teaching of physical therapy students in clinical education. University Microfilms International, #74-18,734.
- Seager, G. B. (1965). The development of a diagnostic instrument of supervision. Unpublished doctoral dissertation, Harvard Graduate School of Education, Cambridge, MA.
- Seldin, P. (1984). Changing practices in faculty evaluation. San Francisco: Jossey-Bass.
- Selleck, T. (1982). Satisfying and anxiety-creating incidents for nursing students. Nursing Times, 78:35, 137-140.
- Seperson, M., & Joyce, B. (1973). Teaching styles of student teachers as related to those of their cooperating teachers. Educational Leadership Research Supplement, 31, 146-151.
- Sergiovani, T. (1976). Toward a theory of clinical supervision. Journal of Research and Development in Education, 9(2), 20-29.
- Shaplin, J. T. (1961). Practice in teaching. Harvard Educational Review, 31(1), 46.

- Sharp, W. H., & Anderson, J. C. (1972). Changes in nursing students' descriptions of the personality traits of the ideal nurse. Measurement and Evaluation in Guidance, 5:2, 339-344.
- Shavelson, R. J., & Stern, P. (1981). Research on teachers' pedagogical thoughts, judgements, decisions and behaviour. Review of Educational Research, 51(4), 455-498.
- Sheehan, T. J. (1970). Medical school climate comparative faculty and student views. Journal of Medical Education, 45, 880-887.
- Sheehan, T. J. (1986). Viewpoint of education and psychology on teaching cost-effective health care behaviours. In C. Friedman and R. Cunningham (Eds.), Proceedings of Conference on Teaching and Learning in Cost-Effective Health Care. Battle Creek, Michigan: W. K. Kellogg Foundation.
- Sheehan, T. J., Candee, D., Willms, J., Donnelly, J. C., & Husted, S. (1985). Structural equation models of moral reasoning and physician performance. Evaluation of Health Professions, 8, 379-400.
- Shibutani, T. (1967). Reference groups as perspectives. In J. Manis and B. Meltzer (Eds.), Symbolic Interaction: A Reader in Social Psychology. Boston: Allyn and Bacon.
- Short, E. C. (1984). Competence: Inquiries into its meaning and acquisition in educational settings. Lanham, MD: University Press of America.
- Short, E. C. (1985). The concept of competence: Its use and misuse in education. Journal of Teacher Education, 26, 2-6.
- Sieber, J. (Ed.) (1982). The ethics of social research. New York: Springer-Verlag.
- Sidentop, D. (1981). The Ohio State University supervision research program summary report. Journal of Teaching in Physical Education, 1, 30-38.
- Simon, R. I., & Dipbo, D. (1986). On critical ethnographic work. Anthropology and Education Quarterly, 17, 195-202.
- Simmons, H. (1989). Ethics of case study in educational research and evaluation. In R. G. Burgess (Ed.), Field methods in the study of education (pp. 114-140). London: Falmer Press.
- Simms, L. M. (1981). The grounded theory approach in nursing research. Nursing Research, 30:6, 357-359.

- Siporin, M. (1975). Introduction to Social Work Practice. New York: Macmillan.
- Sizer, T. R. (1973). Teacher education for the 1980s. In D. M. McCarty & Assoc. (Eds.), New perspectives in teacher education (pp.40-52). San Francisco: Jossey Bass.
- Skeff, K. M., Campbell, M., Stratos, G., Jones, H. W. III, & Cooke, M. (1984). Assessment by attending physicians of a seminar method to improve clinical teaching. Journal of Medical Education, 59, 944-950.
- Skevington, S. (Ed.). (1984). Understanding Nurses. Chichester, New York: John Wiley and Sons Ltd.
- Sleightholm, B. J. (1985). The real world of the nurse educator. The Canadian Nurse, 81, 29-30.
- Slevin, A. P., & Harter, M. (1987). The teaching of caring: A survey report. Nurse Educator, 12(6), 23.
- Smith, D. W. (1968). Perspectives on clinical teaching. New York: Springer.
- Smith, J. P. (1990). Issues in assessment of practical skills in law. PERQ, 12(2), 6-9.
- Smith, R. F. (1982). How to link theory and practice in training courses. Radiography, 48:567, 47-63.
- Smithers, K., & Bircumshaw, D. (1988). The student experience of undergraduate education: The relationship between academic and clinical learning environments. Nurse Education Today, 8, 347-353.
- Smoyak, S. A. (1978). Teaching as coaching. Nursing Outlook, 26, 361-363.
- Sorbal, D. T. (1989). Learning the educator role: A course for medical students. Medical Education, 23, 70-76.
- Spaulding, W. B. (1969). The undergraduate medical curriculum: 1969 model, McMaster University. Canadian Medical Association Journal, 100, 659-664.
- Spencer-Hill, A. (1989). Precepting the clinical nurse specialist student. Clinical Nurse Specialist, 3(2), 71-75.
- Sprinthal, N., & Thies-Sprinthal, L. (1983). The need for theoretical frameworks in educating teachers: A cognitive development perspective. In I. Howey & W. Gardner (Eds.), The education of teachers (pp.74-97). New York: Longman.

- Squire, R. W. (1981). The reliability and validity of rating scales in assessing the clinical progress of psychiatric nursing students. International Journal of Nursing Studies, 18(3), 157-169.
- Stanko, B. (1981). The clinical laboratory experience of senior diploma nursing students: An ethnographic analysis. Unpublished master's thesis, University of Manitoba, Winnipeg.
- Stanton, H. E. (1974). The relationship between teachers' anxiety level and the test anxiety level of their students. Psychology in the Schools, 11, 360-363.
- Stein, P., Allen, L., & Moxley, P. (1982). The nurse as grounded theorist: History, processes and uses. The Review Journal of Philosophy and Social Science, 7:1, 200-209.
- Steinberg, R. J. (1984). Advances in the Psychology of Human Intelligence, Vol. 2. Hillsdale, N.J.: Lawrence Erlbaum Associations.
- Steinmetz, A. (1985). The discrepancy evaluation model. In G. Madaus, M. S. Scriven & D. L. Stufflebeam (Eds.), Evaluation models: Viewpoints on educational and human services evaluation (pp. 79-88). Lancaster, Eng.: Kluwer-Nijhoff Pub.
- Stemmler, E. J. (1987). Promoting improved evaluation of students during clinical education: A complex management task. Journal of Medical Education, 62, 75-81.
- Stemmler, E. J. (1988). Medical education: Is it? Journal of Medical Education, 63, 81-87.
- Stenack, R. J., & Dye, H. A. (1983). Practicum supervision roles: Effects of supervisee statements. Counselor Education and Supervision, 23, 157-168.
- Stern, P. N. (1980). Grounded theory methodology: Its uses and processes. Image, 12:1, 20-23.
- Stillman, P. L., Ruggill, J. S., Rutala, P. J., & Sabers, D. L. (1979). A comparison of physicians and nurse practitioners as instructors in a physical diagnosis course. Journal of Medical Education, 54, 733-734.
- Stillman, P. L., Ruggill, J. S., Rutala, P. J., & Sabers, D. L. (1980). Patient instructors as teachers and evaluators. Journal of Medical Education, 55, 186-193.
- Stoddart, K. (1986). The presentation of everyday life. Urban Life, 15(1), 193-221.

- Stoltenberg, C. D., & Delworth, U. (1988). Developmental models of supervision: Is it development - response to Holloway. Professional Psychology, Research and Practice, 19, 134-137.
- Stone, G. L. (1980). Effects of experience on supervisor planning. Journal of Counseling Psychology, 27, 84-88.
- Stout, C. (1982). Why cooperating teachers accept students. Journal of Teacher Education, 33, 22-24.
- Strauss, A. (1978). Negotiations: Varieties, contexts, processes and social order. San Francisco: Jossey Bass.
- Strauss, A. L. (1987). Qualitative analysis for social scientists. San Francisco: University of California Press/Tremont Research Institute
- Stritter, F. T. (1983). Faculty evaluation and development. In C. H. McGuire, R. P. Foley, A. Gorr & R. W. Richards (Eds.), Handbook of Health Professions Education. San Francisco: Jossey Bass.
- Stritter, F. T., & Baker, R. M. (1982). Resident preference for clinical teaching of ambulatory care. Journal of Medical Education, 57(1), 33-41.
- Stritter, F. T., Baker, R. M., & McCaghie, W. C. (1983). Congruence between residents' and clinical instructors' perceptions of teaching in outpatient care centers. Journal of Medical Education, 17, 385-389.
- Stritter, F. T., & Flair, M. D. (1980). Effective clinical teaching. Bethesda, MA: NIH/National Library of Medicine.
- Stritter, F. T., Hain, J. H., & Grimes, D. A. (1975a). Clinical teaching re-examined. Journal of Medical Education, 50, 879-882.
- Stritter, F. T., & Hain, J. D. (1975b). Clinical teaching re-examined. Journal of Medical Education, 52, 870-872.
- Stritter, F. T., & Hain, J. D. (1977). A workshop in clinical teaching. Journal of Medical Education, 52, 155-157.
- Stroble, E., & Cooper, J. M. (1988). Mentor teachers: Coaches or referees? Theory Into Practice, XXVII(3), 231-236.

