THE THEORY PRACTICE INTERFACE:

A CASE STUDY OF EXPERIENCED NURSES'

PERCEPTION OF THEIR ROLE

AS CLINICAL TEACHERS

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STATEMENT OF AUTHORSHIP AND SOURCES

This thesis contains no material published elsewhere or extracted in whole or in part from a thesis by which I have qualified for or been awarded another degree or diploma.

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ABSTRACT

This research explores how experienced nurses perceive their role as clinical teachers in an environment that is challenged not only with on-going changes in healthcare delivery, but also by the expectation that it will continue to provide positive clinical learning opportunities for undergraduate student nurses.

Schools of nursing in Australia have undergone rapid and far-reaching change as a consequence of the legislated transfer of nursing eduction to the tertiary sector. Expectations that nurse academics will possess higher degrees and be actively involved in research mean that faculty members have less time to be directly involved in their students' learning during clinical practice placements. The literature indicates that the responsibility for moment to moment teaching and learning thus appears to have been implicitly given to clinical staff who may not possess any formal qualifications for teaching, yet are largely responsible for students' learning through clinical placements. Indeed some clinicians report a worrying lack of knowledge of clinical supervision models giving cause for further concern about the nature of the clinical learning environment. Schools of nursing expect that clinical practica will provide opportunities for students to learn how to be a nurse through guided questioning, analysis and critical thinking. It is evident that in some settings, this represents an ideal situation and not the reality.

Critical reflection on these issues has informed the purpose of this research and helped to shape the following questions that focus the conduct of the study:

Research Question One

How do experienced nurses create positive clinical learning environments for student nurses?

Research Question Two

How do experienced nurses resolve the often-contradictory demands of nursing students and those of the practice setting?

Research Question Three

How do changes in the healthcare environment impact on the experienced nurse's role as a clinical teacher?

The theoretical framework for this study was underpinned by the interpretive philosophies of hermeneutic phenomenology and symbolic interactionism, because they acknowledge the personal experiences and meanings of the participants. A case study approach was utilised because it acknowledges the given context of the participants. Data were collected from six experienced nurses through a series of semi-structured interviews, informal interviews and periods of participant observation supported by field notes and the researcher's diary.

Participants identified that their perception of their role as clinical teachers was constructed of three intersecting roles: that of facilitator of learning, assessor and socialiser. This study concludes that several factors influence these nurses' perception of their role as clinical teachers. In particular, the positivist work culture of the clinical setting and nurses' own past experiences and world view of nursing combine to shape these nurses' perception of their role as clinical teachers.

The research concludes that the expectations that students will be supported in their endeavours to be critically thinking, problem solving and reflective practitioners may, in fact, be unrealistic in the current, economically constrained, clinical environment. It is evident that experienced nurses, despite being willing to be involved with clinical teaching, have to function in rapidly changing environments that do not always offer opportunities for nurses to reflect on their practice. However, the creation of positive clinical learning environments in these circumstances requires an increased understanding and appreciation by both schools of nursing and their students of the impact of change on these nurses and their clinical environment. This appreciation may result in more effective collaboration between nursing education and nursing service to assist student nurses to learn not merely through repetitive practice and busywork, but also through opportunities to observe, question and understand their nursing practice.

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GLOSSARY OF TERMS

ACU   Australian Catholic University, established in 1991 as an amalgamation of seven former Colleges of Advanced Education into one national university with campii in three states and one territory of Australia. Bachelor of Nursing courses have been offered at four campii across three Divisions of the University since 1991.

ANCI   Australian Nursing Council Inc. established in 1992 with the purpose of facilitating the development of national standards and processes for the regulation of nursing within Australia.

Buddy Nurse   Clinical nurse who works with one student in an informal teaching relationship that may only exist for one shift.

BN   Bachelor of Nursing. Three-year undergraduate degree, completion of which entitles the graduate to register with the appropriate statutory authority to gain employment as a registered nurse.

Clinical Affiliate / Clinical Associate   Experienced clinical nurse seconded by a university from a healthcare agency to supervise the clinical placement of a group of students within that agency.

Clinical Facilitator   Umbrella term used to describe the experienced clinical nurse who supervises or facilitates a group of students in a healthcare agency for their clinical placement. This term is frequently used to indicate the Clinical Affiliate or Clinical Nurse Teacher.

Clinical Nurse Teacher   CNT: Experienced clinical nurse who works casually or sessionally for a university to supervise the clinical placement of a group of students in an agency.

DRGs   Diagnostic Related Groupings. A method for categorizing patients and reimbursing hospitals based on the diagnosis or reason for their admission. Patients with similar diagnoses are aggregated under the one related grouping.

IDC   Indwelling catherisation or catheter.

IV   Intravenous therapy

LEVEL 1 RN   A registered nurse with limited clinical experience. A Level 1 nurse is expected to assume responsibility for their own actions while promoting professional standards of practice and conduct. With experience, they are responsible for the supervision of more junior Level 1 Registered Nurses and Enrolled Nurses.

LEVEL 2 RN   A registered nurse who has a broad developing knowledge base in professional issues and demonstrates an advanced clinical expertise in a specialty area. They provide support in the management of human, financial and material resources to ensure quality, cost effective and client focused care. The Level 2 Nurse gives direction and support in the areas of quality management, research education and professional development.

McAuley Campus   The Queensland state campus of Australian Catholic University.

Mentor   An experienced nurse whose focus is the development of a deeper relationship between mentor and protégé, capable of influencing major career changes and promoting self-actualisation in both participants of the process. The mentoring relationship is characterised by its intensity, openness, reciprocity and commitment, which allows the growth of both participants in the relationship.

NLN   National League for Nursing. The national body of nursing responsible for the accreditation of the majority of nursing education programs in the United States of America. The NLN lead the movement to promote nursing's agenda for healthcare reform in the 1990's.

Preceptor   An experienced nurse who works with one student to provide advanced clinical competency and role socialisation that assists the student develop, practice or refine relevant clinical skills and develop a knowledge of the organisation's culture, values, rules and regulations, in what is usually a short-term relationship of weeks to months.

RN   Registered Nurse. A nurse who has completed a pre-registration course of study enabling registration with a statutory authority as a practising nurse within that state. Since 1992, all nursing programs in Australia have been at the degree level, however some nurses may still hold hospital certificates. Most have upgraded their certificate to degree level through further study at a school of nursing, or are in the process of doing so.

UAP   Unlicensed Assistant Personnel. Persons who are employed within healthcare agencies to provide care for patients such as hygiene and feeding. They receive varying levels of training ranging from none to four weeks of basic instruction in hygiene, feeding and positioning. Also referred to as Personal Care Assistants or Assistants in Nursing.

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CHAPTER 1:   THE RESEARCH DEFINED

1.1   INTRODUCTION TO THE RESEARCH

Nursing education in Australia has undergone vast changes since its legislated transfer in 1984, from a hospital-based, apprenticeship model of training, to a professional degree preparation in the higher education sector (Daly, Speedy, & Jackson, 2000; Sellers & Deans, 1999). Nursing is currently undertaken as a three-year undergraduate bachelor's degree, offered at twenty-seven Australian universities. Despite the transition of nurse education to the higher education sector, the preparation of individuals as competent, professional, nursing practitioners by necessity, demands that student nurses undertake a variety of field or clinical placements, integrating theory with practice. Nurses within almost every nursing environment, from community and hospice care, to acute tertiary hospitals, interact almost daily with a number of student nurses on clinical practica.

While the models of clinical teaching vary from school to school, groups of eight to ten students are generally supervised by a Clinical Nurse Teacher under some model of clinical supervision. However, it is the nurse in the clinical setting who is paired or buddied to work with the individual student and thus the nurse who bears the brunt of students' queries and complaints; the nurse who implicitly acts as a role model, teacher and socialising agent. On occasions this is formalised into a preceptorship role where one nurse works with one student throughout their clinical placement in order to assist in the integration of theory with practice. At other times, depending on the model of clinical supervision being utilised by the school of nursing, nurses within the wards are asked or even expected, to work with a student for a shift in what is referred to as a buddy-nurse relationship. Because of the wide variety of terms commonly used in the literature to describe the various roles of nurses working in the clinical setting, this research uses the terms, clinical nurse, clinician, and in the Australian context, registered nurse, interchangeably to indicate the nurse working in the clinical setting. The reader is referred to the Glossary of Terms (pages vii-viii) for more detailed explanations of the terms used to describe the various roles of the nurse.

The aim of this research was to explore the perceptions of those nurses who either formally take on a preceptorship role, or informally are buddied with undergraduate students, of their role as clinical teachers. In particular, the research aimed to explore the perceptions of experienced nurses in order to draw on their previous experiences in clinical teaching.

Such research is important because it is acknowledged that it is those interactions which take place between the clinical nurse or their colleagues in the clinical setting and the students that contribute to the development of students' professional values about nursing (Ahern, 1999). University schools of nursing rely heavily on a wide variety of healthcare settings to provide the clinical experience and teaching necessary, not only to assist students develop beginning level competency in their nursing practice, but also to promote the critical thinking skills that are important processes and outcomes of nursing education (Oermann, 1994).

Despite this acknowledgment of the role of the practice setting, the separation of nursing education from nursing delivery is perceived to have contributed to the exacerbation of a "theory-practice gap" in nursing (Dale, 1994; Yassin, 1994). It is widely argued in the literature that nursing functions as a holistic, humanistic act within a largely bureaucratic, performance and outcomes-oriented healthcare system (Antrobus, 1997; Hodges, 1997; Rolfe, 1996; 1998; Upton, 1999). The resulting "dialectic of contradictions" (Hodges, 1997, p. 349) raises an important question about whether the restructuring of nursing education really is "producing visionary nurses grounded in a new paradigm". Hodges (p. 349) further suggests that in fact, the "traditional nursing culture [is] simply being reproduced with new words and new hopes". It is suggested that new nursing education curricula have failed to address the reality of reforms to both the clinical contexts of nursing practice and the role of the nurse.

1.2   THE RESEARCH CONTEXT

In the context of nursing practice and in the role of the nurse, it is evident that many of the current healthcare reforms are reflective of a worldview that increasingly regards health as an economic commodity. "Policies developed under the influence of the economic rationalists have had a general effect on health care provision for the public, as consumers of these services, and on the people who provide these services" (Cordery, 1995, p. 358). In particular, cost containment measures such as managed care are demonstrating a dramatic impact on nursing and subsequently nursing education (Corey-Lisle, Tarzian, Cohen, & Trinkhoff, 1999; Leeder, 1999). The very core of nursing has experienced, and continues to undergo change in response to the challenges presented by economic, social and technological pressures on healthcare and its delivery (Chinn, 1991). These changes can be summarised by loosely adapting the themes generated by Venegoni (1996, pp. 79-86), to describe a future in which nurses will function in healthcare contexts characterised by:

- The movement of sites of healthcare from the traditional hospital to home, community and hospice settings (Department of Community Services and Health (DCSH), 1991; Gardner, 2000)

- Changing demographics of the population with increasing numbers of people aged sixty-five years and older, so that the need for healthcare services will become "care" rather than "cure" (Pearson, 1990, p. 19)

- An increasing adoption of "holistic and humanistic" worldviews on health, evidenced by a focus on health promotion and disease prevention strategies by both individuals and governments (Pearson, 1990)

- An increasing focus on customer satisfaction and quality outcomes coupled with the need to economically rationalise healthcare spending and use of resources (Venegoni, 1996)

- The introduction of economic rationalist models (such as Casemix), that aim to redefine healthcare in a competitive market environment that must be responsive to consumer demands (Clayton, 1995)

- Continued advancement of technology used in healthcare, ranging from pharmacological developments to computerised diagnostic and treatment modalities resulting in an increased expectation of what such technology can offer to the quality of life for the

individual (Venegoni, 1996).

As a consequence, the "revisioning" of nursing education to provide an educational base that will meet these changing needs has seen a decrease in the traditional emphasis on a behavioural pedagogy and a recognition that nursing practice is now characterised by ambiguity, uncertainty, complexity and rapid change (Lindeman, 1992). This paradigm shift has been reflected within change to models of nursing education from hospital-based, apprenticeship system to professional preparation in the university sector (Diekelmann, 1993). Indeed, the revisioning of nursing education from a reductionist, behaviourist approach to an humanistic, patient-centred approach has largely been in response to these changes in the context and delivery of nursing care (Manuel & Sorenson, 1995). At the same time, it is argued that current healthcare policies that attempt to impose an economic, cost-outcome oriented culture on a health service focused on humanistic caring, are contributing to the gap between theory and practice in nursing (Antrobus, 1997).

It is this acknowledgment of an increasing gap between theory and practice that was one issue addressed by *The National Review of Nurse Education in the Tertiary Sector - 1994 and beyond* (hereafter called *The Review*), by the Department of Human Services and Health (DHSH) (1994). This review was established in order to examine the philosophies and mechanisms by which universities and the industry were implementing the principles of the new curricula in Australia. *The Review* highlighted significant problems directly related to the lack of consensus between nursing education and industry about the purpose of a new approach to nursing education and subsequently the desired outcomes of such education. A dialectic tension between the philosophical positions of those involved in nursing education and those involved in clinical practice, the employers, was identified as a contributor to this lack of consensus (DHSH, 1994). One solution to this issue has been the recommendation from *The Review* that schools of nursing focus on the development of clinical teaching models that have the potential to increase the collaboration between nursing education and nursing service (DHSH, 1994). In accord with these recommendations, an increasing number of creative clinical teaching partnerships which aim to address the need for increased collaboration between education and service are being developed (Gassner, Wotton, Clare, Hofmeyer, & Buckman, 1999; Grealish & Carroll, 1998). Through such collaboration, it could be expected that positive, clinical learning environments supporting the teaching-learning process might be created (Lee & French, 1997).

However, examination of the relevant literature also demonstrates that not all clinical placements are providing opportunities for students "to be involved with the problem solving approaches to care, that is, to learn through the experience by reflecting on and discussing aspects of each intervention and then by doing" (Marrow & Tatum, 1994, p. 1251). Furthermore, there is also evidence that experienced nurses, while being expected by schools of nursing to deliver positive, clinical learning environments, often feel ill-prepared or unable to take on the role of clinical teacher (Craddock, 1993; Forrest, Brown, & Pollock, 1996). It is my involvement with clinical teaching within one school of nursing which has encouraged me to further investigate these issues.

The interest motivating this research arose from my experience as a nurse educator and clinical coordinator at Australian Catholic University, McAuley campus (ACU) during which time, issues relating to the effects of economic changes on healthcare and nursing education have been exerting an increasingly obvious impact. Since 1992, I have been involved in teaching in the Bachelor of Nursing curriculum. Students of nursing undertake three years of full-time study in three major strands: Nursing Practice (theory and clinical); Professional Nursing Development (behavioural sciences, law and ethics); and Sciences (anatomy, physiology, microbiology and epidemiology) (Faculty of Health Sciences, 1995). From January 1999, I have also been responsible, as the clinical coordinator, for the negotiation and evaluation of appropriate clinical placements and the selection, preparation and evaluation of experienced nurses to act as clinical teachers to support and supervise students in their field placement learning.

Throughout the undergraduate degree, the student is required to spend an approved number of hours on field placements in order to meet accreditation requirements. These hours are divided between clinical placements within a wide range of participating healthcare agencies and the school of nursing's on-campus clinical simulation laboratory, which allows students to apply and test theoretical principles underpinning nursing practice. This is consistent with the curriculum's intention for nurses to be a 'knowledgeable doer' and 'know why' as well as 'know how'. The length of time spent on clinical placements increases throughout the six semesters of the undergraduate degree, to correspond with the increasing clinical decision-making ability and clinical competence required of the students as they progress through the course. The initial placement in healthcare agencies in semester II is 80 hours, in semesters III, IV and V, the placements are of 120 hours duration each, which increases to 320 hours in

the final semester.

Student supervision on clinical placements is achieved through the utilisation of a number of clinical teaching models, each with the focus of assisting students to integrate theory and research with clinical decision making skills and practical skill development. These models can be described under three general categories. The first is the "Traditional" model that utilises either faculty members who are nurses, or casual, sessional nurses, to supervise students in a ratio of about one to eight (Polifroni, Packard, Shah, & MacAvoy, 1995). The second category is an "Associate" or "Affiliate" clinical teaching model, that involves the secondment of experienced nurses from healthcare agencies to paid employment by a university to supervise clinical placements within their own agency (Grant, Ives, Raybould, & O'Shea, 1996). The third category is a "Preceptorship" model in which one student works all shifts with an experienced nurse, the preceptor, for an extended period of weeks (Moreton-Cooper & Palmer, 1993). (Chapter 2 undertakes a critical review of clinical supervision models.)

It is evident that pressures experienced nurses working in clinical settings as a result of ongoing changes in healthcare delivery models, may be impacting on the ability and willingness of experienced nurses to fulfil their role as clinical teachers. It is timely therefore to seek greater understanding of the extent to which changes in nursing education and nursing practice impact on experienced nurses' perceptions of their role as clinical teachers. The literature demonstrates that these issues are worthy of consideration and are therefore further examined in Chapter 2.

1.3   IDENTIFICATION OF THE RESEARCH PROBLEM

Through my experience in teaching in the BN curriculum and as the clinical coordinator, I have facilitated numerous debriefing sessions with both student nurses and clinical nurses, following students' periods of clinical placements. The purpose of debriefing sessions is to allow both students and clinical nurses separate opportunities to raise critical incidents and issues of concern. This is generally undertaken in small groups of their peers who are thus able to offer support and feedback. There are a number of issues which arise during these sessions which can be broadly classified under the following three categories:

1. Clinical nurses and students report increasing difficulties relating to the adequate clinical supervision and subsequently assessment of student nurses' practical experiences. Polifroni et al. (1995, p. 167) concluded that while students were on clinical placements, "at least 75% of clinical practice time was without direct supervision (no interaction with instructors or hospital staff)." This reinforces the findings of earlier studies (Fretwell, 1982; Jacka & Lewin, 1987), that students experience minimal supervision from either buddy-nurses or their university appointed Clinical Nurse Teacher and raises questions about the understanding and expectations of clinical practice which are held by those nurses involved.

2. Clinical settings are experiencing increasing pressure as healthcare delivery models change in response to economic constraints. This appears to impact on the ability and willingness of nurses to adequately fulfil their role as clinical teachers. Students in debriefing sessions regularly describe incidences during which nurses who are asked to buddy them, respond by rolling their eyes and ignoring them. Similar difficulties are reported in the literature (Carlisle, Kirk, & Luker, 1997). Economically-driven changes to the skill-mix of registered nurses and unlicensed assistant personnel (UAP), the downsizing of hospitals and the subsequent increases in home and community care, have implications for the future of nursing and by association, nursing education (Corey-Lisle et al., 1999).

3. As a consequence of these issues, there is evidence of conflict between students' expectations and the buddy nurses' expectations of what and how learning may occur during clinical placement. This conflict appears to be escalating as clinical settings report increasing workloads. The ambiguity in students' expectations of their clinical placements, has also been articulated by students who reported experiencing powerlessness and confusion because of the dichotomy between the ideals of the university and the realities of the practice setting (J. Willis, 1996; Yong, 1996). It is clear that a paradox does exist between expectations of schools of nursing that students will be assisted to develop as critically thinking, reflective practitioners and the economically driven expectations of the clinical setting.

These issues, while derived from clinical nurses' and students' experiences, anecdotes or opinions, nevertheless are reflected in the literature and thus invite investigation. The contemporary role of the nurse as clinical teacher is largely under-theorised. The research to be reported in this thesis is thus a response to these issues and the acknowledged need for further research to be undertaken to understand how changes in both healthcare delivery and nursing education models may influence nurses' perceptions of their teaching role in a dynamic healthcare system (Paterson, 1994).

1.4   PURPOSE OF THE RESEARCH

The literature reports that while nurses believe they are best positioned to teach students, they are experiencing difficulty in meeting both the needs of their patients and the needs of the students in increasingly busy work environments (Forrest et al., 1996). New curricular approaches in nursing education expect and indeed demand that students' learning will be nurtured in clinical learning environments in which:

> Self-responsibility for learning and ultimate independence in identifying and addressing learning needs will be fostered. Students will be challenged to learn and appropriately supported in their endeavours. Creative and critical approaches will be valued and encouraged (Faculty of Health Sciences, 1995, p. 8).

However, there is a substantial body of literature describing the existence of a gap between the theoretical expectations of new curricular approaches and nurses' abilities to be able to implement such expectations in practice (Hodges, 1997*). The Review* (DHSH, 1994) concluded of this theory-practice disalignment that "the key to bringing the respective expectations and realities into line with each other was the establishment of a more co-operative framework in which higher education and health agencies both contributed to improvement in clinical practice" (DHSH, 1994, p. 5). Consequently, the purpose of this research was to explore how experienced nurses perceive their role as clinical teachers in an environment which is challenged not only with on-going changes in healthcare delivery, but also by the expectation that they will continue to provide positive clinical learning opportunities for undergraduate student nurses. Such an exploration may assist in the creation of more collaborative frameworks between schools of nursing and health agencies.

1.5 EVOLUTION OF THE RESEARCH QUESTIONS

Nursing remains a practical despite the transfer of nursing education from its apprenticeship, hospital-based training into the tertiary sector art (Pearson, 1990; Rolfe, 1998). This transfer has removed the student nurse from the hospital workforce and placed them geographically and paradigmatically in another subculture. Previously, student nurses in apprenticeship, hospital-based training, learned not only how to nurse, but also the concept and role of the nurse, as they were socialised throughout their apprenticeship by the rigid rules, regulations and hierarchical structure of the hospital (Kramer, 1974). Higher education for nurses has meant that socialisation has largely become the role of the university. Subsequently, strategies designed to ease the transition of the student to graduate nurse have been developed. Graduate nurse programs are offered in some healthcare agencies to provide a formal role transition support and socialisation process for the new graduate (Parkes, 1995). However, issues of equity in terms of funding and access raise questions about the long-term future of these programs. Increased collaboration between education and clinical institutions has been advocated as a long-term approach to reducing the stress of transition from one role to another (DHSH, 1994).

This recommendation recognised that the stress of transition from student nurse to clinical nurse role would be minimised by the creation of positive learning environments that support a culture in which teaching and learning are valued. Positive learning environments can be described as those where there are clear, established roles of the nurse as teacher, colleague and carer, so that teaching can be both client centred and student centred (Ahern, 1999). This study sought to examine how positive learning environments in practical settings such as hospitals was established. This was achieved by exploring the perceptions of experienced nurses towards their role in clinical education of the undergraduate student nurse. Paterson (1994, p. 349), in her study of nurse educators' perceptions of their teaching role, defined perceptions as consisting of "a teacher's theoretical, knowledge and value claims in regard to teaching". This study of clinicians' beliefs and the relationship to their behaviour as a clinical teacher was supported by the premise that

> few would argue that the beliefs [that] teachers hold influence their perceptions and judgements, which, in turn, affect their behaviour in the classroom, or that understanding the belief structures of teachers and teacher candidates is essential to improving their professional preparation and teaching practice (Pajares, 1992, p. 307).

Therefore it was appropriate that this study sought to explore the beliefs of nurses in order to contribute to nursing's knowledge about nurses' preparation and practice as clinical teachers. The three research questions below which focused the conduct of the study emanated from the research problem. They have been shaped as the research study unfolded by the experiences of the researcher, the ongoing critical reflection with relevant literature and energetic dialogue with participants.

1.5.1 Research Question One

How do experienced nurses create positive clinical learning environments for student nurses?

This question provided the opportunity for participants to draw on their perceptions of how teaching and learning occur in order to move on to describe how they believe positive clinical learning environments can be created to support and encourage student integration of theory and practice. Participants were encouraged to reflect on their past experiences as clinical teachers to describe strategies that they used to facilitate learning, promote thinking and maximise clinical learning opportunities.

1.5.2 Research Question Two

How do experienced nurses resolve the often-contradictory demands of nursing students and those of the practice setting?

This question considered the participants' descriptions of the theory / practice dichotomy in nursing and, in particular, how they responded to the issue. The concept of the reflective practitioner was explored with the participants to understand their perception of reflection in nursing. The assumption that changes in healthcare contexts have impacted on opportunities for clinical education underlies this question and so links it to research question three.

1.5.3 Research Question Three

How do changes in the healthcare environment impact on the experienced nurse's role as a clinical teacher?

This question recognised that major changes in models of healthcare delivery are occurring within all clinical settings and sought to have participants explore how these changes influence their role as clinical teachers. The question invited participants to describe the impact of change in their own environment and then reflect on how their practice as a nurse and clinical teacher has adapted to these dynamic changes.

1.6   DESIGN OF THE RESEARCH

Since this study was exploring perceptions of experienced nurses towards their role as clinical teachers, it invited a qualitative research design. This allowed the researcher to become familiar enough to describe various aspects of people's life activities as well as gain a sense of the meanings which people give to events in their lives. Furthermore, a qualitative approach also offered opportunities for the researcher to share in the participants' lives, in order to be able to observe, listen, question, hear and interpret the significance they give to their experiences. This is consistent with the philosophy of qualitative research, which aims to discover insights, rather than simply to verify pre-

existing ideas and to "make sense of, or interpret, phenomena in terms of the meanings people bring to them" (Denzin & Lincoln, 1994, p. 2).

Resting within qualitative philosophy, the epistemological position of constructionism was adopted because it takes into account the impact which engagement with the research exerts on participants' construction of meaning (Crotty, 1998). Thus, the influence which both time and the process of being engaged with the research may exert on participants' understanding of clinical teaching, was acknowledged (Guba & Lincoln, 1994).

Within constructionism, an interpretivist theoretical perspective served to structure the research in a manner that was congruent with the philosophical underpinning of the research questions. An interpretivist approach was appropriate because it aims to understand the influence of the participants' context on their behaviour (Candy, 1989). Two research orientations based in the interpretive research paradigm, hermeneutic phenomenology and symbolic interactionism were used to guide the research documented in this thesis. These orientations were guided by the principle that meaning and interpretation of phenomena must be understood by listening to the voices and perspectives of the participants (Strauss & Corbin, 1994). Moreover, both approaches acknowledged that the meanings which participants give to experiences are shaped by their situation, so that it was necessary to observe the participant in context (Crotty, 1998).

A case study approach was utilised in this study in order to orchestrate or organise "the collection and presentation of detailed, relatively unstructured information from a range of sources about a particular …group" (Hammersley, cited in Hitchcock & Hughes, 1995, p. 318). Case study offered this researcher the opportunity to develop a detailed description and understanding of a particular phenomena, clinical teaching, in its natural context. It appeared appropriate to use case study for this research because it provided not only the means by which existing beliefs and theories about clinical teaching could be tested, but also the opportunity and ability for the researcher and participants to develop new theoretical positions on clinical teaching (Sturman, 1997).

Within the orchestration of this case study, data were collected through a series of semi-structured interviews, informal interviews and periods of participant observation supported

by field notes and the researcher's diary. Six experienced nurses responded to the invitation to be participants in this study. The time period for data collection was between July 1998 and August 1999. Their availability and periods of involvement with clinical teaching of students, determined the time period for collection of data from each participant, which continued until saturation of the data was achieved. Each of the participants was a nurse with clinical experience ranging from four to twenty years. Four of the participants held Level 2 registered nurse (RN) positions within their wards, indicative of their advanced level of knowledge and clinical expertise within a speciality area of nursing. These nurses also held some responsibility for clinical teaching within their wards. The remaining two participants held Level 1 RN positions and had at least four years of clinical experience. They were required, as more experienced Level 1 RNs, to take some responsibility for the supervision of more junior Level 1 RNs and new graduates. All participants have been involved with clinical teaching of students either within formal preceptor relationships, or informally as buddy nurses.

1.7   SIGNIFICANCE OF THE RESEARCH

This research is significant for a number of reasons. Firstly, the understanding of the processes of clinical teaching and learning is a largely under-theorised area. This research therefore contributes to the development of nursing knowledge of the phenomena of clinical teaching, specifically from the perspective of nurses with experience in clinical teaching. It has been acknowledged (Forrest et al., 1996; Ives & Rowley, 1990; Paterson, 1994) that insufficient research has been undertaken into clinical teaching and learning, particularly research that examines the attitudes and views of clinicians. While there have been a number of studies that examine the "best" and "worst" attributes of clinical teachers (Nehring, 1990), there are few studies which examine the effect of being a clinical nurse teacher once they have been engaged in that role (Atkins & Williams, 1995; Bain, 1996). Consequently, this research aimed to address this lacuna identified in the literature by seeking to understand the attitudes and beliefs of nurses towards the clinical teaching of undergraduate students.

Secondly, this research offers important insights into the practice of nursing, particularly into the relationship between nursing education and nursing service. One of the major factors that

influenced the transition of nursing into the tertiary sector was the need to establish a greater alignment between nursing education and service (E. Davies, 1991). This study has the potential to contribute to the development of co-operative relationships between schools of nursing and clinical settings, by understanding the attitudes, values and beliefs of clinicians towards nursing education.

Finally, this study may also be of benefit to a specific population of clinicians, who, because of their involvement with this study, may become more aware of their professional responsibility towards the education of student nurses. Insight into their own practice gained as a result of participation in this study provides opportunities for clinicians to become role models both to their peers and to students, thereby assisting to create the requirements of a positive clinical learning environment.

1.8   LIMITATIONS OF THE RESEARCH

This research was concerned with exploring and understanding the impact of change in healthcare environments on the lives of six experienced nurses. It is acknowledged that the study is therefore limited by this case study approach because it only focused on the experiences of these six participants working with the context of one clinical setting. However, Stake (1995) noted that by limiting the case study, a deeper understanding of the phenomena might be achieved. Therefore this small purposive sample allowed for rich, thick descriptions of the phenomena of clinical teaching to be generated so that "readers will be able to determine how closely their situations match the research situations, and hence, whether findings can be transferred" (Merriam, 1998, p. 211). Butler's (1996) reminder that the worldview of the individual colours their perceptions and understanding of events and situations, also served to limit the research in two ways: firstly, the observations of the researcher may be influenced by pre-existing perceptions; and secondly, the information shared by the participants must be influenced by their world view in ways that are unique to each participant, and subject to continuing influence. The extent to which the reader is able to personally engage with the findings presented will thus be limited by their own worldview of the phenomena of clinical teaching. Therefore each reader will apply their own limitations to

the research through a process of engaging with the discussions presented, applying it to their own understanding and perhaps though such a "vicarious experience" (Stake, 1995, p. 87) make generalisations through case to case transfer.

It is acknowledged that the approach to data gathering exerts a limit on the generalisation of conclusions beyond one clinical setting. However, while it is important to appreciate each clinical setting as a unique environment, the study may offer some general insights pertaining to the creation of conditions that support a culture of teaching and learning, which the reader may apply to similar clinical contexts.

1.9   OUTLINE OF THE THESIS

This study explored the perceptions of experienced nurses towards their role in the clinical education of undergraduate student nurses. The introductory chapter has briefly established how this research responds to important issues raised in the literature about the impact of change on nursing education.

Chapter two synthesises and analyses literature pertinent to the purpose of the research. The review of literature was structured under three main sections. Section one examined the use of different models of clinical teaching and underlying assumptions of each model. Section two examined the concept of clinical teaching, in particular the development of reflective practice in nursing education. Section three explored the impact of changing healthcare trends on the practise and future of nursing and how these changes are reported to impact on clinical teaching. The literature reviewed demonstrates that emerging paradigms of nursing education require nurses to be *more* than competent doers, and demand that nurses adopt a critically reflective stance towards their theoretical knowledge and practice. However, the existing disalignment between meeting the service needs of the clinical setting and the educational needs of the student frequently precludes the establishment of positive learning environments in which a culture that values teaching and learning is created.

Chapter three is concerned with the design and methodology of the study. Details regarding the methods and approaches used for the collection and analysis of data were described.

Because this study was concerned with understanding how nurses are responding to change in their clinical settings, a qualitative approach served this purpose best. Within the qualitative philosophy, the epistemological position of constructionism was adopted because it takes into account the impact which involvement with the research may exert on participants' construction of meaning. Two interpretivist theoretical approaches, hermeneutic phenomenology and symbolic interactionism, acknowledged the influence of context on the participants. A case study approach organised the collection of data from a particular group of six experienced nurses through participant observation and interview.

Chapter four presents and analyses the data. A phenomenological data analysis framework was utilised in order to allow emerging themes to be presented back to participants for further dialogue. Sufficient data were presented to allow the reader to develop a "feel" and "sensitivity" for the data, thereby increasing the usefulness of the study. Through the process of comparative analysis, three major themes emerged and were subsequently discussed in the light of the literature reviewed.

Chapter five responds to the research questions and so synthesised the research. Contextual factors which appear to have influence on the participants' perceptions of clinical teaching were examined and some conclusions made for nursing education in general and one school of nursing in particular.

CHAPTER 2:   THE LITERATURE REVIEW

2.1   INTRODUCTION

The purpose of this chapter is to synthesise and analyse literature pertinent to the purpose of the research. Themes important to this study are illuminated through the literature review. The literature reviewed therefore served to highlight the place of this study in understanding the beliefs and attitudes of experienced nurses in relation to their role in the clinical education of student nurses. Subsequent data analysis was informed by themes identified by the review of literature.

