THE CHARACTERISTICS OF EFFECTIVE CLINICAL TEACHERS IN BACCALAUREATE NURSING PROGRAMS

BY

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A Thesis
Submitted to the Faculty of Graduate Studies
in Partial Fulfillment of the Requirements
for the Degree of

MASTER OF EDUCATION

University of Manitoba
Winnipeg, Manitoba

THE UNIVERSITY OF MANITOBA

FACULTY OF GRADUATE STUDIES

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ABSTRACT

Clinical education in nursing is recognized as both an essential, and a highly significant component of professional education for nursing. The clinical curriculum provides experiences designed to prepare students with skills in knowledge acquisition, creative thinking, and a commitment to life-long learning. Clinical education also gives students opportunities to apply the concepts, knowledge, and skills introduced in the classroom to patient care situations. Thus, it is in the clinical area that students must relate theory to practice, learn the necessary technical and personal skills, make clinical judgements, become socialized into the profession, and begin to appreciate its values and ethics (Dunn et al., 1995).

The development of competent practice in students is a primary goal for nursing education. This practice carries with it a significant obligation for the teacher: the professional responsibility to safeguard both the rights of the patient and the rights of the student. Therefore, clinical teachers must not only instruct and support, but also supervise and evaluate. Thus, teaching in the clinical area becomes a most challenging endeavour.

The nursing literature describes what could be considered "themes" characterizing effective clinical teaching. These themes are: the significance of a supportive interpersonal relationship between teacher and student; the necessity for the teacher to maintain clinical competence; the importance of the teacher "role modeling" effective behaviors for the students; the value of the teacher being skilled in teaching methodologies; and the necessity for the teacher to provide a supportive learning environment. What is missing in the literature is a description of the specific indicators necessary to demonstrate these concepts when teaching students.

Therefore, the purpose of this research was to have experienced clinical teachers describe how they go about the business of clinical teaching. Four experienced clinical teachers were interviewed on three separate occasions by the researcher. The participants were asked to identify the qualities they considered to be those of a good clinical teacher, and to describe some of their clinical teaching experiences. In addition, probes were used to elicit further information regarding the five themes identified in the literature. As well as the audio tapes of the interviews, the researcher kept field notes and a reflective journal.

The data obtained from the participants reflected the five themes found in the professional literature. Moreover, in their descriptions of their clinical teaching practices, the participants provided numerous examples of *how they operationalized* these themes.

In addition to the data regarding the five themes, the participants provided information regarding several new emerging themes: the incorporation of humanitarian principles into the teaching of students; the notion of a significant counseling role for the teacher; and the concept of the teacher "letting go", as the role of the clinical teacher becomes that of a "clinical education facilitator".

These results will be of value to those involved in preparing clinical educators for their teaching responsibilities. As well, the new emergent themes provide additional data regarding the role of the clinical teacher, which indicate promising areas for future research.

ACKNOWLEDGEMENTS

Completing a Master's degree solely on a part-time basis thoroughly tests one's resolve. Researching for and writing a thesis adds the final challenge to this process. Completing such a course of studies is only possible with the assistance of many persons. I would like to acknowledge those who have "stood by" me throughout this journey.

I would first like to express my sincere appreciation to the members of my committee, each of whom was an invaluable asset during my scholarly endeavours.

Dr. Lynn Taylor, my advisor: for her guidance and encouragement, her tireless efforts on my behalf, and the wealth of valuable suggestions she continually provided for me.

Dr. Paul Madak, who began by inspiring me with Course 43.610 -Design of Educational Research - and continued to provide me with encouragement and thoughtful feedback, even from the University of Northern British Columbia!

Dr. Annette Gupton, for being my link to the nursing profession, for willingly reviewing my work, and for offering not only valid recommendations, but gracious commendations regarding my efforts.

I extend my heartfelt thanks to Ms. Sherry Ripak, who not only transcribed my interviews, but formatted both my proposal and my thesis. Without her patience, her calm approach, and her technological expertise, this thesis may well not have been completed.

To my participants, who gave willingly and freely of their time; who reflected on each interview so that they could bring me further insights for the subsequent interview; who described their teaching experiences with richness and candor; and who evidenced immeasurable caring for students, staff, and patients alike: my profound gratitude. The nursing profession will indeed be richer because of the significant understandings you have shared regarding your teaching experiences.

Lastly, to my family, who endured this seemingly endless journey, but were still able to nurture and support: To Norm, who took over the "cooking and cleaning", and true to his promise, conscientiously "nagged" me to finish. To Karin, who designed my overheads, put up with my endless computer difficulties, and provided invaluable assistance with technology, thus affording me much needed peace of mind. To Kathryn, who accompanied me on numerous midnight drives to deliver thesis drafts, who dictated script to me, and who always said: "Mom, you can do it!!" Without your love and patience, this endeavour would not have been worthwhile.

To all of the aforementioned, I will be forever grateful for your encouragement, support, and "positive personal regard".

Lastly, with gratitude, I acknowledge receipt of the Ken Seaford Bursary through Seven Oaks General Hospital, Winnipeg, Manitoba.

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CHAPTER ONE

INTRODUCTION

Clinical education is recognized as an essential and highly significant component of professional education for nursing (Bevil & Gross, 1981; Meleca, Schimpfhauser, Witteman, & Sachs, 1981; Wellard, Rolls, & de Sales Ferguson, 1995; Wilson, Soldwisch, Jacobson, &Robertson,1995). In fact, the clinical experience component of nursing programs is considered the "heart" of professional education (Infante, 1981; McCabe, 1985). The clinical curriculum provides experiences designed to prepare students with skills in knowledge acquisition, creative thinking, and a commitment to life-long learning. Clinical education also gives the students opportunities to apply the concepts, knowledge and skills introduced in the classroom to patient care situations. Applying acquired knowledge to patient care situations allows students to develop professional and personal skills, as well as values and attitudes essential for the nursing profession. It is during the clinical education component of nursing education programs that the process of socialization into the professional role begins (Dunn, Stockhausen, Thornton, & Barnard, 1995). Thus, it is in the clinical area that students must relate theory to practice, learn the necessary technical and interpersonal skills, make clinical judgements, become socialized into the profession and begin to appreciate its values and ethics (Dunn, et al., 1995).

To qualify as graduates in the profession, students must demonstrate that they have achieved an acceptable standard of clinical competence (Halstead, Rains, Boland & May, 1996; Harper,1995). The development of competent practice is a primary goal for

nursing education. To demonstrate this competence, graduates must be able to practise in the "real world" (Arpin, 1982). This "real world" practice carries with it several obligations: for the student, the opportunity to practise in a safe environment; for the patient, the right to a reasonably safe standard of care; and for the teacher, the professional responsibility to safeguard the rights of both patient and student. Skillful teachers are required to facilitate professional growth, self-directed learning, skill acquisition, and reflective practice (Higgs, 1992). Clinical teachers must not only instruct and support, but also supervise and evaluate. How this is done either gives the student a growing sense of competence in the abilities being learned, or produces anxiety culminating in an inability to problem solve or use clinical judgement (Wong,1978; Wong & Wong, 1980). Thus, teaching students in the clinical area becomes a most challenging professional endeavour.

The nursing literature describes what could be considered "themes" characterizing effective clinical teaching—concepts such as "good clinical knowledge" (e.g; Benner, 1984; Christy,1980; Clifford, 1993); being "supportive",(e.g; Bergman and Gaitskill, 1990; Brown, 1981; Marcinek,1993); "providing a positive learning environment"(e.g; Flager, Loper-Powers, and Spitzer,1988; Gross, Aysse, and Tracey, 1993; Kushnir, 1986). What is missing in this literature is a description of the specific indicators necessary to demonstrate these concepts to students. How one goes about being supportive or how one provides a positive learning environment is much less well documented than the broader concepts themselves.

Consequently, the research explored what the nursing literature has described as the principal issues to identify prospective strategies which would ensure effective clinical

education. As radical changes to the health care delivery system continue, graduates must possess a sound knowledge base with which to effect valid clinical judgements in a changing and highly stressful environment (Halstead, Rains, Boland, & May,1996; Karuhije,1997). Such changes will demand an even higher level of competence in the clinical teacher. Thus, the purpose of the research was to describe and analyze those specific teacher behaviors, qualities and skills that together comprise a competent and effective clinical teacher.

For purposes of this research, a clinical teacher is defined as: "an instructor of nursing students in the clinical setting" (Bergman & Gaitskill, 1990, p. 36). The broad research question was "What makes an effective clinical teacher?" The specific research questions were:

1. From a nurse educator's perspective, what are the specific teacher behaviors that are judged as evidence of being an effective clinical teacher?
2. From a nurse educator's perspective, what specific teaching behaviors constitute being supportive, clinically competent, a good role model, a skilled teacher, and the provider of a supportive learning environment?
3. From a nurse educator's perspective, are there other dimensions of effective teaching that are not captured by the five themes identified in the research literature?

Possible aspects of these questions could address such issues as the hallmarks of clinical competence, effective teaching methodologies, and the importance of establishing a positive relationship with students. The research questions were explored by having nursing teachers, acknowledged to be effective clinical teachers, describe how they go

about the business of clinical teaching. From these descriptions, the desired competencies of an effective clinical teacher became apparent. These research findings articulating specific teaching behaviors will contribute to a body of knowledge regarding *how* to be an effective teacher. The aim of the research was to broaden our understanding of clinical teaching so that this knowledge can be used by the profession to assist in the development and selection of teachers, the planning of academic and practice components of basic and continuing professional development programs, and the improvement of evaluative procedures for faculty.

CHAPTER TWO

LITERATURE REVIEW

Articles from professional nursing and allied health professional journals were included in the literature review that supports the conceptualization of the proposed investigation. Most of the articles identified were descriptive accounts of practice methodologies, such as Andersen (1991) ; some however, did represent a systematic study of a practice situation, such as Benner (1984), and Higgs (1992).

As earlier noted by Wooley and Costello (1988) there did not appear to be a body of research-supported knowledge that defined effective teaching behaviors. What the nursing literature did identify were broad concepts regarding clinical teaching which were viewed as important for both students and teachers. Those aspects of clinical education that are central to student learning are the relationship between theory and practice, the ability to problem solve, and the ability to think critically. Each of these concepts are discussed in turn.

Aspects of Clinical Education Central to Student Learning

The Relationship Between Theory and Practice

The task of developing a curriculum that will enable students to synthesize academic knowledge and apply practical skills in the clinical area is a major responsibility. A primary goal of nurse educators is to provide educational opportunities in the clinical

setting that will facilitate the preparation of the beginning practitioner (Carpenito & Duespohl, 1981). Maukasc, (1981) and Rolfe,(1993b) stated that in recent years, nursing practice and nursing education have been considered separate from one another. Theory and practice need to be viewed as a partnership, not as two distinct entities. Moreover, Beddome et al. (1995) believed clinical experience should be emphasized as the foundation of nursing theory.

Adding credence to these views, Carr (1980) stated that to create a body of educational theory in isolation from practice is a mistake. Carr argued that practice and theory form a logical partnership, in which educational theory not only identifies educational practice, but also defines and shapes practice. Schon (1983) contended that the relationship between theory and practice is a circular one, with practice generating theory, and theory modifying practice and creating new theory. Rolfe (1993a) concluded that this type of theory is "...implicit in practice, because without it practice degenerates into random and meaningless behavior" (p. 175).

Thus, these authors believed that theory and practice should not be considered as separate entities, but rather as a partnership. Most importantly, it is crucial that students learn how to apply academic knowledge to their practice of nursing within the clinical setting.

The Ability to Problem Solve

In striving to teach students how to apply theory to practice, a second major task of the clinical educator is to facilitate the learning of problem solving. Higgs and Jones (1995) considered technical problem-solving within the broader context of reflective inquiry, with a strong foundation of discipline-specific knowledge and metacognition (the

integrative element between cognition and knowledge). The core elements of knowledge, cognition, and metacognition interact throughout the reasoning (problem solving) process. The student develops the ability to analyze and synthesize data from her/his knowledge base. Metacognition is utilized to reflect on previous observations and to detect links or inconsistencies between data. Experience allows the student to construct a clearer picture of the clinical problem. This in turn, generates further questions in the continuing process of problem solving.

Educating students to become skilled problem solvers is an arduous but essential task. Kolb (1974) rejected the assumptions that the teacher is primarily responsible for learning, and that education is largely based on the acquisition and memorization of ideas and concepts. By helping students learn how to learn, the clinical educator can enhance the students' problem solving ability. Kolb suggested that students, with appropriate guidance from the clinical educator, should become involved in applying their knowledge. Thus, students should be encouraged to ask questions, define problems, collect data regarding problems, formulate outcomes, and test and evaluate those outcomes. In fact, the nursing profession refers to these activities as the "nursing process". The specific activities that comprise the nursing process are identified as: assessment, planning, intervention, and evaluation (Griffith & Christensen,1982).

Kolb (1974) also spoke about theory building and reasoning. The learner's knowledge of theories, concepts, and past experiences influences her/his problem-solving ability. Thus, the ability to identify problems and make decisions about possible solutions increases as familiarity with the subject matter increases (Reilly & Oermann, 1992).

Nursing educators must utilize diverse strategies to encourage the development of problem-solving skills in the novice professional. The goal is to assist the student to develop the ability to cope with the uniqueness, uncertainty, and conflict inherent in the real problems of everyday nursing (Higgs, 1992). For example, novice students do not have past experience to use as a guide or reference point. Therefore, the teacher must encourage students to identify both similarities and differences in their patient situations, and to connect these situations to build their own bank of clinical experiences. In this way, educators facilitate learning by assisting students to build connections between content knowledge and clinical experience (Beddome et al., 1995). Thus, the student is assisted to visualize a complete picture rather than a collection of parts.

These authors contended that the learning of problem solving is a critical task for learners. The teacher's role is to assist the students to learn how to problem solve so that the steps of assessment, planning, intervention, and evaluation can be applied to clinical nursing situations.

The Ability to Think Critically

A third essential outcome of a nursing education program is the development of the ability to think critically (Ford & Profetto-McGrath, 1994; Russaw, 1997;White, Beardslee, Peters, & Supples,1990). Reilly and Oermann (1992) regarded critical thinking as rational thinking involving the evaluation of ideas; the purpose being to improve one's reasoning ability about everyday problems and issues (McPeck, 1990). Paul's (1995) description of critical thinking, in the nursing context, was of a thinking process that analyzes information carefully for its relevance and completeness, that can trace implications and consequences, and that can appreciate multiple perspectives.

In the clinical setting, students are continually confronted with problems that are difficult to solve, either because of the problem's complexity or because of the learner's unfamiliarity with it. The critical thinker seeks reasons on which to base assessments and judgments. Before one can think critically about nursing, however, one must have a basic knowledge of its content, theories and concepts (Cholowski & Chan, 1995). It is the responsibility of the clinical educator to present the framework for critical thinking, and to encourage the development of an attitude of inquiry in the context of developing content knowledge (Reilly & Oermann,1990; Schumacher & Severson, 1996).

The clinical area provides the environment to foster the development of critical thinking skills through the use of critical reflection and action (praxis) (Brookfield, 1987, 1993). Learning to think critically involves not only knowing when to question, but also knowing what sorts of questions to ask. McPeck (1990) referred to this questioning as the use of "reflective skepticism". Students require clinical experience and background knowledge in order to begin the process of critical thinking. Moreover, critical thinking skills develop best in an atmosphere of dialogue, interchange, and problem solving. Students must work with these concepts in the context of real problems, and relate them to actual experiences and previous learning (Meyers, 1986). By learning how to think critically, students will be able to integrate both their present and past learning and use each new learning experience to build new concepts and understandings. Chubinski (1996) argued that the use of critical thinking strategies enhances student interest, creates anticipation for future learning situations, and increases retention.

To have realistic expectations of students is a further strategy to develop student competence in critical thinking. Both the clinical practice setting and the conference

setting can provide opportunities to practise aspects of clinical reasoning. The ability to think critically is not always a characteristic of a novice learner, but more often comes with experience and the acquisition of knowledge. Students require encouragement to express their thoughts, questions and ideas. Students also require assistance, support, and constructive criticism when they have difficulty synthesizing ideas. del Bueno (1994) stated that active learning strategies also help to develop information processing skills that are an essential component of critical thinking. The outcome is that students who learn to think critically are better prepared to be competent, accountable, and responsible practitioners. For instance, Ramprogus (1988), using Kolb's (1974) model of experiential learning, conducted a study to examine the effectiveness of an alternative approach to help students become more skilled both as learners and as critical thinkers. The results suggested that nursing students need to be encouraged in order to be free to carry out inquiries and develop their own learning style. For example, possible nursing actions could be discussed with the educator - either as a teaching plan or as a strategy to promote patient participation in their own care.

Thus, the ability to think critically is considered an essential skill for the nursing student (Pless & Clayton, 1993). To develop this skill, the student must be encouraged to inquire and to experiment. It is by fostering the ability to question and critique that the teacher facilitates the learning of critical thinking.

The foregoing review provides a brief overview of some of the key issues involved in clinical nursing education: how to relate theory to practice, and how to develop problem solving and critical thinking skills. The development of these fundamental skills requires a complex set of teaching abilities. The complexity involved in teaching such skills

provides the basis for five major "themes" discussed in the professional literature regarding effective clinical teaching. The next section discusses these five themes.