- Stuart, G. W., & Sundeen, S. J. (1987). Principles and practice of psychiatric nursing (3rd ed.). St. Louis: C.V. Mosby.
- Stuebbe, B. (1980). Student and faculty perspectives on the role of the nursing instructor. Journal of Nursing Education, 19, 4-19.
- Swanson, A. G. (1985). The 'presidency syndrome': An incipient epidemic of educational disruption. Journal of Medical Education, 60, 201-202.
- Swanson, D. B. (1990). Issues in assessment of practical skills in medicine. PERQ, 12(2), 3-6.
- Swanson, J. M. (1986). The formal qualitative interview for grounded theory. In W. C. Chenitz & J. M. Swanson (Eds.), From practice to grounded theory (pp. 66-78). Menlo Park, CA: Addison-Wesley.
- Swanson, J. M., & Chenitz, W. C. (1982). Why qualitative research in nursing? Nursing Outlook, 30:4, 241-245.
- Szekly, E. (1981). A philosophy of clinical education. The Australian Nurse's Journal, 11:2, 51-52.
- Tabachnick, B. R. (1980). Intern-teacher roles: Illusion, disillusion and reality. Journal of Teacher Education, 162, 122-137.
- Tabachnick, B. R. (1982). Teacher education as a set of dynamic social events. In B. R. Tabachnick, T. Popkewitz & B. Bszekely (Eds.), Studying teaching and learning: Trends in Soviet and American research. New York: Praeger Press.
- Tabachnick, B. R., Popkewitz, T., & Zeichner, K. (1980). Teacher education and the professional perspectives of student teachers. Interchange, 10, 12-29.
- Tabachnick, B. R., & Zeichner, K. (1984). The impact of the student teaching experience on the development of teacher perspectives. Journal of Teacher Education, 35(6), 28-36.
- Tanner, C. A. (1990). Reflections on the curriculum revolution. Journal of Nursing Education, 29(7), 295-304.
- Tardif, C. (1984). On becoming a teacher: The student teacher's perspective. Unpublished doctoral dissertation, University of Alberta, Edmonton, Alberta.

- Tardif, C. (1985). On becoming a teacher: The student teacher's perspective. The Alberta Journal of Educational Research, 31(2), 139-148.
- Thies-Sprinthall, L. (1980). Supervision: An educative or mis-educative process? Journal of Teacher Education, 31(4), 17-20.
- Thomas-Edding, D. (1985). Educating the professional educator. Physiotherapy Canada, 37(5), 295-300.
- Thompson, J. B. (1983). Selected principles of teaching and learning applied to nurse-midwifery clinical education. Journal of Nurse-Midwifery, 28:1, 21-28.
- Thompson, M. L. (1983). Comparison of associate degree and baccalaureate student and faculty perceptions of characteristics of effective clinical teachers. (Doctoral dissertation, University of Kansas). Dissertation Abstracts International, 44, 3361A.
- Tiberius, R. G., Sackin, H. D., Slingerland, J. M., Jubas, K., Bell, M., & Matlow, A. (1989). The influence of student evaluative feedback on the improvement of clinical teaching. Journal of Higher Education, 60(6), 665-680.
- Tier, L. L., & Roberts, B. D. (1980). Curriculum design for associate degree nursing programs: Teaching and evaluation in the classroom, Pub. #23-1826. New York: NLN.
- Tierney, L. M. (1987). The clinical education of medical students: A perspective from internal medicine. Journal of Medical Education, 62, 59-65.
- Tikunoff, W. J., et al. (1975). 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.
- Tobin, K. (1990). Changing metaphors and beliefs: A master switch for teaching? Theory Into Practice, XXIX(2), 123-127.
- Toffler, A. (1985). The Adaptive Corporation. New York: Bantam.
- Tollefson, N. & Chen, J. S. (1988). Consequences of teachers' attributions for student failure. Teaching and Teacher Education, 4(3), 259-269.
- Tonesk, X. (1979). The house officer as a teacher: What schools expect and measure. Journal of Medical Education, 54, 614-616.
- Tonesk, X. (1983a). The evaluation of clerks: Perceptions of clinical faculty. Association of American Medical Colleges, Washington, D.C.

- Tonesk, X. (1983b). Clinical judgement of faculties in the evaluation of clerks. Journal of Medical Education, 58, 213-214.
- Towle, C. (1954). The learner in education for the professions. Chicago: University of Chicago.
- Trimonti, L. P., & Biddle, W. B. (1982). Teaching behaviours of residents and faculty members. Journal of Medical Education, 57, 854-859.
- Turney, C. (1982). The practicum in teacher education. Sydney: University Press.
- Tyler, J. D., & Weaver, S. H. (1981). Evaluating the clinical supervisee: A survey of practices in graduate training programs. Professional Psychology, 12, 424-437.
- Usher, R. S. (1985). Beyond the anecdotal: Adult learning and the use of experience. Studies in the Education of Adults, 17, 59-74.
- Vance, C. (1982). The mentor connection. Journal of Nursing Administration, 12(4), 7-13.
- Van Manen, M. (1975). An exploration of alternative research orientations in social education. Theory and Research in Social Education, 3(1), 1-28.
- Van Manen, M. (1978). Objective inquiry into structures of objectivity, The Journal of Curriculum Theorizing, 1(1), 4464.
- Veiga, J. F., & Yanouzas, J. N. (1984). The dynamics of organizational theory. St. Paul, Minn.: West Publishing Co.
- Verran, L. (1983). Teaching on the ward. Nursing Mirror, 11, 29-30.
- Wagner, D. (1980). Nursing administrators' assessment of nursing education. Nursing Outlook, 28, 557-561.
- Waldfoegel, D. (1982). Education and practice: Partners in the education and training of clinical social workers. In L. Bandler (Ed.), Education for clinical social work practice: Continuity and change (pp. 113-123). New York: Pergamon Press.
- Walsh, K. K., Vandenbosch, T. M., & Boehm, S. (1989). Modelling and role-modelling: Integrating nursing theory into practice. Journal of Advanced Nursing, 14, 775-781.
- Wang, A. M., & Blumberg, P. (1983). A study on interaction techniques of nursing faculty in the clinical area. Journal of Nursing Education, 22:4, 144-151.

- Watson, I. (1982). Socialization of nursing students in a professional nursing education programme. Nursing Papers, 13, 19-24.
- Watzlaf, V. J. M. (1986). Clinical education from the student's perspective. Journal of American Medical Record Association, 27, 33-36.
- Webb, E. J., Campbell, L. D., Schwartz, L. D., & Sechest, L. (1966). Unobtrusive measures in nonreactive research in the social sciences. Chicago: Rand McNally
- Weiner, B. (1980). Human motivation. New York: Holt, Rinehart & Winston.
- Weiner, B. (1986). An attributional theory of motivation and emotion. New York: Springer-Wesley.
- Weiner, B. (1990). History of motivation research in education. Journal of Educational Psychology, 82(4), 616-622.
- Weiner, R. S. P (1989). Models of training. Nurse Education Today, 9, 53-55.
- Weinholtz, L., Friedman, C. P., & Watson, E. R. (1985). A developmental model for teaching in experiential learning settings. Professions Education Research Notes, 6, 3-6.
- Wernieb, L., McGlynn, T. J., Johnson, T., & Munzenrider, R. F. (1981). Faculty supervision of residents in an internal medicine practice. Journal of Medical Education, 56, 1011-1018.
- Westburg, J., Lefever, D., & Jason, H. (1980). Clinical teaching in physician's assistant training programs. Journal of Medical Education, 55(3), 173-180.
- Whelan, E. (1982). Increasing clinical proficiency: A summer clinical course. Nurse Educator, 7(5), 28-31.
- Whitman, N., & Gasper, P. (1989). Back to the bedside: Teaching on nursing rounds. Journal of Gerontological Nursing, 15(8), 6-9.
- Wilcox, K. (1980). The ethnography of schooling: Implications for educational policy-making. Stanford University, ED 199 809.
- Wiley, M. O., & Ray, P. B. (1986). Counseling supervision by developmental level. Journal of Counseling Psychology, 33, 439-445.