2.1.1   Purpose of the Research

The purpose of this study was to explore how experienced nurses perceived their role as clinical teachers in an environment which is challenged not only with on-going changes in healthcare delivery, but also by the expectation that the environment will continue to provide positive clinical learning opportunities for undergraduate student nurses. The research is embedded in issues arising from change - change in healthcare delivery models, change in the role of the nurse and change in nursing education. Public perceptions of what it is to be a nurse and subsequently, how a nurse learns to be a nurse have also experienced major changes. These largely result from the transfer of nursing education from the hospital-based apprenticeship to the tertiary sector. At the same time, the philosophical belief that nursing is about "learning on the job" and "learning by doing" (E. Davies, 1991, p. 151) is being challenged by new curricular approaches which seek to develop the nurse as a critical thinker and reflective practitioner, prepared to challenge and question long-held practices (E. Davies, 1991; R. White & Ewan, 1997). Current literature also reports that public expectations of the new curricula are to prepare nurses who are able to respond to the broader demands of healthcare that are characterised by a focus on health promotion and disease prevention, rather than on the treatment of the sick (Oermann, 1994).

Consequently, this study explored how six experienced nurses perceived their role in fulfilling the expectations of new nursing curricula, as they worked with student nurses in one healthcare setting. The research examined how these nurses perceive their role in supervising, teaching and assessing students in an environment which is characterised by both ongoing changes in how healthcare is delivered and the need to provide learning opportunities for students that will facilitate their integration of theory with practice.

2.1.2 Conceptualisation of the Literature Review

The review of literature in this chapter responds to the need to examine the concept of clinical teaching and learning, as it is implemented in undergraduate nursing education. This will promote an understanding of the perspectives of these phenomena as they are reported by the literature. The three research questions below, that focused the conduct of the study, emanated from the issues that were identified in section 1.3 as being representative of the research problem.

Research Question One
How do experienced nurses create positive clinical learning environments for student nurses?
Research Question Two
How do experienced nurses resolve the often-contradictory demands of nursing students and those of the practice setting?
Research Question Three
How do changes in the healthcare environment impact on the experienced nurse's role as a clinical teacher?

The research questions have thus been developed over time and frame the conceptualisation of the literature that is presented in Figure 2.1. The conceptual framework serves to both reflect the research questions and to identify major themes in the literature that appear relevant in exploring the issues implicit within the research questions.

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┌──────────────────────────────────────────────────────┐
│        Perception of Role as Clinical Teacher         │
└──────────────────────────────────────────────────────┘

┌────────────────┐    ┌────────────────┐    ┌────────────────┐
│ Nurse as       │    │ Developing the │    │ Change in      │
│ Clinical       │    │ Reflective     │    │ Healthcare     │
│ Teacher        │    │ Practitioner   │    │ Contexts       │
│                │    │ Research       │    │                │
│ Research       │    │ Question Two   │    │ Research       │
│ Question One   │    │                │    │ Question Three │
└────────────────┘    └────────────────┘    └────────────────┘

┌────────────────┐    ┌────────────────┐    ┌────────────────┐
│ Models of      │    │ Dichotomy of   │    │ Change in      │
│ Clinical       │    │ Socialisation  │    │ Healthcare     │
│ Supervision    │    │                │    │ Environments   │
│ • Preceptorship│    │ Theory /       │    │                │
│ • Traditional  │    │ Practice       │    │                │
│   model        │    │ Dichotomy      │    │                │
│ • Clinical     │    │                │    │                │
│   affiliate    │    │                │    │                │
└────────────────┘    └────────────────┘    └────────────────┘
                                             ┌────────────────┐
                                             │ Impact of      │
                                             │ Change on the  │
                                             │ Role of the    │
                                             │ Nurse          │
                                             └────────────────┘

┌────────────────┐    ┌────────────────┐    ┌────────────────┐
│ Expectations   │    │ The Role of    │    │ Impact of      │
│ of the         │──▶ │ Reflection in  │ ◀──│ Change on      │
│ Clinical       │    │ Nursing        │    │ Nursing        │
│ Teaching Role  │    │                │    │ Education and  │
└────────────────┘    └────────────────┘    │ the Curriculum │
                                             └────────────────┘

┌────────────────┐    ┌────────────────┐    ┌────────────────┐
│ Preparation    │    │ Assumptions    │    │ Impact of      │
│ for the        │──▶ │ about          │ ◀──│ Change on the  │
│ Clinical       │    │ Reflection in  │    │ Clinical       │
│ Teaching Role  │    │ Nursing        │    │ Environment    │
└────────────────┘    └────────────────┘    │ and Clinical   │
                                             │ Teaching       │
                                             └────────────────┘
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Figure 2.1   **Conceptual Framework of the Literature Review**

2.1.3   The Conceptual Framework

As a result of synthesis of the literature reviewed, three major themes emerged. It thus became apparent that these themes of: Nurse as Clinical Teacher, Developing the Reflective Practitioner; and Change in Healthcare Contexts, are implicit in research questions one, two and three respectively. Accordingly, the literature review is presented using these three themes as the guidelines. A brief introduction to each of these three themes precedes the reporting of the synthesis of the literature and serves to highlight important issues implicit in the research questions. For added clarity, issues that are explicitly identified in the conceptual framework are bolded in the following introductions.

Nurse as Clinical Teacher

Literature that analyses commonly utilised **models of clinical supervision** and their expectations of students is reviewed. As the language of clinical education is ambiguous and frequently used interchangeably, this section aimed to define and clarify meanings associated with terms used in clinical education, such as **preceptorship** and mentoring. Relevant research (Burnard, 1995; Butler, 1996; Heath, 1998a) was thus examined to critically analyse **expectations of the role of clinical teacher** and subsequent **preparation for the role**.

Developing the Reflective Practitioner

Prior to the transfer of nursing education to the tertiary sector, nurses' **socialisation** into nursing was strongly influenced by their training hospital. Therefore key research (Bick, 2000; Grossman & Hooton, 1993) was reviewed to explore the **dichotomy in socialisation** between clinical contexts which continue to value speed and efficiency and the professional ideals of nursing curricula. The role of **reflection in nursing** has become a major focus of research, particularly since reforms in nursing education, which have as their goal the

development of critically thinking, independent practitioners informing **theory and practice** through critical reflection, have been adopted (Lindeman, 1989). It is evident in the literature that nursing education is seeking to promote the **practice of reflection**, both as a teaching-learning strategy and to develop the attributes of a lifelong learner (R. White & Ewan, 1997). Thus schools of nursing expect that students will be assisted to develop and incorporate **reflective practice** into their own practice, by experienced nurses who role model a critical perspective of their own practice. However, it is acknowledged that the realities of the clinical setting, which is largely dominated by service needs and a bio-medical model of care, do not always offer a learning environment in which critical thinking is encouraged, contributing to a **theory / practice dichotomy** (Grossman & Hooton, 1993).

Change in Healthcare Contexts

Economic policies and worldwide healthcare trends are impacting on both **the roles of the nurse** and the healthcare that they deliver (Manuel & Sorenson, 1995). The medical-dominated hospital institution in which nurses previously learned how to be a nurse, typically created a nurse who was primarily seen as "the purveyor of the doctor's routines and wishes and secondarily a provider of what, in her nursing judgement, was the nursing care needed by the patient" (Porter-O'Grady, 1990, p. 182). Nurses themselves (Sellers, 2000) expressed concern about the extent to which the changing philosophy in healthcare from a clinical role to a primary healthcare role is being realised in curricula. Subsequently, relevant literature (Corey-Lisle et al., 1999; Venegoni, 1996) is reviewed that explores current **impact of changes in healthcare delivery on clinical teaching and learning environments** and the **implications of these changes for the role of the nurse** and **clinical education**. As a strategy to better understand the logical sequence of the review of the literature, an overview is detailed in Table 2.1.

2.2   Nurse as Clinical Teacher.

Models of Clinical Supervision

  Preceptorship Model

  Traditional Model

  Clinical Affiliate Model

Expectations of the Role of Clinical Teacher

Preparation for the Role of Clinical Teacher: Teaching the Teacher

Implications for this Research

2.3   Developing the Reflective Practitioner

Dichotomy of Socialisation: Theory and Practice

The Role of Reflection in Nursing Education

Assumptions of Reflection in Nursing

Implications for this Research

2.4   Change in Healthcare Contexts

Change in Health Care Environments

Impact on the Role of the Nurse

Impact on Nursing Education and the Curriculum

Impact on the Clinical Environment and Clinical Teaching

Implications for this Research

2.5   Conclusion to the Literature Review

Table 2.1   Sequence of the Literature Review

2.2   NURSE AS CLINICAL TEACHER

Despite the transition of nurse education to the higher education sector, the preparation of individuals as competent professional nursing practitioners requires student nurses to undertake a variety of field or clinical placements, integrating theory with practice. Nurses within almost every nursing environment, from community and hospice care, to acute tertiary hospitals, interact almost daily with a number of student nurses on clinical practica. These students are enrolled in a variety of university programs and possess varying degrees of competence in, and exposure to nursing. While models of clinical teaching vary from school to school, students are generally supervised by a Clinical Nurse Teacher under some model of clinical supervision. However, it is the nurse in the clinical setting who is paired or buddied to work with the student nurse who bears the brunt of students' queries and complaints and who incidentally acts as a role model, teacher and socialising agent. On occasions this is formalised into a preceptorship role where one nurse works with one student to assist in the integration of theory with practice.

The aim of this research was to explore the perceptions of those nurses who either formally take on a preceptorship role, or informally are buddied with undergraduate students, about their role as clinical teachers. This is important because it is acknowledged that it is those interactions, which take place between the clinical nurse or their colleagues in the clinical setting and the students, which contribute to the development of students' professional values about nursing (Ahern, 1999). Subsequently, a review of literature that examines various models of clinical supervision, expectations of the clinical teaching role and preparation for clinical teaching is necessary in order to identify issues of concern for nurses in their role as a clinical teacher. This process therefore serves to highlight issues important in Question One of this research.

2.2.1   Models of Clinical Supervision

Several clinical teaching and learning models are currently being implemented within schools of nursing which aim to increase the collaboration between nursing education and service. These can be summarised as: the "Preceptorship Model" in which students work on a one-to-one basis with an experienced clinical nurse for a period of weeks most commonly in their final semester (Myrick, 1988); the "Traditional Model" which utilises either casual, sessional nurses or faculty members who are nurses, to supervise students on clinical placements in ratios of about 1:8 (Grealish & Carroll, 1998); and the "Clinical Affiliate or Associate Model" which involves the secondment of nurses from healthcare agencies and their employment by universities as clinical nurse teachers of small groups of eight to ten students for placements within their own agency (Greenwood & n'ha Winifreyda, 1995).

Despite the differences between these models of clinical supervision, there is some confusion between the use of terms to describe nurses who take on the role of clinical teachers within these models. Preceptor, mentor, clinical nurse teacher, clinical affiliate, associate, instructor and supervisor, are all terms variously applied to describe the role of a knowledgeable clinical expert, teaching and guiding the student nurse while on clinical placement or experience (Higgs & Jones, 1995). This has lead to use of the "umbrella term" of "clinical supervisor" (Wilson-Barnett et al., 1995) frequently being used to mean any of these terms, although Burnard (1988) earlier observed that nursing education appears to have slipped into the use of 'mentorship' to describe a process of clinical teaching and learning that is more appropriately termed 'preceptorship'. However, although frequently confused with or used interchangeably for the concept of mentoring, the literature reports that preceptorship is increasingly utilised in both undergraduate and postgraduate nursing education as an individualised method of facilitating student teaching and learning. The Glossary of Terms (pages vii to viii) is offered in order to address this ambiguity in terms used to describe the roles of nurses in clinical teaching.

Preceptorship Model of Clinical Supervision

The term preceptor, as used in this thesis, refers to an experienced clinician, whose role is to assist the student make the transition from working within the university culture, to working within the organisational culture (Bain, 1996). Advantages of the preceptorship model include its focus on assisting the student develop, practice or refine relevant clinical skills and develop a knowledge of the organisation's culture, values, rules and regulations, in what is usually a short-term relationship of weeks to months (Moreton-Cooper & Palmer, 1993; Robinson, McInerney, Sherring, & Marlow, 1999). The student nurse who is allocated to the clinical area generally works alongside the preceptor on the same roster for the whole placement in order to enhance the development of the learning relationship. Preceptors are ideally experienced nurses who possess a commitment to teaching and an ability to understand the student's perspective while acknowledging the needs of the clinical setting.

The United Kingdom Council for Nursing, Midwifery and Health Visiting (UKCC) offers a clear expectation of the role of the preceptor to state that the preceptor will:

- Have sufficient knowledge of the practitioner's programme leading to registration to identify current learning needs
- Help the practitioner to apply knowledge to practice
- Understand how practitioners integrate into a new practice setting and assist with that process
- Understand and assist with the problems in the transition from pre-registration student to registered and accountable practitioner
- Act as a resource to facilitate professional development

(UKCC, cited in Bick, 2000, p. 44).

These expectations describe a clinical teaching role for preceptors in which an understanding of students' education needs are vital and might offer assistance to undergraduate students in their transition from student to beginning practitioner, particularly when it is noted that the preceptor's role is to reduce transitional stress and promote socialisation.

Through role modelling and selection of learning opportunities, preceptors encourage the final semester student to consolidate clinical application of theory and develop independence (Bain, 1996; Hayes & Harrell, 1994). The need for students to be assisted with their transition from undergraduate student to graduate nurse has been earlier described as "reality shock" (Kramer, 1974). This description of the reality shock that new graduates frequently

encountered as they made the transition from their professionally socialising university culture to that of the bureaucratic hospital culture, encouraged the development of solutions to facilitate the transition of graduates on entering the world of work, the hospital. The preceptorship model was proposed by nursing education and service as a strategy to reduce reality shock by enhancing the application of theory to practice and providing opportunities for students to be prepared for their role transition (Myrick, 1988). It has subsequently been acknowledged that a preceptorship experience can promote anticipatory socialisation and so assists the student to better adapt to the realities of practice on graduation (Dobbs, 1988; Goldenberg & Iwasiw, 1993; Hovey, Vanderhorst, & Yurkovich, 1990; Jairath, Costello, Wallace, & Rudy, 1991).

Similarly, research has identified that students' expectations of the preceptor experience is that they will focus on the development of clinical skills competency (Scheetz, 1989) and their ability to transfer theory learnt in the classroom into practice. A preceptorship model of clinical supervision advantages students as they learn to make decisions about patient care in a supportive learning atmosphere and to learn the nuances of being a nurse (M. Wilson, 1994). However, new graduates continue to report that despite being preceptored, their transition to clinical nurse was "stressful", and they were "thrown in at the deep end" in a "baptism of fire" (Bick, 2000, p. 45). It has been reported that goals of university preparation of nursing students are to increase their professional status and promote the development of leadership as a professional attribute (DHSH, 1994). It is therefore disconcerting to find that the precepting experience has not always increased students' perceptions of themselves, or of other nurses, as leaders and autonomous decision makers (Ridley, Spence Laschinger, & Goldenberg, 1995).

Conclusions that there are no significant differences between students who are preceptored and those who are not, challenge both nursing education and service to examine the assumption that a preceptor experience leads to increased clinical skills and competence (Myrick & Awrey, 1988). There is little evidence to support conclusions that students who are preceptored are more clinically competent or adapt to the variables of post graduate employment any more easily or with less stress than do their counterparts who are not preceptored (Jairath et al., 1991). An analysis of the literature describing outcomes of preceptorship programs led Lett (1994, p. 57) to conclude that, "the findings do not indicate that students who are preceptored are any better prepared than those who have not been

preceptored". Factors such as student preferred style of learning, student-preceptor match, clinical expertise of the preceptor and ability of the preceptor to carry out the role, all impacted on the extent to which students perceive the preceptor experience to be of value (Lett, 1994; Meng & Conti, 1995).

This conclusion was reflected in comments from beginning practitioners in a preceptorship relationship: "I think the idea of preceptorship is a good one in theory. However, in a busy ward environment, with staff shortages, it is still limited in practice" and further " I didn't really feel supported, my preceptor had her own job to do, and wasn't there for me all the time" (Bick, 2000, p. 45). Similarly new graduates describing their perception of their experiences of transition from student to staff nurse also reported inadequate support from their preceptor (Maben & Clark, 1998). While these reports have arisen from studies of new graduates, similar conclusions about lack of support from preceptors were drawn from studies of undergraduate students (C. Davies, Welham, Glover, Jones, & Murphy, 1999). Furthermore, the role of preceptor appeared to cause some stress for experienced nurses. While preceptors generally report they enjoy the role, there was also a perception that preceptoring could lead to conflicting responsibilities between meeting the needs of their patient and those of the student (Atkins & Williams, 1995). There was increasing concern expressed that the stress caused by the preceptorship process may lead to reduced standards of patient care (Bowles, 1995).

The literature relating to preceptorship reviewed thus far highlights the difficulties reported by nurses in fulfilling a clinical teaching role while the stress of meeting their patients' needs is increasing. It has been suggested that the traditional role of faculty members in clinical teaching be reassessed (C. Davies et al., 1999; MacCormick, 1995). Relevant literature which examines the role of faculty in clinical supervision models has subsequently been reviewed.

Traditional Model of Clinical Supervision

The 'Traditional' model utilises either faculty members who are nurses or casual, sessional nurses as clinical teachers to supervise and facilitate student learning for specific periods of clinical placements (Grant et al., 1996). This model of supervision allows the school of nursing to utilise clinicians or faculty members who are appropriate for the particular student level and the clinical setting. Being supervised by faculty members who are committed to research and tertiary education and have knowledge of the curriculum advantages students (Grealish & Carroll, 1998). However this approach has been criticised for using faculty members who may lack recent and relevant clinical experience (Napthine, 1996), and for the use of sessional clinical teachers who are outsiders to the clinical setting and may be unaware of the culture and experiences available within the clinical setting they are engaged to supervise (Paterson, 1997). This leads to a potential lack of credibility.

Subsequently a perceived lack of clinical credibility on the part of the faculty member emerged as a major disadvantage of this model (Barnes, Duldt, & Green, 1994; Cave, 1994; Gross, Aysse, & Tracey, 1993; Napthine, 1996). Casual sessional nurses contracted for periods of time to act as clinical teachers, similarly reported a lack of credibility and feelings of not belonging to, or of isolation from the clinical team (de S. Ferguson, 1996) and being not unlike guests in the clinical setting (Paterson, 1997). The impact of this perception of a lack of clinical credibility was exemplified by nurse educators in one study who felt the need to establish credibility in the eyes of the clinical team by volunteering for extra tasks (even though their role was ostensibly to facilitate learning) and memorising information "just in case" they were quizzed by a staff member (Paterson, 1994, p. 355). Such behaviour served to distract the nurse educators from their primary role, which was to facilitate learning for the students. Role satisfaction appeared to be higher when the role of clinical teacher was clear and the clinical teacher fits in and feels a credible part of the team (Clifford, 1999). Clinical credibility and its impact on the extent to which the nurse educator fits in or remains an outsider was summarised by Carlisle et al. (1997), who stated "facilitating students to acquire clinical expertise presupposes that the teacher is clinically competent" (p. 395). This raises questions about how faculty members retain clinical competence.

In recognition of the critical need for faculty staff to retain their ability to support clinical teaching, the "English National Board for Nursing, Midwifery and Health Visiting continues to demand that nurse teachers spend 20% of their time in clinical practice in their new roles as lecturers in higher education" (Clifford, 1999, p. 185). However, while this has been set as the desirable, there exists a wealth of literature showing that clinical teaching is regarded as a token gesture by nurse teachers (Clifford, 1996) and that nurse teachers prioritise classroom teaching over clinical teaching (Carlisle et al., 1997; Jacka & Lewin, 1987). Historically, universities have valued the academic pursuits of research, subscribing to a 'publish or perish' philosophy, at the expense of maintaining clinical skills and thus credibility. The transition of the practice-based discipline of nursing into the tertiary sector in Australia does not appear to have caused a revision of this status quo (Emden & Borbasi, 2000; Martin, 1995). The United Kingdom (UK) as part of the introduction of *Project 2000* diploma level, nursing education reforms, offered one solution to the issue of clinical credibility, by the introduction of one grade of nurse teacher who has responsibility for both clinical and classroom teaching (Carlisle et al., 1997). This role was created in response to the earlier failure of the clinical teacher position (Forrest et al., 1996). However, nurse teachers working in the new academic environment of *Project 2000* admitted that neither they, nor their colleagues, viewed the clinical role as a priority (Carlisle et al., 1997). Thus it appears that clinical teaching activities in the university context are still awarded the least status (Budden, 1994; Gross et al., 1993) and consequently inhibit faculty from pursuing clinical practice with sustained energy in order to maintain their clinical competence.

Positive learning environments are enhanced when both students and ward staff perceive the faculty member as a credible clinician. In response, the literature suggests changing the role of the faculty member from one of directly teaching clinical practice to one of providing support for the student and nurses in the clinical environment (Grealish & Carroll, 1998; MacCormick, 1995; Wilson-Barnett et al., 1995). This proposal was supported by students who considered that faculty members' teaching skills were best utilised in the role of support for the nurse (Forrest et al., 1996). Such a reframing of faculty members' roles may thus serve to reduce the stress experienced by nurses in relation to clinical teaching, by increasing the support available to them from the university. The redevelopment of faculty members' roles to reflect these aims has the potential to support nurses in their relationship with the student by providing feedback and encouragement (C. Davies et al., 1999; Hsieh & Knowles, 1990). Most satisfaction in learning appeared to occur when relevant faculty members developed

close liaison and supportive relationships with their students' buddy nurses (Baird, Bopp, Kruckenberg Schofer, Langenberg, & Matheis-Kraft, 1994). A relationship of this nature between experienced nurses and faculty assisted in the development of closer links between nursing education and service (Gross et al., 1993) and has the potential to reduce the tension and dichotomy between nursing education and nursing practice. Nevertheless, the impact of increasing workloads on nurses appears to indicate that the issue of clinical teaching is far from resolved. Reframing of faculty members' roles to one of support may paradoxically increase the pressure on nurses to adopt more responsibility for clinical teaching.

Nurses in one study (Forrest et al., 1996) agreed that they value the formalisation of their teaching role, yet expressed concern at the increased workload this represents, particularly in a period of rapid change when they considered themselves already overworked. Bick (2000) also noted that although nurses remain positive about their commitment to the clinical teaching role, they felt limited by workload pressures and the lack of time to create an effective clinical learning environment. Further exploration of the reported impact of change on the clinical learning environment was undertaken in section 2.4 and the importance of this concept is reflected within the research questions. However, one solution to the increasing stress reported by nurses, may be the secondment and payment of experienced nurses from the clinical setting to act as clinical affiliates.

Affiliate Model of Clinical Supervision

The "Affiliate" or "Associate Clinical Teacher" model attempts to overcome problems of clinical credibility associated with the Traditional model, by the secondment and employment of clinicians to supervise clinical placements within their own healthcare setting (Baird et al., 1994; Melander & Roberts, 1994). The primary advantage of this model is its utilisation of experienced nurses who are already cognisant of the culture and personnel in their wards and whom their peers subsequently regard as credible, clinical practitioners and appropriate, clinical teachers. The students benefit from having an experienced clinician who also role models a positive relationship with other clinical staff and patients (Baird et al., 1994). This model acknowledges that students' clinical environment and learning are enhanced by the use of clinical teachers who are recognised by their peers as clinically competent, and who are

familiar with the routine and culture of their own healthcare setting (Paterson, 1997).

However, the advantages of familiarity also present one of the major disadvantages of this supervision model. Because they are seconded from within their own clinical environment, clinical affiliates may have to make a choice between being an advocate for their students in situations of conflict with their peers, or risk alienation and a sense of betrayal from the students by appearing to be more influenced by their peers than the students (Bain, 1996). This is similar to the experiences of mentors who also found that the role competed for their time with their patients and lead to role conflict (Atkins & Williams, 1995). Similar concerns about role conflict are voiced by students (Forrest et al., 1996) who found that nurse teachers may not maintain the quality of clinical placements by failing to act on students' concerns about quality of care and clinical supervision. This inaction was subsequently interpreted by the students as acting to maintain the status quo of the clinical environment and refusing to challenge other nurses working in the clinical setting (Forrest et al., 1996).

Nevertheless, despite these identified concerns, the use of expert nurses familiar to the setting appeared to promote a positive learning environment amongst other staff on the wards (Greenwood & n'ha Winifreyda, 1995), who then become committed to and actively involved in student teaching. The utilisation of appropriate teaching models and support for clinical teaching may maximise the benefits of clinical placements by contributing to the growth of a culture that values and promotes student learning. However, it is also becoming increasingly difficult for ward areas to release experienced staff to act as clinical affiliates due to a loss of appropriate staff and the busyness of clinical settings (Forrest et al., 1996). It is evident that the busyness of the clinical setting is impacting on the adequacy of clinical teaching that is offered to students by their clinical supervisors.

While eight or more students may be formally supervised by one clinical supervisor who may be a faculty member, sessional clinical teacher or clinical affiliate, Bick (2000) and Glen and Clark (1999) indicated that this is inadequate because of the difficulties which students experience in accessing their supervisor. Greenwood and n'ha Winifreyda (1995, p. 184) also reported that "students complained about their inability to access their nurse teacher and the episodic nature of her supervision". It is of concern to note that in the clinical learning environment, many nurses "find themselves unable to supervise adequately the number of students reaching their clinical areas" (Duxbury, 1995, p. 61).

Similarly, Polifroni et al. (1995, p. 167) reported that while students were on clinical placements, "at least 75% of clinical practice time was without direct supervision (no interaction with instructors or hospital staff)". One Australian university has acknowledged that the ratio of one Clinical Nurse Teacher to eight or more students means that students cannot receive adequate supervision and teaching, and so rely on the pairing or buddying of nurses working in clinical areas with students who are providing hands-on care (Grant et al., 1996). This reinforces the findings of earlier studies (Fretwell, 1982; Jacka & Lewin, 1987), that students actually experienced minimal supervision from either their buddy nurses or their university appointed Clinical Nurse Teacher.

As a consequence, learners were sometimes left unsupervised and unsupported in roles for which they are under-prepared (Bick, 2000). Recent changes to nursing education appear to have exacerbated this problem so that "the education of students in placement-based learning has fallen by default to mentors / practice assessors" (Glen & Clark, 1999, p. 14). Of real interest to this research is the wealth of evidence which reports that the actual supervision and teaching of students on a moment to moment basis is being delegated to the buddy nurse (Glen & Clark, 1999; M. Wilson, 1994). Subsequently, with the exception of the preceptor model which, by definition is a one to one relationship, researched literature indicates that the actual supervision of student nurses on their supernumerary clinical placements relies on the willingness and ability of other nurses to informally buddy students placed in their ward (Forrest et al., 1996; Grant et al., 1996; Lett, 1994). The formally appointed Clinical Nurse Teachers are left to assess and evaluate their eight to ten students scattered across the healthcare agency. Research suggests that even the ratio of 1:8 is too large to adequately supervise and teach (Gross et al., 1993), although economic trends do not offer any hope of this ratio becoming more manageable.

The literature reviewed thus far indicates that the responsibility for moment to moment teaching and learning at a clinical level appears to have been covertly delegated to clinical staff (Polifroni, et al., 1995; M. Wilson, 1994), usually unprepared as teachers, clinically overburdened and unwilling to take on an extra, unrewarded, unacknowledged role (Lowry, 1992). Students appear to rely heavily on friendly (and sometimes not so friendly) ward staff to assist in the complex process of clinical decision-making according to Wilson (1994). If universities acknowledge that the preparation of clinical teachers is vital to the success of a clinical teaching experience, it is very concerning to realise that the majority of learning in

clinical practica occurs in a largely unguided, unorganised way (Polifroni et al., 1995). This raises serious questions about the quality of clinical teaching opportunities that busy, overworked clinicians can offer. Indeed some clinical supervisors reported a worrying lack of knowledge of clinical supervision models and admitedt that they were "making it up as we go" (E. White et al., 1998, p. 189) giving cause for further concern about the nature of the clinical learning environment. The practicality of one clinical teacher adequately fulfilling the role of supervisor, teacher, role model and assessor, results in students and buddy nurses being unable to access clinical teachers when needed (Grant et al., 1996). This situation increases the stress on students and buddy nurses, and suggests that some clinical placements must fail to meet students' expectations and learning needs if they are indeed unsupervised for 75% of their time (Polifroni et al., 1995).

The literature presented illuminates issues of concern in clinical teaching particularly related to the process of clinical supervision. This illumination assists in exploring Research Question One in relation to nurses' perceptions of how positive clinical learning environments can be optimised. However, it is also apparent that the increasing busyness of clinical settings is impacting on the teaching learning relationship between student and nurse. Schools of nursing expect that experienced nurses will provide opportunities for students to learn how to be a nurse through guided questioning, analysis and critical thinking about issues related to their practice (Marrow & Tatum, 1994). It is evident that in some settings, this represents an ideal situation and not the reality (Polifroni et al., 1995; E. White et al., 1998). The literature which explores expectations of the clinical teaching role is reviewed next.

2.2.2   Expectations of the Role of Clinical Teacher

Nurses either informally buddied with a student or formally acting as a preceptor, are expected to be capable of assisting their students transfer theory into practice, and to identify and maximise learning opportunities so that their students can develop effective clinical decision making skills (Grealish & Carroll, 1998; Myrick & Barrett, 1994). The perhaps unrealistic, expectation of university faculty is that nurses will not only be willing to be buddied up with students, but will also be skilled and thoughtful teachers (Bowles, 1995).

However, the assumption by both nursing educators and the practical setting that nurses, by virtue of their clinical expertise will be appropriate socialising role models and clinical teachers, is challenged in the literature (Coates & Gormley, 1997).

It is of concern to note that the actual selection of experienced nurses to work with students appears to depend not on their expertise and suitability, but rather on their availability to take on the role (Myrick & Barrett, 1994). Twinn & Davies (1996, p. 179) reported a situation in which one respondent commented "I don't think I had any (choice) really. I think my name was put forward...we've got two community practice supervisors...there's one district nurse who's like refused and they needed four, so my name got put forward". Similarly, nurses described that the process of their selection to supervise students' clinical learning ranged from self-selection, to selection by management, or selection by the student (Bishop, 1998). A situation in which nurses were chosen as preceptors or clinical teachers because it is their turn, or because there was no one else more suitable (Cantwell, Kahn, Lacey, & McLaughlin, 1989), must contribute to problems with the establishment of a positive student-teacher relationship which precedes the facilitation of meaningful learning.

Nevertheless, literature supports the principle that experienced nurses must be adequately prepared for their teaching role and supported within this role. Selection of and support for the clinician by faculty have been acknowledged as key processes in the success of any preceptor program (Hsieh & Knowles, 1990; Myrick & Barrett, 1994; Westra & Graziano, 1992; Yonge & Profetto-McGrath, 1990). Sound clinical competence and experience have been identified as critical elements in the selection of suitable preceptors (Westra & Graziano, 1992). Similarly, students judged experienced nurses' credibility as a teacher on the evidence of their clinical expertise (Peirce, 1991). Interestingly, Meng and Conti (1995) argued against the use of 'expert' nurses as preceptors because of their difficulty in explaining the role which intuition plays in their clinical decision making. The 'competent' nurse, who, they reasoned was more likely to remember what it was like being bound by the constraints of rules and fixed steps which characterises the novice's practice (Benner, 1984), was seen as a more appropriate role model and teacher for the novice.

Experienced nurses need assistance in developing clinical teaching skills. To ignore this is to continue to cast clinical teaching as of secondary importance to theoretical teaching and knowledge according to Myrick and Barrett (1994), and perpetuates the belief that the

university is responsible for the development of theoretical knowledge and the clinical setting is responsible for the development of skills and practical knowledge. This will continue to keep nursing education and service divided in their common goal of quality nurse education by separating propositional or theoretical knowledge from practical knowledge, while ignoring the value, if not the existence of, experiential or personal knowledge (Burnard, 1988). Experiential learning is a process though which reflection on experiences is transformed into guidelines for future action, contributing to the store of one's personal knowledge (Parker, Webb, & D'Souza, 1995). One expectation of new nursing curricula is the preparation of reflective practitioners, capable of critical reflection and incorporating reflection on action into future action (Butler, 1996). If students were to incorporate deliberate reflectivity into their learning practice, it would appear necessary for them to have clinical teachers who similarly practise reflectivity. Greater collaboration is needed between nursing education and healthcare facilities to ensure that experienced staff are selected as clinical teachers because they value learning, support the philosophy of critical thinking and are committed to assisting the novice. The challenge therefore, is to assist nurses to develop these characteristics. However, there appears little evidence in the literature that nurses are selected as clinical teachers because of their teaching skills. This may be explained by reviewing the nature of clinical teaching preparation programs.