Themes Regarding Clinical Teaching

A Supportive Teacher Student Relationship

The first theme, the significance of a supportive interpersonal relationship between teacher and student, was discussed in articles by Brown (1981), Slevin and Harter (1987), Allen (1990), Bergman and Gaitskill (1990), Hsieh and Knowles (1990), Mangold (1991), Eyres, Loustau, and Ersek (1992), and Marcinek (1993). Both Brown (1981), and Bergman and Gaitskill (1990) selected a university school of nursing and studied students' and faculty's ratings of effective teacher characteristics. Both authors found the teacher-student relationship to be most important, with mutual respect and confidence in the student of paramount significance. Both studies were limited to a single institution and neither identified specific behaviors underlying the characteristics. Multiple measurements over time as well as replications are needed to verify the findings. However, these conclusions are supported by other authors such as Fothergill-Bourbonnais and Smith Higuchi (1995) who stated that "clinical teachers must know when and how to provide the support and encouragement to help students develop confidence in their ability to nurse" (p. 40).

Pratt and Magill (1983), found that effective clinical teachers are usually described in terms of their "personal attributes, interpersonal regard for learners, professional competence, or specific teaching skills" (p. 462). According to Irby (1978), students tended to describe the best clinical teachers as enthusiastic, clear, and well-organized in

presentations, and adept at interacting with students. McCabe (1985) noted several faculty behaviors that have a positive impact on student learning. These behaviors included personal qualities such as being approachable, providing support in crisis situations, and relating to students as mature individuals. As well, behaviors more closely tied to professional competence, such as, demonstrating a strong knowledge of nursing practice, encouraging independent thinking, providing an opportunity to carry out self-directed activities, and developing the ability to evaluate the students' capabilities and limitations were seen positively (McCabe, 1985).

Allen (1990) and Marcinek (1993) looked more broadly at the issue of the nature of nursing education. Allen (1990) deplored the extreme emphasis on curricular content, as well as the traditional hierarchy, paternalism, and control in schools of nursing. He urged educators to focus on demonstrating a caring commitment to students, actively involving them as partners in learning. Marcinek (1993) echoed these sentiments, and spoke of the importance of a "process driven", humanistic curriculum that gave empowerment and an active role to the learner and promoted collegial relationships between faculty and students. These two descriptive articles, discussing the authors' philosophical beliefs, further underlined the importance of a supportive teacher-student relationship.

Hsieh and Knowles (1990), who conducted a study to examine the development of preceptor relationships, reported similar themes of trust, honest communication, mutual respect, and encouragement as being significant. Melander and Roberts (1994) also noted that nurse educators who recognize staff nurses as clinicians with valued experience, provided a meaningful contribution to student learning. This trust and respect of other

practitioners was markedly apparent to students and guided their practise during the final portion of the nursing education program (Paterson, 1997; Rolfe,1990). Students were invariably impressed with the preceptor's expertise, and the resulting knowledge and experience were invaluable in preparing them for their professional role (Peirce,1991). This student/faculty/staff nurse linkage provided for the maximum utilization of nursing strengths, increasing interpersonal support and more accurate nursing judgements which produced an improved quality of patient care and enhanced participant satisfaction in the teaching/learning experience (Cawley Baird, Bopp, Kruckenberg Schofer, Langenberg & Matheis-Kraft,1994; Letizia & Jennrich, 1998; Melander & Roberts, 1994; Percival & Nester, 1996; Phillips, Davies, & Neary, 1996).

All of these authors agreed that a supportive teacher-student relationship is an essential component of effective clinical nursing education. Such a relationship has a powerful impact on student learning as, when supported, the student feels confident enough to approach new situations and learn new skills.

The Clinical Competence of the Teacher

The second theme in the literature was the necessity for the teacher to maintain clinical competence. Christy (1980), in an historical analysis of clinical practice as a function of nursing education, emphasized the importance of nursing educators having a sound clinical knowledge base, and thus encouraged faculty members to engage in clinical practise. Her analysis, however, provided no guidance regarding either how the profession should go about putting this balance into place, or which behaviors and skills would provide the necessary teaching expertise.

One of the problems underlying the assessment of the clinical skills of nursing students is the distancing of clinical educators from the very practice of nursing that they are teaching (Clifford, 1993). Clifford questioned the practice of assuming a strict lecturer rather than a clinician role, thus distancing the nurse educator from the clinical area. In a study Clifford conducted regarding the assessment of clinical practice and the role of the nurse teacher, only one nurse educator reported visiting clinical areas to update her own skills. Benner (1984) also indicated that many nurses who teach students in the clinical area have much to do to develop their own expertise. Karuhije (1986) argued that if a knowledgeable use of various teaching strategies is imperative for creative and stimulating clinical teaching, then the person performing that teaching role must be adequately prepared (Cawley Baird et al.,1994). One can only assess student performance in the light of his or her own perceptions and expertise. It follows then, that clinical teachers, facilitators, and lecturers must be both educationally prepared and clinically competent.

At the very least, clinical educators must keep up to date with the latest technologies through participation in continuing education offerings and by engaging in current clinical practice as a staff nurse. The possession of an academic degree, by itself, does not guarantee either teaching skill or the ability to create an environment conducive to learning.

The professional literature thus underlined the necessity of the teacher maintaining clinical competence. Only when the teacher was recognized as a competent practitioner, did the student trust her/his guidance in teaching the clinical skills required by the nursing student.

Role Modeling Effective Behaviors

The third theme in the nursing literature was the importance of the teacher "role modeling" effective behaviors for students (Peirce, 1991; Pottinger,1994). Archer and Fleshman (1981), in a descriptive account of faculty and students working together in a community setting, concluded that students learned how to model their own practice by watching and working with competent practitioners as role models. Mogan and Knox (1987) conducted a descriptive study at seven university schools of nursing in Western Canada and the United States in which forty eight teacher characteristics were judged according to a seven point Likert scale. The results showed that being a good role model was the most important characteristic distinguishing the "best" from the "worst" clinical teacher. The study, because of its exploratory nature was not generalizable, but the agreement of faculty and students regarding role modeling warranted, for the authors, replication of the study and research into the concept of role modeling.

In fact, one of the ways students are socialized into the nursing role is through the observation of the teacher providing direct patient care. Educators must be exemplary role models for their students. It follows then, that educators must have a thorough understanding regarding the clinical learning environment, as well as current nursing experiences. Keen and Dear (1983) and Andersen (1991), stated that faculty members can fulfill various positions - such as preceptors and role models. The ability to be an effective role model further underlined the importance of the clinical educator maintaining clinical competence. It is in this way that the educator can provide knowledge, skill, empathy, motivation, and the integration of education and work values.

Skill in Teaching Methodologies

Regarding the fourth theme, the value of the teacher being skilled in teaching methodologies, Infante, Forbes, Houldin, and Naylor (1989) hypothesized that if clinical laboratory experiences were synchronized with nursing theory, and if there was closer collaboration between nursing education and practice (through the use of practising nurses as mentors and guides), students would develop better academic and practice skills. The findings indicated that this model, with the educator assuming increased responsibility for designing learning experiences did, in fact, produce more effective academic and technical skill performance. Carter (1992) in an informational article regarding beliefs about how to coach effectively, cited characteristics such as being credible and supportive, and skills such as goal setting and performance assessment, as significant teaching skills. As with other authors, only generalized concepts were described: specific behaviors underlying these concepts were not identified.

The notion that human beings have an innate predisposition toward growth and development that is often stifled by traditional educational approaches was popularized by Carl Rogers (1969). "The humanistic approach, based on the principle of freedom to learn through guided or self-directed inquiry, has lately been adopted by various schools of nursing as a way of teaching problem solving and inquiry skills" (Ramprogus, 1988, p. 59). Assisted by senior practitioners, who initiate students into the traditions of practice, students learn to become adept in the clinical area of nursing.

Self-directed teaching methods are based on a concept of learning that acknowledges that learning is an individual process. Moreover, this process requires the active involvement of the learner (Higgs,1992; Rolfe,1993b; Walton,1996). This view

recognized the uniqueness of the individual and his or her ability to make choices and decisions about learning (Reilly & Oermann, 1992). Effective mechanisms for self-directed learning assist the professional to link education with practice. According to Dressel and Marcus (1982), the purpose of a university education is to promote the cognitive growth of students, and the development of self-sufficient thinkers and continuing learners. When these goals are attained, students are able to deal responsively with their learning needs and with changes in society's health care needs.

There is no question that nurses must be accountable to those who receive their services (Higgs, 1992). At the very least, students should be accountable to themselves and the need to become self-directed learners. Higgs believed that students in professional schools must be indoctrinated into a pattern of life-long learning which will provide a framework for reflecting on past experiences and preparing for future learning opportunities.

To encourage self-directed learning, professional nursing education needs to utilize a variety of teaching strategies in order to accommodate the varied learning styles of students, and in particular, to encourage interaction among students (Emerson & Groth, 1996; Gross, Aysse, & Tracey, 1993; Titchen & Binnie,1995). An effective means to promote both student participation and reflection on past experiences is to hold small group learning sessions (Carkhuff, 1996; Zerbe & Lachat,1991). Utilizing group dynamics, educators can promote effective learner interaction (Diekelmann,1992). Another small group situation that offers the educator the opportunity for more personal teaching approaches is the pre and post clinical conference. In these settings, students

present and discuss problems encountered on the clinical unit, and receive the suggestions, commendations, or endorsement of both fellow students and the educator (Wink, 1995).

The utilization of negotiated learning contracts is a second strategy to promote independent behavior, autonomous learning and cognitive achievement (Tompkins & McGraw, 1988). The use of the educational contract is a methodology that addresses the elements of student needs, expectations, roles, and course content. Once teachers feel students have attained a certain level of competence in the clinical setting, they can negotiate learning goals and activities that best enhance the students' development (Makielski, 1997). At some point, the clinical educator must allow students a higher level of freedom and risk-taking while learning in order to facilitate the attainment of student goals (Makielski, 1997; Patton et al., 1977; Tompkins & McGraw, 1988). According to their interests and capabilities, students must be allowed to take the initiative to organize some learning experiences. An excellent example of this occurs during the final clinical experience of many nursing education programs, during which the student negotiates a clinical placement and is assisted throughout that placement by a preceptor in the clinical area, with the educator providing the underlying encouragement and support (Peirce, 1991).

A third teaching methodology used to promote self-directed learning is the planning of student-centered courses. The use of this methodology is particularly urgent as we prepare graduates for today's rapidly evolving health care system. Graduates must be prepared to function autonomously; and in addition, to be flexible, innovative and confident. Walton (1996) argued that graduates who utilize creative and critical thinking skills in this environment demonstrate autonomy. Students, if they are to develop

autonomy, must be willing to assume increasing control during their educational program. Educators using effective teaching strategies such as self-paced modules, learning contracts, and computer-assisted programs, ensure that learning takes place in a self-directed manner.

As students progress through a nursing education program, their learning needs and styles will change with confidence and experience. The existing literature suggests that it is important for educators to provide students with sequences of experiences that have both connection and continuity. For example, challenging clinical placements in both health care agencies and the community can be arranged to allow students to utilize their knowledge and reflect on the connections between their learning experiences. As in other areas of teaching, clinical educators must provide the support and encouragement necessary to help students develop confidence in their ability to nurse (Fothergill-Bourbonnais & Smith Higuchi, 1995).

Across the literature reviewed, authors agreed that to be effective, a clinical teacher must utilize a variety of teaching methodologies-such as self-directed inquiry, small group learning, student-centered courses, learning contracts, and preceptored experiences. Only in this way can the teacher hope to address the diverse learning styles of students, and the complex learning required to become a nurse.

A Supportive Learning Environment

The fifth theme identified in the literature was the necessity for the educator to provide a supportive learning environment for students (Gross, Aysse, & Tracey, 1993). Kushnir (1986) analyzed the effect of the presence and actions of instructors on the behavior of nursing students, and emphasized that the mere presence of an observer during

task performance was a well-known stressor. Kushnir asked second year nursing students to describe a personal and stressful interpersonal encounter with an individual of higher status, then analyzed the anecdotes for themes. The findings indicated that the students' stress was due to two characteristics of the instructor: expertise and higher status. The instructor was seen as an expert - and one with higher status - whose evaluation of student performance had consequences for student progress. Kushnir concluded that instructors should de-emphasize their evaluative role and create a supportive learning atmosphere where errors were viewed as learning opportunities rather than occasions for criticism.

The purpose of the survey research by Flager, Loper-Powers and Spitzer (1988), was to determine which clinical teaching behaviors students perceived as important in promoting self confidence. Five factors significant to clinical learning were identified: the teacher as (a) resource; (b) encourager; (c) promoter; (d) benevolent presence; and (e) evaluator. The first four roles promoted self-confidence. The evaluator role, however, was seen as the least helpful. The authors concluded that teachers should focus more on those behaviors that enhance student confidence. The problem with both these investigations was that each had significant methodological difficulties - the utilization of a convenience group in the first study, and the use of a non-randomized sample and a questionnaire without established validity in the second study.

The learning environment is further complicated by the fact that these interpersonal aspects of the teaching and learning process are embedded in a complex work environment. The clinical environment can be unpredictable and chaotic, and poses a much larger threat to students than does the classroom or skills laboratory (Wong & Wong, 1987). This threat is grounded in the students' belief that the evaluation of their clinical

experience will significantly affect their progression within the program. The clinical educator needs to seek out experiences in an unpredictable teaching environment that complement and reinforce the students' knowledge, and through which the students' learning can be fairly evaluated. Despite the concerns of students and faculty about evaluation, conducting effective evaluations is a critical component of clinical education. In fact, Beale (1993) argued that evaluation is most meaningful when it is integrated into ongoing teaching and learning activities. In terms of creating effective learning environments, the need for more attention to evaluation practices is clearly indicated.

Because of the individual ways students learn, student learning styles and teaching strategies must be congruent in order to evaluate the student's progress effectively. The challenge in teaching and evaluating lies in the consideration of the individuality of student learning needs. Knowles (1980) wrote strongly about the individuality of learners, and argued that to educate, one must take the responsibility to promote change in the individual. Change or growth in clinical performance will only be promoted if the student is informed of her/his progress and of the performance areas requiring improvement.

The entire notion of learning in the clinical area is a complex activity. Even more so is the skill of evaluating clinical practice. The clinical evaluation process should reflect the quality of the student's actions, and serve a key role in informing the student of her/his progress. The evaluation of the student in the clinical area should be considered a tool to facilitate learning, not a means to hinder it. Students must be given time to observe and reflect upon experiences, and synthesize their knowledge in order to make appropriate decisions (Flager, Loper-Powers, & Spitzer, 1988; Girot,1993).

Clear expectations are essential both to good evaluation practice and to create a positive learning environment. Brookfield (1991) referred to evaluation as continuous judgements that reflect the political reality of education. Students would benefit from being aware of clinical performance expectations prior to beginning a new clinical experience, and should also be informed, through formative evaluation, of their progress as the experience continues. The student should also be afforded the opportunity to improve in areas of practice that are unsuccessful prior to the summative evaluation. If such practices are followed by the clinical teacher, then the evaluation of the students' clinical practice will be seen as an indication of progress, rather than as a series of negative judgements.

Lastly, in addition to direct clinical supervision, the use of student journals is an effective strategy to identify unobserved student experiences and personal reflections or emotions that could impact on either formative or summative evaluation, and more broadly on the learning environment. After sharing the journal with the educator, students often feel more comfortable discussing the issues that were documented. Journal writing is an effective means by which the educator can gain a clearer understanding of student concerns. Journals also provide a prime opportunity for students to reflect on their perceptions regarding their clinical experiences (Patton et al., 1997).

Students often feel their performance in the clinical area is continually under scrutiny (Flager et al., 1988), and that they are being constantly evaluated without having time for learning (Morgan et al., 1979).The evaluation process should be an effective means to foster growth in learning, not an event to cause fear and anxiety. Students require time to feel confident in differing clinical placements. Educators must be sensitive

to the pressures experienced by students during clinical experiences, and create a relaxed setting where students can maximize their educational potential. Only after significant learning has taken place should the students' performance be evaluated (Flager et al., 1988; Morgan et al., 1979).

A supportive learning environment was seen as the essential factor underlying all the other themes in promoting and securing effective clinical teaching. Therefore, in order to facilitate professional growth and maximize clinical learning, both teaching and evaluative strategies must take individual learning needs, stressors, and styles into account.

From this literature review, it was apparent that there is a paucity of empirical research regarding clinical teaching in nursing. If we are to move beyond a philosophical debate and operationalize concepts, then specific teacher behaviors effective for student learning must be identified. Therefore, if the five themes identified in the literature (a supportive interpersonal relationship between teacher and student, the necessity for the teacher to maintain clinical competence, the importance of the teacher "role modeling" effective behaviors for students, the value of the teacher being skilled in teaching methodologies, and the necessity of a supportive learning environment) are valid concepts for the provision of effective clinical teaching, then what *specific teacher behaviours* do these concepts represent? In other words, how and what does the teacher do to be seen as supportive, clinically competent, a good role model, a skilled teacher, and the provider of a supportive learning environment? Based on this analysis, the research questions which guided this investigation were:

1. From a nurse educator's perspective, what are the specific teacher behaviors that are judged as evidence of being an effective clinical teacher?

2. From a nurse educator's perspective, what specific teaching behaviors constitute being supportive, clinically competent, a good role model, a skilled teacher, and the provider of a supportive learning environment?

3. From a nurse educator's perspective, are there other dimensions of effective teaching that are not captured by the five themes identified in the research literature?