- Wilkerson, L., Lesky, L., & Medio, F. J. (1986). The resident as teacher during work rounds. Journal of Medical Education, 61, 823-829.
- Wilson, S. (1977). The use of ethnographic techniques in educational research. Review of Educational Research, 47:1, 245-265.
- Wilson, S. M. (1990). Innovations in the assessment of teachers' practical knowledge. PERQ, 12(2), 9-13.
- Winder, C. M. (1980). Nursing faculty - catch 22. In S. K. Mirin (Ed.), Teaching Tomorrow's Nurse: A Nurse Educator Reader. Massachusetts: Nursing Resources Ltd.
- Windsor, A. (1987). Nursing students' perceptions of clinical experience. Journal of Nursing Education, 26:4, 150-154.
- Wingard, J., & Williamson, J. (1973). Grades as predictors of physician's career performance: An evaluative literature review. Journal of Medical Education, 48, 311-322.
- Wiseman, J. P. (1987). The development of generic concepts in qualitative research through cumulative application. Qualitative Sociology, 10(4), 318-338.
- Wodarski, J. S. (1979). Critical issues in social work education. Journal of Education for Social Work, 15, 5-12.
- Wolcott, H. (1975). Criteria for an ethnographic approach to research in schools. Human Organization, 34:2, 111-121.
- Wolcott, H. F. (1987a). On ethnographic intent. In G. Spindler & L. Spindler (Eds.), Interpretative ethnography of education at home and abroad, pp. 37-57. Hillsdale, NJ: Lawrence Erlbaum Assoc.
- Wolcott, H. F. (1987b). The elementary school principal: Notes from a field study. In G. D. Spindler (Ed.), Education and cultural process, pp. 245-273. Prospect Heights, IL: Waveland Press.
- Wolf, Z. R. (1986). The caring concept and nurse identified caring behaviours. Topics in Clinical Nursing, 8(2), 77-83.
- Wolf, F. M., & Turner, E. V. (1989). Congruence between students' and instructors' perceptions of clinical teaching in paediatrics. Medical Education, 23, 161-167.

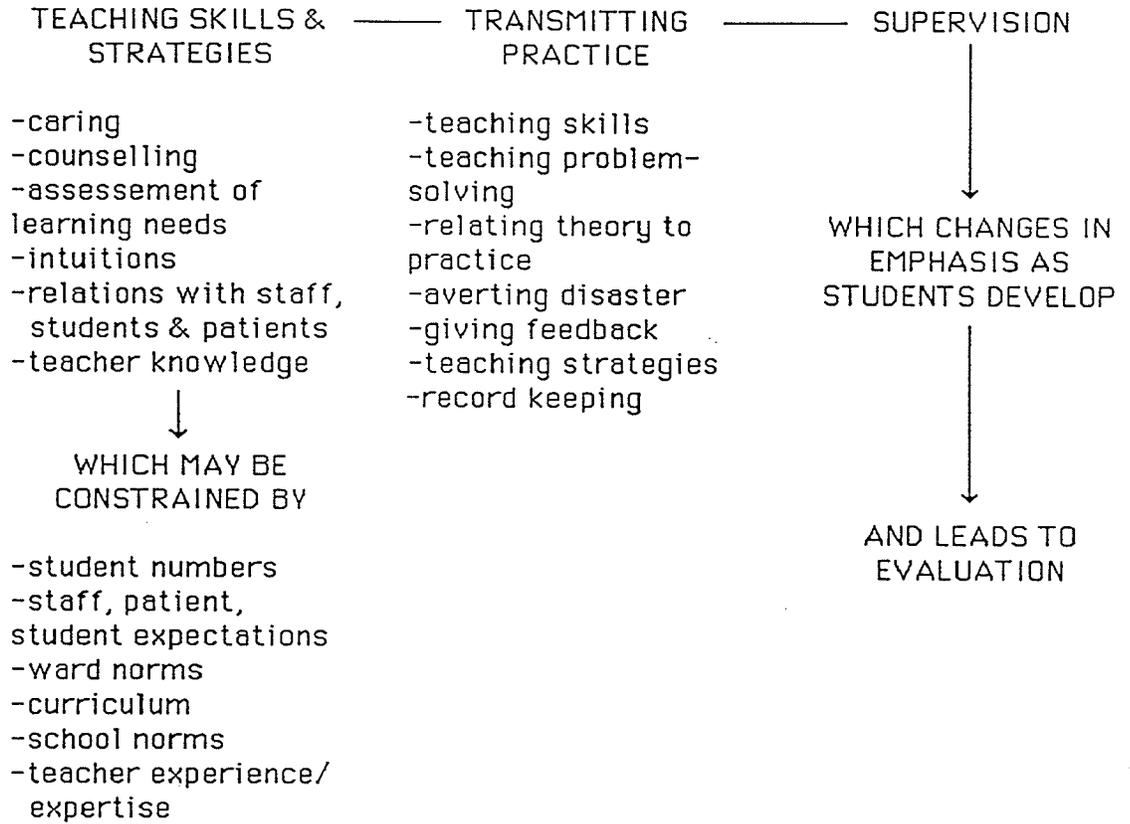
- Wolf, T. M., Balson, P. M., Faucett, J. M., & Randall, H. M. (1989). A retrospective study of attitude change during medical education. Medical Education, 23, 19-23.
- Wong, J. (1987). Towards effective clinical teaching in nursing. Journal of Advanced Nursing, 12, 505-513.
- Wong, S., & Wong, J. (1980). The effectiveness of clinical teaching: A model for self-evaluation. Journal of Advanced Nursing, 5, 531-537.
- Wood, V. (1986). Clinical evaluation of student nurses: Syllabus needs for nursing instructors. Nurse Education Today, 6, 208-214.
- Wood, V. (1987). The nursing instructor and the teaching climate. Nurse Education Today, 7, 228-234.
- Woods, N.F., & Catanzaro, M. (1988). Nursing research: Theory and practice. St. Louis: C.V. Mosby.
- Woodward, C. A., & Ferrier, B. M. (1982). Perspective of graduates 2 or 5 years after graduation from a 3-year medical school. Journal of Medical Education, 57, 294-303.
- Woolfolk, A. E., & Hoy, W. K. (1990). Prospective teachers' sense of efficacy and beliefs about control. Journal of Educational Psychology, 82(1), 81-91.
- Worthington, E. L. (1984). An empirical investigation of supervision of counselors as they gain experience. Journal of Counseling Psychology, 31, 63-75.
- Worthington, E. L. (1987). Changes in supervision as counselors and supervisors gain experience: A review. Professional Psychology, Research and Practice, 18, 189-208.
- Worthington, E. L., & Roehlke, H. J. (1979). Effective supervision as perceived by beginning counselors-in-training. Journal of Counselling Psychology, 26, 64-73.
- Wright, B., & Tuska, S. (1968). From dream to life in the psychology of becoming a teacher. School Review, 76, 253-293.
- Wright, H. J., Stanley, M., & Webster, J. (1983). Assessment of cognitive abilities in clinical medicine. Medical Education, 17, 31-38.
- Yamada, J. K., & Montague, E. C. (1984). Clinical education model for staff training in orthopedic manual therapy. Physiotherapy, 64(7), 1084-1087.