2.2.3 Preparation for the Role of Clinical Teacher: Teaching the Teacher

It has been stated that an understanding of the nature of nursing curricula, theories of nursing, conceptual frameworks and the nature of experiential learning are essential elements of a clinical nurse teacher preparation program (Novak, in Stuart-Sidall & Haberlin, 1983). Offering nurses an understanding of the principles of adult teaching and learning may reduce their anxiety concerning the supervision, assessment and evaluation of students' performance while on clinical placements (Myrick & Barrett, 1994; Westra & Graziano, 1992). Stuart-Sidall and Haberlin (1983) concurred that appropriate preparation and continuing support of suitable nurses would also promote the development of an ethos and culture within healthcare agencies that support lifelong learning, contributing to a positive learning environment for

students and staff alike. It can be further hypothesised that preparation for the teaching experience will reduce the professional / bureaucratic tension between nursing education and service and so contribute to a greater understanding of the students' lives by their buddy nurse.

There appears to be broad support for the inclusion of concepts such as interpersonal and communication skills in preceptorship programs (Mooney, Diver, & Schnackel, 1988; Young, Theriault, & Collins, 1988), as well as principles of adult learning, teaching and feedback (Westra & Graziano, 1992). However, there appear to be few preceptorship programs which incorporate teaching preceptors techniques for developing critical thinking in novice nurses (Meng & Conti, 1995). Existing programs tend to focus on outcomes, rules and skills. This may be explained by remembering that many nurses, including faculty members, have been educated in an atmosphere that rewarded conformity to the hierarchy and a belief that technical rationality was the ideal model on which to base care (Powell, 1989). From this perspective, feedback tactics that give the message "I know you can improve and I'm going to tell you how" (McInnes & Morrison, 1995, p. 17), reinforce the concept of teacher as filler of an empty vessel, congruent with an adherence to a technical-rational paradigm of learning. The technically-oriented model of education views students as in need of being trained in order to achieve the pre-determined competencies which have been identified by those experts in charge (Allen, 1990). Butler (1996) described this as a training solution, an external strategy that imposes someone else's view of how things should be done onto the learner. He proposed that this model of professional development was unlikely to achieve meaningful and lasting change in behaviour because it shifts the responsibility from the learner to the teacher, so that the learner comes to believe that someone "will always tell me what to do and will train me to do it in the way they want" (Butler, 1996, p. 266). Similarly, clinical nurse teachers have been found to be unwilling or unable to share information with their students and involve them in a problem solving approach to patient care, leading to the conclusion that they operate from a 'developmental' model of clinical supervision which fails to appreciate the value of critical evaluation and reflection on one's own practice (Marrow & Tatum, 1994).

Such a lack of understanding of some of the concepts of clinical teaching may, in fact, be due to inadequate preparation for clinical teaching, or due to conflict between the university's expectations of the practicum and the realities of the practice setting (Twinn & Davies, 1996). While it is expected that experienced nurses will be able to create an appropriate learning

environment (C. Davies et al., 1999), nurses themselves were not so confident in their abilities to teach. Clinical nurses "did not know about available models of clinical supervision and had set about it blindly" (E. White et al., 1998, p. 189). This lack of knowledge of clinical teaching was further illustrated by similar reports (C. Davies et al., 1999) that nurses, while confident in their clinical knowledge, were apprehensive about their level of knowledge and skills relating to teaching students. The perception that any preparation for the teaching role was "too little too late" (Twinn & Davies, 1996, p. 189) and is not adequately supported in terms of time and financial commitments (Bishop, 1998), raises concerns about the adequacy of preparation of nurses for their clinical teaching role.

A negative attitude to clinical teaching has also been related to the lack of clinical teacher development (Bishop, 1998). A major Australian study of 493 beginning graduate nurses and 729 experienced nurses with whom they came into contact, reached similar conclusions about the ability of many experienced nurses to be effective clinical teachers (Nurses Registration Board of New South Wales (NSW), 1997). Many beginning nurses reported that they did not feel adequately supported and were, in fact, badly treated by their more experienced colleagues. This report highlighted the lack of skills that experienced nurses were able to demonstrate in facilitation, supporting learning and generally developing a collegial, perceptive relationship which optimises learning. It is concluded that one of the major reasons for the unsupportive environment in nursing is the lack of preparation for their teaching role and the related lack of recognition of the responsibility that nurses have in supporting, mentoring and assessing beginning nurses (Nurses Registration Board of NSW, 1997). When viewed from this perspective, it is not difficult to understand why nurses frequently report low self-esteem and a lack of confidence in their own clinical decision-making abilities, factors that contribute to difficulties experienced in the assessment of students (Duke, 1996). The apparent lack of adequate and appropriate clinical teaching preparation may contribute to the problematic issue of assessment of student learning.

Many problems are raised about assessment in clinical nursing. In particular, there are issues relating to: subjectivity and bias of the assessor; reliability and validity of the assessment tools; difficulty in interpreting assessment criteria; and reluctance to make negative comments; particularly when the assessment is seen as vital to continuance in, or graduation from the course (Duke, 1996; L. M. Ferguson & Calder, 1993; Marrow & Tatum, 1994). A perception by preceptors that failure of the student is intrinsically linked to their own clinical

and teaching competence has also been identified as a potential inhibitor to congruent assessment (Duke, 1996). Preceptorship arrangements which require preceptors to take responsibility for the allocation of their preceptee's workload, may also lead to a perception that the failure of the student is the responsibility of the preceptor and thus indicates failure of the preceptor (Bowles, 1995). Priest and Roberts (1998) suggested that nurses have difficulty with assessment because performance indicators lack clear descriptions of the criteria for each grade and so are open to assessor bias and subjectivity. Despite the fact that assessment is based on nationally approved competency standards developed by the Australian Nursing Council Inc. (ANCI) (1994) confusion continues to exist.

Clinical nurses identified problems with not only the wording of the grading criteria, but also with the expectation that they are not simply assessing successful completion of a number of clinical skills (Twinn & Davies, 1996). New nursing curricula are seeking an assessment of the process of students' development of their nursing practice. This presented a conflict for nurses more used to assessing the hospital-trained student's completion of skills (Twinn & Davies, 1996). Factors such as unfamiliarity with curricula expectations may also result in reluctance to participate in assessment and evaluation of students (Lewis, 1990), and reinforces the need for preparation and support of experienced nurses that is individualised to meet their varied needs. The apparent lack of preparation for clinical teaching, as identified earlier, also contributes to experienced nurses' unfamiliarity with the student's course requirements. While it is hypothesised that effective preparation and support of suitable experienced nurses will ensure that their assessment foci are congruent with faculty expectations (L. M. Ferguson & Calder, 1993), there is little evidence that tests such hypotheses.

It could be argued that faculty members are guilty of holding conflicting views about the responsibility for clinical assessment of students. Faculty members appear to be reluctant to hand over responsibility for clinical assessment, yet assume that the clinical teaching of student nurses by preceptors implies acceptance of the responsibility for clinical assessment of the student (Lewis, 1990). However, not all preceptors (Coates & Gormley, 1997) accept this responsibility. It is concerning to note that some preceptors do not view assessment of the tertiary nursing student with quite the same urgency and rigour as that of the hospital-trained nurse, because of the perception that the students are not part of the permanent staff of the clinical area (MacCormick, 1995). This finding is important to this research because it raises

questions about who is responsible for assessing the clinical practice of this next generation of nurses and may also indicate an underlying failure by experienced nurses to accept the principles of recent reforms in nursing education. This study therefore responds to this lacuna in the literature by exploring nurses' perceptions of clinical teaching within changing healthcare paradigms.

2.2.4   Implications for this Research

Since the curriculum revolution of the late 1980's, educational paradigms focus on the value of student centred learning (Lindeman, 1989) and on incorporating reflection on practice to develop further learning. However, few studies (Myrick & Barrett, 1994) question whether experienced nurses agree with this paradigm and incorporate it into their clinical teaching activities. Much of the research in clinical teaching can be criticised for its emphasis on good and bad teacher characteristics, which continue to perpetuate the concept of clinical teaching as being technically oriented and of being concerned with the product of teaching (Hedin, 1989). Certainly much of the literature continues to portray clinical teachers as desiring concrete "how to" assess skills (McInnes & Morrison, 1995). Powell (1989) suggested that experienced nurses do not learn from their practice because their educative and work environments have valued traditional and hierarchical conformity to a technical-rational type of practice. While clinical teaching paradigms for the future recommended a focus on the integration between the "doing" and "knowing" of nursing through reflection (Lindeman, 1989), further research is needed to understand what factors influence experienced nurses in their assessment and evaluation of students. Questions are raised about whether experienced nurses focus on the assessment and evaluation of students' clinical reasoning abilities or on their completion of skills in the "right" way. It is suggested that the strength of experienced nurses' attachment to a technical-rational paradigm may be so strong that it is difficult for them to come to terms with the concept of learning from experience, and so be incapable of helping their students (and themselves) develop the professional attributes of the reflective practitioner (Powell, 1989).

The changing nature and foci of nursing education have implications for the selection and preparation of clinical nurse teachers. New curricula approaches to learning require that clinical teachers endorse the intent of tertiary education for nurses and whose professional practice is characterised by reflectivity and a life-long approach to learning that supports students' in resolving the dichotomy between theory and practice.

2.3 DEVELOPING THE REFLECTIVE PRACTITIONER

A major stimulus for the transfer of nursing education from the hospital-based training to a professional preparation in the tertiary sector was the need to reduce the existing disalignment between competing perspectives within the nursing profession on the future of nursing (E. Davies, 1991). As a consequence, socialisation to a professional role has come to be regarded as the responsibility of the university. Claims that new curricular approaches are encouraging reflective practice in order to achieve this goal of professional socialisation, are challenged by the organisational culture of the hospital which has traditionally equated good nursing care with speed, efficiency and accuracy in skills and tasks (Grossman & Hooton, 1993; Jarvis, 1992). In contrast, nursing education curricula focus on an holistic approach to patient care (Grossman & Hooton, 1993; Kim, 1993). It could be argued that nursing curricula which focus on the development of the professional attributes of critical thinking and reflectivity are, in fact, setting the students up for failure by ignoring the realities of the clinical setting. The socialisation of nurses within the hospital setting may thus be in dialectic tension with the professional socialisation intentions of the new curricula.

2.3.1 Dichotomy of Socialisation

Traditionally, the socialisation of student nurses undertaking apprenticeship training took place within the task-oriented, hierarchical, bureaucratic context of the hospital setting. Sociologists in the 1950s viewed professional socialisation as being the "learning of values" and the incorporation of these values into nursing tasks (Simpson, Back, Ingles, Kerckhoff, &

McKinney, 1979). Nursing school curricula focused on "skill training and basic theory" (op cit, p. 231) leaving the responsibility for professional socialisation to the employing organisation. It was the role of the hospital to teach the student those values which were to be incorporated into their tasks, so that students "acquired orientations that were consistent with nursing roles in which they were trained in the hospital" (Simpson et al., 1979, p. 234). Any contradiction between the students' professional ideals learned in nursing school, and the realities of the hospital practice, were resolved in favour of the hospitals' orientation which emphasised obedience, "adherence to routines, policies, administrative directives, and physicians' orders" rather than autonomous behaviour by nurses (Jacox, 1978, p. 15).

However, the historical nature of nursing as a female occupation has also played a large role in attributing traditional 'feminine' characteristics such as, nurturance, obedience, subservience and endurance to nursing. There exists a body of literature (Chaska, 1990; Kalisch & Kalisch, 1987; Moorhouse, 1992) describing the development of such attitudes linking 'female' with 'nurse'. The effects of these social attitudes can be observed in both the anticipatory socialisation of the beginning nursing student, and the student's selection of nursing as a profession. Thus, traditional, bureaucratic orientations were described by Bailey and Claus (1969), who found that, when compared with other female tertiary students, nursing students rate higher than the norm in values such as the need to conform, to nurture and to endure. Furthermore, nursing students rated lower in the attributes of leadership, innovativeness, aggression, and autonomy (Bailey & Claus, 1969). Stoller's (1978, p. 11) study suggested that entering students "bring with them preconceptions of the nursing role which mix a common sense version of instrumental activism with a Christian-humanitarian ideal of service". Similarly, Jacox (1978) observed that students selected into nursing courses commonly rank higher in 'obedience scores', when compared with students in other non-nursing tertiary courses. 'Obedience' was both a value that figured prominently in the nursing programs of the 1890s and early 1900s, and a valued feminine trait.

There is little evidence in the literature demonstrating any changes in popular conceptions of the role of the nurse are occurring. Dyck, Rae, Sawatsky, and Innes, (1991) reported that "the public image of the nurse continues to focus on the traditional feminine characteristics of helping others and demonstrating warmth and concern for others" (p. 27). It was subsequently concluded that students on entry to a baccalaureate program still had a low need for dominance and a high need for nurturance and endurance, consistent with the results

obtained earlier by Bailey and Claus (1969). A 'traditional' view of nursing by beginning students as 'task-oriented' was also reported in Andersson's (1993) ethnographic study, which found that the majority of students retain a traditional image of the nurse at the end of their three-year program. Descriptions of nursing as caring and feminine, and medical and scientific frameworks as masculine (Antrobus, 1997), continue to perpetuate a traditional, hierarchical perception of nursing.

However, it has been proposed that nursing hierarchies and rituals actually serve to protect nurses from the anxieties of human suffering by allowing them to focus on the routines and rituals in order to cope with the pain around them (Menzies, 1970). Likewise, ward staff strongly held the view that tradition and not research is the main source of nursing knowledge and skills, and that routines and sameness achieve a sense of order, security and safeness for the staff and students (A. Wilson & Startup, 1991). The use of routine and rituals to achieve a sense of order is also well expounded by educational theorists such as Bates (1984). Rituals are viewed as a "potent form of control" (Bates, 1984, p. 88), whose power lies in their very routineness, so that they are followed without questioning or examination and become part of the lived experience. It is this adherence to, and rapid mastery of the tasks and routines of the organisation, which has for many students and staff, been the covert yardstick by which success as a nurse is measured. Successful transition from student to graduate nurse relies on the graduate's ability to achieve that image of the "good nurse" which has developed throughout their period of anticipatory socialisation as a student (Moorhouse, 1992).

"Role clarification" is described as being one of the most important precursors to effective socialisation into a professional role (Kramer, 1974; Muff, 1982). However, a Swedish study reported that professional socialisation, even for tertiary student nurses, still occurred in very traditional ways, such as tacit knowledge acquisition, leading to role conflict (Olssen & Gullberg, 1988). Corwin, Taves, and Haas (1961) earlier described the phenomenon of role conflict or "professional disillusionment" - the reaction of graduating nurses to the conflict between their professional socialisation developed during their education, and the employing organisation's culture, values and norms. Kramer (1974) later described such a role conflict as "reality shock" and proposed a typology of reality shock resolution of several categories. According to Kramer's proposal, "behavioural capitulation" allowed a nurse to compromise learned skills and behaviour in order to retain their own professional values. The nurse may otherwise choose to leave nursing altogether or to teach these professional values to the

exclusion of all other values. Alternatively, Kramer suggested that the nurse may choose "values capitulation", whereby the organisation's bureaucratic concepts were adopted and their own professional values were compromised. A further choice offered by Kramer was for the nurse to choose neither set of values- a source of conflict in itself it would seem. However, Kramer's preferred solution is that of "biculturalism" in which nurses attempted to combine the opposing conceptions in order to create a viable role concept. Melia (1987) described a type of conflict resolution achieved by the nurses in her study, as they adopted the tasks and skills of the bureaucratic model, yet retained the rhetoric of the professional model, a solution to the dilemma of choices which can be compared to Kramer's "biculturalism".

However, given the quantum of literature devoted to exposing the theory / practice gap in nursing, it would seem that for many nurses, biculturalism is not a realistic method of conflict resolution. The dichotomy, or theory / practice gap between nurses' theoretical knowledge as it is taught within tertiary schools of nursing, and the integration of that knowledge in the clinical setting, has long been identified as a problem by nurse educators, clinicians and students, particularly in the American and British literature (Armitage & Burnard, 1991; K. E. Ferguson & Jinks, 1994; Kim, 1993; McCaugherty, 1991; Rolfe, 1998). It could be concluded that it is the problems that arise as professionally socialised students face the traditional, bureaucratic, socialisation model of the hospital organisation, which may be the real source of the theory / practice gap. Thus it may be the essential socialisation outcomes of each system, which are in conflict. Such a conflict was described by Hamel (1990) as cries from ward staff of: "what do you guys teach these people in school, and from the students of: I tried to do it the way I was taught in school. She (the preceptor) said no,no,no... I was so confused" (p. 88). It is often these cries that are cited to illustrate that the theory / practice gap is caused by a difference in the way in which tasks are taught. This neglects to address the deeper concern of professional or bureaucratic socialisation as the real source of the conflict between theory and practice.

Universities have been described as "discipline-oriented… characterised by the development of theoretical knowledge", whereas the healthcare sector is seen as a "practice-oriented setting [that] tends to emphasise technical expertise and symptomologic assessments" (Grossman & Hooton, 1993, p. 868). Given the ideals of a university education for nurses and the realities in which they practise – a reality that is still largely dominated by service needs and the

traditional bio-medical model, the existence of a theory / practice gap should not be surprising (Grossman & Hooton, 1993).

Nevertheless, while skills and knowledge are important for the new nurse in order to cope with the realities of practice, Martins (1988) and Spickerman (1988) both contend that it is commitment to a professional role that will assist the new nurse make the transition from student to nurse. It can be therefore concluded that nursing faculty should be most concerned with the professional socialisation of their students, in order to develop their commitment to the profession. In this lies the future of nursing and the profession. Carlson-Catalano (1992) and Tanner (1990) agreed that while theoretical knowledge and technical skills are important, student nurses need help to fulfil their professional roles within the bureaucratic hospital setting. Carlson-Catalano (1992) suggested that it is through 'empowering strategies', such as collegiality, sponsorship / mentorship and encouraging participation in change activities, that the professional practice of the nurse will be fostered. In some contrast, H. Cohen (1981) maintained that the educational program itself also plays a role in initiating enforced dependency in student nurses, which is then perpetuated by the bureaucratic healthcare system, as failure to become autonomous. It has been concluded that reality shock and role conflict occur when students realise that the healthcare system and their education both demand "that they produce as professionals and take responsibility for their judgements, while maintaining subservient attitudes" (H. Cohen, 1981, p. 68).

While it can be concluded from the literature that outwardly nursing education appears to be most concerned with the professional socialisation of their students, Pitts (1985) also concluded that there existed a powerful covert curriculum which helped to maintain the structure of the hospital bureaucracy and the domination of medicine within hospitals. Pitts (1985) thus agreed with Cohen (1981), that it is nursing education which "contributes to the maintenance of nursing in its subservient state through transmission of a professionalism that differs markedly from the characteristics normally associated with an autonomous profession" (p. 37). There was also support for this view from Carlson-Catalano (1992) who noted that nursing faculties continue to model hierarchical, authoritarian behaviour that covertly socialises the student to a role congruent with that valued by bureaucratic health systems. This concept of a "hidden curriculum" is not restricted to nursing education as can be evidenced by Bates (1984, p. 88) who concluded that rituals and routines form the "major constituents of the hidden curriculum of schools". Bevis (1988), as one of many nurse theorists who have

attempted to deal with the hidden curriculum, actually defined it as the curriculum of socialisation, "of teaching initiates how to think and act like nurses" (p. 37).

A major stimulus for the transition of nursing education in Australia from a hospital-based training to the tertiary sector was the need to reduce this disalignment or dichotomy between competing perspectives within the profession on the future of nursing practice (E. Davies, 1991). However, recent research reports that the theory-practice dichotomy continues to exist within Australian nursing contexts (Ives & Rowley, 1990; Yong, 1996). Whether this is in spite of or as a result of the transition of nursing into the tertiary sector is unclear. However, it is acknowledged that the expectations of employers accustomed to the traditional hospital-based, nurse training, and those of university educated students "exploring a broader and more flexible autonomy" (DHSH, 1994, p. 5), contribute to the theory / practice tension. The conflict between students' expectations of clinical practice and those of the clinical context is also confirmed in the literature. Students who experienced powerlessness and confusion because of the dichotomy between the ideals of the university and the realities of the practice setting, articulate ambiguity in expectations of their clinical placements (J. Willis, 1996; Yong, 1996).

If the educational paradigm is to transmit professional practices, nursing faculties must change their role from prescribers of knowledge, to experts in learning and content who are able to help students find the deeper meaning of the curriculum (Watson & Bevis, 1990). It is acknowledged that the resocialisation process for faculty would not be easy because "this shift from the limitations of a behaviourist model, with all the sense of comfort it provides for faculty, to a critical social theory perspective can pose a very real threat to the faculty's modes of thinking and interacting with students in classrooms and clinical environments" (Rush, Ouellet, & Wasson, 1991, p. 123). This discomfort continues to exist with some authors concluding that "despite the promised curriculum revolution, faculty who view the knowledge discovery of personal meaning as equal to that of empirical discovery are the minority in traditional nursing education" (Hodges, 1997, p. 352). Selection and preparation of experienced nurses as clinical teachers who accept the broader demands of a student-centred, reflective curriculum may assist students resolve this dialectic tension. However, if professional socialisation within these new curricular approaches is to indeed foster leadership skills and transmit such values as critical thinking, autonomy, and self-reflection, then it is

clear that the covert curriculum transmitted by faculty, must also transmit values congruent with the new overt curriculum which aims to develop the reflective practitioner.

2.3.2   The Role of Reflection in Nursing Education

In response to the need to develop the reflective practitioner, curricula emphases within nursing education are being placed on the development of students' understanding of theoretical principles underpinning their nursing practice. Students are exposed to the principles of adult learning, consistent with the intent of tertiary eduction, which aims to: "develop a graduate who will, at beginning level, be an independent learner, a competent practitioner, a creative and critical thinker and a motivated researcher" (Faculty of Health Sciences, 1995, p. 6). The importance of reflectivity in learning is acknowledged as playing a central role in adult learning theory. "Reflective learning involves the confirmation, addition or transformation of ways of interpreting experience.   Fostering reflective and transformative learning should be the primary goal of adult education" (Mezirow, 1991, p. 117).

Similarly, reflection is central to theories of experiential learning (Kolb, 1984) as a means of linking prior experiences, knowledge and understanding of the experience to discover possible solutions to a present problem. Experiential learning theory is confirmed (Burnard, 1988; Laschinger, 1990) as useful in assisting learners to develop the characteristics of adult learning by allowing them to see the relevance and importance of their previous knowledge in developing solutions to new problems. Student nurses can be encouraged to draw out their own understanding of meanings that they give to the situation as a means of encouraging them to confront assumptions that they make and bring to the experience. Guided reflection allows students to use the interpretations that they make of the experience as a guide for future and further action (Driscoll, 1994). This is supported by Heath (1998b), who believes reflection to be a process by which nurses can begin to make links between the theoretical and research bases of expert nursing practice. Through a process of reflection it is concluded, "making meaning becomes learning" (Mezirow, 1990, p. 1). Subsequently, it is anticipated that through encouraging and facilitating the ability to reflect on their practice, student nurses will develop as life-long, self-directed learners

Faculty of Health Sciences, 1995).

The process of reflection on personal actions, belief structure, values, attitudes and past experience in order to develop, change or evaluate individual actions, emerges as a consistent theme in the education literature on staff development. Indeed there exists ambiguity surrounding the term 'reflection', that subsequently impacts on the conceptualisation of reflective practice and the reflective practitioner. The relationship between attitudes, beliefs and behaviours is a complex one. The importance of assisting teachers to understand their practice by critically reflecting on their beliefs, philosophies and underlying assumptions, was acknowledged by Butler (1996) and Mayer and Austin (1999). In contrast, Guskey (1986) proposed that changes in teachers' beliefs depend on staff development processes that encourage teachers to change their teaching practice. Under this model, (Figure 2.2) instead of reflection initiating change, evidence of positive outcomes in student behaviour precedes, and may, in fact, be prerequisite to significant change in the beliefs and attitudes of teachers.
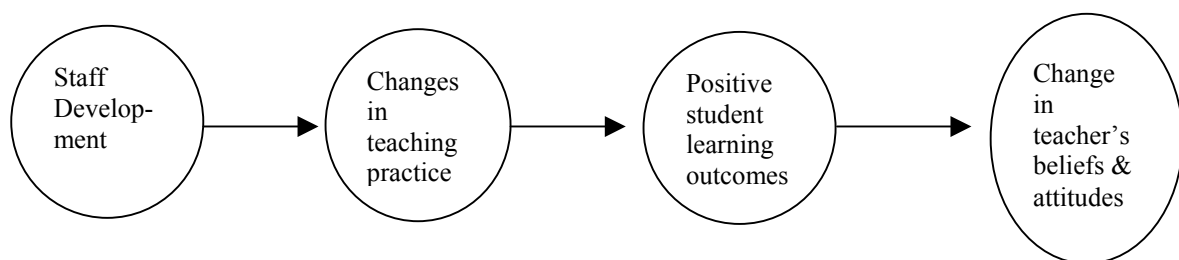
Figure 2.2   **A Model of the Process of Teacher Change**

Source is Figure 1, page 7 in Guskey, T. R. (1986). Staff development and the process of teacher change. *Educational Researcher, 5*, 5-12.

This model proposed that beliefs and attitudes are influenced by positive results of the new behaviour, thus validating their decision to try the new behaviour (Guskey, 1986). The model of teacher change could equally be applied to explain reluctance of teachers to change behaviours. If existing teaching behaviours result in student learning outcomes that are perceived by the teacher to be favourable, it can be proposed that teachers will be reluctant to try any new behaviours.

Similarly, Pajares (1992) has argued that changes in behaviour depend on the individual's belief structure being sufficiently challenged through thinking, until efforts to accommodate existing beliefs with challenging information are unsuccessful, leading to an assimilation of new belief structures. As a consequence, "beliefs are unlikely to be replaced unless they prove unsatisfactory and one is unable to assimilate them into existing conceptions" (Pajares, 1992, p. 321). Changes in beliefs are likely to occur only as a "last alternative", after the individual has made forceful attempts to assimilate new information into existing beliefs (op cit, p. 321).

This explanation is consistent with Guskey's conclusion that changes in behaviour must precede changes in beliefs if lasting attitude change is to occur (Pajares, 1992), and serves to describe the conditions which must be completed before the individual perceives any reason to alter performance and behaviours. However, this development approach to staff development is more reminiscent of staff training rather than an attempt to have participants reflect on their behaviour and assumptions so that learning becomes grounded in their past experiences and beliefs.

Certainly Butler (1996) warns of the influence which a personal world view will exert over all reflection, that in trying to examine the world, there is a tendency to neglect to take off the glasses that causes the construction of a particular view of the world. Butler expands on the concept of reflection in his model of human action (Figure 2.3) to propose that reflection is the overriding process that allows the examination of actions in both the Self and wider Social contexts. Consequently, personal reflection allows the achievement of a greater understanding of individual behaviour in both contexts.

SOCIAL	**SELF**
Public Knowledge	Personal Knowledge
REFLECTION	
Professional Practice	World View
CONTEXT	**CONTEXT**
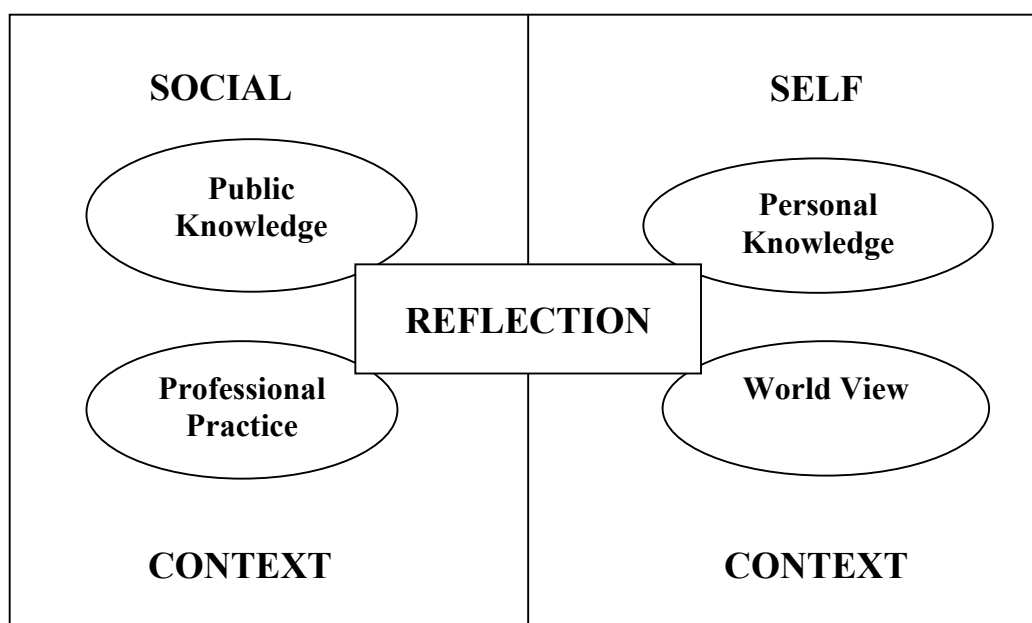
Figure 2.3   **Model of Human Action**

Source is Figure 2, page 270 in Butler, J. (1996). Professional development: Practice as text, reflection as process and self as locus. *Australian Journal of Education, 40*, 265-283.

However, the claim that nursing has encouraged reflective practice leads to a further dilemma. In particular, Jarvis (1992, p. 180) argued that, "(t)he occupational structures within which much nursing, and teaching and other professions, are conducted today seem to preclude the opportunity for reflective practice". The organisational culture of the traditional hospital setting values efficiency and correctness. However, reflectivity demands time to experiment, to consider possible actions and outcomes of care (Jarvis, 1992). It could be argued that nursing curricula that focus on the development of professional attributes of reflection are in fact, setting students up for failure by failing to adequately prepare them for the realities of the clinical setting. Similarly, it has been suggested by Laschinger (1990) that the concrete learning styles of nurses are matched by the predominantly concrete learning environment that exists in current healthcare contexts. As a consequence, the application of Kolb's experiential learning theory (cited in Laschinger, 1990) in such an environment elicits resistance from nurses towards the concept of theory-based practice that is implicit in experiential learning theory. Reflective practice has also been described as paradoxically contributing to the theory / practice gap because some nurses place little emphasis on practising reflection (Driscoll, 1994). In contrast, the reflection doctrine was described

somewhat facetiously as, "(t)he Holy Grail which will rescue nursing practice and education from ignorance and the performance of ritualistic behaviours" (Lauder, 1994, p. 92). It is therefore important to review some of the literature relating to reflection within the education context, to analyse assumptions made about reflection, about the process of becoming professional and about the role of reflection in nursing education.

2.3.3   Assumptions of Reflection in Nursing

The process of becoming 'Real', as explained in the children's story, *The Velveteen Rabbit*, (Williams, 1981) helps to illuminate the conception of reflection. While this simple story described that not all toys were loved enough to become real, perhaps it also raises the notion that not all nurses can become reflective practitioners. James and Clarke (1994) examined the implicit assumption in the calls for nurses to adopt a reflective stance - that all nurses were capable of becoming, and were willing to become reflective. Certainly, there is considerable literature both in nursing and education, which calls for both nurses and teachers to become reflective practitioners. Reagan (1993, p. 195) argued that "every teacher at every stage of his or her career, can and should strive to become a reflective practitioner, knowing that only by making the effort to become reflective and analytic can one really be said to become a good teacher".

However, James and Clarke (1994) warned against some of the assumptions being made in the literature about the role of reflection in nursing by suggesting that while reflective learning strategies may facilitate learning, "there is no evidence to suggest that these strategies develop and promote reflective skills amongst the students" (p. 89). Similarly, it has been argued that, far from being the bridge between theory and practice, reflection may separate thinking from doing, or theory from practice (Lauder, 1994). Thus, while there is considerable opinion-based interest in the concept of reflection and its application to nursing, there is little evidence in the literature of research on the topic. In fact, Burnard (1995, p. 1167) found most of the literature to be "discursive" and lacking in empirical study into the essential question "does reflection make a difference to clinical practice?"

Disenchantment with the process of reflection is largely based in two perceptions. First is the perception that reflection has become nursing's latest "flavour of the month" and a panacea for all of nursing's ills (Burnard, 1995). This is a situation reminiscent of the welcome that was accorded to the 'nursing process'. The second view is that reflection is not a new phenomenon, rather it is something in which nurses have always been engaged: "(t)here is a lot of elitism involved as well, but mainly my concern is the mumbo-jumbo that is bandied around about reflection. What, to my mind we are talking about is simply the process of thinking, of reviewing what has happened and what is likely to happen" (Burnard, 1995, p. 1172). These comments are representative of the emotions and scepticism expressed about reflection. Similarly, Reid (1993) concluded that many nurses believe reflection is an everyday process which "we're doing already". Heath (1998b) cautioned that nurses need to avoid polarising the reflection debate which may otherwise "become the next casualty if it fails to reform nursing practice" (p. 208). Polarisation, with one group insisting that reflection is the answer to understanding caring (Johns, 1995), while another group rejects reflection as being too structured, will only serve to alienate nurses (Heath, 1998b). While there is such confusion amongst nurses about what reflection is and is not, and while the healthcare environment remains focused on patient outcome measurements, then it is likely that nurses will continue to be divided and polarised in their views of the value of reflection to nursing practice and patient care.