CHAPTER THREE

METHOD

The research methodology consisted of "in depth, phenomenologically based interviewing" (Seidman, 1991, p.9). The theoretical orientation of this method was thus a form of phenomenological research in that it attempted to understand the meaning of events in the lives of the participants "from their own point of view" (Bogdan & Bilken, 1992, p. 34). In the present research, the participants' points of view were crucial (Patton, 1990). Although the professional literature identified several "themes" regarding clinical teaching, as described in the preceding literature review, these themes are broad concepts - philosophical notions about the desired characteristics of effective clinical teaching. However, the notion of *how* one could operationalize these concepts was not addressed. Therefore, descriptions regarding *how* the participants actually demonstrated and provided support, competence, role modeling, teaching skill, and a supportive learning environment while teaching in the clinical area, became the cornerstone of this study. Building on this cornerstone, the inquiry process remained open to new insights into effective clinical teaching.

The goal of the interviews was to learn about the participants' experiences in clinical teaching, their perception of those experiences, and the significance they ascribed to them. The assumptions underlying this approach were that (a) there is value in learning about the unique experience of each teacher rather than focusing only on the

commonalities of the teaching experience; (b) individuals learn from past experience and gain maturity by assimilating these past learnings into their current thinking and behaviours; (c) the participants are the experts regarding their own teaching experience. Consequently, the data originated within each participant, and were not limited to the researcher's preconceived notion about what clinical teaching should be. At the heart of in-depth interviewing was a sincere interest in both understanding the experiences of others, and in discovering what meaning they ascribed to those experiences (Seidman, 1991), making this method particularly congruent with the research questions identified.

Participants

This research explored the clinical teaching experience of four participants from the faculty of the baccalaureate nursing program at a large Canadian University. The selection criteria were developed to optimize the selection of participants who were knowledgeable and expert clinical teachers (Morse, 1989). First, teachers chosen held a minimum of a Baccalaureate degree in Nursing. The requirement for university preparation was intended to ensure a consistent basic education in the profession of nursing. Second, to ensure considerable experience in clinical teaching, teachers chosen to participate in the study possessed a minimum of 7 years of both clinical and academic teaching experience and maintained current employment status as a teacher responsible for the clinical education of students. This experience requirement was intended to provided a thorough knowledge of the challenges, processes, and issues in clinical teaching.

Purposeful Sampling Strategies

Participants were recruited through reputational case sampling. Seidman (1991) recommended that, when studying the experiences of individuals at a specific site, the accepted method for gaining access to those individuals is through the person responsible for the functioning of that site. Consequently, the names of suggested participants were requested from the Dean of the Faculty of Nursing or his designate (Appendix A).

As the chief administrative officer of the Faculty of Nursing, the Dean is recognized as a knowledgeable judge of expertise due to his experience in both the practice of nursing and in working with faculty members. An integral part of such experience included the observation and evaluation of teacher performance and competence. Such purposeful sampling is intended to select the most suitable participants - those who are knowledgeable regarding the research topic (Morse, 1989).

The Dean was first contacted to request his support for the study and then to nominate expert clinical teachers from the faculty (Appendix A). The Dean responded that all of the clinical education facilitators in the Faculty met the criteria for knowledgeable and expert clinical teachers. When the identities of potential participants were obtained, selected nominees were contacted by email or by letter (Appendix B). Nominees were selected for contact based on their area of nursing and the year level taught in order to recruit a diverse, as well as a knowledgeable sample. This strategy was chosen to optimize the richness of the data collected.

Data Collection

Seidman (1991) posited that the use of interviewing as a research tool is a powerful way to gain insight into an experience by understanding the participants' perception of that experience. The primary method of data collection was a series of long interviews (McCracken, 1988) using semi-structured, open-ended questions. This methodology was supplemented by the data recorded in the researcher's journal and field notes.

A series of three qualitative interviews was conducted with each participant. The spacing of the interviews allowed time for participants to reflect on each preceding interview, and also provided the researcher with time to listen to the audio-tape recording of the preceding interview and note emerging themes in the data, prior to the next interview. This procedure was expected to yield a richer data base than a single long interview. The format of the series of interviews also distributed the data collection in shorter time periods - over a 3 week period - which is a reasonable time frame for both the participants and the researcher (Seidman, 1991). The interviews were approximately 1 hour in length and were scheduled approximately 1 week apart, at a time mutually agreed upon by both the participants and the researcher. Participants were asked to indicate the preferred day and time for the interviews. Their preferences were given priority. The importance of maintaining both privacy and confidentiality throughout the interviews was discussed with participants, and the days and times chosen were factors to consider in this regard.

In order to enhance privacy and uninterrupted interview time, the interviews were conducted in a closed interview room located in an area seldom used by colleagues or

students. The researcher suggested rooms that were adequate in size, had good natural as well as artificial light, had access to adequate temperature and ventilation control, and were furnished with comfortable chairs. When the participants suggested being interviewed in their homes, the merits of such a location were explored. In the end, the sites were chosen by the participants; with 3 participants being interviewed in an office setting, and 1 participant being interviewed in her home.

A series of open-ended questions was used to facilitate the interview discussions. (Appendix C). Each of the five themes identified in the research literature was addressed in the interview framework. However, these questions were used as a guide only. Using this interview structure, the researcher was able to pursue data as it emerged from the interviews, rather than solely according to a preconceived listing of concepts. As well, the use of an open-ended format facilitated the researcher's ability to elicit data through the eyes of the participants - their values, beliefs, perceptions and thoughts - and to capture new insights about effective clinical teaching.

The model of in-depth, phenomenological interviewing consisted of a series of three separate interviews with each participant (Seidman, 1991). Each interview had a specific purpose, and each provided the foundation for the next. In each interview, the major task for the researcher was to have the participants reconstruct their experiences in clinical teaching. A most important aspect of this process was for the researcher to understand the participants' experiences within the *context* of those experiences.

The series of 3 interviews was conducted as follows. The researcher's task in the first interview was to place the participants' experiences in context by asking her/him to describe the experiences that led her/him to become a teacher of nursing. A significant

question in this interview was: "How did you come to be a nursing instructor?" During this first interview, early clinical teaching experiences that participants felt came to influence their teaching practices were also probed. (Appendix C).

The second interview focused on the participants' present experiences in clinical teaching. The researcher asked the participants to describe the details of their experience - what they actually do on the job. The most meaningful way of accomplishing such descriptions was to ask the participants to reconstruct a day of clinical experience including: how they prepared, what they did with the students, how they evaluated student performance, and what they did to debrief or bring closure to the day's experience. (Appendix C).

The third interview was the culmination of the previous two, in that it asked the participants to reflect on the meaning of their clinical teaching experience, and on the accuracy of the data which was reported from the preceding two interviews. The importance of the third interview was to have the participants both reflect on and interpret their teaching practices; and in addition, to describe further details of their present experience (Seidman, 1991). By engaging in this reflection, the participants were encouraged to ascribe meaning to their experiences, lowering the level of inference required in later data analyses. The description of the researcher's preliminary analysis during the third interview also provided a form of member checking (Lincoln & Guba, 1985).

Throughout, the researcher clarified the participants' perceptions regarding emerging themes - their comments, critique, and endorsement. Revisions suggested by the participants were made and reported as such. As the study progressed, discussion included

previously collected data and the emerging themes in that data. As the participants described their experiences in their own words, different aspects of their teaching experiences arose, and the interview process remained open to exploring these experiences more fully.

All interviews were audio-taped. Participants were assured that no one other than the researcher would have access to the tape-recordings of the interviews or to the field notes made by the researcher. This material was kept in a secure, locked space for the duration of the study. To further safeguard confidentiality, persons, events and locations were described in a manner that would make it difficult to identify a specific participant or any other individuals discussed or described. Identities were disguised by pseudonyms, and by describing participants in such a way as to reduce the risk of being identified.

Although the transcripts of the interviews comprised the primary source of data, a second important source of data consisted of the researcher's reflective and descriptive field notes (Bogdan & Bilken, 1992). The descriptive portion of the notes depicted specific details of setting and summarized the participant/researcher conversations. The reflective portions of the notes recounted the researcher's observations, frame of mind, comments and reflections regarding the methodology, points of clarification, and the climate or atmosphere of the interview sessions.

The Researcher's Role

The role of the researcher was primarily that of an interviewer. The researcher has 35 years of experience in the nursing profession, in various positions in both nursing education and nursing service, thus providing a sound professional base from which to

conduct these interviews. As well, experience at counseling both students and faculty provided the researcher with a comfortable skill level for interviewing. However, these experiences gave the researcher "insider status" that could also prove to be a significant source of bias. Therefore, a conscious effort was made to become aware of and to set aside, as much as possible, any preconceived notions regarding clinical teaching or the particular teaching context. Specific strategies to identify the impact of the insider status on the study included recording in a reflective journal, employing the assistance of others in analyzing the data, and member checking.

The interviews were conducted in an informal conversational style (McMillan & Schumacher, 1993). This meant that the interviews consisted of open-ended, exploratory questions. Because the goal of the research was to learn about the participants' teaching experiences from their own perspectives, the primary role of the researcher was that of a listener. Egan (1975) stressed that it is important for the listener to learn not only about a person's experiences and behaviors, but also about the underlying feelings. He emphasized further that the listener's "ability to listen underlies his ability to understand [the other person] from [his] frame of reference" (p. 69). In order to remain alert to possible biases, personal views were articulated and explored in written reflections and memos prepared, by the researcher, at regular intervals throughout the interview series.

To further reduce the risk of bias, strategies including active listening, rephrasing, clarifying questions, prompting, and summarizing were used throughout the interviews in order to check understandings of statements made. Even though participants were expected to focus on the topic of clinical teaching in nursing, it was emphasized that within that broad topic area, anything they felt was significant, noteworthy or problematic

constituted relevant information. This emphasis maximized participant initiated responses, which further reduced the risk of researcher bias in collecting data.

A reflective journal was kept by the researcher throughout the research process. During the interviews, the researcher made notes highlighting the specifics of the data recorded. This journal recorded the researcher's thoughts and reactions as the interviews proceeded. An example of the recording of reactions included the researcher's amazement at the candor of the descriptions given by the participants. As well, the journal recorded the researcher's reflections on the data at the end of each interview. A notable reflection recorded was the complexity of the role of the clinical teacher. Subsequently, when member checking with participants, the researcher referred back to these reflective notes. The value of such a reflective journal was that it allowed the researcher the opportunity to document her own thinking, her personal and professional values, and any particular views or biases about clinical teaching.

Data Preparation

The audio-tapes of the interviews were transcribed verbatim, capturing nuances such as hesitations, or altered tones of voice when they occurred. The transcripts utilized short, numbered lines for ease of coding. Each participant was identified by pseudonym, and by the date of the interview. Once the tapes had been transcribed, the researcher listened to the audio-tapes while reading the transcripts. This activity enabled the researcher to fill in gaps, correct errors, and add notes regarding non-verbal responses such as pauses, shifting positions, laughing, or varying voice inflections.

The audio-tapes will be destroyed when the data analysis is complete: approximately 6 months following the final set of interviews. Field notes and transcripts including specific verbal content, non-verbal behaviors, and the researcher's insights and speculations as data are collected, will be kept in a secure location for a period of 10 years, and will be used in the publication of the research results, in the writing of a descriptive article, or in formulating teaching or conference presentations.

Data Analysis

The strategy employed to analyze the data was content analysis (Lincoln & Guba, 1985). As the transcripts were read, the researcher used a coding system to identify evolving categories of data, as well as the five themes identified in the literature. As data analysis progressed, categories and sub-categories of data were identified (Burnard, 1991). While the data recorded reflected, at least in part, aspects of the theoretical stance of the profession or some of the words of the researcher, it was crucial that the researcher ensured that the words and meanings of the participants became the foundation of the data reported. As a secondary data source, the researcher's reflective journal and field notes were an additional and significant source of data. These data were subject to content analysis similar to that used with respect to the transcribed interviews. The analysis of these data provided opportunities to elaborate and triangulate interview data.

It was important for the researcher to write memos throughout both the interview and the data analysis processes. These memos recorded the researcher's notations regarding recurring themes, issues that appear to be unclear, and possible explanations regarding the meaning of the data. These memos often focused on information the

researcher wished to pursue later with the participants, for example, teacher behaviors that appeared to encourage students to assume some measure of control over their clinical learning. A further example of the use of memos was to record what appeared to be an emerging theme, so that the researcher could seek information regarding the same theme elsewhere.

Final documentation consisted of a descriptive narration with depth and richness of data - what Eisner (1991) refers to as "attention to particulars" (p. 38) - and an analysis and interpretation of participants' perceptions. Recurring themes of data were highlighted, utilizing extensive direct quotations, to report the participants' experiences, meanings and language accurately.

Limitations of the Research Design

Several possible sources of bias existed with this research. First, was the researcher's own experience at being a clinical teacher and her beliefs regarding clinical teaching. The researcher's own experience has shown that it is possible to be a helpful and supportive teacher, provide challenging patient care experiences, and yet be a fair evaluator of varying levels of performance. Moreover, providing learning time prior to any formal evaluation of performance is purported to help ensure a supportive learning environment. Therefore, the researcher was particularly alert to what the participants said about such issues; whether different from or confirming her own. All interviews were audio-taped so that the raw data consisted of a verbatim account of what was stated by each participant. In addition, the researcher's field notes included comments regarding her feelings, observations, and perception of the climate of the interview. Subsequently, when

transcribing the field notes, the researcher rigorously critiqued the data for these biases and actively searched for negative cases in the data.

Second, since the researcher is a long-standing member of the nursing profession and has been fairly visible in professional organizations, it was possible that some of the suggested participants and the researcher would have prior professional knowledge of each other. This could influence the candor of the data participants share with the researcher, as well as how their perceptions were heard and understood. In addition, the researcher's observations of the personal characteristics and teaching styles of known faculty members could influence the perception of desirable teacher behaviors. For this reason, the researcher attempted to avoid utilizing faculty members personally well-known to her, for fear that any prior assessment of their abilities would influence how the researcher would interpret their information.

In addition to the above stated sources of bias, some additional limitations could also be present. During this study, the researcher interviewed only faculty members in the baccalaureate nursing education program. Students in the same program were not interviewed. Therefore, the results of this research described only one perspective - that of the teacher. Thus, the data reported a faculty perspective regarding clinical education. Although it is important to know about the faculty perspective on the clinical education process, it is equally important to acknowledge that these data do not represent a student perspective on the teaching and learning experience.

A further limitation could be an inconsistency in the researcher's interactive style. To guard against this, the researcher maintained a diligent awareness of the focus and

possible directions of the interview series and critically evaluated the transcripts for evidence that her interviewing style influenced participants' responses.

While it is important to recognize these limitations, the research methodology has been designed to acknowledge and, where possible, to minimize their effects. The results generated by the methodology described are presented in Chapter 4.

CHAPTER FOUR

RESULTS

This study was designed to answer the following research questions:

1. From a nurse educator's perspective, what are the specific teacher behaviours that are judged as evidence of being an effective clinical teacher?
2. From a nurse educator's perspective, what specific teaching behaviours constitute being supportive, clinical competent, a good role model, a skilled teacher, and the provider of a supportive learning environment?
3. From a nurse educator's perspective, are there other dimensions of effective teaching that are not captured by the five themes identified in the research literature?

The data necessary to answer these questions were provided through an examination of the clinical teaching practices of four "expert" clinical teachers who, at the time of the interviews, were faculty members of a baccalaureate nursing program in a large Canadian university.

All participants had been professional nurses for a period of 21-34 years, and had been clinical teachers for 10-31 years. When they were interviewed, all participants held the position of "clinical education facilitator" - the title for a faculty member who has responsibilities for teaching students in the clinical area. Two of the participants teach in the first year of the four year baccalaureate program, one teaches in the second year, and one teaches in the fourth year of the program. This group of participants met the criteria

for "expert clinical teacher" in that all had educational preparation at least at the baccalaureate level, a minimum of 7 years of teaching experience, and current employment which included responsibilities for the clinical teaching of students. The participants' areas of specialization are not identified in order to protect confidentiality. The demographic characteristics of the participants are depicted in Table 1 below.

Table 1: Demographic Profile of Participants

Participant	Educational Credentials	Years as a professional nurse	Years of Teaching Experience
Cynthia	R.N., B.N.	34	31
Lori	B.Sc.N., M.N.	28	18
Lisa	R.N., B.N.	21	16
Jillian	R.N., B.N.	25	10

Five themes for effective clinical teaching were identified in the professional literature: maintaining positive interpersonal relationships with students, maintaining clinical competence, being a positive role model, maintaining teaching competence, and promoting a positive learning environment. Data provided by each participant validated each of the themes identified in the professional literature. As well, all participants, as they described their teaching experiences, were readily able to describe *how* they operationalized these themes. This knowledge will help to move our understanding of these themes beyond the philosophical realm (which had been recorded in the existing literature) and into the operationalization of these themes. Describing how the effective teacher is able to put these themes into practice was, in fact, the purpose of this study.

The Results Chapter presents the participants' beliefs and practices regarding the five themes - the significant concepts regarding clinical teaching - that are discussed in the professional nursing literature. A case presentation format with respect to each of the five themes has been chosen to demonstrate holistically the interplay between the themes, as well as to illustrate individual themes. Throughout, the cases are coded by interview number, (1, 2, or 3); and by transcription line numbers. Because the participants mostly referred to female students, the students throughout are referred to in the female gender. Following the case presentations, indicators for the five themes, both across and between cases, are summarized in tabular form. Second, critical incidents that influenced the development of the participants' clinical teaching are described. Lastly, new observations - emerging themes - that were identified by the participants are discussed.