- Yarcheski, A., & Mahon, N. E. (1986). The unification model in nursing: Risk receptivity profiles among deans, tenured and non-tenured faculty in the United States. Western Journal of Nursing Research, 8, 63-81.
- Yee, Z. (1969). Do cooperating teachers influence the attitudes of student teachers? Journal of Educational Psychology, 60, 237-332.
- Yonke, A. M. (1979). The art and science of clinical teaching. Medical Education, 13, 86-90.
- Yulo, R. J. (1967). An exploration of the Flanders system of interaction analysis as a supervisory device with science interns. Unpublished doctoral dissertation, Harvard Graduate School of Education, Cambridge, MA.
- Yunker, R. (1979). Ethnomethodological approaches to research and evaluation in the professions. ERIC Reproduction Service No. ED 173 377.
- Yunker, R. (1983). The socialization of medical educators. Journal of Medical Education, 58(10), 822-24.
- Zahorik, J. A. (1988). The observing-conferencing role of university supervisors. Journal of Teacher Education, 39, 9-16.
- Zeichner, K. M. (1980). Myths and realities: Field based experiences in preservice teacher education. Journal of Teacher Education, 31, 45-55.
- Zeichner, K. M. (1983). Alternative paradigms of teacher education. Journal of Teacher Education, 34, 3-9.
- Zeichner, K. M. (1988). The structure and goals of a student teaching program and the character and quality of supervisory discourse. Teaching and Teacher Education, 4(1), 349-62.
- Zeichner, K. M. (1989). Preparing teachers for democratic schools. Action in Teacher Education, 11(1), 5-10.
- Zeichner, K. M. (1990). Traditions of reform in US teacher education. Journal of Teacher Education, 41(2), 3-20.
- Zigarmi, D., & Zigarmi, P. (1980). The psychological stressors of ethnographic research. Education & Urban Society, 12(3), 291-322.

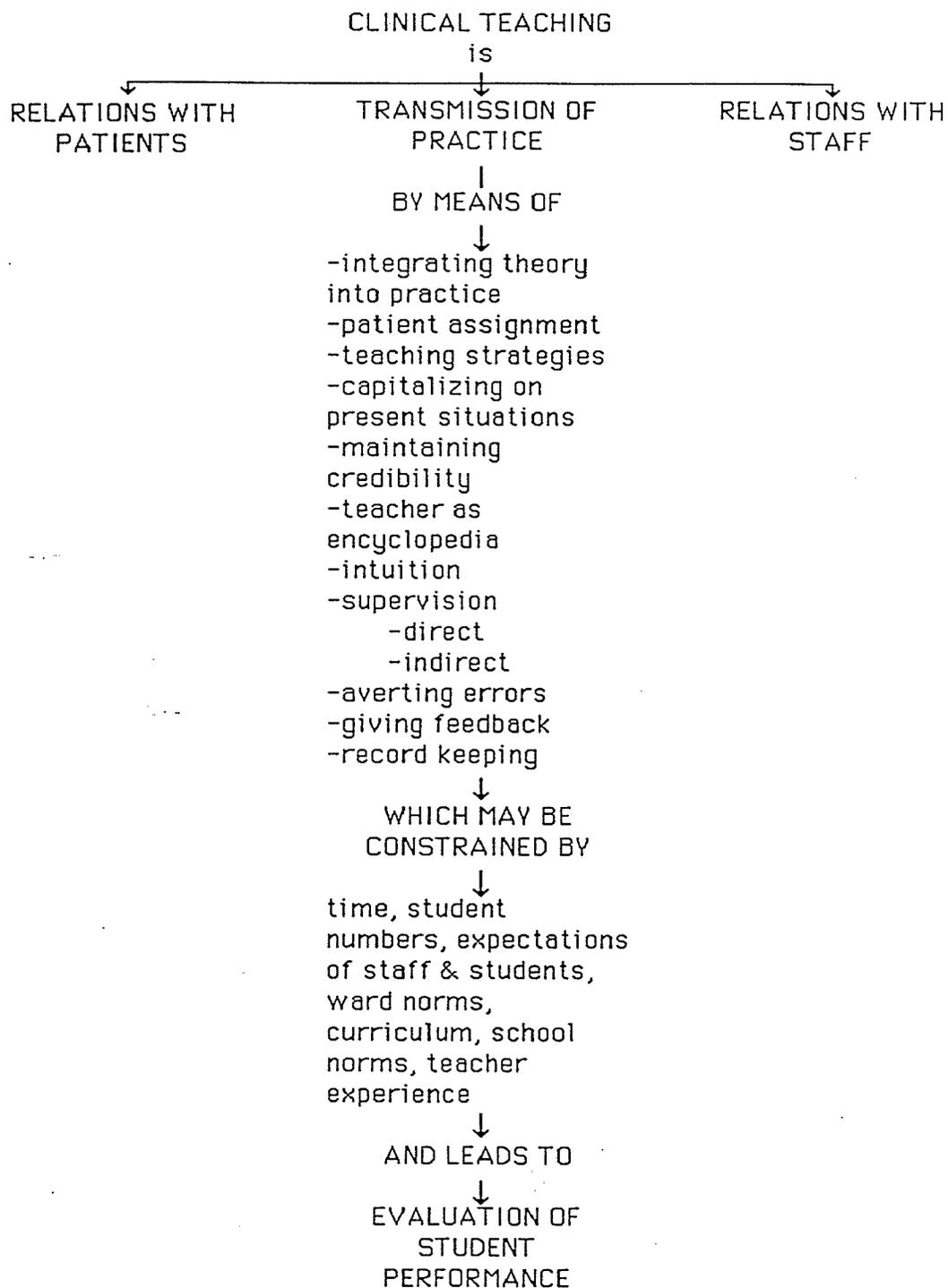
- Zimmerman, L. (1986). Effective clinical behaviours of faculty: A review of the literature. Nurse Educator, 11, 44-49.
- Zimmerman, L., & Waltman, N. (1986). Effective clinical behavior of faculty: A review of the literature. Nurse Educator, 11, 31-34.
- Zimmerman, L., & Westfall, J. (1988). The development and validation of a scale measuring effective clinical teaching behaviours. Journal of Nursing Education, 27, 274-277.
- Zimpher, N. L., de Voss, G. C., & Nott, D. L. (1980). A closer look at university student teacher supervision. Journal of Teacher Education, 31(4), 11-15.
- Zimpher, N. L., & Rieger, S. R. (1988). Mentoring teachers: What are the issues? Theory Into Practice, XXVII(3), 175-182.

**APPENDIX 1: Teacher #1, Concept Map**

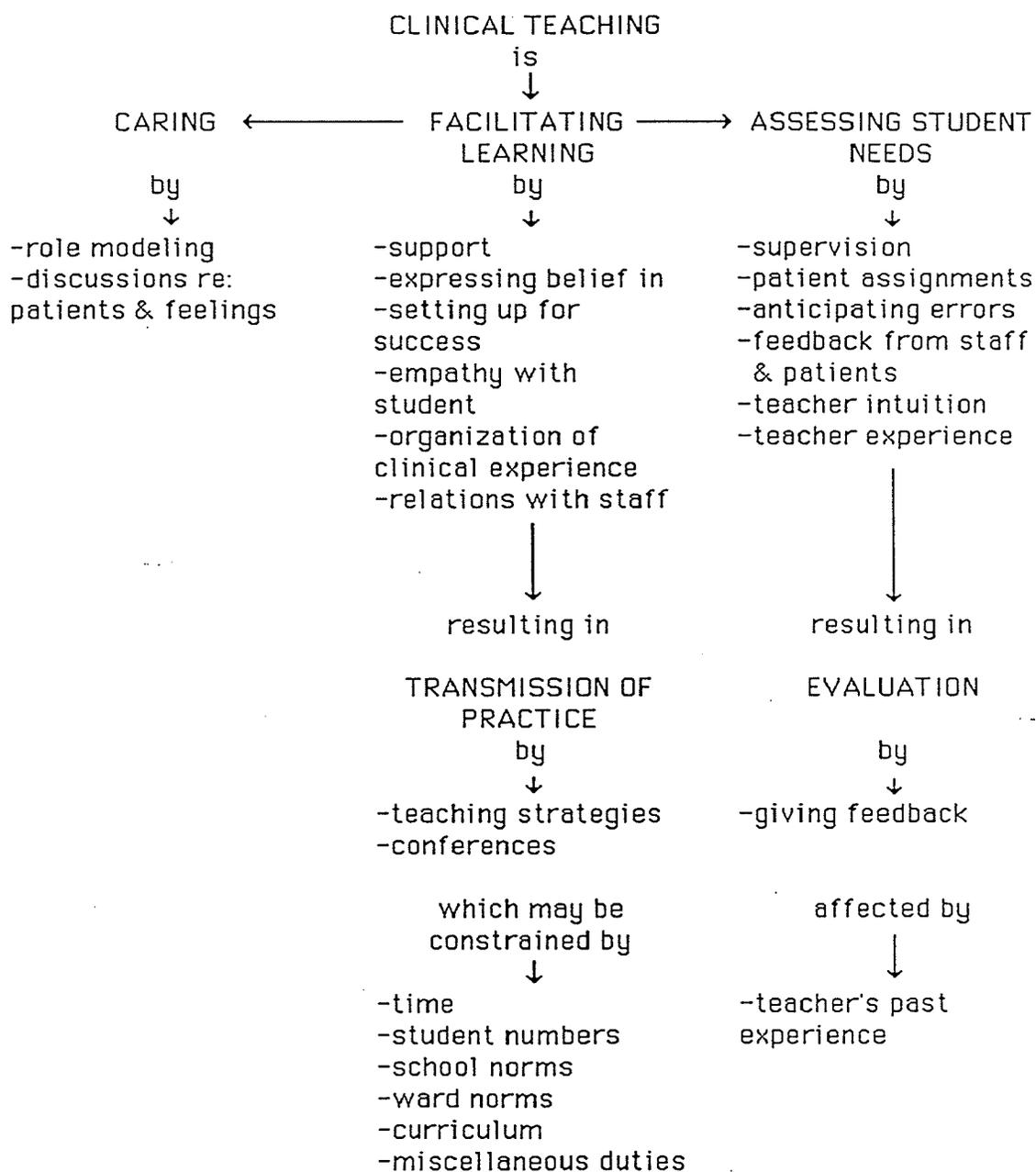
CLINICAL TEACHING  
is  
HELPING STUDENTS TO FUNCTION  
by