Smyth (1992) was also cautious about the role of reflection as emancipatory and empowering for teachers, who may in fact, find themselves on a 'guilt trip' as a result of their reflection. Reflection for Smyth in the context of education becomes a tool for:

> Portraying the problems confronting schools as if they were due in some measure to a lack of competence on the part of teachers and schools and as if they were resolvable by individuals (or groups of teachers), is to effectively divert attention away from the real structural problems that are deeply embedded in social, economic, and political inequalities (1992, p. 287).

It could be argued that the rapid changes occurring in the nature of nursing and healthcare delivery might similarly present an environment characterised by social, economic and political inequalities. In this atmosphere, the process of reflection may shift the blame for problems in healthcare delivery onto the individual nurse and question their competency, instead of addressing the real economic and political constraints that have contributed to the occurrence of these problems.

Other disadvantages of reflection include concerns about the effect that reflection may have on students. Nurses questioned whether it is ethically and morally appropriate to invite student nurses to disclose inner thoughts, perhaps in the absence of a trustworthy, supportive environment (Burnard, 1995). It could be argued that students on clinical practice are most vulnerable because they are in a foreign environment, removed from the support network offered by the university. Engaging in reflection has the potential to confront past experiences which may cause students to re-examine issues which they would not otherwise choose to explore at that moment, or in that environment. Professional dilemmas relating to students' observation of unsafe or unethical behaviour also confuse the reflection debate.

Rich and Parker (1995) questioned whether it is ethically correct to encourage students to discuss and explore incidents of unsafe or unethical behaviour when the student may be simultaneously having to cope with guilt over their response or even lack of response, to an incident. While the value of having students engage in such critical incident reflections may be apparent in helping them to understand the meaning of different responses, it is acknowledged that if students are to benefit from a reflective process they need skilled experienced teachers who are capable of dealing with the array of issues raised (Rich & Parker, 1995). Consequently, having students reflect on their practice has been criticised for its potential to leave the student confused by the absence of firm guidelines and definite answers to critical issues raised in the reflective process (Burnard, 1995). However, other students reported that participating in a reflective process assisted them to learn how to deal with the unexplained and with constantly changing situations, increasing their satisfaction with nursing (A. Smith, 1998).

There also appears to be some disagreement over whether novice nurses in particular, should be exposed to critical thinking and the possible confusion which examination of the novice's practice may engender. Heath (1998a) used Benner's (1984) seminal work to differentiate the needs of the novice from those of the advanced beginner to observe that the novice may lack a sufficient repertoire of experiences to be able to cope with and make sense of the in-depth analysis of reflection. However, it is acknowledged that the advanced beginner may benefit from engaging in a supportive reflective process to encourage development of life-long learning (Heath, 1998a). Dolan (1984, p. 279) described a preceptor preparation program in which preceptors emphasised broad guidelines according to the demands of the hospital unit for novice nurses to follow, whereas more experienced nurses were allowed by preceptors to

question different approaches to clinical practice. However, Meng and Conti (1995) encouraged preceptors to specifically question and challenge the rule-governed behaviour of the novice. This challenging of the beliefs and behaviours of the novice is supported by Butler's assertion:

> Reflection is the process that propels people along the journey from novice to expert...They will not move onto the next stage unless they learn to reflect on their own performance and become less rigid and more flexible by developing and trusting their own personal practical knowledge (Butler, 1996, p. 279).

Hanifin (1993) also found that there was a questioning of the role of critical thinking and reflection amongst novice teachers in the education literature. Novice teachers were assumed to lack the theoretical and technical knowledge that allow them to adequately reflect on their experience and so integrate theory with practice, and may in fact have been "reflecting on ignorance" (Hanifin, 1993, p. 22). Nevertheless, student teachers have well established views about what teaching is and their role as a teacher, based on prior life experiences (Hanifin, 1993). Furthermore, student teachers undergo a lengthy "apprenticeship of observation" (Lortie, 1975, p. 65) as they learn to teach. In contrast, student nurses undergo an "apprenticeship of doing" (Moorhouse, 1992, p. 49) as they learn to be a nurse, which provides a different basis on which to model their teaching practices. Given the increased numbers of mature-aged students enrolled in undergraduate nursing degrees, it appears appropriate for experienced nurses to begin to acknowledge the value which these students, while novices, can share with other students by drawing on their life experiences in order to help them make sense of their nursing practice.

The value of a buddy nurse in helping the novice reflect on their practice was supported by D. Smith and Hatton (1993) who argued:

> We are often so close to our ideas, beliefs and actions that we are unable to distance ourselves from them to be able to hold them up for scrutiny and consideration. We need another to help us to do this; another whom we can trust and respect and whom we feel that we can risk (p. 6).

This concept of another whom we can trust and from whom the novice learns, was supported by Schon's (1987) concept of the 'coach' rather than the 'cop' approach to guiding the development of the reflective practitioner. Similarly, the process of assisting students become professional, was interpreted as "more than getting theory in place and using it to improve practice. Learning nursing practice also involves the development of the student as reasoning professional practitioner who can derive insights from practice"

(R. White & Ewan, 1997, p. 51).

Consequently experiences that confront and challenge prior beliefs and behaviours can contribute to significant learning and development of the student as a professional practitioner. Brookfield (1991, p. 42) noted that "learning is rarely experienced in an anodyne, emotionally denuded way". Rather, for adults the most significant learning occurred when they were challenged and emotionally involved with understanding their own behaviour and beliefs, where there was both cognitive and affective components to their learning. The outcome is one of empowerment, of a sense of transformation about the individual's self-concept as a learner (Brookfield, 1991). Nurses identified that they found the process of reflection uncomfortable for similar reasons: "it actually challenges and brings to the fore the whole idea of change...it is never comfortable and sometimes it can be very frustrating" (Burnard, 1995, p. 1170). Similarly, Rich and Parker (1995, p. 1056) noted that "students do not always feel supported and comfortable in reflection sessions" and on occasion may display affective responses that require good support and intervention. Pursuing reflection in mature-aged students in particular, may provoke anxiety and far from assisting them learn, may in fact, become a block to learning. "The fear of being made to look foolish or inadequate in front of colleagues, peers and patients is a very powerful phenomenon, and this is particularly acute in people who have recently returned to practice, (or) changed their job" (Moreton-Cooper & Palmer, 1993, p. 17).

Reports of students' concerns and experiences of reflection reinforce the need for selection and preparation of nurses as clinical teachers who can role model and support reflective practice. Reflective practice according to Heath (1998b) is the process by which nurses can extract the theoretical bases of expert practice, that contributes to the development of nursing as a research-based profession. However, the question of whether reflective practice increases client care or contributes to improved client outcomes is not answered. The link between patient care, patient outcomes and reflective practice is difficult to make because of the numerous other factors that interact on patient care. It may be "(p)referable to focus on the development of practitioners, accepting the assumption that enhanced skill enhances client care" (Heath, 1998b). Adequately prepared experienced nurses may be able to assist students in a process of reflection that encourages them to uncover the assumptions underlying their nursing practice.

2.3.4   Implications for this Research

There is sufficient evidence in the literature to conclude that nursing education is seeking to embrace the principles of reflection both as a teaching and learning strategy and also as a method of developing attitudes supporting life long learning. The process of critical thinking undertaken with students throughout a preceptorship experience is also recognised as an opportunity for nurses to challenge long-held assumptions, leading to a renewed understanding of their own nursing practice (Stevenson, Doorley, Moddeman, & Benson-Landau, 1995). Similarly, nurses reported personal gain from their experiences with clinical teaching through an increase in professional development (Hovey et al., 1990). If it is accepted that nursing is seeking to encourage reflective practice (Jarvis, 1992), then it should be accepted that nurses who are responsible for the clinical teaching of students, must be capable of role modelling and promoting reflectivity in students' practice, particularly in relation to the assessment of student progress through their course. Suggestions that nurses who are accustomed to the bureaucratic demands of the hospital setting may have difficulty accepting the broader demands of assessment within a student-centred, reflective curriculum, again raise the issue of the impact of change on clinical teaching. The selection of nurses committed to the intent of tertiary nursing education assumes increased importance when an appreciation of the changing healthcare contexts in which most nurses currently practise, is gained. The literature that reports a fuller picture of the impact of change on the role of the nurse, is subsequently reviewed.

2.4   CHANGE IN HEALTHCARE CONTEXTS

It is important for the clarity of the research to be aware of changes that are occurring in the healthcare context. Subsequently, literature that examines changes in the healthcare environment, the role of the nurse, nursing education and in the clinical learning environment is reviewed in order to place the research into the current context.

2.4.1   Change in Healthcare Environments

Healthcare reforms have been major foci of economists and politicians throughout the western world for decades. Most of the reforms in healthcare reflect changes in society as a whole, particularly the economic and sociological conditions in society (Venegoni, 1996). The literature that explores the major factors influencing healthcare reforms is examined in order to understand the impact of changing healthcare trends on nursing practice and nursing education. Venegoni's three categories of i) Sites of healthcare change, ii) Demographics affecting change, and iii) Changing focus of health, have been utilised to organise this section of the review and subsequently inform the research questions.

Changing Sites of Healthcare

A brief synopsis of healthcare reforms in the 20th Century is given here to help place reforms in an historical context. It is acknowledged that this overview does not tell the whole story of healthcare reform. However sufficient literature is reviewed in order to inform inquiry into the question that underlies this research: what has been the impact of change on the clinical learning environment.

Early healthcare was largely an individualised affair delivered in the home, generally by non-professional personnel (Venegoni, 1996). In particular, midwifery services provided home-based care as the norm (Ament & Hanson, 1998). Institutionalised care was mainly reserved for the mentally ill and those who contracted one of the many infectious diseases such as tuberculosis. The Great Depression of the 1930s, combined with increased industrialisation and unemployment, lead general worldwide trends of migration into cities as people sought employment. This trend subsequently increased demands for access to basic healthcare for the masses (Hickey, 1996). The laws of supply and demand guaranteed that despite an increase in the number and quality of hospitals provided, demand for healthcare still increased thereby escalating health costs. (Venegoni, 1996). This position continued for much of the latter half of the century, until rapidly increasing healthcare costs and a focus on management of health stimulated economic responses from governments (Venegoni, 1996).

Subsequent government reforms that attempted to rein in and control health costs have had limited success, regardless of the healthcare system in place. The United Kingdom has a largely public healthcare system, the United States of America (USA) a largely private system, and Australia has a mixture of private enterprise and public funded systems (Leeder, 1999). In Britain, the National Health Service was introduced into a post-World War Two environment, idealistic about providing 'free health for all' (Antrobus, 1997). The desire to improve hospitals' performance and efficiency lead to the introduction of reforms directed at stimulating competition between hospitals and increasing patients' opportunities to choose and change their general practitioner (Leeder, 1999). Similarly, successive governments in the USA introduced a system of healthcare benefits and direct repayment to hospitals, commencing with the Medicare program for the elderly and Medicaid for the poverty stricken and indigent population (Leeder, 1999). Venegoni (1996) observes that in its thirty plus year history, rising costs of health have meant that Medicare has always negatively affected the national USA budget. Australia also introduced a version of compulsory universal health insurance, Medibank, later in 1974 becoming Medicare, funding public hospitals, medical practitioners and medical services in the community by means of a levy on taxable income (Leeder, 1999). In the past decade, both the rising costs of healthcare in Australia and a reduction in numbers of people maintaining private health insurance to approximately 30.3 per cent (Leeder, 1999, p. 28) have seen Medicare struggle under the weight of the demands of equity of access to public healthcare.

While the increase in consumer demands for healthcare offered employment opportunities for nurses, it is the economic rationalist health policies of governments of the 1990s that have exerted the greatest impact on contemporary nursing (Cordery, 1995). "Policies developed under the influence of the economic rationalists have had a general effect on health service provision for the public, as consumers of these services, and on the people who provide these services" (Cordery, 1995, p. 358). Specifically, it has been the various cost containment measures introduced in the past fifteen years, that are demonstrating a more dramatic impact on nursing practice and subsequently nursing education (Corey-Lisle et al., 1999). More recently, managed care, in which the provision of healthcare is contracted with hospital and doctors by a health insurance agency, is increasingly used to contain and manage healthcare expenditure (Leeder, 1999). Further economic responses to

escalating health costs include information management systems such as casemix and the prospective payment system, Diagnostic Related Groupings or DRGs.

The effects of these economic rationalist policies on healthcare can be observed in a number of ways. Firstly, length of stay for patients is decreasing dramatically, consequently increasing the throughput or patient turnover rate (Corey-Lisle et al., 1999). Secondly, more patients are being discharged from hospitals into home or community care. These patients are discharged with higher levels of acuity requiring levels of nursing care that were once only the province of the hospitals (Scott, 1998). A further effect is an increase in emphasis on healthcare providers to clearly establish accountability for practice. Quality management systems such as performance indicators, evidence-based practice, competency based standards and clinical audit are all indicative of the fact that in the new economic rationalist environment, healthcare providers are expected to be able to demonstrate links between patient outcomes and nursing performance (Cordery, 1995; Scott, 1998).

The general decrease in hospital length of stay combined with the resultant increase in acuity of care for patients in the community are reported to have a number of effects on the sites of healthcare delivery (Scott, 1998). The first effect is to reduce the size and number of hospitals, that are thus rapidly 'downsizing' to become "giant intensive-care facilities complete with high-tech equipment and interventions once reserved for truly critically ill patents" (Hickey, 1996, p. 13). The second consequence of economic policies that aim to link hospital funding to patient outcomes, is the emergence of a primary care focus. This can be seen in the development of new healthcare delivery models in sites outside the traditional hospital setting, such as assisted living facilities for ventilator-dependent patients. Another model is the Hospital at Home (HAH) which has been established for approximately fifteen years in the USA and more recently in Australia, as a method of providing a patient-focused, seamless integration of hospital care with community care (Clayton, 1995). HAH services, also known as 'hospitals without walls' in the USA, provide post-hospital care services for patients who are discharged from hospital yet still require regular nursing care. However, while more patients are managed in the home under this model, Gardner (2000) observes that there has been no evidence provided that this model of care results in a sustained reduction of health costs and improved patient satisfaction, or contributes to any reduction to operation waiting lists. What is apparent, is the impact that healthcare reforms are having on the role of the

nurse, on the clinical environment and subsequently on opportunities for clinical teaching. Literature relating to these issues will be discussed later in this section.

Demographics Affecting Healthcare

One of the most significant factors affecting changing healthcare trends is the changing demographics of the population (Hickey, 1996). The increased life span experienced by most people in the western world can be attributed to a number of factors such as:

- greater access to healthcare that has undergone significant technological advances in the areas of pharmacology, computerised diagnostic measures and sophisticated advances in surgery and organ transplantation

- earlier detection and treatment of a range of once fatal diseases such as the major communicable diseases and diseases like cancer, diabetes and Parkinson disease

- significant reduction in mortality rates for infants, children and young adults and a decrease in maternal deaths as a result of better healthcare and access to immunisation programs (Venegoni, 1996, p. 82).

The combined impact of these trends can be seen in projected figures for population composition. Of particular significance is the increasing numbers of people aged over 65 years and specifically aged 80 years or older. There has been a ten-fold increase in the number of people aged 65 years or older, since the turn of the century (Venegoni, 1996). The large number of post World War Two 'baby boomers' is expected to have a significant contribution to the aging population – for example, USA Bureau of the Census figures (cited in Venegoni, 1996, p. 82) estimate that the number of people who will reach 65 years during 2010, 2020 and 2030 are 39 million, 52 million and 66 million respectively. In Australia, the percentage of people aged 65 years or older is predicted to increase by approximately 2 percent between 1991 and 2006, with the numbers of those aged 80 years or older expected to increase in the same time by 4 percent (Hancock & Moore, 1999). Of particular interest to this research is the significance of the increase in the number of frail older Australians aged 80 years or more, with a profound or severe disability. Hancock and Moore (1999, p. 267) estimated that a 1

percent increase translates into a doubling of numbers from 352,800 to 707,600 Australians aged 80 years or more with a profound or severe disability.

The real effect of changing demographics will therefore be seen in the resultant changing focus of healthcare and subsequently nursing care that must be responsive to the needs of this particular population. It is important for this research to appreciate the implications of these demographic changes, because of their subsequent impact on nursing education and clinical teaching opportunities. Similarly, change in the demographics of the population and the sites at which healthcare will be delivered in the future, impact on the focus of that healthcare. Literature that discusses the changing focus of healthcare is subsequently reviewed in order to understand the future role of the nurse and nursing education in this changing healthcare environment.

Changing Focus of Health

The focus of healthcare in developed countries has historically been on the treatment of diseases and illness. Healthcare that will be required in the future for the aging population represents one of the most important factors affecting change to the focus of healthcare delivery models (Hancock & Moore, 1999). The number of people in an aging population who are projected to survive with multiple chronic conditions and disability consequently increases. This is leading to the wider implementation of a care rather than cure approach to health (Pearson, 1990) that recognises the increase in the incidence of chronic illness such as cardiac disease, cerebrovascular conditions and cancer. It is projected in the USA that the practice of health professionals who have graduated in the past decade will mainly be directed towards the care of this aging population (Venegoni, 1996).

It is observed by Porter-O'Grady (1990) that most illnesses treated in hospitals today are the direct results of basic life-style practices. Diseases caused by obesity, smoking, a sedentary lifestyle and prolonged excessive alcohol intake are included. The economic impetus to reduce some of the costs associated with treating these diseases is contributing to a greater emphasis on primary models of care. The objectives for primary models of care consist of an increased emphasis on wellness that encompasses health screening programs to accelerate the

early detection of disease, immunisation and other prophylactic programs to prevent disease and planning to reduce risk factors for disease (Hickey, 1996). Primary healthcare places emphasis on the role of the nurse who will thus be expected to be capable of interacting with clients, medical practitioners and other colleagues to develop client-focused health management and education programs (Scott, 1998).

In contrast, a "public which demands services from the health system too late in the illness cycle" (Porter-O'Grady, 1996) continues to contribute to increased health costs and demand for intensive illness treatments. It is suggested that the advances which have been made in treating many of these illnesses contribute to increased expectations of the healthcare system and wholesale demand for expensive, sophisticated treatments such as organ transplants, joint replacements and care of very low birth weight babies (Hickey, 1996). Furthermore, despite the increased emphasis on primary healthcare, Hickey acknowledges that the population will continue to demand the life-enhancing benefits of secondary and tertiary care, rather than return to the 'dark ages' of medicine. These trends have implications for a change in the role of the nurse to reflect both approaches to the future of healthcare.

2.4.2 Impact on the Role of the Nurse

As healthcare delivery models undergo changes, so the role of the nurse is changing. With nursing budgets accounting for at least 50% of a hospital's operating costs, it is not surprising that measures to reduce health costs target nursing employment (Corey-Lisle et al., 1999). As a consequence, nurses are being made more aware of the need to be responsive to economic debate surrounding issues such as performance outcomes and budgeting of healthcare costs (Porter-O'Grady, 1990). Porter O'Grady (1990) also argued that nurses must become efficient at costing the benefits of their practice in order to be able to compare and justify the cost of nursing services against other service factors and so assess the efficiency of nursing care (op cit.). Other authors (Antrobus, 1997; Huston, 1999) concur that the quality of healthcare, in particular nursing care, can be measured and subsequently valued as a service. It is suggested that managed care systems in the USA have pared down infrastructure costs to such an extent, that "efforts to increase efficiency

and lower costs are most likely to focus on the labor component of the healthcare budget" (Shindul-Rothschild, Berry, & Long-Middleton, 1996).

Within this economically driven, healthcare system, nursing managers are urged to develop different ways of managing and delivering nursing care. In particular, changes to the ratio of professional nurse to enrolled nurse and ancillary personnel are proposed as a method of ensuring the "correct balance of experience and level of skill to provide efficient use of nursing resources for particular case types" (Cornell & Ferguson, 1995, p. 379). This calculation of skillmix is one example of the implementation of a cost management system that seeks to have nurses take on the role of managers, balancing budgets and quality of care. The increased utilisation of the Unlicensed Assistant Personnel (UAP) in the USA, is also being aggressively pursued as another method of cost containment aimed at the labour budget (Shindul-Rothschild et al., 1996). The escalation in the use of this level of care attendants to meet the basic hygiene, nutrition and ambulatory needs of the patient, thus increases the responsibility on experienced nurses to supervise the care given by the UAPs. This effectively narrows the focus of the clinical nurse's role to the delivery of sophisticated, high-tech nursing care, reducing the amount of time which nurses spend with their patients (Corey-Lisle et al., 1999). The implications of the change in skillmix for the clinical learning environment and opportunities for teaching are discussed in section 2.4.4.

Further compounding the impact of skillmix changes are calls for the role of the nurse to be extended. The nurse practitioner program has been established in the USA since 1965 to provide nurses with advanced physical assessment, health promotion and clinical skills, frequently in a specialised area (Moloney, 1992). The role of nurse practitioners is consequently predicted to increase in importance in the provision of primary healthcare particularly because "many of the health problems that plague the well are not of great interest to the disease-oriented medical profession" (Moloney, 1992, p. 194). Calvert-Simms (1993) discussed proposed changes canvassed in the 1989 'White Paper' that would have the role of the nurse extended to "cover specific duties normally undertaken by junior doctors in areas of high technology care and in casualty departments" (p. 26). It was similarly suggested by Ament and Hanson (1998) that certified nurse-midwives could replace most obstetric residents in hospitals. They argued that this was desirable for two reasons. Firstly, the fact that certified nurse-midwives focus on supporting the process of normal births is regarded as more preferable for mothers than the doctor's focus on the

management of complications. Furthermore, costs for the education and utilisation of certified nurse-midwives have been shown to be less than the costs for the education and utilisation of doctors (Ament & Hanson, 1998).

However, there is clearly a lack of clear agreement about what is the role of the nurse. Many authors agree that nurses must be able to define what it is they do. Debate about the role of the nurse in an economically driven healthcare environment is summarised by the observation that "(w)hen nurses can describe what they do in terms that the public and others can understand, they can begin measuring it, evaluating it, and validating its impact on the nation's health, research, and public policy" (Huston, 1999, p. 188). It would appear that the lack of clarity about the role of the nurse is preventing the nursing profession from fully participating in the healthcare reform debate. Nurses do acknowledge that the impact of healthcare reform on their role, whatever they perceive that to be, is increasing workload stresses and reducing opportunities to fully care for their patients (Corey-Lisle et al., 1999). Figure 2.4 illustrates some nurses' perceptions of health care reforms.

Health Care Reform:

↑ **Regulations / Profit concerns**

↓ **RN Staff**

↓ **Job security**

↑ **Unlicensed assistant personnel**

↑ **Workload / work pace**

"inappropriate assignments"

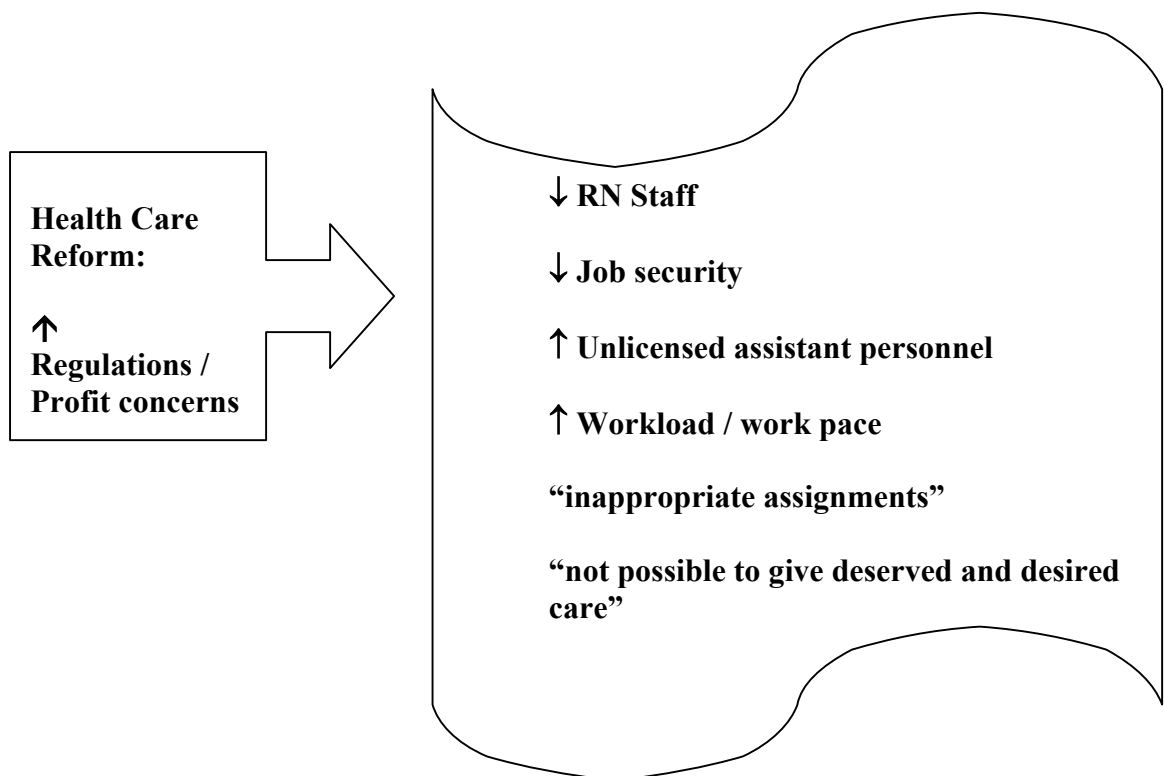**"not possible to give deserved and desired care"**

Figure 2.4   **Nurses' Perception of Healthcare Reforms**

Source is Figure 1, page 32 in Corey-Lisle, P., Tarzian, A. J., Cohen, M. Z., & Trinkoff, A. M. (1999). Healthcare reform: Its effects on nurses. *Journal of Nursing Administration, 29*, 30-37.

It is evident that reforms to models of healthcare are affecting nurses' satisfaction with their roles in this environment. The impact of changing roles of the nurse on nursing education is explored in the next section.

2.4.3   Impact on Nursing Education and the Curriculum

It is widely acknowledged in the literature that nurses need to be exposed to an educational and clinical program that will adequately prepare them to work in the 'new' healthcare environment (Clayton, 1995). There is an extensive corpus of literature that calls for the revisioning and retooling of the curricula in order to prepare nurses who are 'knowledgeable doers', who utilise a research-based practice and who can demonstrate a sound rationale for their nursing practice (Clark, Maben, & Jones, 1997). This expectation in itself generates a dialectic confusion about the direction of nursing education. Nurses need to be increasingly technically prepared to work in the highly technical hospital settings of the future. In contrast, nursing education is told that it needs to prepare students who can work in a more relaxed and less structured, community-focused environment with a greater emphasis on wellness and patient education (Porter-O'Grady, 1990). Evidence of such a dialectic confusion is reported by students who express concern that their health and wellness orientated curriculum does not adequately prepare them for practice in acute, illness-oriented placements (J. Willis, 1996). Nevertheless, the emergence of primary care models demand that nurses gain a broad perspective of social and cultural factors that influence both client and community health (Oermann, 1994). How nursing education is meeting this dialectic challenge is relevant to this research.

Economic rationalist policies that are impacting on healthcare delivery are also extending to education and the tertiary sector (Cordery, 1995). Curricula changes in response have seen a "narrowing of the focus for the registered nurse" (Cordery, 1995, p. 366) in which liberal studies are discarded to make way for measurement-oriented topics. Similarly, the world of work is changing with employers making greater use of temporary, short-term and part-time contracts with education and training "flexigeared to sharply defined technical and vocational capabilities" (Glen & Clark, 1999). It is further predicted that

nursing curricula will increasingly come to be influenced by national workforce priorities in place of academic priorities (Sellers & Deans, 1999). One quarter of nursing work is already reported to be carried out by non-nurses, adding credibility to this prediction (Sellers & Deans, 1999). Nurses need to be able to function in the new "businesslike casemix environment" (Cornell & Ferguson, 1995, p. 378). This expectation of nurses as managers places increased pressure on nursing education to teach nurses management system approaches in order to be able to plan and implement quality and performance outcome systems such as skillmix (Cornell & Ferguson, 1995).

The acknowledgment and increasing reality of changing healthcare delivery models is accompanied by an equal number of calls for the "retooling" or "revisioning" of nursing education, to address not only current service needs, but also future needs (Lindeman, 1992; Porter-O'Grady, 1990). Despite these calls for the "revisioning" and "retooling" of nurse education, there is as yet, no available research to evaluate the extent to which such changes in nursing education are meeting changing healthcare needs. In fact, there are some suggestions that the advances in nursing practice that were sought by the shift of nursing education from a service-based sector to an education-based sector in Australia, have not yet been fully realised (Sellers & Deans, 1999). Furthermore, Sellers and Deans (1999) concluded that in spite of the removal of the student as apprentice and part of the clinical workforce, it is workforce requirements, rather than professional development of nursing as a discipline, that will guide nursing curricula development. Yet, it remains that as the nature of nursing changes due to world wide economic trends, nursing education must be sufficiently flexible to meet the challenge of preparing the kinds of nurses who will be safe and competent practitioners for the future (Hills et al., 1994). Healthcare reforms demand that nursing faculties re-evaluate their preparation of students and the nature of their clinical practice (Oermann, 1994).

2.4.4   Impact on the Clinical Environment and Clinical Teaching

Not surprisingly, given the current changes in healthcare environments, the role of the nurse and nurse education have impacted upon the clinical environment and clinical teaching. Advances in technological care, treatment options, the knowledge of wound care and healing,

combined with the use of case management models such as DRGs and casemix, change the face of the "typical" hospital ward (Venegoni, 1996). No longer do students have multiple opportunities for the practice of skills such as bladder catheterisation, complex wound dressings and injections. Advanced treatment and diagnostic technologies mean that patients are not subjected to long periods of hospitalisation and rehabilitation with the accompanying risk of complications due to reduced ambulation. Increased use of techniques such as keyhole and laser surgery, that are often performed in day surgeries, result in early discharge of patients and impact on the clinical experiences available to students both in hospital and community settings (Gardner, 2000). Expectations by faculty members and nurses of the clinical learning environment therefore need to change to an understanding that repetitious practice of skills is not the only way to achieve clinical competency. This new environment increases the importance of clinical experience for student nurses as they seek opportunities to apply theoretical principles and develop more advanced clinical decision making skills (Oermann, 1994). Similarly, there is an increased expectation that experienced nurses will be able to identify and maximise learning opportunities that facilitate the application of theory to practice, despite the loss of 'traditional' patients. These changes in the role of the nurse place increased pressure on healthcare workers (Moreton-Cooper & Palmer, 1993).

One example of the changing role of the nurse is the displacement of nurses away from areas in which they been traditionally employed, such as operating theatres (Cordery, 1995). Many schools of nursing in the United Kingdom have decided that due to the increased demand for theoretical time, some clinical areas such as operating theatres will be no longer utilised as clinical learning environments (L. Walker, 1998). It could be argued that this is consistent with changing foci in healthcare that envisage health as being more focused on primary health models characterised by a subsequent shift away from a hospital-based, disease focus, towards community-based, disease prevention and caring approaches. (L. Walker, 1998). However, the more immediate problem which arises from the loss of nurses in clinical areas, is that students are being deprived of clinical experiences that are required for them to be able to develop clinical skills that will assist them make the transition from student to beginning practitioner (Cordery, 1995). The shortage of qualified nurses has also been blamed for the difficulty in establishing effective clinical learning environments. Nurses reported that "(y)ou never get the chance to learn things properly. It is always rushed. There is always something else to be done" (Charnley, 1999, p. 34). The deficiencies of the clinical placement as a learning environment were further corroborated by nurses who described poor quality nursing

care, inadequate role modelling and inadequate supervision from clinical staff occurring as a result of increasingly demanding workloads (Forrest et al., 1996).

However, there is general agreement that clinical learning environments must also be involved with changes to nursing education, if student nurses are to experience the type of clinical experiences that will prepare them for practice in broader, more flexible, clinical settings. Porter-O'Grady (1990, p. 187) commented that "(t)his belies today's interventive approach to students in the clinical environment, often perceived as more a burden to bear, than an opportunity to prepare". In addition, Twinn and Davies (1996) concluded that ward staff nurses intimate to students that the burden that they place on the staff is expected to be repaid by the students helping staff with their patient care load. This expectation is directly opposed to the intent of new curricula that student nurses' clinical positions are of a supernumerary nature to enable their focus to be on learning in the clinical setting rather than working. However, *Project 2000* students in England reported that the supernumerary role inhibited their feelings of "fitting in" with clinical staff who otherwise regarded them as "an extra pair of hands, lazy or a hindrance" (Clark et al., 1997, p. 250).