Participant Cases

CYNTHIA

The first participant, Cynthia, has been a clinical teacher for 31 years. During her career, she has taught in most clinical areas. Currently, she teaches second year students in a specialty area that is a particular favourite of hers, and in which she has the most teaching experience.

Regarding the first theme, **maintaining positive interpersonal relationships with students,** Cynthia stated that she feels that the teacher first has to "treat each student as an individual", that each has her/his own uniqueness, and that the teacher has to accept that notion, and know that each student requires a different approach (1, 648). To accomplish this, the teacher "need[s] to listen... to what they're telling [you]" (1, 861).

Moreover, the teacher must be "available" when the student needs a teacher to talk to, but also "physically available": present on the unit when the student is there: observing, assessing, and helping her/him with patient care (1, 863-864). To maximize her availability, Cynthia reported that she "gives her students her home telephone number, and tells them the times that they can [reach] me" (2, 103-104).

Cynthia clarified that, as well, the teacher must be "understanding [and] empathetic" (1, 643). Cynthia also observed that one of the complicating factors is that today's students have many more responsibilities, stress, and life issues than students have had in the past; so the teacher has to take this into consideration, listen to and integrate this information, and try to learn what is happening with the student. For example, today's students experience more pressures with having to juggle studying, working, and family responsibilities. Consequently, Cynthia reported that the teacher must contend with students coming late, and "yawning during clinical experience: I've never seen so many students come yawning in the morning" (1, 669-670). Because of this, Cynthia stated: "I find that I'm trying to cut down on the amount of things I ask them to do clinically, because they've got too many other things to do". (1, 701-703). Cynthia further observed "that clinical, unfortunately, often comes second" (1, 668-669).

Cynthia stated that she consciously makes herself available, and acts as a "bridge between the student and the rest of the medical people, interpreting things to them" (1, 874-875).To do this, Cynthia interprets for staff what the students' responsibilities are: the focus of their assignment, and the care they can give. Cynthia reported that she also tries to be a "friend" to the students, and not just the "ultimate authority" regarding their clinical performance (1, 904, 914). Therefore, she purposely goes for lunch and coffee

breaks with her group of students. In addition, she makes a point of going for coffee with each student individually, and spending one clinical day solely with each student, helping them with their care, or just assessing that their care of patients is appropriate. She refers to this practice as spending "quality time" with each student (1, 934).

Cynthia stated on several occasions that she felt it was extremely important to be fair and to be seen as being "fair", and although all students didn't need an entire day of her time for assistance with their clinical practice, it was important that she provide this guidance for everyone (1, 928). Cynthia reported that it was also important that the students "know that they will each have...that day" with their teacher, assisting them with their clinical practice (1, 939).

Regarding the second theme, **maintaining clinical competence,** Cynthia stated that the good teacher had to be "knowledgeable [about her] subject" (1, 634). She observed that she was a "far better teacher now" than when she began teaching, because of her increased knowledge: "I can answer questions on the spot without looking them up" (1, 636-637). The methods Cynthia has used to accomplish this expanded knowledge base include: spending time working on the units:" it added credibility"; I was "just so much more accepted...after that" (1, 137-147). Another method Cynthia uses is being open to accepting suggestions and guidance from the staff when supervising a student's skill performance: "She[the unit nurse] says...I would suggest you doing that. So I said, O.K. And a lot of the things she suggested were things that she's learned from being there...the things she was saying...were correct, and they were things that certainly helped"(2, 316-320, 322-323).

As to the third theme, **being a positive role model,** Cynthia stated that she is active, enthusiastic, laughs, and in the students' words, is bubbly: "usually pretty bubbly and energetic" (1, 1693)! She noted that her approach is due to both her verbal and non-verbal behaviors: she's happy, "pretty nice" to patients; and always portrays the specialty area as an "exciting area to be in", with many new advances in both technology and methods of patient care (2, 1389-1390). She reported that you have to "be enthusiastic about what you're teaching", care about students, and be flexible and willing to listen to them (2, 411). Lastly, Cynthia emphasized that she loves conveying information that contributes to student learning.

Regarding her relationship with staff, she clarified that she has known this staff for 25 years - some of them are former students of hers. In relating to them, she reported that she is polite, diplomatic, and accepting of what they say. She stated that she listens to their ideas, and tries to understand their point of view. Cynthia clarified that she also tries to convey to staff that what they are doing really helps both the students and their learning experiences, and that she appreciates this assistance. She observed: "They're [the students are] often buddied with a nurse. There's other people out there that can teach the students as well as [I] can, and that's O.K." (2, 245, 225-227). She noted that she reports to staff regularly, keeps them informed, and encourages the students to do the same. She stated that she also tries to have students complete the care of their patients before they leave the clinical area. Cynthia emphasized that overall, she accepts responsibility for both her own behavior, and also for the actions of her students.

Regarding the fourth theme, **maintaining teaching competence,** Cynthia observed that the teacher has to be approachable at all times. Closely related to this notion

is the belief that the teacher is trustworthy. Students have to feel that they can trust their teacher, or they will not feel comfortable talking to her about their clinical practice. As well, Cynthia stated: "You want the students to be able to come up to you and ask questions whenever they [need to]" (1, 641-642).

Cynthia reported that - on the first clinical day - it is most important for the teacher to give the students very clear expectations regarding their behavior, and what they are to learn while in the clinical situation. Therefore, during the students' orientation to the clinical area, Cynthia clarifies what she expects: "You have to have clear, clear expectations as to what you want of the students" (2, 159-160). Her expectations are that [she doesn't] "expect the students to be experts, but [she does] expect them to be safe" (2, 163). "That's the one overriding thing, that [they're] safe" (2, 823-824). She also expects them to report aspects of care to her; that they tell her when they are in trouble: "if you feel you're not getting help...you have to somehow tell me" (2, 248-250). Lastly, Cynthia expects the students to truly care for their patients: "I want to know whether they care" (2, 1027-1028). Cynthia assesses whether or not the students genuinely care for their patients by observing their patient-centered behaviors. For example, she notes whether the students spend considerable time away from their patients or spend the majority of their time *with* their patients: talking to them, teaching them, and supporting them.

She reported that she tells the students there is no excuse for not knowing what they are supposed to be doing, therefore encourages the students to ask questions, but emphasizes that she is always available for assistance: "I'm right here to work with them on the answers" (2, 188-189). To facilitate the students' giving of patient care, Cynthia reported that she has developed work sheets which outline the care required by the

patients, and the order in which the various aspects of care should be provided: "I give them this...whole list of everything that [has] to be done all day...and give it...in order" (2, 500-501). As well, Cynthia clarified that it was important for the teacher to just be there and be approachable because situations in health care often change, and the students won't be able to adapt to these changes unless you're there to help them do so. Cynthia reported that she also assists students when they're performing psychomotor skills. Very often "she will [perform] a skill with them" (2, 940). Cynthia also noted that she will "talk them through" the experience: "So basically, it's just talking them through things. Very often I will do a skill with them. I will get them to do it but I will also do it with them, explaining as we...go along" (2, 939-942).

Cynthia observed that the teacher also has to be "enthusiastic about what you're teaching" and organized in her teaching (2, 411). She stated that to be enthusiastic, one has to like what you're doing. In terms of organization, Cynthia reported that: "you have to be organized. If you're not organized, then the students won't be either" (2, 424-425). She noted that "I find there are some days when I'm not - it does reflect on them" (2, 425-426).

An additional strategy Cynthia uses in her teaching is humor. She stated that you have to be able to "laugh with" the students, and you have to be able to laugh at your mistakes (1, 1103-1104). Her philosophy is that "it's O.K. to make mistakes, we all make mistakes, that seldom are they of 'life and death' significance, and that "we can work together to fix them" (1, 1121). One of the ways Cynthia puts this into practice is by incorporating a "blooper of the day" into the round table discussion during her post-conferences (1, 1144). The practice is that "all of us has to say...what was our blooper

today. And I had to, too" (1, 1144-1145). Thus everyone not only learns from the situations described, but the occurrence of mistakes is normalized, the reality of speaking openly about them is practiced, and the importance of "owning up" to mistakes is strengthened.

Lastly, Cynthia observed that a teacher must learn how to "let go" (2, 205-212, 224-227). She reported that she struggles a great deal with this idea. However, she observed that now that the clinical practice component of the curriculum has been reorganized so that there are "clinical education facilitators" rather than "teachers", the teacher has to be comfortable with having members of the institution staff do some of the teaching. She noted that now that she is a facilitator, she has to think that this means that it "doesn't necessarily have to be me that's doing the teaching. It can be other people" (2, 210-211). Cynthia stressed that this is a philosophical shift for her, but she believes that she now has to learn to feel comfortable with letting others participate in the teaching of students.

In terms of the fifth theme, **promoting a positive learning environment,** Cynthia observed that the teacher must be adaptable and flexible regarding many aspects of clinical education: the patient assignments for the students, the date for handing in assignments, the topic for a post conference. For example, regarding a post-conference topic, the prudent teacher would make a change to promote discussion of a significant issue that had occurred during the day's clinical experience, and thus would logically replace a topic that she had planned for presentation with the more urgent one. Cynthia observed that the teacher must also be "able to re-organize on the spot"- revise "the plan for the day to reflect what is happening" in the clinical situation (2, 463-464). Moreover, Cynthia

stressed that it is important to model this behavior for students, as they also must learn to be adaptable, as this is a necessary skill in the ever-changing field of health care.

As a further way to promote a positive learning environment, Cynthia clarified that, if a student makes a mistake, she will not correct her in front of a patient. Rather, she corrects the student in private, and the student then returns to the patient and explains the error. Throughout each clinical experience period, Cynthia noted that she models the use of therapeutic communication by utilizing such techniques as reflecting and clarifying.

Lastly, not pre-judging students is a quality that Cynthia reported was particularly important for the teacher. "I think one of the things you have to be very careful of is not to pre-judge students before they come" (3, 817-818). Therefore, she does not look at any reports from previous teachers - unless the matter is crucial - until she has worked with the student for at least two weeks. She clarified that sometimes she finds that what has been reported to her regarding student behavior is, in fact, something else entirely. Cynthia uses both observation and assessment skills to identify the appropriateness of student behaviors. Should she observe behaviors that, for example, demonstrate the provision of incomplete care for patients, or a lack of necessary knowledge, she then refers back to previous evaluative reports. At this point, Cynthia must ascertain whether what she is observing is a previously noted pattern of unacceptable behaviors or a newly observed behavior. Once that decision is made, appropriate corrective actions are planned. Her message is that teachers need to be extremely careful regarding previous evaluative reports, and to make their own observations regarding student behavior prior to judging them. More generally, Cynthia placed a great deal of importance on using student

behaviors to make teaching decisions. She cautioned "If you see a behavior, check it out right away. Don't wait" (1, 1540).

LORI

The second participant, Lori, has been a clinical teacher for 16 years. She currently instructs fourth year students in a most challenging specialty area, and one in which she has a wealth of experience, both as a clinical manager, and as a teacher in both diploma and baccalaureate programs.

Regarding the first theme, that of **maintaining a positive relationship with students,** Lori stated that the most significant quality of a good teacher is the ability to develop positive relationships with students. She observed that the teacher needs to connect with the student on a personal level. Her belief is that if the teacher " cares for students, they will learn to care for patients" (1, 87-88). She observed that you have to model caring, and the "absolute-most important" way to do this is through the relationship with students (1, 90). If "the teacher treats the students with disrespect [or] suspicion", then the necessary bond will not be developed, and the teacher will "know [that she is] you're not being a good role model for them" (1, 91-93).

Related to the development of this positive relationship with her students, Lori observed that a very important role for the teacher is facilitating the personal growth of the students, and in particular, enhancing their own self-awareness. Lori reported that "helping students in their personal growth and development is an important aspect of helping people...become good nurses" (1,387-389). She stated that she is "amazed at how open students will be when you...are sensitive to them, and when they're hurting, you are

'there' for them" (1, 390-392). Moreover, Lori observed that it is important to teach students that all humans are equal, "that we're...moving toward healing and wholeness, and in that relationship both grow"(1, 418-419). Lori truly believes that people's personal issues and attitudes are the very factors that inhibit them from relating well to patients and staff. Therefore, she notes that it is extremely important to help the students develop on a personal level, to facilitate this development, and to give students permission to be authentic with the teacher.

Lori reported that she doesn't feel she needs to motivate today's students too much because they are highly motivated themselves. However, she acknowledged that she feels she does provide motivation by "being who I am and being enthusiastic about the work that I do, and by taking an interest in them, and taking an interest in the patients, and the families" (2, 886-888). She stated "I think if you show that you're interested, they're [the students are] more likely to be interested too" (2, 889-890). She stated that rather than having to motivate students, the teacher has to be careful not to de-motivate them. Students can be "de-motivated" if the teacher makes things "too rigid, by not allowing them to be creative", or "by not allowing them to disagree with the teacher's opinion" (3, 746, 751-753). Other teacher behaviors that have a negative effect on students include "being authoritarian, not trusting, standing there for every move, being uncaring towards a student, having unrealistic expectations" (3, 769-771).

Regarding the second theme, that of the teacher **maintaining clinical competence,** Lori observed that one of her strongest beliefs is that the teacher has to be knowledgeable. She emphasized that a person can't teach if "they don't know what they're teaching" (1, 684). She also believes that the teacher has to like nursing, and like

being involved in giving care, and should assist her students and the staff in giving patient care whenever possible. Lori stated that she has a commitment to life-long learning, at both a personal and a professional level. She reported that "it's very important for the teacher to teach in an area where she is clinically competent, and that you maintain that competence" (1, 690-691). She acknowledged that the teacher has to work hard to keep up to date with new developments in her field of nursing. Thus, Lori reports that she sees it necessary for the teacher to be constantly researching, "taking educational courses...[attending] workshops, inservices", and reading literature from related fields: "doing whatever you need to do" : all in order to be aware of the current thinking and advances in the field (1, 691-693).

As to the third theme, **being a positive role model,** Lori reported that she believes she accomplishes this largely by helping the students with their care. She stated that she likes "to get my hands dirty and get in there and intervene" (1, 749-750). She also feels that her own "personality type that...value[s] relationships [and] harmony, [being able to put herself] in other people's shoes, [and being] able to explain things in a way that people understand, makes an effective teacher of adults" (3, 862, 865, 867-868).

Lori reported further that she acts as a positive role model through developing and maintaining positive relationships with staff. Lori stated that she has a very respectful and mutually supportive relationship with the unit staff, the head nurse, and the clinical nurse specialist. Each helps the other in their various roles, and Lori often "defers final decisions [regarding patient care] to the staff" (2, 1089). As well, Lori stated that she considers herself to be one of the staff, thus she conducts inservice education sessions with the staff, brings relevant resources to their attention, and assists with patient care whenever she can.

Lori referred to her relationship with staff as a very open, two way relationship. She clarified that she feels that if "you [the teacher] don't connect with staff - your students will suffer and you will suffer" (2, 1127-1128). Conversely, she stated "that if you [the teacher] and [the] staff get along, I think it reflects on the relationship between the staff and the students" (2, 1132-1133). Once such relationships are established, the staff are more than willing to assist the teacher with the students, help choose appropriate patients, or help supervise or teach students during their clinical experience. Lori can then utilize the staff as additional teachers for the students.

Regarding the fourth theme, **maintaining teaching competence,** Lori observed that teaching is a "very nurturing...caring role", and that these behaviors must be modeled for students (1, 94-95). Furthermore, Lori clarified that the teacher has a significant role to play as a counselor: "it's that counseling role that I really think is so important" (2, 176-177). She cited the value of having a private office, so that the students could just come for a chat. During such visits, the student would often "just drop in and start talking herself about some issue in [her] personal life that was affecting [her]...ability to practice [her] profession" (2, 162-166). Alternatively, the situation could be that, from what the student is saying, you realize that she has set her "standard so high, she'll never be able to consider [herself] successful, because she has been comparing her own skill level to that of the teacher" (2, 184-185). Once the teacher knows this, she can then help the student understand what is a more realistic goal for herself as a student.

As part of this counseling role, Lori observed that it is also important for the teacher to teach the students how to see the whole person - both the family members as well as the patient - to look beyond today, and think about what will happen to this person

after discharge. Lori stated: "they [the students] focus on the individual...they often don't even ask questions about what's happening at home" (3, 809, 810, 805-806). Lori noted that this is not easy in today's world. Because of our emphasis on technology and theory, the focus of health care is often on the myriad of physical tasks that must be done, not on providing the much needed care and support for both patients and families.

A further important role for the teacher is to help socialize the students into the real world of nursing. To this end, Lori reported that she talks to the students about their current patients being "just patients like other patients they've looked after" (1, 441-442). On the first day of clinical experience, she introduces them to the staff, and to the multi-disciplinary team. She reported that she encourages the students to talk to all members of the health care team when they have questions about their patients. She also involves the students in patient conferences, and notes that "they're quite amazed actually, when they share something at a conference, and people listen to them. I think that helps instill confidence" (1, 449-451).

As a further means of socializing the students, Lori stated that "the first thing I do in their orientation, I go over 'my rules'" (3, 924-925). She clarified that she gives the students a "handout that outlines her expectations" regarding such topics as: research, documentation, and performing nursing procedures: basically, "if in doubt, check it out with me" (3, 925).

Another factor in socializing the students is to teach them that they need to be able to adjust their plan for the day, or the care plan for their patients. Lori emphasized that the students need to learn to be sensitive to what is happening at the moment, that situations continually change, and that heath care workers have to be able to handle that occurrence.