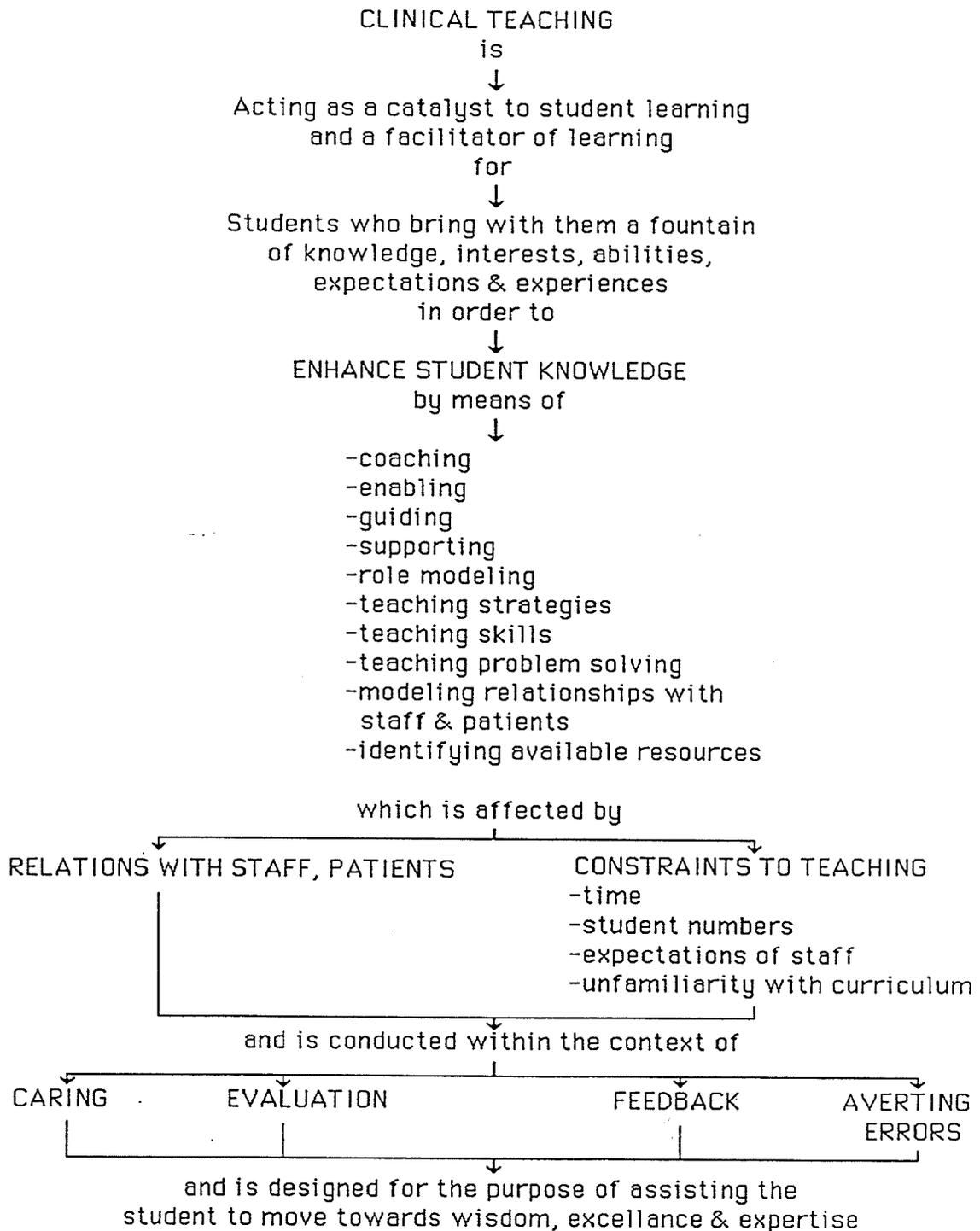
## APPENDIX 2: Teacher #2, Concept Map



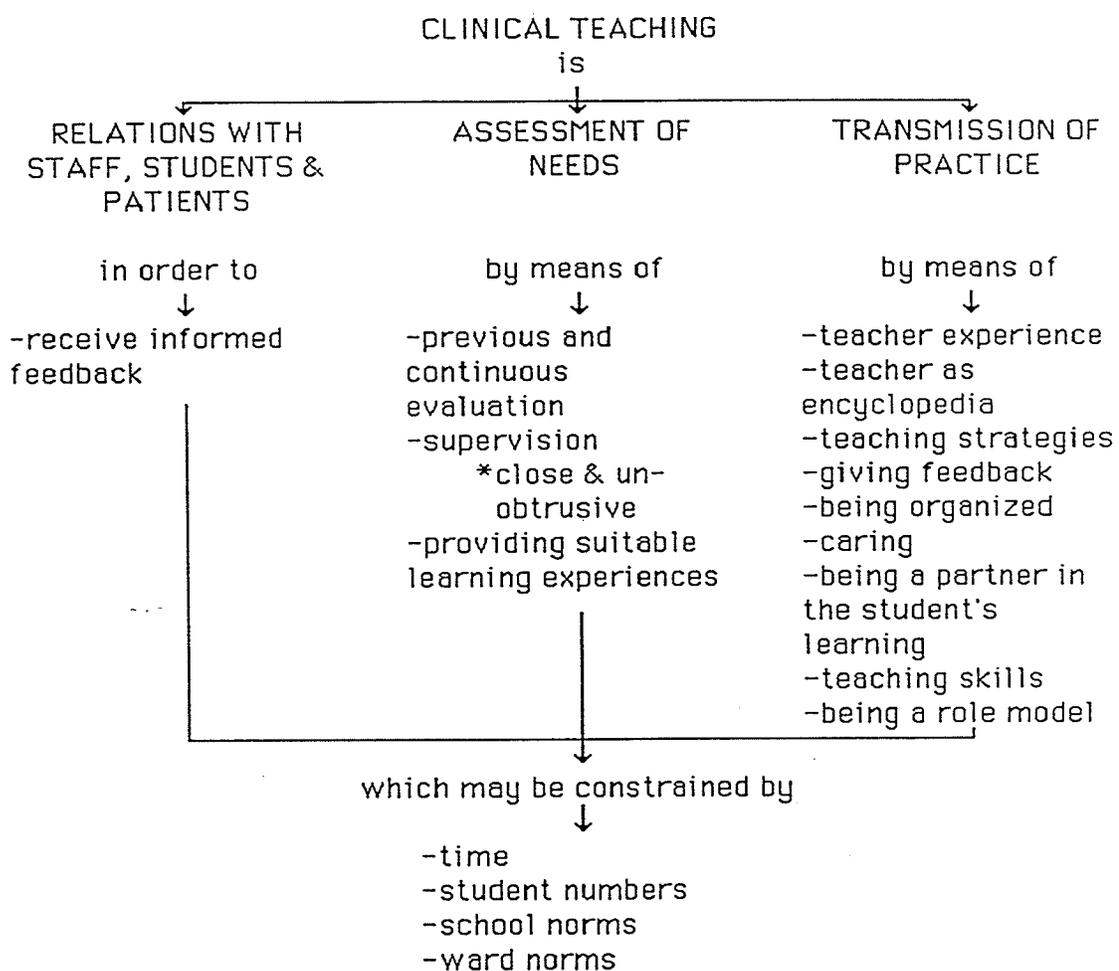
### APPENDIX 3: Teacher #3, Concept Map



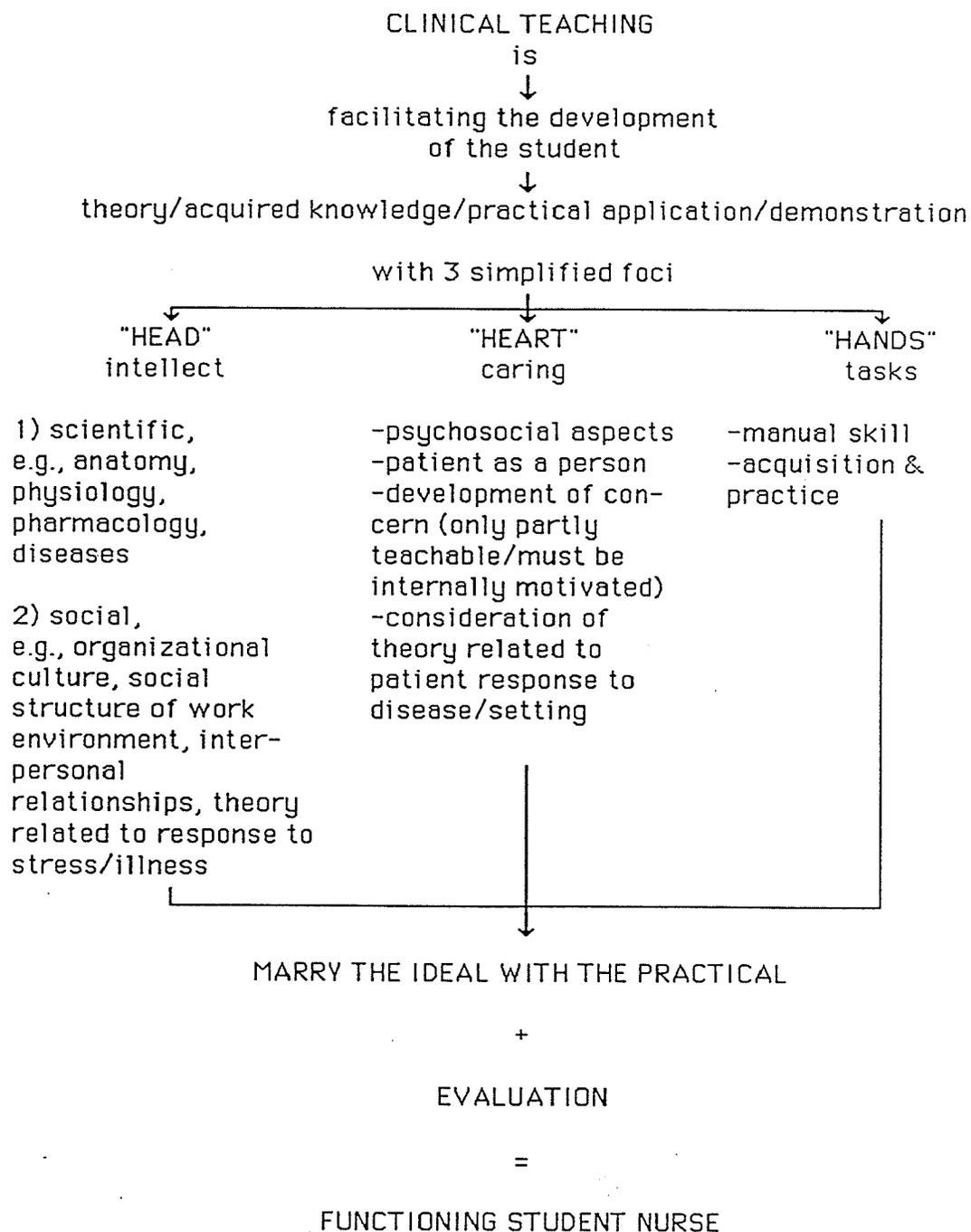
### APPENDIX 4: Teacher #4, Concept Map



### APPENDIX 5: Teacher #5, Concept Map



## APPENDIX 6: Teacher #6, Concept Map



Research Questions	Dimension of Perspectives	Dimension of Symbolic Interaction	Major Data Gathering Techniques	Data Analysis
1. Elements of perspective	Ideas about clinical teaching	Definition of setting	Interviews Observations	Listing incidents Generating tentative propositions
2. Assumptions about clinical teaching and students	Ideas, Actions, Judgements	Process by which definitions develop and change Relationship between perspective and behavior	Interviews Teacher-student observations Observations of clinical teaching	Listing incidents Confirming or disproving propositions Developing categories Model building
3. Contextual variations which influence the perspective	Ideas, Actions, Judgements	Process by which definitions develop and change Relationship between perspective and behavior	Teacher-student, teacher-patient and teacher-staff observations Interviews	Listing incidents Confirming or disproving propositions Developing categories Model building
4&5. Synthesizing perspective and practice	Judgements, Actions	Process by which definitions develop and change Relationship between perspective and behavior	Interviews Observations (teacher, teacher-student, teacher-staff, teacher-patient) Review of student evaluative records written by teacher	Listing incidents Developing categories Model building

APPENDIX 7: Data Collected

## APPENDIX 8: Reactivity Analysis Tool

\*Note: Although the analysis is based on an actual incident, many of the details have been fabricated for the purpose of illustrating the use of the tool.

**Data Item:** X. (the teacher) asked A. and B. (students) if they

would "like practice making an occupied bed". She told them that a nurse had "a bed to do" and that she had volunteered the students. A. and B. agreed and X. said, "We don't know this patient so I'll come in a minute and see how you're doing." In six minutes, X. entered the patient's room and observed the