The complaint of a 'lack of time' emerged as a consistent issue in much of the literature reviewed in relation to clinical teaching, preceptors' views on their role, and students' expectations of the clinical placement. Nurses frequently complained about being too busy or too stressed to teach, due to the increased pressure of patient care demands (Wilson-Barnett et al., 1995). It has been suggested that the conflicting demands of their workload preclude nurses from adequately discussing issues with students, rather they are required to leave the student to "learn by doing" (Twinn & Davies, 1996). This finding is of particular interest for this research because it describes an important impact of change on the clinical teaching roles of nurses.

The literature further cautioned that burdening already taxed nurses with the extra role of clinical nurse teacher, in addition to their clinical responsibilities, risks the development of 'burnout' if nurses do not perceive that there are sufficient benefits to the role (Dibert & Goldenberg, 1995; Lewis, 1990). The lack of acknowledgment of the increased stress placed on nurses in fulfilling preceptorship responsibilities may eventually lead to a situation where preceptorship ceases to be a viable clinical teaching strategy (Bain, 1996). These comments are consistent with the findings of Yong (1996) in her study of students' experiences on

clinical placements. Similarly, Grant et al. (1996) reported that while nurses generally enjoy teaching students, one quarter of nurse participants perceived that clinical teaching was too time-consuming.

Nevertheless, the risk of preceptor burnout is not new. In 1989, Greipp warned "considering the nationwide nursing shortages, it would seem that nursing preceptors are at high risk of burnout from overuse, abuse, and devaluation of the role, to the point where they could view acting as preceptors a burden" (p. 183). Evidence in Australian nursing of staff burnout, is the increasing frequency with which hospitals and healthcare agencies are making themselves unavailable for student placement due to a cited lack of available staff to supervise students (Napthine, 1996). Similar problems are also reported in the USA, where it is observed that, within a 'for-profit' healthcare environment, the impact of managed care particularly on large, teaching hospitals, is resulting in conflict between provision of services and provision of education and research opportunities (Leeder, 1999). Such economic constraints on clinical education increase the support that nurses require in order to effectively participate in clinical teaching.

However, frustration at a perceived lack of tangible rewards for clinical teaching and minimal support during the teaching process, compound the stressors experienced by nurses and impact on their commitment to the clinical teaching role (Forrest et al., 1996). One response to the increased stress is a number of suggestions that schools of nursing should be paying experienced nurses to act as preceptors (Atkins & Williams, 1995). A study of a clinical supervision trial in the UK also concluded that clinical supervision in some of the areas surveyed appears to be more popular because of the availability of funds for the trial, leading to the conclusion that the matter of fidelity of clinical supervision is becoming an issue that will persist (E. White et al., 1998). The issue of money for staff time and staff training as clinical supervisors was similarly raised in a survey of 273 trust nurse executives in England and Scotland (Bishop, 1998). However, despite the clear evidence of these findings, most nurses appeared to be supportive of the extra demands which students place on the workload of the preceptor and the ward environment (Atkins & Williams, 1995).

2.4.5 Implications for this Research

Change in healthcare contexts encompasses change in healthcare delivery models, sites of healthcare, demographics, future focus of healthcare and the role of the nurse. The introduction of economic rationalist driven policies into healthcare responds to escalating healthcare costs and also aims to reduce the dependence of health costs on the public system. Such worldwide economic trends that increasingly view health as a commodity to be marketed, may be beyond the immediate control of nurses. However, it is acknowledged that there appears to have been a largely uncritical acceptance from health professionals of standardising procedures such as competency-based practice, DRGs and casemix. In this for-profit, healthcare environment, nursing education programs at all levels are urged to ensure nurses have a basic understanding of nursing practice that encompasses casemix management systems and increased accountability (Cornell & Ferguson, 1995).

However, not all nurses agree that the profession should accept this economically driven image of the future of nursing. Sellers (2000) argued that nurses must take action or perish. The literature reviewed in this section describes dramatic changes in the clinical learning environment resulting from change to patient demographics and the focus of healthcare. Of particular relevance to this research is the finding that student nurses are being deprived of the opportunities to develop clinical skills which will assist them make the transition from student to beginning practitioner, largely because of changes to the skillmix of staff in clinical areas and the removal of nurses from some traditional roles of practice such as operating theatres. Furthermore, the finding that due to the increased busyness of the clinical setting, students are being required to learn by doing, rather than through critical analysis and reflection, is cause for concern. Such conclusions increase the need for experienced nurses to be supported in their goal to identify appropriate clinical learning opportunities that will allow students to develop the characteristics that will enable them to practice in future healthcare contexts.

2.5 CONCLUSION

This chapter has reviewed conclusions reached by the literature as it relates to the broad concept of clinical nurse education. Themes important to this study have been illuminated through the literature review. The literature reviewed therefore serves to highlight the place of this study in understanding the beliefs and attitudes of experienced nurses in relation to their role in the clinical education of student nurses.

Clinical field experiences offer student nurses the opportunity to develop clinical practice skills as well as playing an important element in the socialisation of the student into the culture of nursing. However, the depth of learning that may take place during a clinical nurse - student interaction, depends on the beliefs, values and attitudes of the nurse towards clinical teaching of students. Examination of the benefits and perceived advantages of preceptorship as an anticipatory socialisation strategy and as a method of promoting clinical competence and confidence, suggests that preceptorship is a valuable clinical teaching tool. It can be concluded that the student-preceptor model promotes the development of safe and competent practitioners, thereby meeting professional and community expectations of nursing education.

While current literature endorses preceptorship as one clinical teaching strategy, there is a need for further research into the selection, preparation and support of experienced nurses to enhance the delivery of quality clinical teaching, which acknowledges the implications of changing trends in healthcare on the future needs of student nurses. There are few studies which examine the effect on experienced nurses once they are engaged or have been engaged, in clinical teaching particularly in the Australian nursing education context. Experienced nurses who are engaged in teaching of student nurses need to be adequately selected, prepared and supported by nursing education and nursing service, throughout their engagement in teaching. The principles of new nursing curricula that focus on the development of life-long learning and reflectivity, need to be introduced to nurses who may be employed in organisational structures that historically have valued efficiency and adherence to correct procedures. In order to be effective clinical teachers and role models, nurses thus need encouragement and support in questioning and reflecting on their own practice.

The literature review has highlighted that further research is needed to examine the impact of clinical teaching on the lives of experienced nurses, in order to understand the variables that influence their satisfaction with, and performance in the role. It is recognised that change in healthcare contexts is a key variable influencing the clinical teaching role of the nurse. The hermeneutic and symbolic interaction perspectives guiding the study support this recognition of the contexts in which experienced nurses practise. The review thus serves to provide a broader understanding of what clinical teaching means for nurses. It is against this understanding that analysis of the data can proceed in order to explore the perceptions of six experienced nurses of their role as clinical teachers.

CHAPTER 3:   DESIGN OF THE RESEARCH

3.1   INTRODUCTION

The purpose of this chapter is to justify the research design adopted in the exploration of experienced nurses' perception of their role as clinical teachers. The nature of nursing has experienced, and continues to undergo change in response to the challenges presented by economic, social and technological pressures on healthcare and its delivery (Chinn, 1991). The 'revisioning' of nursing education to provide an educational base which will meet these changing needs has seen a decrease in the traditional emphasis on a behavioural pedagogy, and a recognition that nursing practice is now characterised by ambiguity, uncertainty, complexity, and rapid change (Lindeman, 1992). This paradigm shift has been reflected within change to models of nurse education from a hospital based, apprenticeship system to a professional preparation in the university sector (Diekelmann, 1993). Underpinning these new models of nursing education is the belief that nursing is an humanistic profession whose basic philosophy respects the right of individuals to interpret and make sense of their own experiences, that are then interpreted in light of the individual's own world view (Munhall, 1989).

Given the purpose of this study, the research design must be able to guide the researcher to assist the participants of the research to reflect upon and describe the affects that changes to their working environment are having on their role. The philosophy underlying the research questions is concerned with the nature of what it is to be human (a clinical nurse), the nature of change in the environment and how the two interact. This is consistent with the nature of nursing itself which is "concerned with some fundamental questions about the nature of human beings, the nature of the environment, and the interaction between the two" (Munhall 1989, p. 21).

As a consequence, the purpose of the research invited a qualitative approach that allows the researcher to gain a sense of the meaning which people have constructed of events and experiences in their lives (Crotty, 1998). This approach seemed appropriate as it took into

consideration the belief that human situations "can only be understood from the standpoint of the individual actors" (Candy, 1989, p. 3). The role of epistemology is to address the nature of knowledge and provide a philosophical basis for understanding how knowledge is possible (Crotty, 1998). It is therefore important to make explicit the epistemology inherent in the theoretical underpinning of this research. Table 3.1 offers an overview of the four elements of the research design for clarity of understanding and the subsequent text addresses each one in turn.

3.2	**Epistemology**	Constructionism
3.3	**Theoretical Perspective**	Interpretivism • Hermeneutic Phenomenology • Symbolic Interactionism
3.4	**Research Methodology**	Case Study
3.5	**Data Collection Methods**	Participant Observation Field notes Interviews: Semi structured and Informal

Table 3.1   Research Framework

3.2.   EPISTEMOLOGY: CONSTRUCTIONISM

It is because this research is interested in the reality or meanings which individuals have assigned to their experiences with change in their working environment, that the epistemological position known as constructionism (Crotty, 1998) or constructivism (Guba & Lincoln, 1994) was adopted. The aim of constructionism has been described as seeking an understanding and reconstruction of those meanings or constructions of reality held by participants, that allows for new interpretations and more sophisticated constructions to emerge over time (Guba & Lincoln, 1994). Thus, the influence which both time and the process of being engaged within the research may exert on participants' understandings of the meaning of their constructions of reality, is acknowledged (Guba & Lincoln, 1994). Constructionism therefore takes into account the impact which engagement with the research exerts on meaning, so that knowledge is not regarded as a fixed concept but rather as individually constructed (Crotty, 1998). As a consequence, differences in the constructions of meaning in relation to the one phenomenon are all valued and accepted as "multiple knowledges" (Guba & Lincoln, 1994, p. 113) that coexist between competent participants. Constructionism thus allows for multiple meanings to emerge, rather than one objective truth-awaiting discovery (Crotty, 1998).

3.3   THEORETICAL PERSPECTIVE

A theoretical perspective is based on a way of looking at the world and constructing an understanding of the world. The theoretical perspective must be congruent with the purpose of the research and justifies the selection of particular methodology and methods to fulfil that purpose and to answer the research questions (Crotty, 1998). The theoretical perspective provides a logical basis for the processes involved with the research; it structures the research design; it gives direction to the data to be collected; and it provides a basis on which analysis of the data findings can proceed. Furthermore the theoretical perspective allows the "complexus of assumptions" (Crotty, 1998, p. 66) which are buried within the research methodology to be understood.

All research is underpinned by a set of beliefs which define the nature of reality, the nature of the relationship between what is to be known and the researcher and finally, the methodological question about how this knowledge is to be known (Guba & Lincoln, 1994). Popkewitz (as cited in J. Walker & Ivers, 1997, p. 23) identified three research paradigms: "empirical-analytic" or quantitative, "symbolic" or phenomenological / qualitative and "critical". Similarly, Candy (1989) described three research paradigmatic orientations; quantitative, interpretive and critical paradigms. Denzin and Lincoln (1994) extend the paradigm debate past critical and post-modern positions, to contend that there is a post-post period or "the fifth moment" to forecast a future for research characterised more commonly by "messy", "uncertain" and "experimental" research (p. 15). However, it is Candy's (1989) conclusion that these paradigms are not discrete, mutually exclusive entities, but rather a representation of "clusters of assumptions and broad orientations" (p. 8), which has influenced the choice of orientation for this research. Rather than expect any one paradigm to be able to meet all the needs of this research, an interpretive approach was utilised because it represents the most appropriate "goodness of fit" (Candy 1989, p. 10) for the phenomena under inquiry.

3.3.1 Interpretivism

The aim of interpretivism is to understand the values, attitudes and beliefs which influence people to act in a particular manner (Candy, 1989). Such an approach assists the researcher to understand the nature of the participants' interaction with their working environment. Interpretivist research also takes into account a number of assumptions. These are:

- the influence of the context on human behaviour;
- the difficulty in gaining complete objectivity because of the influence of personal meaning on the participants;
- the emphasis on the development of understanding of a number of individual cases rather than seeking to make generalisations; and
- the influence of the researcher's own value systems in relation to the research problem (Candy, 1989, p. 4).

As a consequence, the research orientations chosen to guide the conduct of this research must attend to the influence of context and personal meanings on both researcher and participants as they seek to construct their understandings of the phenomenon of clinical teaching. Within the interpretivist paradigm several approaches to research have been developed; hermeneutic phenomenology and symbolic interactionism are two research orientations based in the interpretivist research philosophy which consequently guided the research documented in this thesis.

Hermeneutic Phenomenology

Hermeneutic phenomenology is a research orientation, which has its roots in the phenomenology tradition. The German philosopher, Husserl first used phenomenology as a philosophical perspective to study how people experienced their world, based on the assumption that "*we can only know what we experience* by attending to perceptions and meanings" (Patton, 1990, p. 69). Three implications can be extracted from this perspective (Patton, 1990) which further explain phenomenology as a philosophy and as a method of inquiry. The first explains the focus of phenomenology- that it is important to know "what people experience and how they interpret the world" (Patton, 1990, p. 69); the second implication directs the phenomenological researcher towards participant observation, "because it is only possible to understand another's experiences by going through the same experience" (Patton, 1990, p. 70). The final implication relates to the belief of researchers using a phenomenological perspective that the purpose of phenomenology is not only to understand individual experiences, but also to analyse these experiences to reveal the "essence" or core meanings of these experiences (Patton, 1990, p. 70).

Like phenomenology, hermeneutics is concerned with understanding. The term *hermeneutics* is derived from the Greek verb *hermeneuein,* meaning to interpret. The messenger of the Greek gods, Hermes, is also associated with interpretation (Odman & Kerdeman, 1997). However, Heidegger (1889-1976) as cited in Odman and Kerdeman (1997) posited that the person exists in relation to the world so that any understanding and interpretation of the person's experiences must take into account the influence of the

person's situation in their world. Thus "(h)ermeneutics is defined as the theory and practice of interpretation" of human experience (Van Manen, 1990, p. 179), whereas phenomenology can be described as the study of human phenomena which describes the "quality of lived experience…and the meaning *of the expressions* of lived experience" (Van Manen, 1990, p. 25).

While Van Manen (1990) acknowledged the debate between phenomenology's focus as description and hermeneutics as advancing an interpretation of that description, he concludes that in seeking the essences of lived experiences, the researcher is, in fact, "interpreting the phenomenological text" (p. 26). Furthermore, the act of naming or describing lived experience is, in itself, an interpretation by the researcher of the meaning that the phenomenon holds for the participant. From this perspective, Van Manen concluded that the terms "phenomenology and hermeneutics are employed interchangeably" (1990, p. 26).

The importance of acknowledging the situational or relational tradition of both participant and interpreter, is supported by Kneller (1984). A need to attend to the perspective or standpoint of the researcher as well as that of the participants, because of the influence of the researcher's context or viewpoint on their interpretation of the data is also acknowledged (Patton, 1990). The act of reflection on experiences past, of describing lived experiences is a fundamentally, self-interpretative act. In order to reflect on the meaning of past experiences, the participant must engage in self-interpretation and analysis. The researcher then engages in further interpretation as they seek to clarify and deeply understand the meanings of these interpretations (Leonard, 1994, p. 55).

This dialogue between understanding and interpretation is termed the "hermeneutic circle" (Odman & Kerdeman, 1997). It encompasses three assumptions based on the Heideggerian phenomenological view of person: "understanding, preunderstanding, and interpretation" (Leonard, 1994; Odman & Kerdeman, 1997). The hermeneutic approach assumes that the researcher, by virtue of a shared and common language and culture is able to see or understand the phenomenon. Secondly, it is assumed that the researcher has some beginning level of understanding of the phenomenon gained through their familiarity with the phenomenon, termed preunderstanding, which allows them to interpret meanings in context and relation to the situation (Leonard, 1994; Odman & Kerdeman, 1997).

It is these assumptions underpinning the hermeneutic circle which have caused phenomenology (and hermeneutics, if Van Manen's proposition that the terms are used interchangeably, is accepted) to be criticised for the influence of 'preconceived categories' or 'background knowledge' over the researcher's interpretation of the phenomenon (Salsberry, 1989). However, Heidegger describes his hermeneutic phenomenology as beginning with a phenomenological 'forestructure' of understanding which is then deliberately used to, "unfold that pre-understanding, make more explicit what is implicit, and grasp the meaning of Being" (Crotty, 1998, p. 97). Thus hermeneutic phenomenology requires that both researcher and participants be aware of that pre-understanding of the phenomena to be studied and thrust aside their tendency to immediately interpret the phenomena (Crotty, 1998).

As a consequence, the following underlying assumptions have guided the choice of research orientation within the interpretive paradigm:

1. Nothing is predefined or taken for granted;
2. Human behaviour is shaped in context and events cannot be understood adequately if isolated from their contexts;
3. Experience is to be taken and studied as a *whole,* or holistically;
4. Methods of inquiry for carrying out these aims must be appropriate to the aims (Sherman & Webb, 1988, pp. 3-4).

The central question of hermeneutics asks "what are the conditions under which a human act took place or a product was produced that makes it possible to interpret its meanings?" (Patton, 1990, p. 84). This basic tenet of hermeneutics emphasises the importance of acknowledging the research context and its influence on interpretation of data. The basic question posed by this research similarly seeks to understand the effect of the particular context in which nurses are working, on their ability to be able to participate in the clinical teaching of student nurses. The study is steeped in the knowledge that recent and ongoing changes to the education of student nurses, combined with economic, social and technological changes have impacted on the working lives of experienced nurses.

Furthermore, the goal of interpretive phenomenology is to "respectfully understand the lifeworld, critically evaluating what is oppressive, ignorant, or troublesome from the

perspective of the participant and identifying sources of innovation and liberation within everyday practices" (Benner, 1994, p. 123). The philosophical stance of hermeneutic phenomenology was therefore appropriate for this study which sought to understand how nurses perceive their role in clinical teaching, in light of the changes to their working environment. It is this focus on understanding the participants' perspective of their working context through reflection on the phenomenological text, which intimately resonates with the concept of reflective practice within nursing, examined in section 2.3.

It has been suggested that hermeneutics can contribute to the practice of education and education research by understanding the meanings with which participants interpret particular educational strategies or models (Odman & Kerdeman, 1997). It was therefore particularly appropriate to use hermeneutics to guide this study so that the meanings with which nurses understand the processes of clinical teaching can be interpreted. Similarly, symbolic interactionism seeks to explore the understandings inherent in our culture in order to understand the standpoint of others (Crotty, 1998).

Symbolic Interactionism

Consequently, the second research orientation that frames the research design is symbolic interactionism. Symbolic interactionism arises from the qualitative tradition called Interactionism which views people as active creators in their world (Blumer, 1969). Symbolic interactionists assert that people are unique in their ability to define their situations and shape their world, by "taking into account shifting definitions of their condition over time, and creating and constructing their own actions and realities" (H. S. Wilson & Hutchinson, 1991, p. 267). Meaning is created by experience. Symbolic interaction is therefore 'akin' to phenomenology because both traditions focus on the meanings of experiences in everyday life (Chenitz & Swanson, 1986, p. 4). Symbolic interactionism is consistent with qualitative assumptions that view the world as socially constructed and subject to multiple interpretation and is:

> guided by the assumption that people do have patterns of experience through which they order and make sense of their environment, although their world may appear disordered or nonsensical to the observer. The order or pattern derives from their shared social and symbolic interactions (Hutchinson, 1988,

p. 125).

Furthermore, while these experiences are unique to each individual, the symbolic interactionist tradition recognises that people who are in common situations will develop a shared perspective of the situation because of their common definitions (Bogdan & Biklen, 1998). Although it is recognised that each participant in this study has developed a unique personal knowledge through experience, their shared experiences of nursing in a common context indicate that they will also develop a common stock of symbols which may incorporate gestures, facial and bodily expressions, rituals, routines and myths, and particularly in nursing, language (Schwandt, 1994). Experienced nurses could thus be expected to develop a common perspective of what it is to be a nurse and of their role as a clinical teacher because of their shared experiences, problems and interactions. Consequently, it is appropriate for this study to utilise symbolic interactionism in order to understand the meanings that the participant nurses make of their experiences. How such meanings and shared definitions of clinical teaching developed, is of importance to this study. Thus, it is the multiple meanings of clinical teaching which have developed which are of interest to this research. While it is acknowledged that factors such as the work environment, motivation and expectation of the role influence behaviour, it is the "interpretation" of behaviour which is the focus for the symbolic interactionist researcher (Bogdan & Biklen, 1998, p. 24).

Blumer (1969) has generated three main principles that guide the symbolic interactionist approach. The first principle is that people do not simply respond to stimuli or act out cultural scripts; rather, "they act towards things on the basis of the meanings that these things have for them" (Blumer, 1969, p. 2). The meanings which people construct are thus personal and derived from their interaction with their environment and previous experiences. Individuals interpret stimuli and respond in what they judge to be an appropriate manner for that occasion, using symbolic communication involving gestures and language (Byrne & Heyman, 1997).

This gives rise to Blumer's second principle which is that "the meaning of such things is derived from, and arises out of, the social interaction that one has with one's fellows" (Blumer, 1969, p. 2). Symbolic interaction thus stresses the ongoing interaction one has with others and how such interactions may contribute to the individual's personal beliefs and

behaviours. While the unique views of individuals are recognised, it is also understood that these views respond to socialisation within the particular environment (Byrne & Heyman, 1997).

Consequently, the final principle: "that these meanings are handled in, and modified through, an interpretative process used by the person in dealing with the things he encounters" (Blumer, 1969, p. 2), guides an understanding of the way in which individuals deal with meanings constructed from social interactions. Nurses, therefore, both create their own culture through the meanings they attach to rituals, routines and language, and are influenced in that interpretation by their culture which defines their work role and attitudes towards their work (Byrne & Heyman, 1997). The implication of the symbolic interactionist approach is that the individual's perspective has to be taken seriously and the meanings that they attach to events and things must be understood from their perspective (Crotty, 1998). "Methodologically, symbolic interactionism directs the investigator to take, to the best of his ability, the standpoint of those studied" (Denzin, 1997, p. 99).

3.4   RESEARCH METHODOLOGY

A number of methodological approaches are situated within the interpretivist theoretical perspective. Case study is one research approach, which arises from the holistic, interpretivist tradition of research. Case study seeks to understand parts or patterns within cases by understanding the inter-relationships between parts and thus how they form a whole (Sturman, 1997). This holistic or systemic approach can be contrasted to the analytic approach, which assumes particular parts, or patterns can be studied in isolation. From this contrasting position, it can be seen that an holistic approach such as case study is most appropriate for research that seeks to understand the whole pattern of phenomena (Sturman, 1997). Furthermore, case study design, because of its extensive description and analyses of phenomena aims to gain a deeper understanding of the phenomena and of the meaning which those involved in the study give to their experiences (Merriam, 1998). It is therefore appropriate that a case study approach was used to orchestrate or organise "the collection and

presentation of detailed, relatively unstructured information from a range of sources about a particular …group" (Hamersley, cited in Hitchcock & Hughes, 1995, p. 318).

3.4.1 Case Study

A literature review of case study reveals a number of strengths and weaknesses. Case study has been criticised for being "soft" with many uncontrolled variables, for being ambiguous in design and inherently biased (Hutchinson, 1988). However, it has also been argued that the case study speaks to nurses because it highlights particular human experience and real-life problem (Hutchinson, 1988). Furthermore, case studies are particularly useful in examining the "how" and "why" aspects of real-life phenomena which cannot be manipulated by the researcher (Yin, 1989, p. 9). The extent of data required to answer the how and why questions inherent in a case study also serve to strengthen it as an approach that will yield meaningful results (Hutchinson, 1988). However, the strength afforded the case study by the large quantum of data yielded also reveals a weakness: the presence of so much data may overwhelm the researcher and so thwart effective data management and analysis causing the researcher to become stalled (Yin, 1989). Because it seeks to understand a bounded, defined case, the case study has also been criticised for its lack of generalisability to the wider population. However, the deep probing and intensive analysis of the multifarious phenomena occurring within the defined unit allows generalisations about the wider population to which the unit belongs to be made (L. Cohen & Mannion, 1994). Certainly it has been suggested by Stenhouse (1980) that one problem of case study is the need to gather evidence in such a way as to make it verifiable and accessible to critical assessment. This issue of verification pertains to validity issues, which is addressed in detail in section 3.9.

Nevertheless, it is the elusive concept of 'usefulness' of the case study, which needs to be considered. Five issues which influence the usefulness of case studies have been described (S. Wilson, 1979) that are relevant to this study. These issues are:

1. Role of the reader- the data gathered in this case study focuses on the role of the nurse as clinical teacher. Experienced nurses reading this study may identify with and interpret aspects different to those interpreted by a nurse educator or student nurse. Thus different interpretations may influence the usefulness of the study.

2. Time to read and length of case studies- while it is acknowledged that one of the strengths of the case study is its ability to address interwoven, complex multiple details over time, the length of the completed report may also reduce its usefulness.

3. Values and theoretical orientations of readers- because people tend to read and remember what is congruent with their pre-existing values and beliefs (Butler, 1996), the judgement of whether a report is useful or not may be clouded by the reader's own theoretical framework, potentially reducing its value.

4. Experience, style and expertise of the reader- the inexperienced reader may not appreciate the description of a case alien to their own experiences, yet the more experienced reader may find their own experiences more illuminative and valuable than the description offered by an unknown researcher.

5. Generalisability and the context of the reader- the contentious issue of generalisability of one case study to a wider context is given some direction by the suggestion that "the more congruity between the subject of the case study and the place where the information is going to be used, the more likely it is to be of interest" (S. Wilson, 1979, p. 454).

However, it has also been proposed that case study can only be generalised in a more "naturalistic" way, if the reader uses the case study to extend their own experience, increasing their "feel" and "sensitivity" for the phenomena described, so that they gain "tacit" knowledge from reading the case study (Stake, 1994, p. 6). Sturman (1997) argued that for naturalistic generalisation to be made possible, the researcher must endeavour to document all the characteristics of the known case so that generalisation to a new case may be made in the full knowledge of the context of the case. The identified strengths and weaknesses of the case study therefore serve as a guide for the conduct of the research documented in this thesis. The issues of context, generalisability and usefulness as they

pertain to validity are further addressed in section 3.9.

The research undertaken in this thesis can thus be described as the story of a particular phenomenon in its own right and in its natural setting. The phenomena or case to be observed has been described as being a "specific bounded system, which is made up of variable numbers of integrated, working parts" (Stake, 1994, p. 236). Merriam (1998) described case study as more concerned with process issues and the context of the situation rather than content or product issues. This definition is congruent with the major research question within this thesis, which seeks to understand nurses' behaviour in clinical teaching (process) particularly as they respond to change within their working / teaching / learning environment. Furthermore, the purpose of case study has been described as the deep probing and intensive analysis of the multifarious phenomena occurring within a unit (L. Cohen & Mannion, 1994). As a result of this deep probing, generalisations about the wider population to which the unit belongs may be made (L. Cohen & Mannion, 1994).

The major feature of a case study is its "concentration upon a particular incident" (Hitchcock & Hughes, 1995, p. 317). Therefore, this case study has as its focus a group of nurses who were involved with the clinical teaching of student nurses throughout their clinical field placement. The relationships and events occurring between the individuals participating in this study can be viewed each as single cases and as linked events, so that the case study "evolves around the indepth study of a single event or a series of linked cases over a defined period of time" (Hitchcock & Hughes, 1995, p. 317). In this case study, the period of time was while the participants were engaged in clinical teaching of students enrolled in the undergraduate BN at ACU. Thus the particular incident of focus was the experience of these nurses as they were involved in the clinical teaching of the students.

The choice of case study as an orchestrating perspective is also justified when further characteristics of case study are noted in this study; it is the 'story' of the nurses' involvement in clinical teaching and their perspective of the factors which influence them, which was the focus of attention. Furthermore, case study is appropriate because the focus of the defined case is a contemporary phenomenon which is being studied within its real context (Hitchcock & Hughes, 1995). Case study is most appropriate when the researcher has little control over events; in this study the purpose of the research was to observe,

document, analyse and interpret the situation and events in order to gain a deep understanding of the experience of the participants. The purpose of the study was not to control, influence or manipulate the outcomes.

In summary, case study offered this researcher the opportunity to develop a detailed description and understanding of a particular phenomena, clinical teaching, in its natural context. It appeared appropriate to use case study as an orchestration for this research because it provided not only the means by which existing beliefs and theories about clinical teaching can be tested, but also the opportunity and ability for the researcher and participants to develop new theoretical positions on clinical teaching (Sturman, 1997).

3.5   RESEARCH METHODS: DATA COLLECTION

The procedures for data collection and subsequent analysis are guided by the research design. Several possible ways of collecting study data within a case study design have been described. These include documentation, archival records, direct observation, participant observation, interviews and physical artefacts (Yin, 1989). Consequently, within the orchestration of case study, two research methods were utilised in order to gather and organise data; participant observation and interview. The time period for data collection was between July 1998 and August 1999. Participant's availability and periods of involvement with clinical teaching of students, determined the time period for collection of data from each participant.

3.5.1   Participant Observation.

The first research method used in this study was participant observation. For the holistic researcher, participant observation means submersion in the natural setting (Patton, 1990). The researcher was thus able to: observe ongoing behaviour as it occurred and support such observation with field notes; to develop meaningful relationships with the participants

over an extended period of time; and to avoid reactive bias to data because of the more natural environment (L. Cohen & Mannion, 1994). Participant observation required that the researcher share as closely as possible in the daily life of the participants within the case study. This has been described as a "challenge to combine participation and observation so as to become capable of understanding the program as an insider, while describing the program for outsiders" (Patton, 1990, p. 207).

However, participant observation has also been criticised for its potential to deliver subjective, biased impressions of particular incidences that lack precise and quantifiable measures (L. Cohen & Mannion, 1994). Furthermore, it has also been noted that the usefulness of participant observation is largely determined by the researcher's ability to gain access to the group or event, so that the reality of the participants may be accurately observed (Merriam, 1998). The issue of potential bias in participant observation has been further expanded into three problems (Yin, 1989, p. 93):

1. The investigator may be required to take an advocacy role that compromises their external status
2. The participant investigator may follow an apparently common phenomena and become converted to the cause being objectively observed, thus compromising the investigation
3. Finally, the researcher may be required to spend a disproportionate amount of time interacting with the group and so have insufficient time in which to complete observations.

Solutions to the problem of bias in participant observation including, investigator focus on increasing objectivity, exploiting their subjectivity to the advantage of the research, and working to diminish their effect on the phenomena being observed by increasing self-awareness, have been recommended (Davis, 1986). When approached from this perspective, the self becomes the instrument for participant observation. New ways of seeing or thinking about a situation may arise because increased awareness of the self has lead to a greater understanding of why one responded in the situation. The researcher sought to meet this challenge by spending time immersed in the context, developing rapport and close relationships with the participants. The degree of rapport that developed over time allowed the

participant observer to gain access to confidential information and situations that would be unavailable to other researchers (Merriam, 1998).

Participant observations were undertaken during the period of most intense data gathering, August 1998 to November 1998. While the researcher entered the field on a weekly basis for this period of observation time, the busyness of the clinical environment and the availability of the participant determined the number of observation sessions. In total, thirty-two sessions of observation were completed, with each participant being involved on at least four occasions. The length of time for each observation session ranged from thirty minutes to two hours with most being less than one hour. During the majority of observation sessions, the researcher stood quietly in the clinical environment in order to observe and document the interaction between participant and their student. Conversation with the nurse, student and patient took place as appropriate in order to maintain the normal daily life of the participants (Cohen & Mannion, 1994). Participant observation therefore, was utilised to facilitate the collection of rich, meaningful accounts from the nurses who participated in this study, about their perceptions of their role in clinical teaching. Field notes also served to support such observations and understandings and maximised the quality of information gained in such interactions.

Field notes were consequently taken during participant observation to record descriptions of participants' interactions with their buddy students or preceptored students. When possible, notes were also taken of informal conversational interviews. Comparisons were then able to be made between what participants were actually observed to do in relation to facilitating clinical learning opportunities with their students, non-verbal behaviour related to clinical teaching and verbal descriptions of their perceptions. Wherever possible, these field notes and jottings were developed into full descriptions as soon after the observation as possible in order to increase the usefulness of both the period of participant observation and field notes as data sources. While this proved to be difficult to achieve on some occasions, usually due to the busyness of the observation environment, these field notes allowed a beginning data analysis of the situation just observed (Merriam, 1998) that could be further explored during interview. This is consistent with the orientation of symbolic interactionism, which notes that meaning is always subject to negotiation that may lead to new interpretations of meaning, perhaps resulting in change (Bogdan & Biklen, 1998). Figure 3.1 provides an example of observation notes made by the researcher during one

period of participant observation with the participant, Roslyn.