Lori reported that she tells her students "don't go into the room 'with an agenda', because if they do, then they concentrate on their agenda, stop listening to the patient" (3, 708-709). "And so they don't pick up on the cues, and they don't go where the patient needs to go, they go where their agenda is" (3, 721-723).

From what Lori reported, it seems clear that she uses an inquiry method when teaching students clinically. She stated: "I think it's very important that you teach them how to question and think for themselves" (1, 109-110). Therefore, Lori does not give the students all the answers, but rather leads them from their current knowledge to new levels of understanding. Thus, Lori helps them talk or think things through by asking questions such as: "What did you see there?", or "What do you think is happening?" (2, 980-981). Lori observed that it is also important to allow students to disagree with the teacher, and to express their own perspective regarding a situation.

Lori reported that to coach students, she does a lot of "dry runs, especially if it's a complex skill that they've never done before" (2, 578-579). She stated that she has the student handle the equipment, and "just talks them through" (2, 580) the procedure prior to going into the patient's room. She then accompanies the student while she performs the skill, staying with her in the patient's room until the procedure is completed.

Lori reported that a further important quality for the teacher is to be able to "learn from your own mistakes" (2, 97). She observed that "when a teacher makes a mistake, that often means going back and saying to the student, 'I made a mistake'" (2, 98-100). Lori emphasized that the teacher must also acknowledge when she does not know something. Students do not respect a teacher who is unable to admit when she is wrong. Moreover, this teacher behaviour gives the students permission to not know everything as

well. When they come across something they need to know and do not, then they must find out: they must not be afraid to ask, or to seek assistance. The message should not be that the teacher has all the answers, and it is important that the students understand this principle. "It's not kind of a one way street where I have all the answers. I think that's important to teach students" (1, 419-420). Once again, the desired behaviours are modeled for the students by the teacher.

Regarding the fifth theme, **promoting a positive learning environment,** Lori stated that she believes the most significant factor is to begin by developing positive relationships with students. Thus, when giving feedback regarding the students' performance, Lori reported that she likes to provide this as situations occur. However, when it is time for the formal evaluation to be given, she softens the process and tries to make it a little less formal by following up "on some of the personal issues that they may have discussed with me", finding out how they're doing, and "[giving] them some positive reinforcements and some pointers for areas they can improve on" (2, 1237-1238, 1230-1231, 1233-1234).

Lori stated that she also uses the students' journal entries as a means of giving them positive feedback regarding their experiences. Lori noted that these entries are especially useful when a student is quiet and shy, or thinks she is not doing well; and Lori knows from her description of her behavior that she is doing just fine, then Lori can give her the appropriate feedback. She encourages students to write examples, to "brag a bit" in their journals, as she is aware that "there's lots of things out there that they do that they might do very, very well. But I don't see" (2, 813, 814-815). Lori stated that she instructs students to "tell me about those things in your journal, so that then you can give them

positive reinforcement" (2, 816,821). Lori clarified that she also looks for progress regarding what the students write in their journals: she believes it is "more important how far they've come, than how far they are" (3, 1120-1121).

Regarding the evaluation of students, Lori stated that the most important factors regarding this responsibility are to be observant, and to listen to your own intuition: "a lot of it is, is quite intuitive" (1, 195). Therefore, she keeps notes regarding each student's behavior, particularly regarding the kind of questions they ask; suggestions they make; journal entries that indicate how they're thinking, how they're applying theory; and whether they raise ethical issues.

> If they ask you good questions, and they come with good suggestions, and they write things in their journal that indicate that they're thinking, and that they're applying the theory to the clinical area, and they raise ethical issues...you're getting a pretty good picture (3, 1047-1051).

Lori stated that she prefers to have numerous examples, either from the students themselves, or from her own observations, but that she will use a single example of a behavior if it is a particularly valid one. Lori reported that she analyzes her notes as to what she saw, felt, or heard that gave her a certain impression regarding a student. She stated that this feeling is often related to a "pattern of behaviors" that she has observed over time: "...it's usually a pattern; it's usually not one thing" (1, 268-269). As well, Lori stated that she "looks for progress in their journals from beginning to end" (3, 1119). In these instances, she reported that it is time to discuss her observations with the student. In order to make these judgements, Lori emphasized that the teacher needs to be on the clinical unit when the students are, in order to assess their behaviors. She stated that she observes "the students' attitude, their strengths and weaknesses, how they relate to

patients, how they relate to the staff, how they relate to her, and what they tell her: "their attitude is so important" (2, 761-763). Open evaluation is also critical to Lori's decisions to allow students more independence in their practice. Lori explained that she observes students less frequently as she gains confidence in their practice. Lori further observed "when I get a sense that I can trust [a student] to come to me when needed, and to make realistic and sound judgements, then I don't necessarily need to be in the patient's room" (1, 206-208).

Lastly, Lori acknowledged that being a teacher is hard work. In her words, "you can't just sort of slack off and....kind of let it happen" (1, 121-122). She observed that the teacher has to "think ahead, be prepared,... [and] try to make the learning experience as fruitful as possible" (1, 122-124). So this job can be "very complex in terms of... [choosing appropriate] patients" for the students (1, 124-125). Lori reported that some of the issues she has to consider are choices the students make regarding patients to look after, needed skills experience, communication knowledge, and whether the patient and family will provide a good learning experience for the student. "I try to look at the whole picture when I look at the patient and the family....Are they [the students] going to learn as much as they possibly can in this particular situation?" (1, 130-133). Almost as a concluding statement, Lori reiterated that: " I do think it's also important what they...get taught clinically. And I think it comes from the role modeling" (1, 558-560). Lori considered this especially important in the areas of communication skills, supportive relationships, and the notion of caring.

LISA

The third participant, Lisa, has been a clinical teacher for 16 years, and currently teaches first year students in the clinical area. This is the students' first experience at giving care to patients, and they are placed in a community hospital for this learning opportunity.

Regarding the first theme, **maintaining positive interpersonal relationships with students,** Lisa reported that she believes that first, the teacher must adopt "more of a supportive role and [be an] encourager...that definitely seems to be the most appropriate" role for the teacher with first year students (1, 536, 537, 535-536). Moreover, she observed that when the teacher is not being a facilitator, then the students' level of anxiety increases. In that situation, the learning context becomes one in which the student is primarily afraid of making a mistake, literally becomes intellectually immobilized, and so makes even more mistakes as she/he is focused on her anxiety and is not thinking clearly. "Often they [the students] were so...nervous that...that created problems for them" (1, 772-773). To combat this possible occurrence, Lisa reported that she purposely tells the students, whenever she can, how much they help both the patients and the staff. She emphasizes to them that they perform tasks that provide "some relief [for] the staff too", and that "it really cheers people up ... people get a bit of attention" when students spend time with them (1, 975-976,974-975). Lisa stated that in this way, she hopes to encourage and validate the students, and give them the sense that they really "help to make a difference on the floor for the staff, and also for the patients" (1, 982-983). Lisa also identified that she believes a large portion of what she uses is her own enthusiasm for what she does; and her enjoyment in "[sharing] that with them so that they

can...experience that pleasure...of success: even though they may not even recognize it as a success" (3, 1053-1055).

Lisa stated that she also acts as the students' buddy, saying, "Oh, we can do this" (3, 464-465)! Nor does she leave the students alone in difficult situations, but if they wish to try something on their own, she'll say "O.K...., but I'll check back in 5 minutes" (3, 1089). Lisa also observed that it is important for the teacher to be aware of the students' level of fatigue, and not to push continuing an experience when the students are too tired to learn. "I really don't try to push that too much. I've learned, that's been a learned thing for me. I used to do that a lot"(3, 999-1000). Lisa clarified that when she began teaching, her mindset was: the students are mine for today, so we will complete all the items on my agenda-even if we are late getting off the clinical unit.

Lisa reported that she gets the staff involved with the students while they are giving care, so that they can experience being part of the health care team. She stated that she believes most students are well motivated, but that "fear is more of a problem" than motivation (3, 1091-1092). She observed that students are "afraid of hurting someone, or [of] not doing it [a procedure] properly" (3, 1111-1112). She reiterated that, because of this, she sees her major role as being a supporter and an encourager of students, and someone that helps them solve problems.

Although Lisa does not consider student motivation to be a major problem, she acknowledged that being "so serious and intense", are teacher characteristics that have a negative effect on students (3, 1119-1120, 1148). In summary, Lisa clarified that "maintaining a positive relationship with students is no different than how you maintain a positive relationship with anyone. I try to really understand them and I try to ask them

questions in a way that's not threatening" (2, 1460-1464). She clarified further "I tend to use some humor to build relationships. I share aspects of my own experience. I don't think it's...anything different from how we build relationships...you're honest with them" (2, 1466-1470).

Regarding the second theme, **maintaining clinical competence,** Lisa stated that the teacher has to "know her stuff": have "a strong theory base so that [she] can apply [theory] easily" in the clinical setting (2, 169-170). She stated that because she is teaching in a different clinical area this year, she finds that she is "hitting the books and reading more" in order to maintain current knowledge (1, 456-457). Lisa reported that an attribute of the effective teacher, and a further benefit of maintaining competence, is that the teacher can then be a true resource for the staff.

Regarding the third theme, **being a positive role model**, Lisa observed that this is a skill that she feels is strongly tied to her own enthusiasm: "being enthusiastic myself... that's a big piece of what I use" (3, 1048-1049). She further observed that her own personality traits have a significant role to play. She stated that she is a "relatively friendly person, who doesn't brush people off, and who doesn't have an abrupt manner" (2, 1499-1450, 1490, 1500). She stated that she takes time to find out who her students are, and what concerns them. "I try to really understand them...and see...where they're coming from" (2, 1462, 1464-1465).

For Lisa, a most important aspect of teaching is "being able to establish positive rapport with the staff, and be a resource for them"(1, 466-467) . She noted that "people will ask you questions if they see that you...are knowledgeable" (1, 469-470). However, Lisa reported that she usually waits for the staff to initiate the request for information.

Lisa reported that she also ensures that the staff are well informed about what the students can do. For each clinical day, she writes a note for staff "telling them what we will be doing, and what our expectations are for this experience" (2, 579-580). Lisa stated that she also leaves her name and phone number for the staff, should they have any questions about the students' assignments. She noted that "I have to work really hard to get the staff to be on board", but that once a positive relationship is developed, then the staff become a significant resource for both her and the students (2, 664-665).

Regarding the fourth theme, **maintaining teaching competence,** Lisa observed that students naturally look to the teacher as leader: "I think that's by default. In fact it's relatively easy. They look to me as a leader" (2, 1552-1553). Moreover, when students have confidence in the teacher, they will adopt the teacher's practices. "If the teacher demonstrates the practice the way it's to be done, they [the students] will do it" (2, 1564-1565). However, Lisa noted that the teacher first has to demonstrate organization, patience, a real love for nursing and what she does, and energy" (1, 440-441).

When asked about how she orientates students to the clinical area, Lisa reported that she begins by "[including] elements of the course that require [explanation]" in her orientation to the clinical experience (3, 1162-1163). She tours the facility with her students, and introduces the students to "every one of the staff that comes along that I know" (3, (1179-1180). Lisa has the students complete a treasure hunt for items they should be able to find, and shows them where important items are located at the nursing station (such as the patients' charts and the Kardex). Lisa also has the students note the location of fire extinguishers, as she feels this is "basic information they are expected to know wherever they work" (3, 1271-1273). During this full day of orientation, Lisa

remains cognizant of appropriate teaching methodologies and student fatigue levels. Therefore, in order to avoid having the students sitting in a classroom for 8 hours, Lisa schedules sedentary activities alternatively with more active tasks.

Lisa clarified that she considers coaching to be an important teaching strategy. When coaching, Lisa first assesses whether the student has done some preparation: "I first check to see...did you get a chance to do some reading about this" (3, 1306-1308). If she/he has, then Lisa will go over the skill with the student before they go into the patient's room. Lisa reported that then "we'll go through...the steps. I'll tell them a little about what's on the tray" [needed equipment], and how the institution's tray differs from the trays they can practise with at school. Then the necessary equipment is gathered together, the procedure is reviewed, and they proceed to the patient's room. Once in the room, Lisa clarified that the student performs the skill with Lisa observing. If an error is made, Lisa will not say anything in front of the patient, unless it is crucial: "I don't like to...do anything that's going to...make the patient a little concerned about who is doing [the procedure] nor undermine the students" (3, 1339-1341). If such a situation occurs, Lisa reported that she will say "O.K., that's good", and will finish the procedure herself (3, 1345). During this type of skills performance, Lisa clarified that it "becomes my role...talking to the patient", which seems to put the student "at ease", while still allowing her to "focus on the student" (3, 1384-1387). After they leave the patient's room, Lisa reported that she debriefs the student regarding her performance, and the student completes the necessary recording regarding the skill.

Regarding the fifth theme, **promoting a positive learning environment,** Lisa reported that she believes her major role is to support the students in their learning

attempts. Thus she provides them with considerable information regarding their patients, and what they must research in preparation for clinical experience. She has the students work in pairs, so that they always have peer support. Lisa clarified: "I often work them in pairs - with certain things that seem particularly intimidating at first" (1, 632-633). In this way, each student has peer support as well as teacher supervision. Lisa also encourages the students by accompanying them when the perform a skill. Lisa reported that another strategy she utilizes to show support, is to "really work with the students...I don't just sort of direct them to do things, I'm in there" assisting with actual patient care (1, 623-625). As well, Lisa clarified that, if she sees that a student is "overwhelmed" about a skill, she will say: "You know...why don't you watch me this time", she will then perform the skill herself, accompany the student the second time, and they will do it together (3, 467-468).

Regarding the evaluation of the students' performance, Lisa stated that, contrary to what she did when she first began teaching, she does not: "evaluate a lot right on the spot" (1, 533). Instead, she ensures that a student has performed a skill several times before she evaluates that performance. She stated that she makes the assumption that "most of the students are going to be able to handle this course", so she doesn't come down hard on them until she sees signs that the student is in trouble (1, 568-569). As well, Lisa observed that: "now I think I use more intuition than I used to" (1, 564-565).

Lastly, Lisa reported that one of the most important facts she has learned during her teaching experience, is that the way we approach and provide support for students really makes a difference. She emphasized that the school's procedures and policies cannot be applied literally - in a "black and white fashion" - that they "are there for a reason. And they're quite useful" (1, 1109-1110). However, it is "the way we approach and use them

[that] can really make a difference" (1, 1110-1111). That difference is in the degree of support and encouragement the student feels when the teacher applies "the rules".

JILLIAN

The fourth participant, Jillian, has been a teacher for 10 years, and currently is responsible for teaching first year students in the clinical area. For this experience, the students are assigned to a community hospital. As with Lisa's students, this is the first time these students have cared for patients; and for many of them, the first time they have been inside a health care facility.

Regarding the first theme, **maintaining positive interpersonal relationships with students,** Jillian reported that she tells the students "to ask questions, never to go into something blindly, and never assume anything" (2, 984-985). She stated that she encourages the students to come to her with any question, but she also encourages the students to do their own research. If a question regarding a diagnosis arises, Jillian will have the student who asked the question, plus another student, present the topic at the next post conference. Thus, the student has peer support, assistance with the task, and is not left alone to find the information.

Regarding teacher behaviors that have a negative effect upon student learning, Jillian cited a "condescending attitude, the 'I know everything, you know nothing' attitude -'I will mold you'" (3, 683-684). Jillian stated that what is important is that the teacher gives the message that she can be approached. Therefore, in order to maintain positive relationships, Jillian tries to be as flexible as possible, both regarding the students themselves, and also regarding their ability to function on the clinical unit. She observed

that if she feels she can trust a student and her/his decision making abilities, she gives her/him a considerable amount of freedom. "If I am sure that I can trust a student and trust their decision-making abilities,...I will give them a fair amount of freedom" (3, 728-730). This means that she isn't checking on that student every few minutes. Jillian reported that she has heard students say "nothing drives them more crazy than having an instructor constantly breathing over their shoulder" (3, 732-733). In fact, she stated that you can do a lot of observing "from a distance. You don't necessarily have to be one foot behind them to see how they're relating to the staff, and their patients, and their peers" (3, 756-758).

Regarding the second theme, **maintaining clinical competence,** Jillian emphasized that she believes a teacher "should be an expert clinician - should know what you're doing" (1, 97). In Jillian's words, "if the teacher flounders, it's the first thing the students pick up on" , meaning that not only will they not respect the teacher, but they will also learn that "knowing for sure" does not matter (3, 1167-1168). Moreover, the teacher's not knowing "makes the students more apprehensive, [especially] at this [the beginning] level. They think, "if they can't depend on their instructor, who can they depend on?" (2, 216-217).

Furthermore, Jillian reported that she begins to assess the students' knowledge by "asking them about their [patients]: their diagnosis, why they're in the hospital, and if they had done any research" regarding their patient (2, 1027-1028). Jillian stated, "I don't think you can really look after someone if you don't know what kind of problem they came in with, and what sort of history they have" (2, 1029-1031). Jillian also questions the students regarding the medications they will give and the procedures they will perform. Jillian reported that she tells the students that "it is an expectation of mine that they be

very well prepared for administering their medications and if they're not, they will lose out on the experience" (2, 1162-1164).