students from the foot of the bed. "OK. Let's do an environment check here. A., what is wrong here?" A. looked around the bed and said, "I don't know." X: "The bed. The bed. Should it be that low?" A. and B. both said, "no" and A. raised the bed. X: "Where's the linen? Do you have it ready?" B. pointed to the windowsill and X. looked at the pile of linen. "What about a drawsheet? Do you have one? No? Well, you'd better get one then. We'll wait until you get it. Did you forget anything else?"

The teacher continued to direct the students through the procedure by means of questions and direct advice. The students did as they were directed until it was time to turn the patient on his side. X. said, "Let me help. I'll help you" and began to turn the patient. The patient, an elderly man, had been silent until this point. He began to scream loudly, "Oh, oh. My chest. You're killing me. God damn bitch. God damn nurses. Leave me alone. Oh, it hurts. Get out of here." He then turned to face me directly, "You're just lying here peaceful and they come up and just about murder you. You shouldn't have

to put up with it.

## 1. Emotional Valence Between Principals

### Participants

- a) Patient: The students and the teacher had not talked to him other than to tell him what to do (e.g., "lift your leg"). X. told me that he has been in "the last room for a long time and the staff feel they're babysitting him." A nurse had commented to X. that he liked "Lots of attention". Had he responded to X. because he wished to be recognized and paid attention to by the students and teacher? Had he perceived me as someone who would or could help him? Because I had not participated in making the bed, did he see me as the one who would be sympathetic to his concerns? Would he have experienced so much pain and expressed it as loudly if he had not had me as his audience?
- b) Students: The students appeared flustered (i.e., they stammered, their cheeks became flushed) the more questions they were asked. Were they embarrassed by being questioned and found lacking in front of me and the patient? Did they require all the assistance they received from X. or did their embarrassment/other emotions cause them to passively

submit to her directives?