Figure 3.1 Participant Observation Notes

Observation Notes   16 Sept 1998. 10.15am, after morning tea
Ward 2   Roslyn and 2nd year student "A"

Roslyn and "A" working together to do complex wound dressing. Ward is fairly busy, several post-op patients. Roslyn and "A" have end cubicle of 4 patients and next room with 2 patients. Patient has had complications following abdo surgery, wound dehiscence, receiving IVT, O_2, Morphine infusion. I wonder whether she is too complex for the student? Ros allows "A" to prepare for the dressing, prompts her for more supplies due to nature of wound. Has student done this dressing before? Wound is long, inflamed with fistula from old drain site. "A" is to pack the fistula today. "A" is having difficulty deciding the order in which to proceed, Ros offers advice on how to manipulate the instruments, dressing and packing to maintain sterile field. "A" is very slow, and patient drifting off to sleep, Ros says she is mostly 'out of it' due to the morphine. "A" is becoming confused and says "they said it would take a whole packing but I can't get any more than half into the fistula". Seems concerned at not being able to do it properly. Ros is getting tetchy, and suggests that it took the whole pack yesterday. "A's" actions seems to be less and less purposive. Ros appears to have finally had enough and sighs before offering to put on a pair of sterile gloves and help "A" with the packing. "A" is determined to finish herself and says she is confident that is all the packing that will go in the fistula. Ros seems happy that the student has finished the dressing by herself, says 'good on you to keep at it, you did well in the end'. I wonder whether they went through the procedure together before, or if "A" has watched her do it. Minimal interaction with the patient who keeps waking up and looking at her abdo then drifting off to sleep again. Neither Ros nor "A" speak to patient. I smile and nod, she doesn't respond. We leave room to allow "A" to clear her trolley and document intervention. Total time for dressing was 25 minutes. In the treatment room Ros is getting tetchy at the time taken for this procedure.

Data collected through participant observation and field notes were thus transcribed so that coding for data analysis could commence.

3.5.2   Interviews

The second research method used in this study was interviewing. Interviews were a necessary source of case study data (Merriam, 1998) because they provided the researcher with important insights into the phenomena being studied from the perspective of the participants. The interview was valuable in qualitative research because "it is prepared and executed in a systematic way, it is controlled by the researcher to avoid bias and distortion and is related to a specific research question and to a specific purpose" (Sarantakos, 1993, p. 177). Furthermore the interview has been described as "a purposeful conversation, usually between two people, but sometimes involving more, that is directed by one in order to get information from the other" (Bogdan & Biklen, 1998, p. 93). Interview was therefore chosen as the primary data collection method because it is "the main road to multiple realities" (Stake, 1995, p. 64). Two types of interview were subsequently used in this study; guided (Patton, 1990) or semi-structured interviews (Burns, 1997), and informal, unstructured interviews (Merriam, 1998) with the participant nurses within the defined boundary of the case study.

The Semi-structured Interview

Interviewing in qualitative research generally occurs in a largely open-ended and less structured manner which allows participants to reveal their perceptions of the concept under study (Merriam, 1998). This type of interviewing resonates with the basic tenet of hermeneutics that emphasises the importance of acknowledging the research context and its influence on interpretation of data. The essential question posed by this research similarly sought to understand the effect of the particular context in which nurses are working, on their ability to be able to participate in the clinical teaching of student nurses. Furthermore, the semi-structured interview is consistent with symbolic interactionism assumptions that view the world as socially constructed and subject to multiple interpretation because it is the "interpretation" of behaviour which is the focus for the symbolic interactionist researcher (Bogdan & Biklen, 1998, p. 24).

However, it has been suggested by Merriam (1998) and Patton (1990) that while some specific information is usually required from each participant, a more relaxed, semi-structured approach is appropriate for most of this type of interview. The use of an interview guide (Patton, 1990) subsequently provided some guidance to the questions to be asked yet allowed the interviewer greater flexibility in the sequence and wording of the questions (L. Cohen & Mannion, 1994). Consequently, the research questions served to focus the development of a broad framework of questions which were utilised as a guide for these interviews. During semi-structured interviews, this framework helped keep the research focused, yet allowed the flexibility to also use emerging ideas and themes that arose during interviews as further triggers (Merriam, 1998). The following interview framework thus allowed the researcher to "explore, probe and ask questions that elucidated and illuminated that particular subject" (Patton, 1990, p. 283).

Interview Framework

- Professional details
- History of involvement with clinical teaching
- Personal theories of teaching and how learning occurs, particularly in the clinical setting
- Support required for clinical teachers and clinical teaching
- Strategies used to foster positive clinical learning environments
- The nature and effects of change on the clinical setting.

Each participant was involved in three semi-structured interviews. The initial interview in August 1998, involved all participants and researcher in a discussion that explored their perceptions of the phenomenon of clinical teaching in a broad sense. This interview was followed in November 1998, by face to face, semi-structured interviews between the researcher and each of the participants. "Repeated face-to-face encounters between the researcher and informants directed understanding informants' perspectives of their lives, experiences, or situations as expressed in their own words" (Taylor & Bogdan, 1998, p. 88), and allowed beginning data analysis. These face to face interviews gave the opportunity for the researcher to present back to each of the participants some of the partially analysed data for comment and further examination. The researcher conducted further semi-structured

interviews on two occasions with half of the participants and the researcher in order to give opportunity for further comment and discussion of the data. In this way, fresh insights and understandings of the partially analysed data were obtained, leading to more meaningful discussion of major issues (Patton, 1990). These validating interviews were positioned in August 1999 after the process of participant observation and informal interviews were completed. This also responded to the ethical need to authenticate the analysis of the data and confirm meanings identified by the researcher as valid.

However, it has been suggested (Yin, 1989) that interviewing is fraught with danger for the novice researcher. The potential exists for the data to be subject to the bias of the researcher and interviewees, and to be less useful because of either the poor recall of the case by the interviewee or the inability of the interviewee to clearly articulate their experiences (Yin, 1989). Similarly, it is also important to remember that the data collected during interview represents the participant's unique perception and perspective of the events being discussed (Patton, 1990). Furthermore, the researcher is also bound by a selective perception of the situation. Consequently, several measures were employed to increase the accuracy of the data collected in this study. Semi-structured interviews were tape recorded in order to provide accurate data for analysis and allowed those present to focus on the discourse rather than the process. The potential exists for the presence of tape recorders to exert an influence over the spontaneity and full participation by interviewees in the interview process (Yin, 1989). However, audio recording advantages data collection by allowing the interviewer to listen and record contextual notes such as non-verbal behaviour and insights suggested by the interview (Merriam, 1998). Interview data were transcribed and edited by the researcher in order to begin a process of data analysis that identified emerging themes that could be presented to the participants for further discussion during subsequent interviews. This early form of data analysis was true to the research design and served to contribute to the validity of data collected. The issues of validity are more fully explored in section 3.9.

The Informal Interview

The second form of interviewing utilised was open-ended, unstructured (Burns, 1997), informal or conversational (Patton, 1990) interviews with each participant. The main advantage of the informal interview is its use in spontaneous situations which may yield rich detail about the interviewee's perception of the incident, during the "natural flow of the interaction" (Patton, 1990, p. 280). Informal interviewing allowed the researcher to take advantage of particular events and of the participants' availability and willingness to share insights into their understanding of clinical teaching. When used in conjunction with participant observation, informal interviewing constitutes an important method of collecting data (Patton, 1990) because the collection of data can occur naturally and conversationally during the observation of the participant in a particular situation. Open-ended interviewing further advantages participant observation by allowing indepth accounts of the experiences observed (Burns, 1997). By utilising informal, open-ended interviews with the participants, the researcher was able to follow up on previous conversations, clarify observations, or "go with the flow" and allow participants to lead the conversation into new areas (Patton, 1990, p. 282).

One strength of the informal interview is that it allowed the participant to direct and focus the interview so that each interview was able to change to be responsive to individual needs and contexts of the participant and situation (Patton, 1990). Thus, for example, a conversation with a participant following a particular incident allowed them to recall and reflect on feelings during the interaction. On occasions and when appropriate, further discussions with the participant often illuminated further insights into the understanding of clinical teaching, giving both participant and researcher the opportunity to build upon and corroborate previous data. Thus, participants were able to reflect upon previous conversations and offer further information. This also attended to the need to validate the data and make reflective data reciprocal.

Figure 3.2 provides an example of notes made on 16 September 1998 during one informal conversation with the participant Roslyn that followed up the participant observation session conducted earlier in the morning and detailed in figure 3.1.

Figure 3.2 Informal Conversation Notes

Informal Conversation Notes 16 Sept, 1998

Ward 2 Roslyn, (lunch with Ros)

Q   How did you feel when "A" was doing the dressing earlier?
Ros   It was pretty frustrating because she was so slow and uncoordinated, but I kept thinking, she's got to learn somehow, so she's got to do it herself, so I let her go until the end. Now she's done it. I'm pretty happy with that.

Q   Do you feel she was appropriately prepared for the dressing?
Ros   I asked her if she wanted to do it, she hadn't seen the patient before but we both wanted her to do as many dressings as possible because it's not that often you get those big dressings anymore, it's all done by laparoscopy now, so that was important for her to have a go even though it was a bit hard for her.

Q   How did she feel about it later?
Ros   I did have a talk to her about it, I said she did well to keep going, that she could have let me take over but now she's done it and she'll be right for tomorrow. So she was pretty happy in the end.

Q   What were you most happy with your role?
Ros   That I let her finish, she's really learned from this that she can do it herself. She was slow but her decision making was sound.

Q   What would you do differently next time?
Ros   I should have let her watch me first, I didn't realise she was so nervous. I also wish I had let her see it is important to talk to the patient, but it was hard because she (the patient) was so out of it and so I just wanted the "A" to finish and let the lady sleep.

The data obtained through these informal conversations were transcribed in order to facilitate coding and data analysis.

The number of informal interviews varied from participant to participant and was dependent on the time frame available and the willingness and availability of the participant to engage in discussion about observations made by the observer researcher. However, the researcher endeavoured to engage with each participant on at least three separate occasions so as to provide multiple opportunities for participants to interact with the process of data collection and initial data analysis. Interviews were concluded when preliminary data analysis yielded no fresh observations, leading the researcher to conclude that data saturation had been

achieved with each participant.

However, Patton (1990) suggested that it is this ability to respond to individual situations, which is also a source of weakness of the informal interview. The amount of data generated from numerous different conversations can become difficult to analyse for emerging patterns, particularly because informal interviews are not standardised. Nevertheless, while this unstructured nature of the interviews does have the potential to result in a large, divergent collection of apparently unconnected pieces of information, this form of data collection does allow the researcher to respond to the situation occurring, to the worldview of the participants and to their fresh insights into the situation (Merriam, 1998). Patton (1990) further noted that informal interviews may take more time to conduct and are more vulnerable to the conversational skills of the researcher. Descriptions of the informal interviews were noted as part of the field notes in as much detail as the time allowed by the context of the situation. Whenever possible, direct quotations, descriptions of the conversation and comments were made as close to the event as possible (Merriam, 1998). These recordings, along with the field notes and interview transcripts, constituted the major form of data collection from the participants.

3.6   RESEARCH METHODS: DATA ANALYIS

The interpretivist orientations of hermeneutic phenomenology and symbolic interactionism that underpin this research direct the creation of a collaborative partnership between researcher and participants. Such a partnership facilitates the reflective analysis and self-interpretation of data that leads to new understandings and new data to be incorporated into the research. This dialogue is consistent with the principle of the hermeneutic circle. This cycle of data collection, partial analysis, reflection and reinterpretation leading to further data, also contributes to triangulation. However, it has been acknowledged by Keeves and Sowden (1997) that substantial problems can arise in qualitative data analysis because there is no recognised structure to qualitative data collection, when compared to the formal standardised instruments tested in the quantitative scientific world. Consequently, they propose the development and implementation of a conceptual framework to describe the key factors in the investigation and the assumed relationships between them. It is argued

that a conceptual framework focuses the collection of qualitative data and guides the analysis of the evidence collected (Keeves & Sowden, 1997). The key issues relating to each of the research questions and the major three themes arising from data analysis serve to map key elements related to the phenomenon of clinical teaching and to identify relationships between these elements. Figure 3.3 is presented to describe the conceptual framework developed to provide a map of the phenomena being investigated.
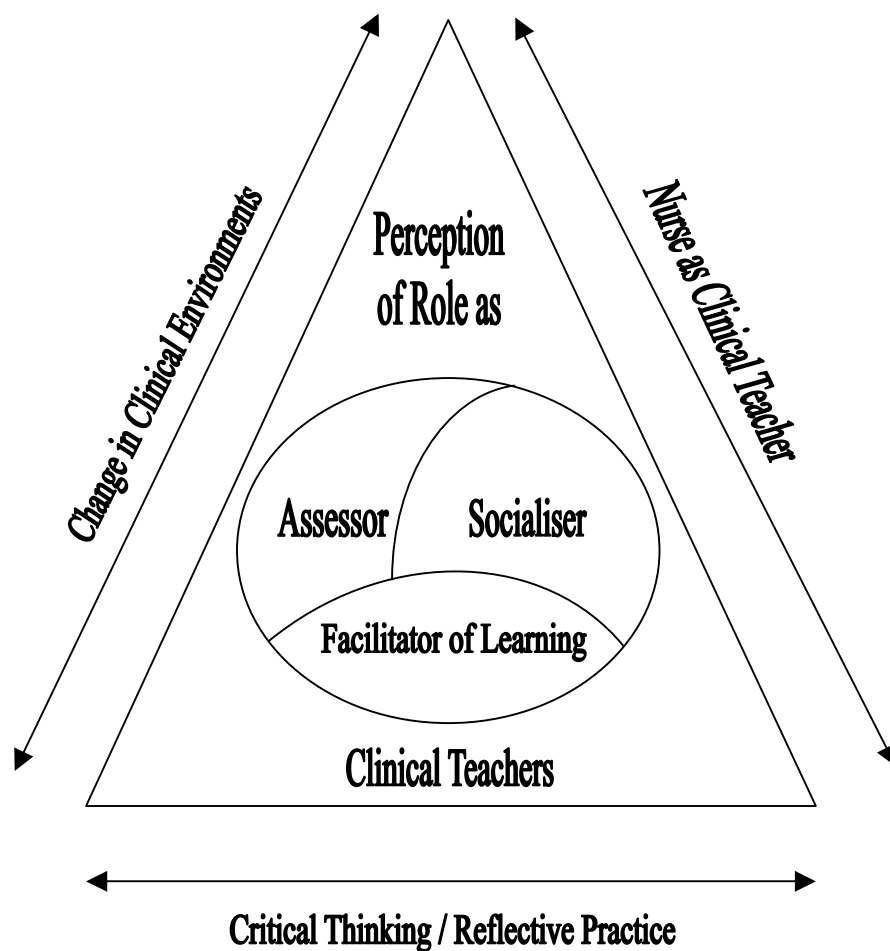
Figure 3.3 **Conceptual Framework of the Phenomenon of Clinical Teaching**

While the use of the conceptual framework provides some focus for the collection and analysis of data, the two research orientations of hermeneutic phenomenology and symbolic interactionism, also underpin and guide the process of data analysis in order to "treat the evidence fairly, to produce compelling analytic conclusions, and to rule out alternative interpretations" (Yin, 1989, p. 106). It was therefore appropriate that the technique of phenomenological analysis (Merriam, 1998) was utilised in order to analyse data. Phenomenological analysis explores the phenomenon from different perspectives in order to answer the question "how did the [participants'] experience of the phenomenon [of clinical teaching] come to be what it is?"(Merriam, 1998, p. 159).

Therefore Colaizzi's (1978) phenomenological data analysis framework was utilised in the analysis of the data. This framework is consistent with the orientations of hermeneutic phenomenology and symbolic interactionism which recognise that all participants contribute a unique interpretation of the phenomena to this study and requires that analysis procedures such as constant comparison with other voices and other data, be carried out to allow the researcher to question the evidence and their own interpretation of the evidence (Strauss & Corbin, 1994). Table 3.2 presents a summary of the principles of Colaizzi's (1978) data analysis framework.

1. Protocols – All of the participants' descriptions, or protocols, are read in order to acquire a sense of the whole.

2. Extracting significant statements - Significant statements and phrases that relate to the topic are extracted from each transcript.

3. Formulating meanings – The meaning of each significant statement is spelt out. Care is taken to ensure that the meanings arrived at are close to the original protocols. Creative insight is required to move from what the participants said to what they mean.

4. Clusters of themes – The above activities are repeated for each protocol and the aggregated formulated meanings are organised into clusters of themes that are common to all of the participants' protocols. The clusters of themes are referred back to the original protocols in order to validate them. If it is found that clusters of themes cannot be validated then the preceding procedures are re-examined or recommenced.

5. Exhaustive description – An exhaustive description of the investigated topic is integrated from the results of everything discovered so far.

6. Formulation of a description of the phenomenon in a statement of identification – An effort is made to formulate an exhaustive description of the researched phenomenon in as unequivocal a statement of identification of its fundamental structure as possible.

7. Final validating step – The researcher returns to each participant, and asks each participant about the validity of the findings. If any new data emerges at this point, then it must be worked into the final product of the research

Table 3.2 **Phenomenological Data Analysis Framework**

Based on Colaizzi, P. (1978). Psychological research as the phenomenologist views it. In R. Valle & M. King (Eds.), *Existential-phenomenological alternatives for psychology* (pp. 48-71). London: Oxford University Press.

The stages of data analysis and how they were used in the study will now be considered in more detail.

Stage 1   Transcripts of interviews, observations and field notes, or protocols, were read during the process of data collection in order to acquire a sense of the whole.   Significant statements and phrases that related to the topic were extracted from each transcript, which were returned to participants for elaboration during later interviews.

Stage 2   The meaning of each significant statement was spelt out. Care was taken to ensure that the meanings arrived were as close to the original data. This process was repeated for each transcript and the aggregated formulated meanings were organised into clusters of themes that were common to all of the participants' meanings. The clusters of themes were referred back to the original data in order to validate them.   Ten themes were identified in the beginning stages of data analysis: Socialisation, Learning, Clinical Nurse preparation, Assessment, Reflective practice, Expectations of students, Impact on life of the RN, Expectations of clinical teaching and learning, Ward perceptions and Beliefs of self as clinical teacher. Code words were written in the right hand margins of the transcript sheets as illustrated in Figure 3.4 below, taken from the second round of semi-structured interviews.

_____

<u>Interview Transcript</u>	<u>Coding</u>
I think you've got to find out what their level of knowledge is to start with and go from there, whether it's in regard to taking obs for example, do they know how to, do they understand what the measurements mean, building from the basics upwards. And whether you do that on a one on one basis or in a group, it's individual as to how people learn. Some people prefer group work and some people prefer one on one, you just need to work it out with them and to ask them which way they learn better. (Barbara)	Assessing student Learning needs Beginner's learning needs Skills based Assessing, understanding students Learning theory- basics to complex Teacher directed activity Difference in learning styles Individual learning styles Acknowledging learning differences Allowing students to direct learning Collaboration with students
I think they learn by example too, I'm sure that if you see someone doing something bad or some way that they haven't seen before, they are going to pick up on it, and say "I saw that nurse doing that and why is she doing that". Because they really do pay attention even though you mightn't think that they are watching you doing things. So you really do have to be on the ball the whole time setting a good example because the visual cues are what they pick up a lot and learn from. (Jeanne)	Learning by example Being a role model Learning from mistakes Variance in observed practice Role model Questioning staff practices Learning by observing Role model – being 'on the ball' Learning by watching Need to be competent practitioner

Figure 3.4 Coding of Interview Transcript

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<u>Stage 3</u>   An exhaustive description of the investigated topic was integrated from the results of analysis so far. The processes of coding, writing memos, summarising and diagramming (Keeves & Sowden, 1997) were used in order to organise the analysis of the data. Once significant clusters of themes were extracted, memos were written to record changing ideas about the data that emerged during the process of analysis. The initial ten themes were returned to each participant in subsequent interviews and conversations in order to validate their wording and meaning. As a result of ongoing data analysis, attempts were continued to formulate an exhaustive description of each theme in as unequivocal a statement

of identification of its fundamental structure as possible. . This allowed the researcher to note areas that needed further development or those that were overwhelmed with data and in need of re-examination. This resulted in the collapsing of several themes to a smaller number of core themes, systematically relating them to other themes, validating those themes and filling in themes that needed further refinement and development (Strauss & Corbin, 1994) as illustrated in the coding notes in Figure 3.5 below.

Encompasses:
Beliefs about the role of the student / expectations of the student
Expectations of RN's to be involved in clinical teaching, from within own ward, the hospital, and university

Links to Learning by Doing, Fitting In, Learning from Experience, Impact of change on RN

3/1 Ward in particular and the hospital in general doesn't support RN's in role as Clinical Teacher   feel overloaded   Link to changes in skillmix / busyness
3/2 Support from the uni
3/3 Recognition
3/4 Knowing the curriculum
9/10 majority of staff appreciates that not everyone is at the same level   Learning from experience

3/5 Support for preceptor
3/7 Facilitator's role in CT - teaching the student and the facilitator.
3/5 CT seen as more positive if support from the uni increases- if facilitator (outside CNT fits in) ie is good, having students is OK, but if facilitator just dumps students then CT is a nuisance   Link to Theme- Fitting In.
1/7 uni hasn't prepared students
1/9 Own experiences as new grad more supportive link to theme Learning from experience
1/13 Personality clashes- judgemental-critical Horizontal Violence Link to Fitting In
1/14 stress of ward related to skillmix and increased busyness-Link to Learning by doing/ Impact of change

9/12 culture of ward depends on RNs level of confidence and number of students-can't put students with new grad as she would be intimidated by students' question when she is still a novice herself.

Figure 3.5   **Coding of Theme 3: Expectations of role of clinical teacher.**

Stage 4   In the final validating steps, the researcher returned analysed data to each participant to check the validity of the findings. It was the reinterpretation of emerging themes, important to the process of data analysis in hermeneutic phenomenology and symbolic interactionism, which gradually allowed the researcher to clarify relationships within the data. Discussion of the findings began through these relationships. Through this process of data analysis, an indepth interpretation of the lived experience of the nurses participating in this study was sought.

3.7   RESEARCH PARTICIPANTS

The six participants in this study were selected from experienced nurses working in a large metropolitan Brisbane hospital, who were involved with the clinical teaching of student nurses enrolled in the undergraduate BN at ACU. Students were placed at the hospital as part of their clinical experience. The criteria set for the purposive sampling of participants is as follows:

- Registered nurse
- Minimum of three years clinical experience
- Current employee with a hospital which placed students for their clinical experience
- Previous experience of, and involvement with, clinical teaching of undergraduate ACU, BN students.

The case study was bounded to include only those nurses with at least three years clinical experience in order to ensure that the participants possess a reasonable degree of clinical expertise. This decision was based on the premise that experienced nurses are more appropriate professional and clinical role models for the students and thus may be able to provide greater insights into their role as clinical teachers of students. Nurses who met the criteria were subsequently approached by letter and invited to participate in the research. The invitation outlined the purpose of the study, the criteria for participation in the study and explained the research design and data collection methods to be employed. The length of the study, steps to be taken to ensure confidentiality and anonymity of participants,

expectations of the study and how findings would be communicated to the participants, hospital, university and wider community were also addressed. Participants were advised that ethical clearances would be obtained from both the participating facility's Research Ethics Committee and the ACU Research Projects Ethics Committee. Details of the ethical clearances obtained from both the University and the site of employment of the participants, including both consent form and Letter of Information to participants have been included in Appendix 1.

The time period was chosen because the researcher had a six month period of study leave from July 1998 to December 1998, offering an ideal opportunity for the researcher to be able to enter the field during this time and commence data collection. While the students' experience of clinical placement is beyond the scope of this study, this time period also allowed the researcher to observe some interactions between students and experienced nurses participating in the study. Six clinical nurses subsequently responded to the invitation to be involved in the study and an initial interview was held to begin to establish a relationship and rapport between researcher and respondents. Table 3.3 provides further details concerning each participant's area of clinical expertise and previous experience with clinical teaching.

Name	Age range	Clinical practice area	Clinical teaching experience
Alison	25-35 years	8 years acute care – surgical nursing. Level 2 RN. Responsible for monitoring clinical teaching in ward.	Working in preceptorship relationship with students. Has also acted as a buddy nurse to students.
Leisa	25–35 years	10 years acute care – spinal injuries / rehabilitation. Level 2 RN. Responsible for monitoring clinical teaching in ward.	Working in preceptorship relationship with students. Has also acted as a buddy nurse to students.
Roslyn	25-30 years	4 years acute care - surgical / medical nursing. Level 1 RN.	Acting as a buddy nurse with students. Has also preceptored students.
Barbara	35-45 years	20 years acute care - mental health nursing. Level 2 RN.	Acting as a buddy nurse with students. Has acted as the university's Clinical Nurse Teacher to supervise groups of students.
Kim	25-35 years	10 years acute care – oncology nursing. Level 2 RN.	Working with students in preceptorship relationship.
Jeanne	25-30 years	4 years acute care - medical nursing. Level 1 RN.	Acting as buddy nurse with students. Has worked in preceptorship relationship with students.

Table 3.3   Summary of Participants' Details
Note: Participants' names have been replaced by pseudonyms.

Interview times took into account the variables impacting on the research context and the availability of the participants. Information about the process of data analysis was discussed with each participant in order that they understood that interviews would be audiotaped when possible and assisted by field notes. Full access to transcripts of the taped interviews and field notes were made available to all participants in order to confirm the accuracy of the data and to give participants the opportunity to reflect on and clarify interview transcripts. This provided further important evidence as participants reflected on and validated initial insights (Patton, 1990).

However, while the above discussion offers some insights into how issues which may be potentially encountered during data collection may be understood, a number of unforeseen circumstances occurred which impact on the collection of data. Because of their unusual and perhaps unique nature, it appears of value to the research to examine them here in order to consider the effects which these circumstances exerted on the participants and the context being observed.   As these events were of a personal nature, it appears more appropriate to analyse the implications in the first person.

3.8   ROLE OF THE RESEARCHER

As the purpose of this research was to explore how experienced nurses perceive their role as clinical teachers, a qualitative approach represented the most appropriate theoretical perspective. The personal background of the researcher is thus of interest to the research, particularly when this may exert some influence on the research. This approach also rests within the assumptions of interpretivist theories which recognise that inquiry is always influenced by the values of the researcher and respondents (Candy, 1989, p. 4). Kneller (1984), whose principles for hermeneutic inquiry make explicit the importance of acknowledging the situational or relational tradition of both participant and interpreter, supports this position. Patton (1990) further acknowledges the need to attend to the perspective or standpoint of the researcher as well as that of participants, because of the influence of the researcher's context or viewpoint on their interpretation of the data.

As described in section 1.2, I have been a lecturer in nursing since 1992 and clinical coordinator since 1999. In both these roles and in my previous clinical work history as a paediatric nurse and a hospital-based nurse educator, I have developed broad links with a number of hospitals and clinical agencies, including the site of this research. Indeed, it is this perception of myself as not only a lecturer but also an experienced nurse, which could reasonably be expected to increase the research participants' acceptance of my presence in the wards as a colleague, as nurse and as lecturer with a particular interest in clinical teaching. However, in my private life, I have been married to a high profile politician for twenty-six years. Prior to the commencement of this research, my husband, a member of

the State Legislative Assembly, became the Health Minister, then Leader of the Opposition in state parliament. As a result of an election, he was sworn in as the Premier of the state just four weeks prior to my planned period of participant observation.

Subsequently, my appearance in the hospital wards was not as a lecturer or even as a nurse, but as the newly elected Premier's wife. While staff tried to receive me as colleague, I was frequently aware that patients, nursing personnel, medical officers and ancillary staff viewed my presence on the wards with some ambiguity. Numerous media interviews in which I was asked about my perception of my role as the 'First Lady' of the state perhaps contributed to this ambiguity. It was certainly regarded as 'unusual' for the wife of the Premier to have her own career, particularly one that encompasses full-time work, rather than accept the expected honourary roles of patron and charity worker. As a consequence I was often sought out by past colleagues or patients, loudly and effusively congratulated and asked whether this meant I would now 'give up work' or 'would I be influencing or advising my husband on health policy issues'. This latter comment usually came from medical friends, nurses or management personnel. In the existing climate of rapid change in health care, was often accompanied by suggestions about the direction which the state's health care policies should take.

The effects of this perception of my role were at times difficult for both the research participants and the students to comprehend and on occasions I observed their behaviour to change markedly. While Merriam (1998) notes that participants who are aware that their actions are being observed will tend to adjust and alter their behaviour to a more acceptable manner, my perception was that participants and students were unduly influenced by this change in the perception of my role. On occasions I noted that they appeared uncomfortable with my presence and the attention which this occasioned.

On reflection of this situation, my response was to delay the process of participant observation for a period of weeks to allow some time to elapse after which I anticipated that my presence on the wards would be less of a novelty. To an extent this appears to have been a reasonable strategy, however it is difficult to ascertain the residual effects which my role as wife of the Premier exerted on the environment being observed. I did and continue to take on a public role in this capacity. I am patron of a number of organisations and frequently speak at public functions, particularly in relation to raising the awareness of

mental health and rural health issues. Data collection was thus delayed for a period of four weeks and extended over a longer period. Reflection on this dilemma has lead me to conclude that the strategy to extend the time frame for data collection did assist to 'normalise' the perception of my role from wife of the Premier to nurse, lecturer and researcher.

One major concern that I held was that the research participants and students would view me as an authority figure. Given that my husband was now responsible for the direction of the state's health policies, I anticipated that participants might find it difficult to speak openly and frankly about their perception of the effects of change on their health care environment. However, as time passed, my relationship with the participants 'normalised' so that we regarded each other as colleagues both interested in understanding their perspective of clinical teaching. While the participant observer is expected to stay "sufficiently detached to observe and analyse" (Merriam, 1998, p. 103), my experience in this research was that I needed to establish a degree of familiarity and sense of collegiality with the participants to allow them to reconceptualise my role as co-researcher. The extent to which I was able to achieve sufficient detachment that allowed objective observation and analysis will be judged by the reader's perception of the description of the research. The extent to which this research resonates with the reader's own experience of clinical teaching will indicate whether, as researcher, I have been able to identify the effects of this situation on the process of data collection and subsequently account for them in interpreting the data.

The process of recording my reactions to events occurring in the field and subsequent reflection on these observations became an important method by which I was able to acknowledge and understand these experiences. The act of reflection on experiences past, of describing lived experiences is a fundamentally self-interpretative act – in order to reflect on the meaning of past experiences, the participant must engage in self-interpretation and analysis. Patton (1990) suggests that the researcher's insights, reflections and ideas about the situation thus become an important part of the data base contributing to the validity of qualitative analysis.

3.9   ESTABLISHMENT OF VALIDITY

The issue of achieving validity in qualitative research is not as clear-cut or easily defined as in quantitative research, in which the focus is on the measuring instrument. "In qualitative research *the researcher is the instrument*" (Patton, 1990, p. 14). It is therefore the skill, competence and rigour of the interviewer in qualitative research, which is vital in establishing validity in qualitative research. Qualitative research is concerned with descriptions of phenomena from the unique perspective of the respondent (Janesick, 1994; Patton, 1990). Validity of these descriptions is determined therefore by the 'credibility' of the explanation given of the situation (Janesick, 1994). Credibility refers to the truthfulness of the data. It is enhanced when strategies are put into place to check on the inquiry process and to allow the direct testing of findings and interpretations by the human sources from which they have come (Guba & Lincoln, 1994). Three principles guiding data collection (Yin, 1989), were utilised in order to deal with the problems of establishing the validity of a case study approach.

1.   Using multiple sources of evidence

Triangulation is generally regarded as a process of using multiple sources of data in order to clarify meaning and perception, and to verify the reputability of the interpretation (Stake, 1994). The use of multiple sources of data in case study allows the researcher to present a more convincing finding or conclusion. "A multimethod triangulation approach to fieldwork increases the validity of evaluation data" (Patton, 1990, p. 245). Furthermore, the use of multiple methods of observation strengthens the findings and relationships advanced because the different perspectives obtained thus provide support for the findings (Keeves, 1997). The multiple sources of data collection employed in this study have been outlined in section 3.5. They include semi-structured interviews, conducted with all participants at the beginning of the study and then with smaller groups of participants throughout the study. These interviews were tape recorded and transcribed. Secondly, informal conversational interviews on a one to one basis with participants and relating to the situation being observed, were similarly noted as descriptions, direct quotations and researcher comments that were recorded as soon as possible. Finally, participant

observation, where extensive field notes were recorded by the researcher and transcribed as soon as possible to reduce loss of data, was employed.

During subsequent semi-structured and informal interviews relating to the research questions, participants were asked to clarify and reflect on evidence transcribed from earlier interactions. In this manner, participants were able to corroborate or clarify perceptions and interpretations, thus contributing to the validity of the evidentiary base. This triangulated interpretation reflects the research as a process that is contextual, "relational and interactive" (Denzin, 1997, p. 319) and incorporates all understandings of the phenomena which the multiple methods of data collection reveal. This process of corroboration also served to ensure that multiple analysis or 'analyst triangulation' was achieved, thereby increasing the validity of the data that later formed the basis for further guided interviews. The hermeneutic approach underlying this research design also supports triangulation as the appropriate way of bringing researcher and participants directly into the circle of interpretation (Denzin, 1997).