Regarding the third theme, **being a positive role model,** Jillian observed that establishing and maintaining good public relations with others is a most important characteristic for the effective teacher. She stated that: "I also think that we have to be good public relations people...we are guests in a facility, and we always have to keep that in the back of our mind"; therefore, an atmosphere of mutual respect should be maintained (2, 348-350). She clarified that she believes that unless the teacher is an "effective communicator...if we aren't communicating well with both our students... and the staff on the units, I think nobody enjoys the experience in the facility" (2, 345-348). Jillian clarified further that she achieves positive relationships "largely by [her] approach" (2, 1070). She stated that she enjoys being on the units, always greets the staff on her arrival, and observed "I certainly try to have a fairly relaxed atmosphere around myself when I'm talking to the staff" (2, 1075-1076). She feels that the students, observing her relationship, know that they too can approach the staff. Overall, Jillian stated that she and the staff "treat each other as peers", have a respectful, reciprocal relationship, and interact as professional colleagues, each with a different role (3, 961).

Her approach applies to her interactions with students as well. In fact, Jillian reported that a hospital staff member, observing her interactions with her students, commented on how approachable she is: "You know, you're a good teacher...because you're so approachable, your students aren't afraid to come and talk to you and tell you if something...has gone wrong" (2, 1095-1098).

Jillian reported that she feels she has a fairly good sense of humor, and that "I think that all of my students have seen me laugh on the units: whether it be at myself, or laughing with patients, or with staff, and being able to do that freely, without worrying about someone judging me. And therefore, I won't judge my students if I find them laughing on the units" (3, 903-907). Jillian observed that she believes a sense of humor is essential in the health care field, in order to relieve some of the inevitable pressure of the situation. In her words, "I personally don't think I would have survived all these years if I didn't have a sense of humor. Many times that's saved me"(3, 911-913).

Regarding the fourth theme, **maintaining teaching competence,** Jillian emphasized that there are two major qualities a teacher must have: "the teacher must never forget what it feels like to be a student, and the teacher must never discipline 'in public'" (1, 56-57). Following that, Jillian observed that the teacher needs a great deal of patience. She stated that the teacher has to remember that many students have no health care background, and are "deathly afraid when they come on the units...[therefore], a good part of my job is to make them feel comfortable so they can perform" (1, 61-63). Jillian reported that "initially I attempt to give the student a client that I feel [she] will be easily able to care for" (2, 977-978). Then, within a week or two, she gives the student a patient that she thinks is more challenging.

Jillian also clarified that she starts her orientation for the students with a "fairly quick walk through of the nursing units" to which "the students will be assigned" (3, 775-776). She stated that she gives them an overview of "what kind of patients they may be dealing with, introduces them to the staff, and tells the staff what the students will be doing, and that they will be seeing a lot of us" (3, 779-780). As well, Jillian reported that

"the first day that the students have me, I give them my expectations" (1, 1158-1159). Jillian reported that she has developed a "Clinical Orientation Manual" that includes such information as when the clinical assignments are posted, when students are expected to come to the clinical area to do their research, when they should report to the clinical unit for the experience, how to complete patient research, the information they have to research for medication administration, critical observations that should be made regarding patients, samples of appropriate recording, directions about entries in their reflective journals, and what to report to staff at the end of the day's experience (3, 798). In addition, Jillian gives the students a "daily schedule of what happens on the units...so they have something to go by when they're very new to the unit" (2, 1185-1186).

When coaching a student through a first time skills experience, Jillian stated that she "helps the student gather [the necessary] equipment... then we'll very quickly go through the procedure. I will then ask the student how [she] would proceed" (3, 977-979). At that point, Jillian will add additional information as necessary. When they then go into the patient's room, Jillian is "there as an observer and a very minimal participant. I let the students run the show. I will only intercede if I feel they are doing something incorrectly, or if I feel [their actions]may harm the [patient]" (3, 984-987). After the patient has been settled, the student puts the equipment away, and she and Jillian have a debriefing session, and discuss "how things went, how they felt they did" (3, 1017-1018). If the student performing the skill has allowed other students to be in the room, then they can assist her with the skill performance. In that case, the other students become part of the debriefing session as well. Thus everyone learns, no one feels threatened, and the student performing the skill receives support from her peers.

Jillian noted that another important trait for an effective teacher to have is being open to realizing that the students don't have the experience the teacher does. Therefore, the teacher must provide learning opportunities to complement the experience they obtain on the units caring for patients. Jillian reported that she therefore schedules time so that students can observe procedures that are well known to the experienced nurse, such as a CT scan, but usually unknown to the beginning student: "I send students with the patients" (1, 82). In this way, Jillian stated that she assists the students to learn not only how procedures are performed, but also "understand the patient's feelings" regarding the experience (1, 85).

According to Jillian, another crucial quality for the effective teacher is to be able to "read" their students: not only by gestures and facial expressions, but regarding their ability to understand (2, 328-329, 332). Jillian talked about the increasing numbers of students for whom English is a second language, and that it is very important to be both extremely "careful" and "very precise" in communicating with them (2, 341). "They have a great deal of difficulty understanding the directions we give them" (2, 332-333). Techniques such as "[going] over your directions several times, and ask[ing] them to repeat it [them]" can be effective (2, 341-342). Lastly, Jillian stressed that this ability to be able to communicate with all students is one that she considers essential for being an effective teacher. She stated that the effective teacher must be "an effective communicator" (2, 345).

Regarding the fifth theme, **promoting a positive learning environment,** Jillian stated that she first relies on her approach: the way she interacts with patients and staff; and notably the "give and take" relationship she maintains with members of the nursing

staff, so that both are free to ask the other questions. When the students observe that type of interaction, she noted that they learn not to be afraid to ask questions either.

Jillian stated that she tries to give immediate feedback to students, almost on a daily basis, regarding how they're doing in the clinical setting, "whether it be with how they handled a difficult [patient] or a difficult situation or a complex procedure" (3, 1089-1090). Jillian reported that she also gives feedback to the entire group in post-conference, telling them that "if I was having some problems with a student, or felt they were having difficulties, I would be addressing it on an individual basis, and usually addressing it immediately" (3, 1094-1097). If Jillian does have to see a student, she confirmed that she does so in her office, "and I would ask them to tell me how they think they're doing, discuss with them what problems I see them having...indicate areas...where they might improve, and how, different ways they could improve" (2, 692-695).

To determine readiness for evaluation, Jillian clarified that she looks for "steady progress in the students" (2, 675-676). In contrast, "if they consistently show the same behaviors whether it be lack of credibility, irresponsibility, not preparing adequately for clinical", then improvement is required (2, 676-678). Observing such behaviors, Jillian reported that she would address the issue with the student immediately, before the behavior was beyond correction. Jillian emphasized that one of her major considerations regarding the evaluation of performance is the student's "ability to judge [a] situation, and to make decisions....I feel that if I can trust a student to be able to make the proper judgements, then...that I think is a priority" (3, 360-361, 363-365).

Jillian summarized her beliefs about clinical teaching by stating:

> I think reflecting back...to how it is being a clinical instructor, I think it's one of the most challenging things that I've ever had to do, and also one of the most enjoyable. Because I think you have to pool all of your resources that you've learned way back when you were a student, to when you were working as a general duty nurse, to beginning your teaching career. You have to pool all those resources when you're working in the clinical setting. (3, 1221-1228)

Unique and Shared Characteristics Across Participants

The preceding section provided information about how each of the participants operationalized certain categories of clinical teaching characteristics. The participants were individuals with unique experiences, characteristics, and behaviors. Although participants identified characteristics that were unique, a number of qualities, identified as necessary for the effective teacher, were shared among participants. Tables 2 through 6 show both the shared and unique characteristics identified by the participants. The individual tables represent the data obtained regarding each one of the five themes identified in the professional literature.

Table 2: THEME 1 - MAINTAINING POSITIVE INTERPERSONAL RELATIONSHIPS WITH STUDENTS

	Participants			
Indicators	Cynthia	Lori	Lisa.	Jillian
Be able to develop positive relationships	•	•	•	•
Treat each student as an individual	•	•	•	•
Connect with student on a personal level	•	•	•	
Facilitate personal growth		•		
Be enthusiastic, interested	•	•	•	•
Be approachable	•	•	•	•
Be understanding, empathetic	•	•		
Be fair	•			
Be available				
for assistance with patient care	•	•	•	•
for counselling		•		
Be a supporter, encourager, facilitator				
work with students	•	•	•	•
assign students in pairs (peer support)			•	•
Use humor	•		•	•
Avoid negative behaviors, e.g. serious rigid condescending	•	•	•	•

Table 3: THEME 2 - MAINTAINING CLINICAL COMPETENCE

Indicators	Participants Cynthia	Lori	Lisa.	Jillian
Be knowledgeable	•	•	•	•
commitment to life long learning		•		
work on units to increase credibility	•			
be open to suggestions/guidance from staff	•	•	•	•
act as a resource for staff		•	•	
maintain current knowledge	•	•	•	•
Like nursing and being involved in patient care	•	•	•	•

Table 4: THEME 3 - BEING A POSITIVE ROLE MODEL

Indicators	Participants Cynthia	Lori	Lisa.	Jillian
Be enthusiastic	•		•	•
portrays clinical area positively	•	•		
Like and know the clinical area	•	•	•	•
Enjoy what you do	•	•	•	•
Assist students with patient care	•	•	•	•
Like nursing and being involved in patient care	•	•	•	•
Maintain positive relationships with staff				
diplomatic, polite, respectful	•	•	•	•
accepting	•	•		
listens to staff's ideas	•	•		•
tries to understand staff's point of view	•	•		
informs staff about students activities	•	•	•	•
reports to staff regularly	•	•	•	•
helps with patient care as feasible	•	•	•	•
provides inservices, resources for staff		•	•	
Accepts responsibility for self and students	•	•	•	•

Table 5: THEME 4 - MAINTAINING TEACHING COMPETENCE

	Participants			
Indicators	Cynthia	Lori	Lisa.	Jillian
Clarify expectations for clinical experience	•	•	•	•
Be approachable at all times	•			•
Be trustworthy	•			•
Be adaptable and flexible				
written assignments	•			
clinical assignments	•	•		
Be organized	•	•	•	
Do not prejudge students	•	•		
Use inquiry method	•	•		
Coach students through new experiences	•	•	•	•
Learn from mistakes	•	•		
Maintain positive relations with staff	•	•	•	•
Socialization to the "real" world				
orientation to clinical experience	•	•	•	•
students as members of the health care team			•	
ability to adjust daily plan	•	•		
Evaluation of performance				
use of observation	•	•	•	•
use of intuition		•	•	
consider journal entries	•	•	•	•

Table 6: THEME 5 - PROMOTING A POSITIVE LEARNING ENVIRONMENT

	Participants			
Indicators	Cynthia	Lori	Lisa.	Jillian
Develop positive relationships with students	•	•	•	•
Be supportive	•	•	•	•
Be flexible	•	•	•	•
Work with students to give care	•	•	•	•
Use humor	•		•	•
Give feedback regarding performance as soon as possible				
observe for steady progress		•		•
utilize reflective journals	•	•	•	•
Student readiness for evaluation		•		•

Critical Incidents

Additional information about the participants' unique beliefs regarding clinical teaching was gleaned from the "grand tour" question posed in the first interview. The participants were asked: "Could you describe for me one of the most memorable/ meaningful experiences in your teaching career? Did this experience influence your later teaching? If so, can you describe how?" This query was designed to elicit from the participants a description of a significant situation in their teaching experience. These experiences described, as the subsequent data confirm, the most significant characteristics that each participant felt defined the effective clinical teacher and shed light on how clinical teaching expertise is developed through unique experience.

For Cynthia, that situation was about teacher-student relations, and how she worked with an ESL (English as a Second Language) student and helped her develop from a frightened individual, who was hesitant to do almost anything, to probably one of the best students in the class, "making independent decisions, looking happy, looking like she really wanted to be a nurse" (1, 1262-1263). This was accomplished by spending extra time with her - which the other students felt was *too much* time. From then on, Cynthia has spent one entire day of each rotation with each student. This situation taught Cynthia that she needed to spend "quality time" with each student individually. Moreover, in this way, Cynthia reported that the students know that "I have been there for them when they needed it" (1, 1308-1309).

Cynthia's story emphasized the importance of not only spending equal time with students, but of ensuring fairness, generally. This theme was consistent throughout her descriptions of her teaching experiences. She discussed practices such as how she

allocated equal time to each student, that she was flexible regarding when students handed in assignments, and that she consciously avoided pre-judging her students. Although these practices were related to what current issues were complicating the individual student's life and her ability to study; each contributed to the purposeful and studied "fairness" of Cynthia's clinical teaching, and the relationship she established with each student.

For Lori, the most meaningful situations were when she gained a deeper understanding of working with people - that led to a shift in her thinking - some progression in her growth as a person. The situation Lori described occurred during her first clinical rotation with students. She had a student who really was not doing well, and therefore had to be taken to "student review" (a formal meeting during which the student's progress to date is reviewed, and a plan either to facilitate improvement, or to dismiss the student is formulated). Thinking back on the situation, Lori felt she really was not fair to the student: she did not give her enough feedback or warning regarding what was coming. What she learned "with experience [was]...not to be so hard on people" (1, 655-656). She observed that with experience, a teacher "[has] a better idea of what to expect...for the particular level of student" (1, 656-657). In addition, Lori learned that as a teacher you must deal with issues as they occur. For example, she now talks to the student about any problem she had at the end of the same day. If there is a pattern of behaviors, she speaks to the student in private, identifies that there is a problem, discusses what can be done about it, and "put[s] some kind of plan in place" as soon as possible (1, 661).

Lori's memorable experience centered around relationships; and the notion that life involves the process of striving to learn and to grow. Self-actualization was a strong

theme that underlined all of Lori's teaching practices, as well as the relationships she established with patients, staff, and students alike. She saw great importance in connecting with students on a personal level, facilitating their personal growth, and counseling them as appropriate. As well, she emphasized encouraging the students to think for themselves, facilitating a sense of control for them, allowing them to have their own perspective on situations, and teaching them the importance of learning from their own mistakes.

Lisa's memorable experience occurred in her early days of being a clinical teacher, when she was teaching on a medical unit in a community hospital. The students were in the second year of their program and were giving medications to their patients. Lisa worked from a grid of information that she felt the students should know about the medications they were about to administer; and moved from student to student, supervising their preparation and checking their knowledge. She states that she would say things like "good job", and try to give the students some helpful information, but that she was really functioning solely as an evaluator. In her words: "my whole...demeanour was one of making sure they knew the stuff... But often they were so nervous that that created problems for them. And I could see that at some level - and I would want to make allowances for it but...And when I found out that they called me [Sergeant A]...that really bothered me" (1, 770-779). In fact, Lisa referred to this situation several times throughout the series of interviews, and it was clear that the situation had not only been a devastating one for her, but had had a profound and lasting impression. This experience influenced Lisa as a teacher because, as she stated now "I really tend to downplay that role...I'm fairly selective now" (1, 793-795). Lisa reports that today, students see her "as someone

who's teaching them, who shows them, who encourages them, who problem solves with them" (1, 796-798).

Lisa's memorable experience taught her that the important factor was the teacher being an encourager and a supporter of students, helping them prepare for their clinical experience, and working *with* them: rather than merely being someone who adhered to the rules and, above all else, implemented the school's policies and procedures to the letter. This theme of being primarily a student advocate, although she did not use the term, was an integral part of all Lisa's teaching efforts: from the assistance she gives students in preparing for their clinical assignments, to the coaching assistance she provides when students are performing skills, to her assumption that most students will be able to handle the demands of the program.

For Jillian, a memorable situation occurred during her second year of teaching. She was working with first year students on a medical unit of a community hospital. On the day in question, Jillian felt she "had been 'on the students' cases' all day" due to the number of complex situations and skills with which they had had to cope (1, 90-91). So at post-conference, she said to them I'm "sorry I've been so hard on you...but real life will be harder" (1, 92-93). The students, instead of saying something like, yeah, that was too much, said "we understand" (1, 93). This response amazed her and "made [her] stop and always be honest with students" (1, 94). She feels that "to be honest teaches them, [the students] to be honest with me" (1, 95-96).

For Jillian, the situation occurred early in her teaching career, and taught her the importance of being open and honest with students, of clarifying the teacher's

expectations at the outset of an experience, and of modeling respectful relationships with others. This belief was clearly visible in the approach Jillian maintained with her students.

Each of the participants voluntarily related early teaching experiences which were clearly either painful for them to recollect, or represented what had been a most difficult lesson. None the less, each experience caused the participants to first, reflect on these experiences: how these situations had affected them, and the meaning they ascribed to them. Secondly, these experiences motivated the participants to adopt teaching strategies that would be most helpful for students. Moreover, these "critical incidents" confirmed those characteristics that were most significant for the participants regarding being an effective clinical teacher. The incidents have been presented separately here to underline the importance of each incident in forming the basis of the teaching practices adopted by each participant. Moreover, these incidents were prophetic of the tenets of the individual teaching philosophy that shaped the teaching practices for each of the four participants.

New Observations

Several new observations about important characteristics of effective clinical teachers can be made based on the data presented. The first two characteristics will be discussed relative to the indicators that differed across participants; namely, the counseling role of the teacher that focused on assisting the student to attain self actualization, and the notion of "letting go" as a function of being a "clinical education facilitator".

In addition, one other new categorization of the data can be made. This data has to do with what the writer would describe as an "humanitarian philosophy" that was woven throughout the work of the teachers with their students. The data from all participants

include numerous examples of how teachers encouraged students to adopt the following behaviors: maintaining respectful relations with others, truly caring about their patients, being honest and ethical, being helpful to one another ("I often work them in pairs" Lisa 1, 632-633), assuming responsibility for their own learning (or notifying others if unable to fulfill responsibilities), owning up to mistakes, discussing them openly, and learning from them ("All of us has to say – what was our blooper today" Cynthia 1, 144-1145); being on time for scheduled activities; and respecting the "rules" of the teacher. Such matters were not relegated solely to the operation of the clinical experience per se, but were expected to be demonstrated as well by how the students went about the daily business of living. While these new observations suggest areas for future research, there is insufficient evidence to suggest creating new themes at this time.