- c) Teacher: X. had said she was hungry and eager to be off the ward when the opportunity to make a bed arose. Did this cause her to be less patient with students and to direct them more than was her usual style? Did she feel uncomfortable not knowing the patient and consequently believe that she should offer the students more direction? Did her preconception of the patient needing "babysitting" affect the way in which she spoke to the students and ignored him?
- d) Researcher: I felt perplexed about X.'s behavior. It is untypical of her to ignore patients and to "take over" student situations. Is it possible that the patient was aware of my concern for him and responded to my nonverbal cues by telling me his feelings about the situations? I felt awkward not responding to the patient but felt that to comment may have caused X. to be defensive.

## 2. Distribution of Power Among Principals

- a) Patient: Perhaps the most powerless in this situation. He had no opportunity to make decisions about what was to be done to him. Did his powerlessness affect his reaction to the

teacher? Did he perceive her as the one with the most authority in regard to his care and, therefore, lash out at her for assuming that authority? Did he think that my dress (i.e., wearing a lab coat) was associated with an authority figure who could correct the situation?

- b) Students: I have observed these students on other occasions and B. is generally assertive with X. She has rarely needed direction from X. X. calls her "a very strong student". What is it about today's situation which caused her to be so unprepared for the procedure and so submissive in her interactions with X? Did she feel that because X. knew the patient, and she did not, that X. had the upper hand in this situation? Was the procedure unfamiliar to her and did her subsequent lack of confidence result in her submissiveness? Because she failed to answer X.'s first few questions correctly, did she lose the confidence to answer the questions which followed?

- c) Teacher: This incident is so atypical of X.'s usual teaching style. Why did she assume the dominant position in this situation? Did she feel she had an obligation to the nurse that the students carry out the procedure quickly and correctly? Did

she sense that the students were unfamiliar with the procedure and that they needed her direction?

- d) Researcher: I felt powerless to help the patient. He appeared to be genuinely in pain and it was sad that he had been pretty much disregarded throughout the procedure. The patient appeared to be a victim of the teaching-learning process. I was unsure of how I could phrase it to the teacher to determine her perceptions of the situations without revealing my personal attitudes. How did this affect my further interactions with X?

3. Importance of the Interaction to the Identity of the Principals

- a) Patient: According to X., he was left alone in the room for most of the day by the staff and was largely ignored, even though the staff recognized his need for attention. He may have perceived this interaction as an opportunity to receive the attention he desired from the staff.
- b) Students: This was their first actual experience making an occupied bed. They both had commented to X. that they were not totally confident about the procedure but would do their best. Does this explain why B. reacted so differently in this situation than in others? Does the first time performing a

skill affect the students' response to the teacher and how they behave in her presence?

- c) Teacher: X. asked the nurse if the students could make the bed because she said that she believed that her role as a clinical teacher is to avail the students of each opportunity for skill practice. She expressed ambivalence about taking the time to supervise the students because she was anxious to leave the ward. Having told me about her philosophy, did she feel she had to prove that she would implement it?
- d) Researcher: I was quite bored by the time this incident arose. X. had supervised bed-making most of the morning. I realize that initially I thought this was just going to be another boring bed-making. That explains why my note-taking is so sparse at the beginning of the incident. I can now recall an entire conversation between X. and the students before they entered the patient's room that was not recorded.

#### 4. Goal of the Interaction for Each Principal

- a) Patient: What was his agenda for the interaction? It seems as if he may have yelled at X. because she and the students had not recognized his agenda; i.e., to be acknowledged as a person

and not just someone the students performed a procedure on.

- b) Students: They seemed to concentrate on receiving the teacher's directions and preparing themselves for the next question she would ask. Did they see the patient as an active participant in this procedure? Were they aware of him as an individual with human needs?
- c) Teacher: She had admitted she was in a hurry to leave the ward. Was her directive approach the result of her desire to speed things up? She asked the students several theory-based questions throughout the procedure. Later, I discovered that the students had an exam the next week which would include some of this content. A. has not done well in his previous nursing exams. Did X. feel that this situation was an opportunity for her to review theory content and prepare the students for the exam?
- d) Researcher: I focused on what I perceived as the ignoring of the patient and the patient's response. There is little specific details provided about the nature of questions asked by X. or the students' responses. Have I concentrated on the extraordinary because of my familiarity with the situation

of the teacher supervising students making beds? In the future, I should identify when I am bored and alter my tracking of the teacher to prevent my missing or overlooking details. I did not really have to observe X. supervising 13 bedmakings that morning.

5. Effect of Applicable Normative or Cultural Criteria

- a) Patient: Nurses are supposed to care about patients. They are not supposed to hurt patients. He referred to the teacher and students as "nurses". Did he feel that they had contravened the principles of the nursing profession? Did he think I was not a nurse because I did not wear a nurse's uniform? Is this why he spoke to me about his concerns?
- b) Students: When a teacher tells you to do something, a student generally does it. X.'s interaction with the students was dominant and directive. The students were submissive and followed the directions without comment. Do students arrive at a point during their basic education when they feel they can respond to a teacher's directions in a more assertive or questioning manner? What factors are involved in a student's ability to disagree with or contravene a

teacher's directions?

- c) Teacher: She had assumed the territory of the staff nurse in requesting to make the bed of a patient not assigned to the students. Did this affect the way in which she determined her approach with the students? With the patient?
- d) Researcher: I recognize now that my feelings toward the patient had been influenced by things X. and the staff had said about him earlier that day. I knew he was elderly, frail, without family or visitors and largely neglected by the nursing staff on the ward. Did I enter the room already feeling sympathy for this patient? How did this affect my response to him; to X. and the students?

APPENDIX 9: Ethical Committee Review

The University of Manitoba

SCHOOL OF NURSING

ETHICAL REVIEW COMMITTEE

Proposal Number 89/2

Proposal Title: "The clinical teachers perspective: An Ethnographic analysis of the Perspectives of Four Nursing Educators".

Name and Title of

Researcher(s): Barbara L. Paterson, R.N., B.N., M.Ed.

Interdisciplinary Ph.D. student.

Date of Review: February 6, 1989.

Decision of Committee: Approved:  Not Approved:

Approved upon receipt of the following changes: \_\_\_\_\_

With the changes submitted on February 23, 1989.

Date: March, 10, 1989.

Theresa George, R.N., Ph.D. Chairperson

Associate Professor

Position

NOTE:

Any significant changes in the proposal should be reported to the Chairperson for the Ethical Review Committee's consideration, in advance of implementation of such changes.

## APPENDIX 10: Description Of Study For Teachers

The \_\_\_\_\_ School of Nursing has granted approval for this study to increase our understanding of what actually occurs when a teacher teaches students in a hospital setting. The study will occur over a period of one school year and will involve observations of you by the researcher as you teach on \_\_\_\_\_ (name of clinical area) and interact with students, patients, staff and visitors. The researcher may jot down a few notes during these observations. She may also request to interview you at times. These interviews may be tape-recorded. She may also request that she review your written records/observations of the students' clinical performance.

You are assured of complete confidentiality. Your name will not be used on written notes or in the final report of the study. Instead, you will be assigned a code number (e.g., 201) throughout the study. The notes written by the researcher will be stored in computer files to which only the researcher has access. Tapes of interviews conducted by the researcher will be stored in a locked compartment to which only the researcher has access. The notes will be destroyed and the tapes will be erased at the completion of the study. They will not be shared with any other participant in the study.

You are free not to take part in the study. If you decide to participate in the study, you will be asked to sign a Consent Form. Your signature on such a consent indicates your willingness to participate in the study.

There may be no direct benefits to the participants in this study but there may be changes in nursing education following the completion of this study. There will be no health risks to you resulting from your participation in the research.

You are free to withdraw from this study at any time even after giving your written consent. Your employment will in no way be affected by your refusal to participate in this study or withdrawal from this study. You are also free to refuse to participate in specific aspects of the study.

You will be given a copy of this description of the study and the Consent Form. Please feel free to contact the researcher, Barbara Paterson, at any time (phone 668-2550) if you have any questions about the study.

**APPENDIX 11: Consent For Teachers**

This is to certify that I, \_\_\_\_\_  
(print full name), agree to participate in the clinical teacher's perspective study conducted by Barbara Paterson. I have been told that Ms. Paterson is a doctoral student in the Interdisciplinary Ph.D. program at the University of Manitoba and a nurse. I have heard the explanation of the study and have read the attached description. My participation is voluntary. I understand that if I do not wish to participate in this study that this will not affect my employment in any manner.