It is acknowledged (Patton, 1990) that because individual perception is not a static and fixed construct, triangulation will not always yield exact, consistent replicas of the data. Certainly, the object of this naturalistic inquiry was not to seek the objective truth about clinical teaching. Rather, its purpose was to gain an understanding of clinical teaching that is grounded in the perspective of the participants. This is consistent with Denzin's advice (1997) that every method will reveal a different slice of the phenomena, however, triangulation, when combined with interviewer rigour will serve to increase the interpretative base of the case study. Furthermore, using a combination of participant observation, semi-structured interview and informal interview increased the validity as the strengths of one method can compensate for the weakness of another approach (Marshall & Rossman, 1995).

2.   Creating a Case Study Data Base.

The creation of a formal, retrievable data base in which all evidence that is collected during the course of the research is stored, served to increase the validity of the case study (Yin, 1989). Separating the evidentiary base from the final report of the study allows for easier access to, and subsequent review of, the data by other researchers. Therefore an evidentiary

data base was maintained throughout this study, comprised of the researcher's transcribed field notes, interview audiotapes and interview transcription. By incorporating all data into the case study data base, converging evidence could be more clearly interpreted, therefore increasing internal validity (Anderson, 1990).

3.   Maintaining a Chain of Evidence.

Any external observer of a case study should be able to follow a clear chain beginning with the collection of evidence from the research questions through to the findings or conclusion of the case study. By ensuring that the evidence which is collected was accurately portrayed and appropriately examined in order to reach the conclusions, the researcher has achieved construct validity and increased the overall quality of the case (Yin, 1989). The establishment of such an audit trail also served to indicate a strong correspondence between the result, the literature reviewed or knowledge already established about the phenomena (Keeves, 1997). The extent to which a clear chain of evidence can be achieved during this study appears to depend to a large degree on the richness and accuracy of the case study database. Throughout the process of data collection, sufficient attention was paid to the maintenance of the database in order to facilitate the establishment of a chain of evidence. This increased internal validity as the case study itself strives to follow what is happening in the studied situation (Anderson, 1990). This was of particular usefulness in allowing the researcher as well as participants to follow the circular trail of evidence which develops as preliminary analysis of the interview data is presented back to participants for further comment which then forms part of the next phase of data analysis.

While serious attention was paid to increasing the usefulness or credibility of the research though establishing the validity of the research design, Janesick (1994, p. 21) observed that the "traditional" views of generalisability and validity often limited researchers interested in "questions of meaning and interpretation in individual cases". She continued that the true value of case study lies in its very uniqueness. It can be concluded that the real validity of this study thus lies in its usefulness and extent to which it resonates with the experience of the reader. In addition, the process of giving back the case study to the participants for further reflection and reinterpretation also contributes to the validity of the study by ensuring that dialogue is maintained between the researcher, the participants and the data.

3.10   ETHICAL ISSUES

Questions about the ethical conduct of research have been challenged by arguments that all decisions about research design are inherently contaminated by the researcher's own personal and ethical position (Archbold, 1986). Patton (1990) similarly expresses a concern about the extent to which the researcher's biases or preconceptions may influence data collection, analysis and reporting. It would seem necessary therefore, that the researcher attempt to overcome this inherent contamination by considering ways in which its influence can be reduced or monitored. These concerns can thus be examined from an hermeneutic phenomenological perspective to explain that the researcher, as a human being, will always be in "a circle of understanding" in which something is understood because of pre-existing beliefs and experiences (Plager, 1994, p. 72).

The researcher brings to this study a preunderstanding of nursing, of teaching, of being a student and of being a nurse, which gives a shared background with the participants. The researcher has sought to overcome any misunderstandings by clarifying these preunderstandings personally and with participants prior to the study. This bracketing or setting aside of the researcher's own preconceptions of clinical teaching was also congruent with the process of phenomenological analysis of data (Merriam, 1998). The reaction of participants and other staff to the presence of the researcher may have also influenced the research (Patton, 1990). Certainly, in this study, participants and other staff may have sought to demonstrate an overly positive clinical teaching environment and exemplary behaviour towards the students, resulting in a 'halo' effect. On the other hand, the presence of the researcher may have caused increased anxiety and stress in participants who fetl that their nursing care was being observed and evaluated.

Particular issues relating to role of the researcher have been described in section 3.8. These effects may have been overcome by the fact that the researcher is also a nurse, albeit a university lecturer, with a long and deep interest in understanding the process of clinical teaching. These personal beliefs were expressed and acknowledged at the outset of the study

in the expectation that such full and complete disclosure would assist the researcher establish credibility. The establishment of credibility as a nurse and educator also served to increase the participants' perception of the researcher as competent to be investigating the phenomena. Further competence was achieved by following the procedures outlined in section 3.9 relating to validity that were necessary to establish quality of data analysis (Patton, 1990).

The strength of the researcher – participant rapport may have also contributed to a shift in the personal and ethical position of the researcher. Strauss and Corbin (1994) noted that there was nearly always such a degree of interaction between the participants and researcher as to result in some degree of reciprocal shaping. During this study, the process of data collection and data analysis has almost certainly resulted in a change of understanding of clinical teaching by both researcher and participants. It has been advised by Patton (1990) that such personal insights which develop through involvement and experience with the research, form an important and rich source of data themselves. Thus, in this study, shifts in attitudes were fully recorded and accepted as part of the data to be interpreted in Chapter 4.

3.10.1 Ethics Clearance

In accordance with the requirements of the respective Research Ethics Committees, participants received material to read outlining their involvement, rights and responsibilities in order to gain consent. Prior to data collection, the participants were each advised, both verbally and in writing, that they were free to withdraw from the study at any time and confidentiality would be maintained. Ethical approval for this research was obtained from both the ACU Research Projects Ethics Committee and the participating facility's Research Ethics Committee and made available to all participants. Copies of the ethics application and letter to participants are provided in Appendix 1. The issue of participant anonymity was overcome by using pseudonyms in order to protect their identity. This issue was taken seriously in this study in order to gain full cooperation and trust of the participants, who may have otherwise been reluctant to reveal their personal reflections and beliefs. Participants' were informed of their right of access to the accounts of their informal conversations and guided interviews. This access formed an important

part of the phenomenological technique of data analysis utilised in the study, therefore access to this data was inherent in this process. Such free access to their accounts may also broaden the perspective of the individual participant inside the case, so that they may begin to see the broader view from the researcher's outside view of the site. It has been suggested (Everhart, 1977) that this may overcome the problem created by the insider's overfamiliarity with the norms and practices of their organisation, so that they gain some of the outsider's freshness to the environment and the ability to still be surprised by differences in the voices of the participants.

On most occasions interviews were conducted at times to suit the participants' work requirements. Informal, unstructured interviews which frequently followed periods of participant observation, were usually able to be conducted in a quiet area of the ward to allow participant to return to their ward area if required. Semi-structured interviews were conducted in a room away from the ward area to reduce the amount of interference from the ward situation and to establish a quieter reflective environment. This appeared to have been useful as participants reported feeling relaxed and thus described their perceptions without being pressured by the ward environment.

3.11   DESIGN SUMMARY

The general approach and rationale for the research design that is presented and discussed in Chapter Three appears to be consistent with the humanist philosophical beliefs of nursing underlying this research. A qualitative research approach is most congruent with the research, which is concerned with the nature of what it is to be human (a nurse), the nature of change in the nurse's environment and how the two interact.

Three research questions emerge which focused the research.

Question 1   How do experienced nurses create positive clinical learning environments for student nurses?

Question 2   How do experienced nurses resolve the often-contradictory demands of nursing students and those of the practice setting?

Question 3   How do changes in the health care environment impact on the experienced nurse's role as a clinical teacher?

The research design was interpretivism incorporating the research orientations of hermeneutic phenomenology and symbolic interactionism. A case study approach was adopted because it allowed the study to focus upon a particular event, clinical teaching, in a defined boundary. The relationships and events occurring between the individuals participating in this study can be viewed each as single cases and as linked events. Strategies were outlined to account for issues of validity, particularly as they pertain to qualitative research. As a consequence, Table 3.4 presents an overview of the research design to assist the reader follow the study.

Research Question One	Interview Guide	Sources of Data	Time Frame
How do experienced nurses create positive clinical learning environments for student nurses?	• How would you describe your philosophy of nursing? • What are your beliefs about teaching and learning? • How would you describe the learning culture within your working environment? • Describe yourself as a clinical teacher. • What has been the most satisfying aspect of clinical teaching? • When have you been most dissatisfied with clinical teaching? • What motivates you to be involved with clinical teaching?	**Literature Review**	▲▼ January 1997 to March 2000

Research Question Two	Interview Guide		
		Data Collection:	
		Establishment of relationship with participants	July 1998
		Preparation of interview guide	July 1998
		First semi-structured interview with whole group	August 1998
How do experienced nurses resolve the often-contradictory demands of nursing students and those of the practice setting?	• How do you understand the dichotomy between meeting the service needs of the clinical setting and meeting the educational need of the undergraduate student nurse? • What are your beliefs about the role of the student? • What are your expectations of the student? • What support is offered to you as a clinical teacher? • What support would assist you in clinical teaching?	Participant observation and Informal interviews	▲ August 1998 to ▼ November 1998
		Early data analysis and preparation of themes to be presented at final validating interviews	▲ September 1998 to ▼ November 1998

Research Question Three	Interview Guide		
		Further semi-structured interviews	November 1998
How do changes in the healthcare environment impact on the experienced nurse's role as a clinical teacher?	• What changes are occurring in your practice context? • How have these changes impacted on your nursing practice? • What has been the impact of these changes on your role as a nurse, as a clinical teacher? • What pressures are there on you to be involved in clinical teaching, from within your own ward, the hospital, the university?	Continuation of data analysis and Final validating steps with participants	November 1998 to August 1999
		Data analysis and synthesis	January 2000 to October 2000

Table 3.4   Summary of the Research Design

CHAPTER 4:   ANALYSIS AND DISCUSSION OF FINDINGS

4.1   INTRODUCTION

The purpose of this chapter is to present an analysis and subsequent discussion of the data gathered in order to explore how experienced nurses perceive their role as clinical teachers. The study was set within the clinical environment of one healthcare agency during a time of change within nursing. The six research participants were all experienced nurses within the healthcare agency and regularly involved with clinical teaching of undergraduate students as part of their role as nurses. A case study approach served the research purpose best because it seeks to understand parts or patterns within cases by understanding the inter-relationships between parts and thus how they form a whole (Sturman, 1997). Data were collected through a series of semi-structured interviews, informal interviews and participant observation supported by field notes and the researcher's diary.

The major research questions that focused this study were:

Research Question One:

> How do experienced nurses create positive clinical learning environments for student nurses?

Research Question Two

> How do experienced nurses resolve the often-contradictory demands of nursing students and those of the practice setting?

Research Question Three

> How do changes in the healthcare environment impact on the experienced nurse's role as a clinical teacher?

Because of the theoretical framework that underpins the research design it seemed appropriate to utilise Colaizzi's (1978) phenomenological analysis framework in the analysis of the data. This was consistent with the intent of the two major approaches which guide this study, hermeneutics and symbolic interactionism, to direct the analysis to examine the nature of the environment in which the six participants are embedded in order to explain their perceptions of their role as clinical teachers. This was important for it allowed the impact of the context within which the participants are situated to become apparent.

In order to increase familiarity with the participants, Table 4.1 offers a description of the working history and clinical context of each of the six participant nurses.

Name	Nursing Qualifications	Clinical Practice Area	Experience with models of Clinical Supervision
Alison	Hospital based certificates in general nursing, and maternity.	8 years acute care – surgical nursing. Level 2 RN.	Works as preceptor with final semester students. Occasionally acts as buddy nurse to students.
Leisa	Hospital based certificates in general nursing and rehabilitation.	10 years acute care – spinal injuries / rehabilitation. Level 2 RN.	Works as preceptor with final semester students. Occasionally acts as buddy nurse to students.
Roslyn	University graduate with BN.	4 years acute care - surgical / medical nursing. Level 1 RN.	Regularly acts as a buddy nurse with 1st, 2nd and 3rd year students. Has also preceptored final semester students.
Barbara	Hospital based certificates in general nursing and mental health nursing.	20 years acute care - mental health nursing. Level 2 RN.	Usually acts as a buddy nurse with 2nd and 3rd year students. Has acted as the university's CNT to supervise groups of students.
Kim	Hospital based general nursing certificate., Diploma in Oncology Nursing	10 years acute care - oncology nursing. Level 2 RN.	Works with 3rd year students in preceptorship relationship.
Jeanne	University graduate with BN	4 years acute care - medical nursing. Level 1 RN.	Regularly acts as a buddy nurse with 1st, 2nd and 3rd year students. Has also preceptored final semester students.

Table 4.1   Summary of Participants' Clinical Teaching Experience

4.2   PRESENTATION AND DISCUSSION OF FINDINGS

The focus of this analysis and discussion relates to the perceptions of these six nurses of their role in the clinical education of undergraduate student nurses. This study was embedded in the assumption that each of the six participants was committed to clinical teaching of student nurses as they undertake their clinical practice within healthcare agencies. This assumption was proven correct as all participants stated that they enjoyed clinical teaching and regarded this as an important part of their role as a nurse. However, the context in which they practice is one that is characterised by contradiction and change. This is consistent with the broad tradition of nursing as a "dynamic dialectic of contradictions" (Hodges, 1997, p. 350). Through a comparative analysis of the data a number of major themes emerged. The major themes were:

- Role as Facilitator of Learning
- Role as Socialiser
- Role as Assessor

The following inter-related themes also emerged through the analysis.

- Learning as Task Mastery
- Learning from Experience
- Fitting In
- Learning the Realities of Practice
- Being a Gatekeeper
- Dialogue in Assessment
- Change in the Clinical Learning Environment

These themes provided some orchestration in order to discuss the findings. The following Table 4.2 is therefore offered as a "road map" to guide the reader through the chapter.

<table>
<tr><td colspan="2" align="center">**Presentation and Discussion of Findings**</td></tr>
</table>

4.3   Role as Facilitator of Learning

- Learning as Task Mastery
- Discussion of Learning as Task Mastery
- Learning from Experience
- Discussion of Learning from Experience

4.4   Role as Socialiser

- Fitting In
- Discussion of Fitting In
- Learning the Realities of Practice
- Discussion of Learning the Realities of Practice

4.5   Role as Assessor

- Being a Gatekeeper
- Discussion of Being a Gatekeeper
- Dialogue in Assessment
- Discussion of Dialogue in Assessment
- Change in the Clinical Learning Environment
- Discussion of Change in the Clinical Learning Environment

4.6   Summary of Findings

Table 4.2   Sequence of the Presentation and Discussion of Findings

4.3   ROLE AS FACILITATOR OF LEARNING

This theme describes how participants perceived their role in facilitating learning. Their role was to assist students learn the basics of nursing. However, participants did not describe their beliefs about teaching and learning as formal theories. They did describe their facilitation of learning in ways which reflect a number of popular approaches to learning such as, learning as task mastery, role-modeling, reflective practice, principle-based learning

and experiential learning. In reality there remain differences in how they interpreted these common philosophies.

4.3.1　　　Learning as Task Mastery

Most participants generally adopted a task mastery approach to learning. For them, learning was a process of "practising" until the student is comfortable with the procedure. Leisa expressed annoyance with students who believe that "once they've done it once they know how to do it and so they don't want to do it anymore." Similarly, Kim reported frustration with students who "will say, oh no, I've done showers, I don't need to know how to do them again." Leisa's belief was that students need to be confident with the basics of patient care:

> The hard thing for me is to try and get across to them that the more they do
> it, the more comfortable they'll be so that when they actually graduate
> that's not going to be a stepping stone, they're already comfortable with
> doing observations etc. I just think that a lot of the attitudes that they come
> out with is that once they've done it once, they know how to do it and so
> they don't want to do it anymore. It's hard to get across to them that I've
> probably done more blood pressures in my life but it doesn't mean that
> I'm going to stop doing them, you've still got to do them everyday (Leisa).

Similarly, Alison used a list of clinical learning opportunities that have been developed by her unit to direct the students' learning towards tasks that they may not have yet achieved. Students were encouraged to "book themselves in" to complete a procedure, so that she knew which skill each student had attempted. While this belies the principle of holistic patient care, Alison rationalised her approach by saying "I think you have to be honest with them and say, you've got to achieve these competencies to pass your prac otherwise you don't move on." Leisa clearly termed her philosophy of learning as "learning by doing". She described one example of a final year student who was reluctant to take on his own patient load in the unit:

> For the first days I put him up in acute care with two of our level 2s (experienced clinical nurses) and they said, well what do you want to do, would you like to work alongside one of us or take a patient. And he said I'd just watch. Well there's no watching here, there's only doing in our ward. So he didn't like that but we let him go and just work along for a couple of days and then we said to him on the Wednesday, tomorrow you'll be taking a patient load, you'll be taking room 1, and he just didn't even show up the next day (Leisa).

Incidents like these reinforced for Leisa that students need to be encouraged to take a patient load, rather than watch or observe a nurse, otherwise they will not be learning. However, Leisa's views of learning as doing, influenced her to note that "I think how much they learn depends a lot on the students, how much they will get involved in what we are doing. Because a lot of times if we get busy they can be forgotten, but if they pitch in like everybody else, I think they learn a fair bit." Jeanne, who actively encouraged students to attempt procedures that they may not have learned, also shared this belief that students learn best by doing:

> I say, do you want to put a catheter in, despite whether they're second year or third year. They say, oh I haven't put one in before, I say, that's all right and I always get them to do it. I say, if you just watch me now, there may not be another opportunity on this prac, trust me I'll be there, we go through like a little step process, and we talk about it first. We then go and set up and I talk all the way through, then they actually do it. And they'll say, now what do I do? And I say now you attach this or do this, and so by the end of the catheterisation they've done it, they've learnt from it and for next time they are going to be so much more advanced with it (Jeanne).

This approach was adopted because it may be months before students had another opportunity to undertake a similar procedure and:

> if you keep saying every opportunity you'll just watch this one, you're never going to be able to do it. I say let's do it together, they're nervous as all hell, but then they get over it and they love it and they say oh thanks for that. I think one took about 50 minutes but I don't care. Anything like that, the same as naso-gastric tubes they say, I haven't put one in, I say that's okay we'll do it together, but I always make them do it (Jeanne).

However, it appeared that this focus on the students' achieving mastery of tasks took precedence over holistic patient care or patient comfort. Jeanne also undertook to expose

students to learning experiences which they might not "see again", even if it involved the student leaving the unit:

> Even if it's not on the ward, I try to get them to go because it may be the only opportunity to learn something. Whether it's tracheostomy changes or just different things happening that the student might not ever get the chance to see again. Sometimes they may just also want to do the exciting things and they are not prepared to do the basic nursing care, which is a large part of your work. As much I encourage them to go and see the tracheostomy changes and things, they really need to practice doing dressings, doing the medication round, learning what medications they are giving out. In some way that is probably just as much our fault because it is our expectation. They may see it differently, but we sometimes encourage them to see the exciting things (Jeanne).

Thus Jeanne acknowledged that while she believes the student's focus should be on learning the basics, there was a conflict for her that, as university students, these students were not exposed to as many clinical experiences as she was in her training. As a consequence, she still tried to make sure they "saw" as much as possible.

While Alison demonstrated a commitment to task mastery, she also asked students to take some responsibility for their clinical learning objectives so that she could direct their learning into areas in which students thought they were "weak". For Alison learning was then a process of "working" to achieve the standards that demonstrated to her that the students "knew what they were doing". Alison's own experience as a hospital-trained nurse also influenced her belief that university students were not receiving as many clinical opportunities as she was. Thus her advice to the students was based on her belief that 'doing' skills is important:

> You try and encourage them to do things because I know when I did my training we didn't have a choice of, if you didn't know how to do a thing then you didn't do it. It was there and you had to do it, so you had to go and find out how to do it. You couldn't just say, well I don't know how to do it so I won't do it. I guess that means in our ward I say to the students well find all the things to do and get it over and done with. The sooner you've done it the better off you'll feel about doing them again. When I trained you didn't have that opportunity not to do it, you had to do it (Alison).

Given their focus on task mastery and achieving standards it is apparent that most participants demonstrate an adherence to a technical-rational approach to learning in which having standards of teaching was important. Subsequently, Leisa, Kim and Alison all expressed the need to establish and maintain uniformity in teaching. Leisa commented: "I find it hard because I share my job with somebody else and we both teach exactly the same way and we set that up when we started. But once they leave us and go to another preceptor then you've really got to make sure that they teach what you're teaching." Alison added: "Because we found in our ward that we'll teach the student or new grad something one way and another RN will say, 'Oh no you don't do it that way, do it this way.' So the student can run into a lot of problems because they don't know who's telling them the right thing." Leisa even expressed anxiety at returning from holidays:

> I find it hard when I go on holidays and I know that someone is relieving me and I know that I'm coming back the week after someone is finished orientation and I just think Oh, I hope that they have kept the standards that I've set and are teaching things the same way that I did (Leisa).

It was agreed that students could be easily confused by the lack of uniformity, which is "supposed to be throughout the hospital in regard to procedures anyway, but different specialty areas do things slightly differently. So it can be hard for them to adjust to the differences in each area" (Leisa). Thus, some participants tried to follow an approach based on teaching the principles of care. Kim, in particular noted that "probably the easiest way for us to explain is with tracheostomy dressings, everyone does them totally differently but so long as it's clean and you follow the principles, then it is fine." Nevertheless, teaching by principles was occasionally very frustrating for Kim. Patients in her ward are usually immuno-compromised; so that nursing care is adapted to suit the needs of individual patients. This it was difficult for her to explain to the students who question her actions. As a consequence, she felt compelled to "justify what I'm doing, explain that what I'm doing isn't wrong it's just that it's shorter", particularly where:

> We cut corners here as in cut corners not to compromise the patient, but then for some things, like there are nine ways to skin a cat, you find the easiest way. And then you have to think is that the best for this patient? That's the right way, but however you've got to do it this way (Kim).

A number of other participants also demonstrated this difficulty in explaining their clinical practice. Barbara decided that it was because:

> I think nurses do a lot of things that you don't know you do. You don't give any value to it. I remember when I first started doing my psych (mental health nurse certificate), in my first essay, they said well, this is not very good, you haven't put in all the things you do in here. You haven't put in all the stuff about how you look after manic patients. I replied, but everybody knows that, I wouldn't put those down, why would I put that in? And I was told, but people don't know what nurses do. Because we don't see it as important (Barbara).

This belief that nurses devalue their own practice was also evident in the approach of other participants. "Nursing is devalued by nurses themselves because we don't recognise the complexity of what we do, as a consequence there is no perceived need to describe what we do because we don't see it as particularly important" and "You have done it a million times and so it is no big thing for you, yet the student might be doing it for the first time and they see it as very scary". Alison described an interaction with her student which illustrated her difficulty in explaining her clinical knowledge:

> I was putting an IV in this morning and I said, well you can set up the IV and she said, oh okay. Then I said, well you can start now, and she said, oh we did this in first year, and I said okay, that's good. And she hasn't done it since, so while it's just putting together the burette and it's not hard but, I think oh gee I remember the first time (Alison).

However, what the researcher observed was a frustration at the difficulty with which the student was experiencing in remembering the steps of setting up an intravenous infusion set. This frustration is again evidence that most participants describe their role in facilitating learning as being based in the students achieving task mastery. It was thus difficult for them to break down their actions and explain the complexity of decision making which underpinned their practice.

In contrast, Barbara viewed her role in facilitating learning as a process of role modeling her philosophy of nursing based in an empathic, holistic view of the individual. Learning was facilitated by having students with her, watching, observing, listening and talking until students feel comfortable enough to take on a patient load themselves. She extended her

belief in people's individuality to the students and recognised that many were "frightened" by mental health nursing. Barbara dealt with this as she "tried to remind herself of how they must feel". This empathic approach to patients was reflected in Barbara's approach to learning, "I really think my aim is to get the students to have an understanding, a feeling [for mental health nursing] and not to be too frightened". She actively sought to develop this empathy in her students by asking them to place themselves in the patient's situation and to "think that it could be me or my mother, so it changes how you look at mental illness". Barbara's selection of learning activities for her students also was based in the need for the students to see the patient and their care as a whole. Students were taken out into the community mental health team whenever possible so that they were exposed to an integrated approach to mental health nursing. Barbara summarised her role modelling approach to teaching and learning:

> I think in nursing they can learn a lot by observing. So I think for myself I teach better by saying, come with me and I'll show what to do, you can see how I do it. The thought of myself giving a lecture is just horrifying for me, it mightn't be for other people, but I'd be much more confident showing somebody on the ward how to deal with a patient and teaching that way (Barbara).

In particular, Barbara was interested in helping the students develop a "non-judgmental" philosophy of nursing. She frequently explained that people were all different and while they may respond in ways which would not be the choice of the student:

> Not everybody has the same choices as we have. You may think to yourself that somebody should leave their husband because they're doing whatever, you don't know what's right for that person. They don't have the same support and choices as we might have, so I try to get the students to be non-judgmental. It is one of the hardest things to do (Barbara).

Although Barbara accepted primary responsibility for her students, she also believed that "teaching on the wards is a global thing really". However, because most participants believed that the students learn by doing, facilitating learning was also observed to be sometimes difficult. Participants expressed concern that they were under a great deal of pressure to be constantly "on the ball the whole time setting a good example, because they [the students] really do pay attention even though you think they might not be watching you" (Alison). Roslyn agreed with this view, "you can't really slack off even though some

times you might want to". Leisa also felt that "you have to be careful if they do see a bad habit that they don't pick it up themselves." As a consequence, participants agreed that clinical teaching was sometimes "hard" and "tiring". On occasions the pressure to be constantly performing in front of the students clearly influenced their behaviour. One participant and her student were observed while the student undertook a catheterisation procedure. To the student's annoyance, the nurse immediately put on a pair of sterile gloves and proceeded to assist the student who had not asked for assistance. The nurse explained her actions as necessary to make the procedure faster for the patient. However, the student was distressed and felt that she had not been trusted to undertake the procedure on her own. Thus, a hesitant student and an anxious nurse, were factors in an experience that did not allow the student to learn anything except that she was too slow and questioned her own competence.

An analysis of these data in the light of contextual factors in which these nurses practise, illuminates their perceptions and assist in understanding their perceptions of this element of their role in facilitating learning.

4.3.2   Discussion of Learning as Task Mastery

The emphasis on learning as task mastery which is evident in these participants' descriptions of their role, is embedded in two factors: firstly their own philosophy of being a nurse; and secondly an adherence to the technical-rational approach to learning. It is the influence of these two contextual factors on the image of self as clinical teacher that is of interest to this study.

The participants describe a common set of meanings about nursing. These meanings are derived from their own experiences of nursing and personal meaning of being a nurse. Participants in common describe a philosophy of nursing that is "holistic" and based on "delivery of total patient care".

Patients need and expect good basic nursing care with attention to things like personal care and hygiene. That is what nursing is about, whether you can walk in and scan the whole patient and notice the subtle changes or cues and assess them. Nurses are assessing the whole time; that is what allows us to pick up the early subtle changes and to respond (Leisa).

This statement is reflective of all participants' beliefs about the nature of nursing and subsequently directs their role in nursing education. This is their role, to assist the student "to learn the basics, complex technical skills will come later." Their aim is to get students to appreciate the patient holistically. This philosophy of nursing is embedded in their experiences of nursing as being connected with the "real" person, rather than primarily focused on the increasing technology utilised in nursing. However, it is apparent that these participants' facilitation of learning conflicts with this holistic perspective of the patient. In particular, their own experiences of nursing and their own nurse training influence their beliefs that clinical practice should be a time for 'doing'. Facilitating learning thus appears to present some role conflict for these nurses. On one hand they feel comfortable showing and demonstrating elements of their practice to the students. Facilitating learning from this perspective allows them to transmit their own philosophy of nursing to the next generation of students and is thus a source of role fulfilment (Clifford, 1999). They draw on their own experiences and meaning of nursing to role model an empathic, holistic approach to patient care. On the other hand, when they feel under constant observation and pressure to maintain this role, it becomes "too hard". The presence of students is reported as an element that contributes to feelings of tension and apprehension (Atkins & Williams, 1995).

Thus while these nurses do share the contemporary view of nursing as holistic and relationship forming (Upton, 1999) they also are required to meet the demand for increasingly complex care. The level of technical knowledge needed by nurses who are working in today's intense, acute care hospitals is described as "awesome" (Porter-O'Grady, 1990, p. 145). This expectation shares greater congruency with the traditional view of nursing as 'scientific'. The continued dominance of the traditional scientific paradigm of nursing (Upton, 1999) therefore appears to influence participants' perceptions of learning as doing, more strongly than their holistic view of nursing. For example, Jeanne's comment about having a student carry out a catheterisation procedure for which she has not been

theoretically prepared "they're as nervous as all hell…I think one took about 50 minutes but I don't care", indicates that she is prepared to prioritise the needs of the student to 'do' a task ahead of the patient's possible discomfort. This participant draws on her beliefs about learning rather than her beliefs about the patient in order to fulfil her role of facilitating learning. Tension is consequently experienced between the imperative to 'get the work done' and allowing the student to complete the patient's care independently (Robinson et al., 1999).

Consequently, the consistent focus on behavioural pedagogical approaches such as learning by doing as described by the participants, results in an emphasis on the application of content rather than reflection on that content (Diekelmann, 1993). This approach is illustrated by comments such as: "And they'll say, now what do I do? And I say now you attach this or do this, and so by the end of the catheterisation they've done it" (Jeanne), and "I guess that means in our ward I say to the students, well find all the things to do and get it over and done with. The sooner you've done it the better off you'll feel about doing them again" (Alison). Students are rewarded for the repetition of tasks and skills, and the application of rules in such a behavioural, task mastery approach to learning (Diekelmann, 1993). However, this behavioural approach is inconsistent with the philosophy of new curricular approaches to nursing education which seek to have the student learn through a problem-solving, reflective inquiry (Benner, 1993).

Some nurses do concur with this theme of learning by doing (de S. Ferguson, 1996) and describe an approach to education based on "helping as much as I can" (p. 837). The process of 'doing' on clinical practice is used by new graduates to become comfortable in the ward area (Charnley, 1999). However, this approach is principally utilised by students to avoid being described by ward staff as "lazy" (Clark et al., 1997), reinforcing the behavioural dominance of the clinical environment. The process of "learning by doing" (Lortie, 1975) is widely recognised as an appropriate method through which experienced, graduate practitioners achieve professional development. In this context 'doing' becomes 'experience'. However, it is questioned as to whether this model of learning is suitable for

novices who require structure and guidelines in their practice rather than being urged to "find all the things to do and get it over and done with" (Alison).

Tertiary nursing students, who may have no previous experience of the situations in which they are expected to perform, need "rules and procedures to follow so that the performance can be done without experience" (Butler, 1996, p. 278). Jeanne's insistence on students doing procedures which they have never before experienced, could thus be interpreted as providing novices with some rules and procedures to follow. Similarly, a task mastery orientation to teaching is represented in the literature (Paterson, 1994). Nurse educators, who report utilising a task mastery orientation to ensure that their students are achieving standards and meeting learning goals, subsequently lend support to the behavioural orientation of participants in this study (Hodges, 1997). Furthermore, the step-by-step approach used by some participants to guide students through unfamiliar nursing interventions could be described as providing guidelines according to the demands of the hospital unit for novices to follow (Dolan, 1984).

However, 'learning that', rather than 'learning why' is described as inappropriate for nurses who need insight, involvement and reflection to deal with the complexities of future healthcare systems (Glen, 1995). Similarly, the behavioural approach to learning implicit in the statement: "you have to be careful if they do see a bad habit that they don't pick it up themselves" (Alison), is regarded as inappropriate for the profession of nurses (Glen, 1995). Such comments are indicative of a perception of learning as unreflective imitation. Consequently no provisions are made for thinking and questioning; students are expected to repeat the task as demonstrated. Nurses do not have a history of peer evaluation. As Kim explains, her peers do not question her practice so she is unused to justifying her actions. It is subsequently difficult to conclude that participants have a deep understanding of the principles underlying teaching and learning if they demonstrate such difficulty in explaining the rationale underpinning their actions to students. How teachers select and organise appropriate learning opportunities is one of the challenges of being a teacher. These participants demonstrated that they select learning activities based on their belief that students learn through a task mastery approach. However, they experienced difficulty in

supporting the learner because these "beliefs have not been fully articulated, or examined for effectiveness or consistency" (Bouffler, 1987, p. 55).