In summary, Tables 2 through 6, and the critical incidents described, clarify the operationalizations of the 5 themes reported in the literature, that the participants achieved. The cases that were presented, representing each of the four participants, placed these operationalizations in context.

CHAPTER FIVE

DISCUSSION

The research questions this study was designed to answer were:

1. From a nurse educator's perspective, what are the specific teacher behaviors that are judged as evidence of being an effective clinical teacher?
2. From a nurse educator's perspective, what specific teaching behaviors constitute being supportive, clinically competent, a good role model, a skilled teacher, and the provider of a supportive learning environment?
3. From a nurse educator's perspective, are there other dimensions of effective teaching that are not captured by the five themes identified in the research literature?

The results have been reported in each category of data. The broad patterns of data obtained across all four cases, are now discussed.

Similarities of Findings Across Cases

Tables 2 through 6 illustrate a number of similarities regarding the desired qualities of the teacher across all four cases, and the congruence of these qualities with the descriptions of expert clinical teaching contained in the professional literature.

Such characteristics as the ability to establish and maintain positive relationships with not only students, but with the staff and patients of health care agencies; the

importance of maintaining clinical competence; the value of being a positive role model; and the necessity of promoting a positive learning environment; were all described by the participants as significant qualities for the effective teacher. However, the notable feature of the data obtained from the participants was that, as well as providing descriptions of teacher characteristics, it further provided a wealth of information regarding *how* the teacher could incorporate these desired behaviors and qualities into her everyday work with students. Even though the importance of these qualities for the teacher, and the adherence to the philosophy of care were congruent, each participant had unique methods for achieving the desired results. Specific examples of how the participants used different strategies to meet the same characteristics follow.

Regarding establishing and maintaining positive relationships with students, Cynthia saw great importance in spending one entire clinical day of each rotation working exclusively with each student; and going for coffee breaks not only with her student group, but once with each student individually. In this way she had the opportunity to enhance her understanding of the students as individuals. In contrast, Lori focused on getting to know the students personally by working with them while giving patient care, and by assisting them with personal growth through counseling initiatives. Lisa and Jillian emphasized providing support by performing nursing tasks with students, and by assigning students to work in pairs in order to provide peer support for every one.

Regarding establishing and maintaining positive relationships with the nursing staff members of the institutions where they taught, Lori and Lisa spoke of being a resource person for them. Lori conducted inservice education sessions and assisted with aspects of patient care. Lisa spoke of the value of maintaining clinical competence so that the teacher

could be a valid resource for staff, and provide them with requested and pertinent resource materials. Both these participants reported that staff members were not only very appreciative of this assistance, but that they also then responded by willingly assisting the teachers with the instruction of students.

As to the importance of maintaining clinical competence, all participants reported that being knowledgeable clinically was an imperative quality for the effective teacher. Cynthia spoke of the value of enhancing credibility by obtaining clinical practice in the clinical area in which you teach. Lori spoke of her philosophy of life-long learning, and thus the necessity of regularly attending pertinent continuing education seminars. Lisa reported the necessity of self study in order to keep knowledge current. Jillian emphasized the importance of maintaining clinical competence by accepting the responsibility to learn about current care practices in the clinical area in which you teach.

Being a positive role model was also endorsed by all participants as an essential quality for the effective clinical teacher. Most observed that they achieved this not only by their approach while on the nursing units, but through their interactions with staff as well. Cynthia spoke of the importance of listening to and accepting the suggestions of experienced staff members. Lori reported that she conducted herself, and felt as if she were, a member of the unit staff. Lisa spoke of how important it was to keep the staff well informed regarding the objectives for the clinical experience, and the responsibilities of the students. Jillian emphasized being relaxed and at ease with nursing staff members, and of maintaining an egalitarian and reciprocal relationship with them. Each of these strategies demonstrated to the students how one could maintain positive working relationships with others, and thus modeled effective behaviors.

Lastly, regarding the promotion of a positive learning environment, each participant utilized various individual strategies to accomplish this. Behaviors such as going for coffee with students, or following up on personal stories the student has shared with the teacher were strategies used to indicate interest in the students as individuals. As well, being flexible regarding both the type of clinical assignments, and also assignment due dates, plus arranging additional clinical experiences when requested by students, demonstrated a willingness to encourage the students to exercise some measure of control within their educational program. Providing peer support for students while giving care, and not evaluating performance until the student has had several opportunities to perform that same skill or aspect of care, were additional strategies used to promote a positive learning environment. Lastly, being positive themselves, and demonstrating good spirits and laughter while on the units were further measures, used in individual ways, by all the participants. Each of these strategies contribute to the formation of a positive learning environment, one in which students feel comfortable enough to embrace new learning challenges.

Differences in Indicators across Cases

Although the teacher behaviors related to the five themes discussed in the professional literature were mostly congruent, significant differences occurred across participants. The first major difference in the data from the participants, had to do with the teacher's positive relationship with her students. For Lori, one of the more senior teachers, the "positive personal regard" she maintained for her students became a counseling issue for her. Although a counseling role is referred to in the professional literature as part of

the teacher's interpersonal behaviors, Lori's beliefs in this regard focused on assisting the student with the attainment of self-actualization. She spoke frequently about the need for the teacher to facilitate the self-growth of the student, and to enhance the student's understanding of the human condition. Whereas all the other participants were meticulous in the assessment and care of their students, Lori took this concern to a higher, almost spiritual level.

The second difference was expressed by Cynthia, who had the most teaching experience, and had to do with the recent restructuring of the clinical education portion of the baccalaureate curriculum. This restructuring influenced the role of the teacher, in that the clinical teacher is now called a "clinical education facilitator" rather than a "clinical teacher". For this participant, this change was a matter of considerable concern, as it forced her to reconsider what her teaching role now entailed. Cynthia stated that she struggled a great deal with this notion, but had finally endorsed the idea that she could now freely accept assistance from other nursing staff members in the teaching of students. Interestingly, she was the only participant who raised this issue, although this curricular change would affect the teaching role of all participants.

Other than these two significant differences, teacher behaviours were largely congruent across participants. Within the discussion regarding new observations, a further emerging theme has been noted.

Interplay of Themes Within Cases

What became increasingly clear as the data analysis proceeded was the fact that the distinct characteristics and behaviors of effective teachers, as reported in the

professional literature, were in fact, a set of intricately intertwined, and highly positive interpersonal behaviors, through which the teaching of students was accomplished. *How* these teacher characteristics and behaviours are so closely intertwined (Figure 1, p. 86) is now explored.

The first theme, that of establishing positive interpersonal relationships with students, cannot be accomplished without the teacher acting as a positive role model; and thus utilizing personality traits that enhance her teaching, such as a genuine interest in other people, and maintaining a mutually respectful and supportive relationship with the facility staff. In addition, the teacher's ability to establish positive relationships with students will not be fully realized unless she practices teaching methods that demonstrate her teaching competence, and her understanding and care of students; and thus maximize the available learning opportunities for them. Moreover, the relationship the teacher establishes with her students will not continue to be positive unless she is able to promote and sustain a positive learning environment - one in which students are respected, supported, encouraged - and provided with timely and relevant guidance and feedback.

Similarly, in order to maintain clinical competence, the teacher must not only subscribe to life-long learning as a professional, but must demonstrate this competence in the performance and teaching of professional nursing skills. Perhaps more importantly, clinical competence is also demonstrated by being a positive role model, by interacting respectfully with staff members, by coaching a student through a first time skill performance, and by providing a supportive learning environment.

Being a positive role model requires demonstrating not only respectful relations with staff members, but also providing competent, direct patient care. Competent care

cannot be demonstrated without possessing the clinical competence to provide that care, without maintaining respectful relations with other staff members, nor without the teacher having the teaching skills to do so. Moreover, this demonstration will not be effective for students unless it occurs within a positive learning environment where collegial relations exist between the teacher and the staff, and where the student feels comfortable to learn.

Similarly, maintaining teaching competence cannot be achieved without both clinical competence and teaching expertise. Again, neither of these qualities will be meaningful unless the teacher can establish and maintain positive interpersonal relations with both students and staff members. Competent teaching will only be effective within a positive learning environment.

Lastly, promoting a positive learning environment will only be accomplished if the other four qualities are in place: namely, a positive and supportive relationship with students, a respectful and reciprocal relationship with nursing staff, demonstrated current clinical competence, and evident expertise at teaching. All of these qualities are required in order to promote a positive learning environment.

Because of this intricate interplay of the five themes, the role of the teacher becomes even more complex, as each of the five qualities identified for an effective teacher is dependent on all the others. Therefore, the absence or weakness of one quality will not only compromise the behaviors related to that specific quality, but will weaken the overall effectiveness of the teacher.

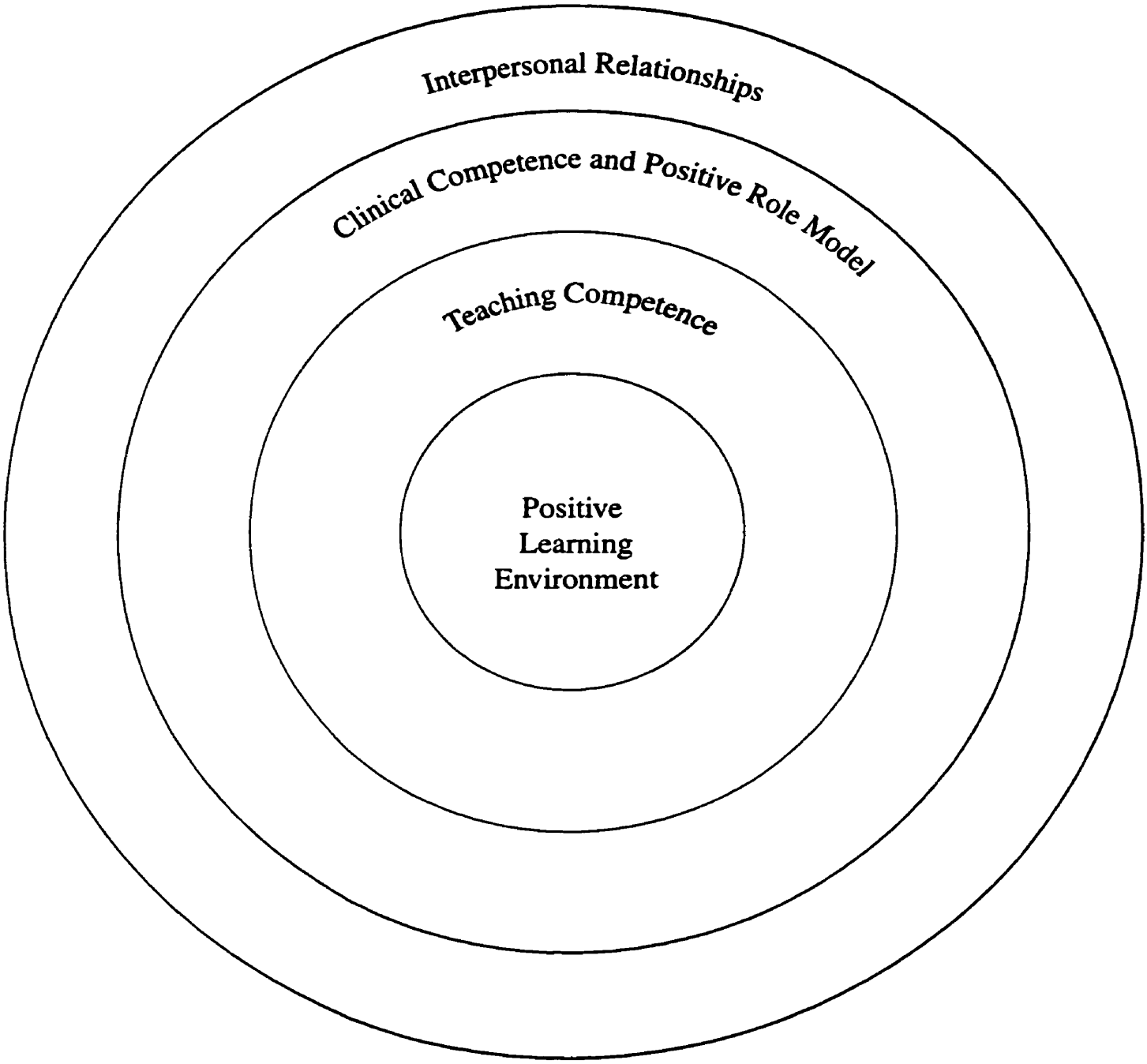

Figure 1. The interplay of themes within cases

Implications for the Preparation of Clinical Education Facilitators

The data obtained from the participants provided several observations that could be viewed as implications for the preparation of clinical education facilitators. These observations were made by the participants in the context of describing what it was like to be a clinical teacher today, and the factors within both the education and the health care systems with which teachers have to contend. The majority of these observations have to do with the management of students.

The first implication has to do with the course load of current students. In this regard, participants reported that today's students had an increased course load as well as increased personal responsibilities; both of which compromised their work as students. These responsibilities meant that the students often had evening classes, in addition to classes during the day, which resulted in tired students, who openly yawned during clinical experience periods. Moreover, for the teacher, this often resulted in the provision of extra preparation materials for the students, knowing that they would not have time to do adequate research on their own. For one participant, this was done even though she believed that, ideally, students should complete their own clinical research. For another participant, the student work load resulted in her decreasing what she expected of the students during their clinical experience.

A second factor regarding the management of students focuses on the patient assignments the students are expected to carry. In the real world, an average patient load is approximately 10 patients; during the educational program, the patient load for students is much less. Thus, students graduate without being prepared for the real situation; and so

their stress, frustration, and marginalization as they begin their professional practice is markedly heightened.

A third factor regarding student management is the size of the student group the teacher is expected to teach clinically. Generally, teachers currently work with groups of 8 students. As well, the teacher may have two groups of students during the same clinical course, but with clinical experience sessions scheduled on different days of the week, thus doubling the number of students for whom the teacher is responsible. Eight students was reported to be not only too large a group to manage adequately, but also too large a group for whom to provide the needed guidance and support.

A fourth factor having to do with the management of students, focuses on the preparation given to ESL students regarding the use of the English language. The participants who discussed this matter stated that often the students do not have the necessary communication skills to perform adequately during the clinical experience component of the program. The participants could recount many examples of "missed communication", cultural differences that were perceived as disregard for the dignity of patients, a lack of requisite knowledge, and therefore the necessity of the teacher spending more time with these students - to ensure safe practise - than with the other students.

In addition to the above factors regarding the management of students, participants also expressed concern for their professional colleagues. The participants observed that the current staffing situation and the condition of the health care system caused stress for all - facility staff members, teachers, and students alike. Because of this, new graduates must often handle several part-time jobs, are seldom supported or mentored as they should

be, and thus are strangers in each job situation. In Lisa's words, "a lot of them [feel] like they're drowning" (1, 887).

Trustworthiness of the Findings

A debate exists regarding the necessity of holding the findings of a qualitative study up to the scrutiny of evaluative criteria. Lincoln and Guba (1985) proposed four criteria which can be used to measure qualitative studies. These four criteria are: i) credibility (internal validity), ii) dependability (reliability), iii) confirmability, and iv) transferability (external validity).

Credibility. This criterion has to do with whether or not the findings make sense, not only to those who are studied, but to those who read the study. The researcher must utilize methods by which the research findings can be "double checked" to ensure that the interpretations of data are consistent with the participants' meanings. This strategy included such practices as rich descriptions, member checking, and having the researcher's advisor review and discuss the data analysis. In addition, the frank disclosure exhibited by the participants added credibility to the data.

Dependability. This criterion enables the reader to follow the process and procedure of the research (Talbot, 1995). The process must be seen to be both transparent and consistent. In addition, dependability can also refer to the stability of the data over time. In this study, dependability was optimized by a detailed description of procedures, and through the use of a semi-structured interview framework.

Confirmability. The underlying issue with this criterion is whether the research findings are free of researcher bias. The description of the methodology of this study

allowed both readers and other researchers to follow the sequence of data collection and analysis. This description of the methodology also identified the potential impact of the researcher's insider status, and outlined the system of electronic storage of data and thus its availability for re-analysis.

Transferability. The basic issue with this criterion is the relevance of the findings for other settings. Although the results were not directly generalizable to other settings, the description of the characteristics of the participants and the sample selection process provided sufficient detail for subsequent researchers to be able to use a similar methodology to obtain participants for a comparable study.

Conclusion

The research findings support that each of the five themes identified in the professional literature represent both meaningful characteristics and valid behaviors regarding clinical teaching in nursing. Moreover, in their descriptions of their clinical teaching experiences, the participants provided many examples of *how* the teacher could incorporate into her clinical teaching, specific and sometimes different practices, reflecting each of these broad philosophical concepts. The discussion section above describes both the extent to which and the manner in which the participants' clinical teaching experiences demonstrated the use of the five themes.

As the discussion chapter indicates, not only did the data support the information contained in the professional nursing literature, but in addition, several emergent themes were identified. Each of these themes - of incorporating "humanistic principles" into the work with students, of enhancing the teacher's counselling role, and of "letting go" -

could become potential factors in characterizing effective teaching. Indeed, given the chaotic state of our current health care system, and the increased work load of our students, these emerging themes may well become necessary qualities of the effective teacher if she is to be truly able to assist the student in future educational programs.