I have had the opportunity to ask questions and have received satisfactory answers. I understand I may ask Barbara Paterson further questions should they arise, at any time. I understand that my participation will involve a minimum of eight hours and a maximum of sixteen hours per week during the study. I also understand that my participation will involve formal interviews in the teacher's office, in which I will be asked questions about what I think about clinical teaching and my reactions to specific situations which have been observed by the researcher. These interviews will be tape recorded. I am aware that approximately three quarters of my participation will entail my being observed by the researcher as I teach in the clinical area and interact with students, patients and staff. I understand that the researcher will write some notes during and following the observation sessions. She may ask me to discuss my reactions to what she has observed immediately following an observed situation. The researcher will also review notes/records I write concerning students' clinical performance during the study.

I understand that all information pertaining to my participation will be identified by code number and that the data and my identity will remain confidential. I understand that at the completion of the study, the notes

will be destroyed and tapes erased. I understand that the information may be published but my name will not be associated with the research.

I understand that if the researcher has access to information outside the realm of the study which may have ethical implications, she will discuss this with me and then, if the matter requires further resolution, will direct it to the head nurse of the clinical area or, if appropriate, to my immediate supervisor. The researcher will inform me if she intends to direct the matter to an individual other than myself.

I understand that I may receive a copy of the results of this study upon request.

Signature of Teacher: \_\_\_\_\_

Signature of Witness: \_\_\_\_\_

Date: \_\_\_\_\_

---

Please print your name and address if you wish to receive a copy of the results of this study:

NAME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

**APPENDIX 12: Description Of Study For Students**

Your clinical teacher, \_\_\_\_\_, has consented to participate in a research study to increase our understanding of what actually occurs when a teacher teaches students in a hospital setting. The study will occur over a period of one school year and will involve observations of the teacher by the researcher as he/she teaches on \_\_\_\_\_ (name of clinical area).

As you have been assigned by the school of nursing to \_\_\_\_\_'s clinical group, you are also being asked to participate in the study. Your participation will involve being observed periodically by the researcher as you interact with your clinical teacher. It is the performance of the teacher and not your performance which is the focus of the observations. These observations may take place at a patient's bedside or in any location on the clinical area (e.g., medication room, hallway, conference room). During the observations, the researcher may jot down a few notes about how the teacher interacts with you.

You are assured of complete confidentiality. Your name will not be used on written notes or in the final report of the study. Instead, you will be assigned a code number (e.g., 201) throughout the study. The notes written by the researcher will be stored in computer files to which only the researcher has access. Tapes of interviews conducted by the researcher will be stored in a locked compartment to which only the researcher has access. The notes will be destroyed and the tapes will be erased at the completion of the study. They will not be shared with any other participant in the study.

The \_\_\_\_\_ School of Nursing and the \_\_\_\_\_ Hospital have given their approval for this research. You are free not to take part in the study. If you decide to participate in the study, you will

be asked to sign a Consent Form. Your signature on such a consent indicates your willingness to participate in the study by being observed in your interactions with \_\_\_\_\_. It also grants your permission for the researcher to review \_\_\_\_\_'s written reports of his/her observations and evaluation of your clinical performance (e.g., final evaluation, clinical progress notes, daily anecdotal records).

You may refuse to consent to being observed by the researcher in the clinical area. However, the researcher will observe situations (e.g. post-conferences) in which you are a member of a group (more than two students present). If you have refused to participate in the study, your individual contribution(s) to the group process will not be recorded in the study.

There may be no direct benefits to the participants in this study but there may be changes in nursing education following the completion of this study. There will be no health risks to you resulting from your participation in the research.

You are free to withdraw from this study at any time even after giving your written consent. Your clinical evaluation and/or clinical grade will in no way be affected by your refusal to participate in this study or withdrawal from this study. You are also free to refuse to participate in specific aspects of the study (e.g., to refuse to be observed by the researcher when you go with your teacher to prepare for a specific procedure in which you have had no prior experience).

You will be given a copy of this description of the study and the Consent Form. Please feel free to contact the researcher, Barbara Paterson, at any time (phone 668-2550) if you have any questions about the study.

### APPENDIX 13: Consent For Students

This is to certify that I, \_\_\_\_\_  
 (print full name), agree to participate in the clinical teacher's perspective study conducted by Barbara Paterson. I have been told that Ms. Paterson is a doctoral student in the Interdisciplinary Ph.D. program at the University of Manitoba and a nurse. I have heard the explanation of the study and have read the attached description. My participation is voluntary and will entail a minimum of a half hour and a maximum of three hours of observation by the researcher per week. I also understand that the researcher will review reports/notes written by \_\_\_\_\_ about my clinical performance. I understand that if I do not wish to participate in this study that this will not affect the evaluation of my clinical performance and my clinical grade in any manner.

I have had the opportunity to ask questions and have received satisfactory answers. I understand I may ask Barbara Paterson further questions should they arise, at any time.

I understand that all information pertaining to my participation will be identified by code number and that the data and my identity will remain confidential. I understand that at the completion of the study, the notes will be destroyed and the tapes erased. I understand that the information may be published but my name will not be associated with the research.

I understand that I may receive a copy of the results of this study upon request.

Restrictions to consent (if any): \_\_\_\_\_

Signature of Student: \_\_\_\_\_

Signature of Witness: \_\_\_\_\_

Date: \_\_\_\_\_

---

Please print your name and address if you wish to receive a copy of the results of this study:

NAME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

Criterion Variable	Teacher #1	Teacher #2	Teacher #3	Teacher #4	Teacher #5	Teacher #6
Goal structure	Task Mastery	Task Mastery	Professional Identity - Mentoring	Moral Responsibility	Moral Responsibility	Ability - Evaluative
Primary focus	Students' ability to master learning goals established by teacher and curriculum	Students' ability to master learning goals established by teacher and curriculum	Development of students' personal identity as professionals	Student learning and welfare	Student learning and welfare	Teacher's ability
Role Identification	Teacher	Teacher	Nurse-Teacher	Teacher-Nurse	Nurse-Teacher	Teacher
Clinical Teacher's Role	Gatekeeper to the profession; to provide learning experiences which will result in student mastery	Gatekeeper to the profession; to provide learning experiences which will result in student mastery	To empower students to think for themselves	To assist students to feel worthwhile and competent in the clinical area; to function as a catalyst to students' learning	To form a partnership with students in meeting their learning needs; to equip students with decision-making skills	Gatekeeper to the profession; to maintain control and to demonstrate clinical and teaching ability
Perception of Students	Individuals to be molded into functioning practitioners	Vessels to be filled with teacher's knowledge and expertise	Owners of their own clinical learning experience	Individuals who are growing as professionals and people; who need the nurture and support of the teacher	Travellers in unfamiliar, frightening environment of the clinical area	Vessels to be filled with teacher's knowledge and expertise

APPENDIX 14: A Comparison Of Perspectives

Criterion Variable	Teacher #1	Teacher #2	Teacher #3	Teacher #4	Teacher #5	Teacher #6
Attributional focus	Student success due to appropriate assignment, availability of learning tasks, and student effort/ability. Student failure the result of assigning tasks beyond the experience/capabilities of the student; to lack of suitable learning experiences; and lack of student's effort or ability.	Student success due to appropriate assignment, availability of learning tasks, and student effort/ability. Student failure the result of assigning tasks beyond the experience/capabilities of the student; to lack of suitable learning experiences; and lack of student's effort or ability.	Student success due to student's ability and motivation. Failure due to teacher's inability to intervene effectively.	Student success due to student's ability and motivation. Failure due to teacher's inability to intervene effectively.	Student success due to student's ability and motivation. Failure due to teacher's inability to intervene effectively.	Student success largely due to teacher's intervention. Failure is the result of the student's lack of ability or effort.
Role of the nursing staff	To provide opportunities for student learning; to assume responsibility for tasks which are beyond the student's capabilities/experience; to provide feedback when requested re: students' clinical experience.	To provide opportunities for student learning; to assume responsibility for tasks which are beyond the student's capabilities/experience; to provide feedback when requested re: students' clinical experience.	To encourage active professional socialization of students.	To supplement the teacher's activities.	To supplement the teacher's activities and to communicate changes in ward practices.	To provide opportunities for student learning; to assume responsibility for tasks which are beyond the student's capabilities/experience; to provide feedback when requested re: students' clinical experience.