In examining the practices of experienced clinical teachers, this research has highlighted helpful, supportive teacher behaviors as well as clarifying harmful, alienating teacher practices. Moreover, this research has provided not only rich data, but also considerable insight into the values and beliefs of experienced clinical teachers. These values and beliefs underlie the importance of the five themes regarding clinical teaching practice. Furthermore, the data obtained clarifies methods by which the teacher can incorporate these themes into her clinical teaching.

Because the credibility of qualitative research is heightened by the preponderance of evidence collected in separate studies over time, replications of this study are recommended. Further research, either qualitative, quantitative, or both, is required to confirm and elaborate the operationalization of these themes. Such research would add to this beginning examination of how the clinical teacher maintains positive interpersonal relationships with students, maintains clinical competence, acts as a positive role model, maintains teaching competence, and promotes a positive learning environment. Our increasing knowledge of these five themes, and of the new emerging themes, will be highly significant, not only for future faculty members of nursing education programs, but for our future students as well. As Fawcett (1978) contended, it is only when theory and research are integrated that science can be advanced.

CHAPTER SIX

REFLECTIONS

The qualitative design of this research yielded much breadth and depth of rich data regarding how one goes about being an effective clinical teacher. A number of methodological factors contributed to this outcome. Some of the decision-making with respect to the research process are described as "reflections" to enhance the confirmability of the findings.

The methodology allowed for the selection of a purposeful sample of participants with considerable experience at being clinical teachers. The use of 4 participants was a valid decision. First, these participants secured the collection of much rich data. Second, the data collected from this group of participants provided for the achievement of both consistency and saturation of the data. The literature regarding qualitative research speaks positively of this rationale (Polit & Hungler, 1997; Talbot, 1995).

The responsibility for the selection of participants rested with the Dean of the baccalaureate program whose faculty included potential participants. Although the criteria of educational preparation, amount of teaching experience, and current job responsibilities were explicit, the criteria of "acknowledged expertise at clinical teaching" was left to the Dean's judgement. In the letter to the Dean, I requested that he provide me with a list of names of faculty members who, in his opinion, met the criteria specified for participants in this study. The response of the Dean indicated that, in his judgement, all clinical education

facilitators met the criteria for "expert clinical teachers". Consequently, the participants from the clinical education facilitator group self-selected (or volunteered) for the study. Each faculty member who volunteered to be a participant in the study did, in fact, meet the selection criteria outlined. However, because participation in this study was entirely voluntary, it is possible that participants chose to be involved because of a particular interest in, or a pre-conceived bias regarding, the topic of the study. Although all participants had considerable experience at teaching clinically, it is impossible to determine whether or not this was an operating factor in this study.

The series of three semi-structured interviews, with a specific purpose for each (Seidman, 1991), as well as the prepared, semi-structured interview prompts, were most valuable in eliciting the desired data. As well, the data collection strategies that afforded the opportunity to return to the participants to verify data throughout each interview, and formally at the beginning of each subsequent interview, were highly effective (Seidman, 1991). The "grand tour" question in the first interview yielded unbelievably relevant personal data regarding the participants' beliefs, which was prophetic in terms of the data subsequently collected from them regarding the five themes discussed in the professional literature.

The data from all participants not only endorsed the validity of the 5 themes, but provided numerous examples of how these themes could be operationalized. Moreover, the researcher was diligent in examining the data for the "negative case". None were found regarding any of the five themes reported in the professional literature. Rather, several new emerging themes were identified: the relevance of an humanitarian philosophy when working with students, the significance of an enhanced counseling role for the teacher, and

the necessity of being able to "let go" when the historical role of the clinical teacher becomes that of today's "clinical education facilitator".

I was impressed by several noteworthy characteristics of the participants themselves. First was the unquestioned willingness and commitment to this research project. Participants engaged in reflection between interviews regarding what had been discussed previously. Participants frequently came to the interviews with a prepared outline of data to add, or specific points they wished to raise. I was amazed at the frankness and honesty with which situations were discussed, even when the description appeared to be painful, or still of concern for the participants. Moreover, each participant demonstrated genuine caring for students, nursing staff members, and patients alike. The incredible work necessary to maintain this professional position was unquestionably apparent. Such participant characteristics further underlined the credibility of the data reported.

Post experience interviews are discussed by Lincoln & Guba (1985) as having the potential to yield only rationalized accounts of actual events. That discussion identified a definite risk with this type of study. None the less, I would note that the degree of consistency across participants would indicate that either the teaching experiences themselves, or the participants' rationalized accounts of them, appear relatively congruent, and therefore, accurate. Moreover, the detailed descriptions, the apparent emotion, and the degree of concern expressed by the participants as they described specific instances of their teaching experiences; as well as the congruency across each participant's descriptions of the development of their teaching practices, further supports the veracity of their descriptions.

Although I possessed insider status, this status is felt to be necessary in qualitative research regarding professional practice so that the researcher will understand the nuances of the information provided by the participants. However, I had to take care to ensure that this insider status did not result in interference with the objectivity of both the data collection and the data analysis processes. Throughout the interviews, my insider status was controlled through frequent member checking as each interview was in progress, and during a period of formal member checking regarding each previous interview that was conducted at the beginning of subsequent interviews.

Only one participant was completely unknown to me as the research began. I had met one participant many years previously, but had not been in contact with her until the beginning of the study. I had met another participant only a few months prior to starting the research. I had known the fourth participant for many years and thus knew her well, both personally and professionally. Participants known to the researcher can provide either a positive or a negative influence on the research. For the participant well known to the researcher, it is possible that she could have altered the data provided, knowing that I would be quite aware of most situation(s) she described. We discussed the fact of our previous professional association before the study began, and concluded mutually that our prior knowledge of one another would not be a negative influence on the study. Moreover, considering the depth and frankness of the data collected, and the congruence of this data with that obtained from the other participants, it would appear that the well known participant did have a most positive impact on this research. It seems probable that the participants viewed me as a concerned and interested peer, who understood the world

of clinical nursing education, and who was highly motivated to learn about their experiences as clinical teachers.

As an instrument in the research process, I had considerable opportunity to influence the results of the study, (Polit & Hungler, 1997). Therefore, care was taken to ensure that I acted primarily as a listener and a facilitator for the description of the experiences, thoughts, and responses of the participants. For the most part, I was successful in making a conscious effort to avoid expressing my own or others' opinions. However, on infrequent occasions, I found myself expressing an opinion, usually in support of a participant's description that seemed particularly difficult for her to discuss. However, the consistency of data across participants would indicate that such statements did not influence the participants' descriptions of their teaching experience.

Lastly, the extensive quotations used to support my interpretations within the data analysis section are not only plentiful but replete with the beliefs, values, insights, and experiences of the participants. The broad data base, the rich detail regarding the experiences described, and the repeated opportunities provided for member checking, all support the trustworthiness of the findings. Overall, the data indicate that the methodology was sound; and that the findings are credible.

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Appendix A

Letter to Dean

Helen E. Sundstrom
31 Larchwood Place, Winnipeg, MB. R2H 1M2

August 2,1999

Dr. David Gregory, Dean
Faculty of Nursing
University of Manitoba
Winnipeg, Manitoba
R3T 2N2

Dear Dr. Gregory:

I will present my research proposal to my thesis committee during August of this year. I discussed this proposal with Dr. Janet Beaton last spring, and received her approval in principle.

The purpose of the study is to describe and analyze specific teacher behaviors, qualities and skills that together comprise a competent and effective clinical teacher. The goal is to broaden our understanding of clinical teaching so that this knowledge could be used to assist in the selection of teachers, the planning of academic and practice components of basic and continuing education programs, and the improvement of evaluative procedures for faculty members. My thesis advisor is Dr. Lynn Taylor, Director, University Teaching Services, Centre for Higher Education, Research and Development.

The study will be qualitative, conducted by interviewing participants. In order to obtain a purposeful sample of participants, I will use a reputational sampling method- soliciting the names of appropriate participants from experts in the field. In this regard, I am seeking your assistance in identifying 6 teachers from your faculty who meet the following criteria:

1. have from seven to ten years academic and clinical teaching experience in nursing education programs;

2. hold a baccalaureate degree in nursing (minimum);

3. are currently employed as a teacher with clinical teaching responsibilities

4. are acknowledged by both colleagues and students as a "good clinical teacher".

I will choose 4 teachers to be participants for this study. My rationale for requesting 6 names is to ensure securing 4 participants from your faculty should some decline.

As the researcher, my role will be primarily that of an interviewer. I will conduct three in-depth qualitative interviews with each participant, of approximately one hour each, scheduled one week apart. I will begin by asking open-ended questions to obtain data regarding the participants' teaching experience. Subsequently, the participants will focus the interviews by describing their experiences while teaching students in the clinical area.

Confidentiality will be maintained by using pseudonyms for participants when collecting, recording and reporting data; by ensuring that individual data is known only to me; and by securing private and uninterrupted interview time. Participants chosen will be required to sign an informed consent form prior to the beginning of the study. They will have the opportunity to discuss the emerging patterns of data as the study progresses and will be able to receive the results of the study when completed.

As I would like to begin conducting these interviews by November of 1999, could you inform me of your recommendations regarding suitable participants by September 8,1999? Following receipt of the recommended teachers' names, I will contact them by phone initially, then forward an explanatory letter and arrange a meeting to discuss the research more fully with those who agree to participate.

I would be pleased to meet with you should you wish to discuss this research in person. If you have any questions or require further information, please do not hesitate to contact me at the address above, or by leaving a message at my office by phoning 632-3169 (voice mail). Please note that I will be away on vacation from September 8 - 27,1999.

My sincere thanks for your assistance. Your experience with faculty members will be most helpful to me as I begin choosing participants for this project.

Yours sincerely,

Helen E. Sundstrom, R.N., B.Sc.N.

Appendix B

Letter to Participant

Helen E. Sundstrom

31 Larchwood Place, Winnipeg, MB. R2H 1M2

Date.....,1999

Participant's Name
Address (Line 1)
Address (Line 2)

Dear :

My name is Helen Sundstrom and I am currently a nursing educator at Seven Oaks General Hospital. As part of the requirements for a Master's degree in Education at the University of Manitoba, I am conducting a study on the characteristics of effective clinical teachers for my thesis, under the supervision of Dr. Lynn Taylor.

The purpose of this study is to describe and analyze the specific teacher behaviors, qualities and skills that, in the perception of experienced clinical teachers, characterize competent and effective clinical teachers. The results of this study will contribute to a better understanding of effective clinical teaching and to professional development initiatives for clinical teachers. The study will be conducted by interviewing participants from the Faculty of Nursing at the University of Manitoba, with respect to their teaching experiences.

In order to obtain the necessary data, I have chosen to interview 4 teachers from The University of Manitoba Faculty of Nursing. In order to select these faculty members, I asked the Dean of the Faculty of Nursing or his designate to recommend faculty members who meet the following criteria:

1. have from seven to ten years clinical teaching experience in nursing education programs;
2. hold a Baccalaureate degree in Nursing;
3. are currently employed as a teacher with clinical teaching responsibilities;
4. are acknowledged by both colleagues and students as "good clinical teachers".

Through this process, you have been identified as a faculty member who meets the above criteria.

If you choose to participate, I will conduct a series of three interviews with you, each approximately one hour in duration, scheduled approximately one week apart, over a three week time period. The dates, times and locations of these interviews will be arranged by mutual consent. During these interviews, I will function primarily as an interviewer. The questions asked during the interviews will be of two types: questions to obtain "base line" data regarding your teaching experience with nursing students in the clinical area, and questions asking for descriptions of your teaching experiences and practices. I will audio-record the interviews in order to collect and analyze the participants' actual words. It is the participants' exact words and phrases that will comprise the data for this research. After the audio-taped interviews have been transcribed, I will provide an opportunity for you to discuss your perception of the "emerging themes" in the data collected during my interviews with you. In total, your involvement in the research will require approximately 4 hours.

Confidentiality will be maintained by using pseudonyms for participants when collecting, recording and reporting data; by ensuring that individual participants are known only to the researcher; and by securing privacy and uninterrupted interview time. For the duration of the study, all audio-tapes, transcriptions, and research notes will be kept in a secure locked location. Any references that might inadvertently identify a participant or a student will be removed or masked by using pseudonyms. However, complete anonymity in this type of research is impossible due to such factors as the small sample size and the fact that the identity of the Manitoba program is well known.

In accordance with the practice of the Faculty of Nursing, once the research is completed, all data sources will be kept for a period of 10 years before being destroyed. These data sources will be stored in a secure, locked location for this period of time. The retained data may be used in writing a research article, or may be used in the preparation of teaching or conference presentation materials. The research data will not be used for purposes other than those stated.

Participation in this research is wholly voluntary. As a participant, I will ask that you sign this information and consent letter prior to the beginning of the study. Throughout the study, you will have the opportunity to request that certain information not be recorded, that the interview be stopped if you become uneasy or uncomfortable, or that transcribed information be modified to reflect your intentions more accurately. As well, you will have the right to withdraw from the study at any time.

All participants who provide their permanent mailing address to the researcher will receive a summary of the research findings within one year of the completion of the study.

Would you call me to indicate whether you would be interested in participating in this study? You can reach me either at 233-3254 (evenings); or by leaving a voice mail message at my office: 632-3169. If you are interested in participating, I will be pleased to discuss the research project in more detail. You may also contact my thesis advisor, Dr. Lynn Taylor, at 474-7456.

Thank you for considering this request. Your recognized expertise in clinical teaching is an essential asset for such a study. I hope that you will consent to be part of this research and I look forward to hearing from you in this regard.

Yours sincerely,

Helen E. Sundstrom, R.N., B.Sc.N.

Please complete Part A & Part B below.

A. I consent to provide data for use in the Master of Education study described above:

YES..... NO.....

Participant signature: Participant name (please print):

....

Date: .....

B. I consent to provide data for use in the preparation of teaching or conference presentation materials:

YES.....NO.....

Participant signature: Participant name (please print):

....

Date: .....

If you wish to receive a summary of the results of this research, please provide your permanent mailing address below:

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.....

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Appendix C

INTERVIEW GUIDE

INTERVIEW # 1: INTRODUCTORY QUESTIONS (Demographic)

1. How long have you been a nurse? How long have you been teaching in the clinical area?
2. How did you decide to become a nurse educator rather than a practitioner?
3. What types of teaching positions have you held (e. g; diploma, baccalaureate)?
4. In what clinical area(s) do you teach?
5. What level of student do you instruct?
6. What do you consider to be the qualities of a good teacher? Probe: Could you give me some examples?
7. Could you describe for me one of the most memorable/meaningful experiences in your teaching career? Did this experience influence your later teaching? If so, can you describe how?

INTERVIEW # 2: OPENING PROMPT

In this study, I am interested in learning about your perceptions regarding your experiences as a clinical teacher in nursing. To begin, could you describe a day of clinical teaching—a) how you prepare, b) what you do with your students, c) how you evaluate student performance, d) what you do to debrief or bring closure to the day's experience?

During this interview, the researcher will keep short notes to remind her of probes to elicit certain categories of data, and to help her choose probes. In addition, the researcher will ask the participants to give examples of experiences they are describing. As well, the researcher will refer back to Interview #1, as necessary, to obtain richer descriptions of experiences, and to clarify data obtained in that interview.

SAMPLE INTERVIEW PROBES

During the second interview, the researcher will utilize the following probes to help ensure that consistent categories of data are obtained regarding the five themes, across all participants. These probes will only be used to collect categories of information not spontaneously addressed in a participant's description of a typical day.

In addition, the researcher will ask the participants to provide examples regarding situations and experiences described. Probes such as: "Can you tell me about a time when...." will be used to elicit detailed descriptions. Examples of such probes could include: "Can you tell me about a situation when you did not get along with a student..."; or "Can you tell me about a situation where you did really well with a student..."

SAMPLE PROBES:

Theme: Maintaining Positive Interpersonal Relationships with Students

1. How do you usually motivate students?
2. How do you encourage their learning attempts?
3. Are there some kinds of teacher behaviors that have a negative effect on student learning? If so, could you give me some examples?
4. How do you maintain positive interpersonal relationships with students?

Theme: Clinical Competence

1. How do you orient students to the clinical area and prepare them for clinical experience?
2. How do you assess a student's knowledge?
3. How do you help students apply this knowledge to their clinical practice?

Theme: Being a Positive Role Model

1. How do you portray interest and enthusiasm in your teaching, and in your role in the care of patients?
2. Are there any personality traits that you think enhance your teaching?
3. Could you describe some situations in which students observe you relating to unit staff? What are your typical behaviors in such situations?

Theme: Teaching Competence

1. Can you describe how you "set down the rules" for clinical experience with you as the teacher?
2. Could you describe how you coach a student through a first time skill performance or clinical experience?
3. What would you consider to be a problem situation in clinical teaching?

Theme: Promoting a Positive Learning Environment

1. What do you do to show support and encourage student questioning and learning?
2. How do you know when students are ready to be evaluated?
3. Could you describe how you give feedback to students regarding their clinical performance?
4. Are there any other strategies you use to create a positive learning environment?

INTERVIEW # 3: REFLECTION AND INTERPRETATION

The focus of the third interview is to have the participants both reflect on and interpret their teaching practices. In addition, the researcher will ask participants to provide further details regarding their current teaching experience. To begin this process, the researcher will review the data obtained to date, and invite the participants to elaborate and interpret that data. Probes such as "Can you tell me some more about that?" or "Can you give me a different example?" will be used.

Based on the data provided, the researcher will follow up with at least one question regarding each of the five themes. Specific questions will be determined by the data generated in the first two interviews.