Furthermore, there are numerous instances reported in the research data that illustrate that the participants were not able to fully explain the intricacies of their professional knowledge in a way from which students can understand and learn. Marrow and Tatum (1994) concurred with this conclusion that some nurses have difficulty explaining their actions clearly, particularly in regard to "cutting corners" when carrying out a procedure, raising further questions about the quality of learning that occurs in such occasions. In another example Barbara commented:

> You haven't put in all the stuff about how you look after manic patients. I replied, but everybody knows that, I wouldn't put those down, why would I put that in? And I was told, but people don't know what nurses do. Nursing is devalued by nurses themselves because we don't recognise the complexity of what we do, as a consequence there is no perceived need to describe what we do because we don't see it as particularly important (Barbara).

Alison agreed: "You have done it a million times and so it is no big thing for you, yet the student might be doing it for the first time and they see it as very scary". Individuals who have considerable experience and knowledge, such as experienced nurses, do encode material relating to a topic differently to novice learners (Schuell, 1986). This may assist to explain the difficulty which some of the participants experienced in explaining the rationales for their nursing interventions and decisions. Articulating professional knowledge in nursing is extremely difficult because of its complex interactions, however this is not an acceptable rationale for nurses' failure to explain what they do in such as a way that students can learn from their explanation (James, 1995).

Subsequently, the continued adherence of the nurses in this study to a technical-rational model of nursing as evidenced by their beliefs of learning by 'doing' and encouraging students to 'do things', may be explained by their apparent lack of any formal knowledge of the principles of teaching and learning. Not knowing any better, these participants simply recreate their own learning experiences as a student for their own students. This approach was evident in Alison's comment "(y)ou try and encourage them to do things because I

know when I did my training we didn't have a choice of, if you didn't know how to do a thing then you didn't do it. It was there and you had to do it, so you had to go and find out how to do it." Registered nurses involved in clinical teaching are reported to demonstrate a similar lack of awareness of the principles of adult education and learning preferences of students (Brammer, 1999). Subsequent frustration at the lack of interest or willingness of students to repeatedly practise skills, likewise indicates a lack of understanding of the principles of adult learning on which new curricula are based. Benner (1993) warned that nurses need to have an understanding of the processes of clinical learning and clinical skills acquisition if student nurses are to understand complex clinical cases and explain the conceptual complexities embedded within those cases. This study concludes that experienced nurses' perceptions of their role as a facilitator of learning remains fixed in the belief that students learn best through a task mastery approach.

Such conclusions generate questions about the efficacy of preceptor or clinical teaching workshops currently provided by universities aiming to prepare nurses for their role as preceptor or clinical facilitator. Some nurses appear to be more concerned about the procedural information which they receive from the university relating to students' objectives and learning needs (Brammer, 1999). This suggests that preceptorship programs appear not to offer nurses appropriate strategies to develop critical thinking in student nurses (Meng & Conti, 1995). This inadequate preparation for their teaching role was similarly recognised as a major factor in nurses' inability to facilitate learning (Nurses Registration Board of NSW, 1997). Furthermore, existing programs appear to reinforce the notion of teacher as filler of an empty vessel, representative of the technical-rational paradigm of learning (McInnes & Morrison, 1995). Butler (1996) warns that such 'training' programs are unlikely to result in meaningful change in the behaviour of the teacher. Indeed these nurses lack understanding of the principles of teaching and learning, which underpin the current critical, reflective approach to nursing education. The purpose of learning through such training programs is to achieve mastery and efficiency. The point of learning in nursing should be to facilitate a "breadth and depth of understanding, a degree of critical reflectiveness and corresponding autonomy of judgement" (Moreton-Cooper & Palmer, 1993, p. 11). Universities and hospitals could be thus accused of perpetuating the adherence

of nurses to a technical-rational paradigm because of the failure of current preceptorship programs to offer nurses adequate professional development and support for their responsibility in clinical teaching.

Nevertheless, it is evident that despite an adherence to standards, most participants recognise that as students develop through experience, that they are more able to cope with some ambiguity in practice. Their own experiences as a student and with clinical teaching thus influence their selection of clinical teaching strategies.

4.3.3   Learning from Experience

The theme of 'learning from experience', encompassed participants' perception of facilitating learning through processes that can be broadly related to experiential learning theories. These nurses' adherence to a belief of learning as task mastery continued to influence their role. However, past experiences of teaching and learning also provided a base of understanding from which their current role of facilitating learning was drawn. Consequently, their beliefs about the extent to which it was their responsibility for motivating students varied with prior experience and their own concepts of learning. Reflection on past experiences with teaching and learning encouraged some participants to foster reflective practice with students.

Participant's beliefs about their role in motivating students ranged from seeing that they do have a part to play in motivating students to learn: "I think if you can make them interested, then they will learn" (Jeanne), to seeing motivation to learn as the responsibility of students:

> You also need to direct the responsibility for learning back to the student, because you can only give them so much direction, they have to take some responsibility for their learning as well. You can spoon feed them, but until they motivate themselves to want to learn and do things then the decision is theirs to make (Roslyn).

In contrast, Alison felt that her role was to motivate students, an approach reflective of her belief in learning by doing:

> You are doing that constantly anyway. You often say to them, you should remember to take any opportunity you can, and you've got to get in and do this and if you hear in handover that someone is having this done and you know that you haven't achieved that competency yet, or if you've never seen it before, then make sure that you ask that nurse if you could watch or do the procedure. So that's all motivating them to get up to date with their skills and to see new procedures (Alison).

She extended this belief to other staff, whom she felt should also be taking some responsibility for assisting students learn:

> Staff will come up to me and say, she didn't do such and such, And I say well tell her, don't tell me, there's no point telling me. You need to tell them. And they may say, well I'm not going to tell her and so I say well, don't complain to me if you are not prepared to help them along, you've got to take some responsibility as well (Alison).

However, Roslyn expressed some empathy for her students by remembering her own experiences as a university student, to explain why students do not always appear to take responsibility for patient care:

> I think I floated along as a student. I do remember thinking about it because I don't think I ever took any responsibility for the patients really. Even if you were told they were your responsibility you still thought, they're not mine really, I can't do anything by myself anyway, so they're still not my responsibility. And that feeling that even if you didn't get it all done, you knew someone else would be there to do it for you (Roslyn).

In contrast, Alison's view, based on her experiences as a student was:

> I know that students get tired of going out on prac all the time and it's hard because they have to go to work afterwards half the time and work the weekends, but it really needs to be reinforced that this is the time when they are going to learn a lot of things and they should make the most it while they can (Alison).

Similarly, Roslyn became frustrated when students do not seem motivated, particularly when she spends extra time preparing herself for the teaching role:

> You put all this time and extra effort for no reward, you don't get paid any extra and you might go home and write something up for them, or spend a bit

of time talking through things in your lunch break. It's all extra stuff that you're putting in for them and if they are chewing their fingernails and looking out the window and not listening to a word you are saying, and you think well, why am I here and why am I bothering? (Roslyn).

In particular, it was agreed that students who wanted to be on that placement or ward usually displayed a more positive attitude which assisted with their learning: "I think they must want to learn, must have some interest in the subject." Leisa cited a situation in which a student was obviously uninterested in the clinical placement and the effect that this lack of interest exerted on staff attitudes towards teaching the student:

> One student we had just didn't want to know about the ward, he was at the end of the year and couldn't be bothered. But we had to fill out his assessment sheet and we said well, you've got to achieve these things to pass and we have no hesitation in saying, no you didn't, so you've really got to take the opportunity while you're here (Leisa).

Thus while their focus on learning by doing remains dominant, participants acknowledged the value of their past experience in teaching and learning, in shaping their understanding of learning. Leisa acknowledged that her attitude towards motivating students stemmed from her own experiences as a student: "Sometimes it was hard for us (as students) we would get thrown into a ward that you had no idea about and had to do these things, so I don't think we need to go that extent (with the students), but the encouragement we give them probably stems from that." However, Alison also questioned herself when she experienced difficulty in motivating students: "I've also found that if you've explained something in a hundred ways and it's not getting through to the nurse, then maybe it's the way I'm explaining it." Participants therefore agreed that the decision when to "let go" and give someone else the responsibility of teaching the person is a difficult one. "There comes a time when you have to step back and say, well you've got to do it for yourself, I can't do it for you anymore. And that is hard to do sometimes, to pull back from them, because they constantly ask you to do something for them" (Roslyn). However, with experience they agreed: "you learn to realise that you don't have to tell the students everything" (Kim). Alison concurred that learning to let go is an important part of her role:

> I think being able to know when to pull back from students, as well as knowing when to say well I've shown you 2 or 3 times, now you need to have a go. And whether you set up a pretend situation for them or you go let

them go straight into doing something with a patient. You need to have that sense of where the student is up to and whether they can cope with that or not (Alison).

Jeanne described an interaction with a student in which she recognises the student's need for increased autonomy as she gained confidence:

She might only take on one patient because there's more things to do for that patient and then each day, we put her back in the same area and she'd take on three patients, and then by the end of the four weeks she'd be taking on the whole five or six patients in the ward by herself doing all the care, everything, but I'd be overlooking (Jeanne).

Positive evaluation of this experience appeared to boost Jeanne's self esteem as much as it did the student's. So while students were not regarded as 'expert', there was an understanding that with increased confidence, students can slowly be introduced to variations in practice. "And if they realise that it is not going to work for them, then they have to look at a different avenue, so they learn a different way. Someone might show them something different and they can say well that wasn't right for me but this feels right" (Jeanne). Leisa identified that she preferred to ask students what their objectives for the clinical placement were. "I think you've got to find out what their level of knowledge is to start with and go from there, whether it's in regard to taking observations for example, do they know how to, do they understand what the measurements mean, building from the basics upwards". Jeanne agreed, "I guess to start off to learn they have to have a basis of knowledge, whether it's in a classroom, they need some knowledge to start that learning and for them to go away and think about what has been taught to them and then to start applying it." For Barbara, the process of talking to students, allowing them time to observe and question patient care, was a means of increasing their confidence so that they can achieve increasing levels of competence:

It also gives them a chance, once they've seen the patient and they are more comfortable. I guess that comes back to being confident. You're not going to throw somebody into doing something if they are not confident, having not seen it or not really know what they are doing or what the principles are behind it. They've got to be comfortable and confident enough so that they can actually learn (Barbara).

It is clear that their own experience as students has greatly influenced most participants in their role as a teacher. Barbara expressed initial concern that she had no experience as a teacher and while she could show students what to do, she was hesitant about her ability to be an effective teacher. Her past experiences as a student strongly influenced her perception of herself as a teacher:

> I had no experiencing in teaching, but I just know from being at university that some people are very good teachers and some aren't very good. I didn't know because I had no experience at all, so I didn't think I would be very good at it. But I found that I actually enjoyed it and the girls, about half of them, really enjoyed it, they really responded. And so you respond to their enthusiasm (Barbara).

For Roslyn, learning through experience was also a major influence in how she approached clinical teaching. "The students learn by trial and error and you also learn by trial and error in the way that you approach teaching somebody something." Consequently, Roslyn acknowledged that reflection on her past experiences in teaching influenced her choice of future strategies so that next time she may approach it totally differently because of the student's response to her teaching style:

> You definitely learn by your mistakes, so I find if you do have people who are having problems and you are pulling them up and showing them the right way, then it is something that they are always going to remember because you have told them that they did that wrong and this is how you have to do it, and it will stay with them (Roslyn).

However, this approach is still embedded in the task mastery approach, illustrated by her correction "and this is how you have to do it". Alison similarly relied heavily on her own experiences as a student in her role as teacher:

> I guess just remembering, I'm just coming up to my fourth year and so I can still remember what it was like as a student and things that I would have liked to have been different when I was a student. So I try to do them differently when I've got a student (Alison).

All participants acknowledged that the value of reflecting on their own practice, particularly as a clinical teacher, lies in making them more aware of teaching strategies, how different people learn, and the need to assess how people learn best. Jeanne and Leisa described how clinical teaching not only helped them to understand how much knowledge they had

acquired since graduation as a nurse, but also to appreciate that they did indeed utilise this theoretical knowledge base in their practice. "You take knowledge for granted that you don't use every day, or you don't think you do. But when you're actually talking through things and explaining it you realise that you do use that knowledge"(Leisa).

Barbara's style was to actively role model a reflective approach by her frequent use of prompts and cues such as: "why do you think we would do something like that", and "what would you be looking for". She encouraged students to think like this before they do a procedure "to try and get them to think why are they doing it and what are the things they need to be observing while they are doing the procedure and then what they will do when they have finished the procedure before we actually go and do it". This approach had even been extended to new graduates in Barbara's ward. They were encouraged to reflect on their day's performance with their buddy nurse by asking themselves "what did I do well today and what would I like to have done better?"

However there remained a general agreement that their own nursing practice was positively influenced by encouraging students to question and think about the nursing care they were giving or observing. Although they remain committed to a facilitative approach based on learning as task mastery, most participants valued the students' questioning of their practice because of the opportunity it offered to reflect on their rationales for nursing care:

> It makes you think is there another way I can do it, because I think a lot of the time you just do things the way you were taught how to do it. I think a lot of the time with nursing that we stick to our old practices. I've always done this, whether it's right or wrong. After a while it becomes habit and the habit becomes routine and you don't want to change. The change might mean it's easier, but you're reluctant to change (Roslyn).

Nevertheless, Kim was also sometimes taken aback when students question her practice, because it is not the usual culture for nurses to query each other's care. However, her questioning of students prior to their carrying out of a procedure, was principally to ensure students "avoid mistakes". Kim explained that in her unit:

> I like to try and have a quick run through of the procedure before you get to the patient, because some of the patients know the procedure so well,

that they would know if the student made a mistake. And it gives the
student a chance to ask questions before they get to the patient (Kim).

Similarly, Leisa appeared to align herself with the patients and protect them from students' potential mistakes because the patients "get sick of being guinea pigs for the students". While students were encouraged to rehearse their actions prior to implementing unfamiliar procedures in particular, learning remained a process of completing tasks correctly. Even patients were reluctant to accept any deviation from the ward routine. This belief appeared to be well established amongst long term patients in Leisa's unit, who occasionally were observed to question a nurse about the student's competency in doing a procedure. Kim's justification for this approach was that it avoids embarrassing students in front of patients. "Because I think it always makes the student feel bad, even though you are not deliberately trying to be mean, sometimes they can be made to feel really small when you have to say, no stop and start again." The students in Kim's ward also contended with anxious and watchful relatives of patients. As she warned them: "don't be put off by the relatives, student nurses here are being watched because the relatives do worry." Alison agreed that "you've got to be careful you don't embarrass them cause they think oh, what a stupid thing to do". However, when the situation was one which may have serious consequences, such as a medication error, Alison believed it was important to warn the student of the grave nature of their mistake. She described an incident in which a student gave an intravenous antibiotic to a patient and then said, "oh, now which one was it that I gave?" Alison's response was to make the student aware of the dangers inherent in not being alert with medications: "I mean oh goodness; you've got to know what you're giving. You've got to know what you're doing, you're in third year, you've got four weeks left, wake up, wake up, or somebody's going to be dead".

Clinical teaching appeared to assist these participants to become "more aware of teaching strategies, just how different people learn". However, despite acknowledging that individual differences in learning occur, teaching approaches based on the philosophy of 'learning by doing' was the predominant approach of almost all participants. This resulted in conflict between their beliefs about nursing as 'holistic' and with the expectations of new curricular

approaches inherent in tertiary education which aim to develop the reflective practitioner (Benner, 1993).

4.3.4 Discussion of Learning from Experience

These nurses' beliefs of learning as task mastery continue to influence their teaching role. However, their own past experiences of teaching and learning also provided a basis of understanding from which their current role of facilitating learning was drawn. Comments such as: "I can still remember what it was like as a student and things that I would have liked to have been different when I was a student. So I try to do them differently when I've got a student" (Roslyn), imply the acceptance of an approach to learning based on experiential learning and reflective practice. It is therefore important to this research to understand the influence of these two contextual factors, a technical-rational approach to learning and their own experiences of learning, on the participants' image of self as clinical teacher.

In learning from experience, some participants do reflect on their past experiences as a means of discovering solutions to existing problems (Parker et al., 1995). That there were "nine ways to skin a cat" within one participant's understanding of her practice indicates that for this nurse, reflecting on her past practices to "think is there another way I can do it" (Kim) is turning thinking into learning (Mezirow, 1991). Stevenson et al. (1995) similarly find that reflecting on questions asked by students or preceptees encourages preceptors to challenge their own practice and knowledge.

While one participant (Kim) was uncomfortable with students' questioning of her practice, she does acknowledge the value of questioning long-held practices. In particular, participants utilised the opportunities which such shared discussion afforded them in challenging their own practice (Burnard, 1995). Despite the influence of their beliefs of learning as task mastery, these respondents allowed their own experiences to

shape their role in facilitating learning. This finding corroborates one aim of *The Review* (DHSH, 1994, p. 16) for nursing to focus on "reflective practice, problem-based learning or experiential learning". One nurse's utilisation of an empathic approach to learning through engaging students in "listening, watching, and observing" (Barbara), is supported (Severinsson, 1998) as contributing to the development to learning, which increases professional knowledge and awareness of experiential learning. Preparatory activities such as reading and reviewing of pharmacology as reported by some participants, have similarly been endorsed as increasing professional knowledge (MacCormick, 1995).

Nevertheless, while some participants did engage students in a reflective dialogue, this study cannot conclude that all participants consistently and actively incorporated such an approach into their role of facilitating learning. The difficulty with which some of the participants articulate and explain their nursing actions may, in fact, be resolved through a reflective approach. By deliberately engaging in a process of reflection these nurses may be assisted to overcome this difficulty in explaining the realities of their nursing knowledge. This is because:

> as nurses practise, they know more than they can communicate. Some of what is known in practice can be expressed in words, actions, movements or sounds, but much of what is known cannot be fully expressed. Attempting to express knowledge helps nurses focus, shape, influence, and communicate with what is experienced (Chinn & Kramer, 1993, p. 56).

A similar lack of knowledge, particularly of theories of clinical teaching has been reported by E. White et al. (1998). Likewise, Marrow and Tatum (1994) found that nurses who were undertaking clinical supervision lacked a conceptual framework of supervision and teaching. These participants relied solely on their own past experiences as a student to develop a theory of teaching, yet universities are urged to select nurses who possess competent clinical teaching skills and a sound knowledge of the curricula and its philosophies to act as clinical teachers (Myrick & Barrett, 1994). While prior knowledge of the profession may teach one about nursing, professional experience of nursing does not necessarily teach one about teaching (James, 1995). This "apprenticeship of observation" (Lortie, 1975) does not translate into a theory of teaching. It is suggested that the perception of teaching gained

through such an apprenticeship may present the clinical teacher with a challenge to correct the distorted images of teaching thus acquired (James, 1995).

The nurses in this study appeared to rely on their own limited experiences of teaching: "I had no experience in teaching, but I just know from being at university that some people are very good teachers and some aren't very good. I didn't know because I had no experience at all, so I didn't think I would be very good at it" (Barbara) and:

> I think it's really the way we learnt ourselves. All those example are things I would have been exposed to and picked up as a student and what has been told to me by my preceptors and facilitators. So I think well, it worked for me and seems to work for everyone else, so you just continue it on (Roslyn).

Roslyn's comments indicate an absence of any examination of prior experiences with teaching, which is echoed by Lortie (1975) who warned that there was some danger in relying on one's own experiences as a student as a basis for developing a theory of teaching and learning. Mayer and Austin (1999) also noted that personal sources of teaching knowledge obtained from experiences as students significantly influence teachers' practical application of teaching theory. These images of teaching may present a barrier to a deep reflective examination of their teaching practices in order to achieve an understanding of the intricacies of learning.

The role of facilitating learning continues to cause conflict for these participants, despite extensive utilisation of their past experiences as both student and clinical teacher. In particular, difficulty is experienced when making the decision to "let go" and let the student take over increasing levels of patient care. This decision required that the participant trusted both their own clinical judgement and that of the student. A degree of flexibility was required in order to allow students more opportunities to integrate theory with practice. Nurses who are more familiar with a traditional model of education do not appear to possess a high degree of flexibility and so have difficulty with the need to let go of the responsibility for students' learning and adopt a more facilitative style of teaching (Atkins & Williams, 1995). This difficulty was also reported by mentors who acknowledge that students must adopt responsibility for their own learning, yet continue

to find that the subsequent decision to let go, remains very stressful (Atkins & Williams, 1995).

Differences in participants' perception of their responsibility for students' learning is corroborated by Paterson (1994), who also found that nurse educators differentiated between a sense of personal efficacy in the motivation of students and a belief that students determine their own learning. It could be suggested that these nurses therefore might seek to impose their own perceptions about situations onto students, rather than to adopt a more facilitative approach to learning. This is the basis of experiential learning. Their task mastery approach to learning may in fact, cause them to be incapable of recognising the 'teachable moment' (Brookfield, 1991) because of their focus on learning as doing. As a consequence, some participants do experience difficulty in establishing a balance between allowing the student clinical independence and providing close supervision. However, when an appropriate level of supervision is reached, both student and participants appear to respond positively. The literature supports those participants who expect students to adopt a proactive learning role with their buddy nurses and to demonstrate increasing levels of motivation for their own learning (Robinson et al., 1999).

Some participants do adopt less prominent approaches to motivating students such as: "starting with the basics and building on" and, "So you may find it easier to do it a different way, but so long as you follow the principles then it should be okay", that acknowledge the contextual nature of nursing. In particular, the advice offered to students, "if they realise that it is not going to work for them, then they have to look at a different avenue", indicates that some participants do apply learning principles based on Benner's (1984) seminal work of 'novice to expert' skills acquisition. These approaches are supported as pivotal in encouraging the next generation of nurses to develop a more cognitive and contextual orientation towards their knowledge base (Diekelmann, 1993; Grossman & Hooton, 1993). A further outcome of the application of broader, more contextually based principles of nursing care may be a strengthening of their own understanding of the holistic nature of nursing. However, not all participants' practice is

based in these principles of nursing as evidenced by these nurses' concerns about 'maintaining standards' within a behaviouristic approach to nursing.

Consequently, while students were on occasions encouraged to think about their own actions, it appeared primarily to either overcome their lack of theoretical preparation for the situation or as a rehearsal of the procedure to 'avoid mistakes'. Nevertheless, Paterson (1994), whose participants agree that learning from error was acceptable provided the student "learned from the experience", supported the theme of "learning by mistakes". Some nurses' encouragement of the rehearsal also served to reduce fears that they might be held responsible for mistakes which they feel they may not have been able to prevent (Moorhouse, 1992). Such fear supports Kim's questioning of her students prior to their implementation of a new procedure. Questioning in this situation does not represent a reflective element of experiential learning. Rather, its purpose was to ensure an avoidance of problems for the patient and the nurse.

Furthermore, it was not evident that the participants consistently engaged with their students in a process of discussion based on the outcomes of any such questioning after the experience, consistent with the expectations of experiential learning (Laschinger, 1990). It could be concluded that the participants' pre-questioning of their students served to role model a belief about nursing and learning as focused on the successful completion of tasks. This apparent lack of the utilisation of reflective practice in assisting students to learn from their clinical experiences further indicates a lack of understanding of the value of shared and personal experiences and their potential for facilitating learning (Moreton-Cooper & Palmer, 1993).

It could subsequently be concluded that these nurses' perceptions of their role as clinical teachers was focused on assisting students to develop, gain or refine skills (Moreton-Cooper & Palmer, 1993). This is congruent with their perception of learning as task mastery. However, their focussing on this behaviouristic perspective of learning resulted in less emphasis being placed on the holistic role of the clinical nurse. New curricular approaches to nursing education which are embedded in patient-centred, holistic

approaches, expect that experienced nurses will be facilitators of student-patient interactions that provide the necessary learning experiences for the student to integrate theory with practice (Ahern, 1999). It is suggested that under this model, the role of a clinical teacher is optimised by engaging students in questioning, explaining and providing necessary support (Ahern, 1999).

However, the busyness of the clinical environment of these nurses, which recurs as a common theme in the literature, may explain the absence of widespread reflective practices incorporated in their role as facilitator of learning. The lack of time to create positive clinical learning environments in such a busy, chaotic environment precludes both teachers and learners from taking time to reflect on their practice (Jarvis, 1992). The perception of clinical practice in busy clinical environments, as an opportunity for students to "pitch in like everybody else, I think they learn a fair bit" (Roslyn), rather than as a period of observation, questioning and thinking, is considered inappropriate. Jarvis (1992) suggested that the busyness of present healthcare settings that reinforces this perception of clinical practice as an opportunity to "do things", was driven by the technical rational approach of practice settings. It is therefore not surprising to note that new graduates continue to report a "baptism of fire" (Bick, 2000) as they are expected to 'hit the ground running'. Busyness in the clinical environment subsequently recurs in the following section as an important contextual influence on the participants' perceptions of their role as socialiser in clinical teaching.

4.4   ROLE AS SOCIALISER

The importance of assisting new graduates in their transition from student to practitioner has long been recognised in all practice disciplines (Dobbs, 1988; Lortie, 1975). Since the introduction of tertiary education as the sole point of entry into nursing in Australia, the socialisation of students through their status passage from student to graduate nurse has undergone change (Moorhouse, 1992). This is reflected in the importance that the participants of this study attached to their perception of their role as socialiser. Two major elements of this role were identified through comparative data analysis. These were, 'fitting in' and 'learning the realities of practice'. It was the belief of all participants that their role as socialiser was an integral part of their clinical teaching role. Their goal was to assist students in their socialisation by learning how to fit in to the culture of the clinical setting through coming to understand the realities of nursing practice. However, these themes cannot be understood in isolation from the remainder of the study. The participants' perception of their role as socialiser is underpinned by their task mastery understanding of clinical practice as a time for the students to be learning by doing and taking opportunities to practise their skills (section 4.3). The next section further analyses the participants' perceptions of how students should be using their clinical placements to learn how to fit in to the realities of nursing practice.

4.4.1   Fitting In

Participants' perceptions of their role in socialising students were appropriately summarised by Alison:

> I guess that it's little things rather than one particular experience. Like if the student's done their own dressing. They may come in and say 'I've already done that dressing' and you think, great. You've watched them for three days and you know they can do it and they just go ahead and do it, which is really good. They've thought about checking for the 12 o'clock

pills and they say, 'no we've already done it'. Things like that that they should be doing because that's part of them functioning as an ordinary RN, learning some time management and using their initiative. So that we are not just baby-sitting (Alison).

Subsequently, all participants agreed that students should be aiming to achieve these goals throughout their clinical placement. Students were viewed more positively if they take the initiative for their patients' care. This was also seen as an opportunity for the student to demonstrate that they were developing appropriate clinical decision-making abilities and were therefore capable of assessing the patient and initiating appropriate treatment. Participants remarked that the strain of having students was eased if:

they took the initiative to get a patient out of bed for a shower. Because that becomes a bit tiring, when they don't take the initiative and just ask questions all the time, like what can we do now? And they should be able to see that there are things to be done. The medication round has taken a lot longer to do because we've gone through every drug and then there are things that I'm trying to catch up with (Jeanne).

This appeared particularly important when the buddy nurse spent time explaining a procedure to the student, and consequently fell behind in her own work. "So when they come up and say I've done that dressing, or we'll do those close obs (observations) because they can see that you are really busy, that's nice to feel they are starting to use their initiative" (Barbara). It is also felt that this allowed the students to enjoy their clinical experiences much more because they become more confident and are regarded as valued members of the ward team. Students who developed such team cohesion and confidence were seen as more likely to take responsibility for their own learning, further contributing to the perception that they are "fitting in". "So that is a big thing for them to feel comfortable enough to say to you am I doing the right or wrong thing here? But it is about having that confidence" (Kim).

Thus students who showed this initiative were viewed more positively because they attempted to reduce the workload for their buddy nurse. Kim expressed particular frustration when students do not display this initiative or take extra time because of the more specialised nature of her ward:

The students are here to learn but, I just find it's too much at the stage they're at, especially the second years. I know I was a student myself but I had a totally different training. They say 'I need to practice injections'. They're drawing them up but it's them taking ages to do it. I understand they need to learn it, but it is frustrating when you're busy. When you get pool staff in here and you are the only regular person and you've got to keep your eye on everything. It gets a bit much (Kim).

Such frustration was similarly identified by some participants who had to decide between waiting for the student to initiate nursing care that is required for a patient, or intervening in that care because it was obvious that the student had underestimated the time that will be required (Robinson et al., 1999). One participant clearly demonstrated the tension she experienced between meeting the student's need to be independent and her need to be completing tasks quickly and efficiently. In this observed instance, a student was preparing an infusion pump by mixing morphine and water. The participant nurse explained that the solutions should be firstly drawn up into separate syringes, then mixed to achieve accuracy. The confused student recommenced the procedure yet splashed herself with morphine. The nurse's frustration at the student's lack of coordination and fine motor skills was clearly evident as she brusquely took over the task from the student. Later, the nurse explained she had discussed the procedure with the student and was obviously frustrated at the student's slowness and time taken to attend to the task.

A second observation was made of another participant nurse and her student doing the ward drug round. It was observed that the student read out the drug order, the nurse dispensed the medication out of the package and handed it to the student to give to the patient. When asked why she was not following standard legal procedure, the nurse explained that she did it this way to help the student with unfamiliar drug names and doses, and she was able to explain the medication as they went along. "It also saved time because otherwise the medication round took too long." The student was caught in a dilemma between pleasing the buddy nurse by not slowing her down, yet wanting to act more independently and according to the principles of medication administration. On reflection by the nurse, a compromise was reached, in which the student only administered the drug round for her patients. This

allowed the participant to supervise the student more appropriately and still have time to attend to her own patients' needs.

Occasionally other staff also appeared to assume that having a student meant that the preceptor or buddy nurse could be given a heavier patient care load, when in reality "the students cause you to take double the amount of time that you would normally take because you need to show them things" (Jeanne). Barbara agreed that while she enjoyed teaching, there are occasions when she becomes so busy that her students were forgotten and, "some days when you've got a big patient load and a million things happening you have to say, I'm sorry that I haven't had time to show you anything, but thanks for your help. They sort of get involved in the ward especially when we get frantic" (Barbara). These experiences conflict with the popular view that students should help to ease the workload and raise questions about the supernumerary nature of clinical experience.

These participants agreed that staff shortages and an increasingly demanding workload were adversely affecting effective clinical learning environments, increasing the need for students to fit in, to ease the pressure on busy staff. As a consequence, students were frequently regarded as an answer to staff shortages, despite their supernumerary status while on clinical placements, because:

> It is important for them to feel that they are not a hindrance to the ward. Especially now that it is a much more stressful environment that the student knows that we may be understaffed and overworked and under a lot of stress but they are still a great help and we appreciate them being there. Sometimes we may not show it or say it but they are a really great help (Barbara).

This was a recurrent theme, with all participants repeating that students were frequently regarded "as another set of hands...even though we know they are supernumerary." Jeanne admitted that on occasions students couldn't be treated as supernumerary because of the extreme busyness of the ward area. She explained that "the students were here for four weeks and we basically treated them as RNs because it was so busy." It was obvious that under these circumstances, students' learning needs became forgotten. However, they were regarded positively because they used their initiative, did not have to be repeatedly

told what to do and subsequently 'fitted in' with the ward's expectations. Similarly, Roslyn told of the effect of a busy ward on a student:

> who was so willing to learn, which is excellent. And he's confident that he knows what he's doing and will go ahead and use his initiative, which is good, where a lot of other students will have to be told all the time this needs to be done now, but at the same time, because the ward was so busy, it was hard to spend the time when he wanted to learn something. Because I knew if I just went ahead quickly and did it that it would be over and done with and I could get on. But I realise that, well someone had to teach me as well, someone had to make the effort (Roslyn).

The expectation that students will use their initiative to act, rather than ask questions, appears to be in conflict with the expectations of schools of nursing that students will use clinical practice as a time to be asking questions about their practice as they learn to link theory and practice (Benner, 1993). It is evident that increasingly busy work settings may impact on students' socialisation through clinical placements.

The busyness of the wards was cited by participants as a reason why students and even new graduates may not be perceived as 'fitting in' to the ward environment. Roslyn described how her ward has received several new graduate nurses after they had spent six months in another ward, to find that the new nurses had never been shown how to independently organise a patient's discharge plan. "They come to our ward and because they've done six months elsewhere, we really neglect them which is wrong, because we don't have time to do anything else. We just assume that they've got all that basic stuff" (Roslyn). Barbara supported this: "when you're busy and there's a few things happening, you're very keen to quieten things down and you forget about the students".

The concept of fitting in was even extended to participants' perceptions of clinical facilitators who were employed by universities to supervise groups of students. Some facilitators were described as not possessing the appropriate clinical skills to support students' learning because "sometimes they just come down and dump the students in the morning and you would never see them for the rest of the day" (Kim). However, facilitators who visited the wards regularly to monitor their students' progress, asked questions about learning opportunities for the students and appeared interested, were regarded more

positively as a facilitator because they similarly fitted in with these nurses' expectations of facilitation. For Kim, the pressure of having students was sometimes exacerbated when students had a facilitator who was as unsure about the nursing care as the students. As a consequence, Kim found that on occasions, she was required to explain differences in nursing care to the facilitator as well as the students.

The attitude of the students as to whether they wanted to go to that particular ward was also regarded as an important indicator of how easily they will fit in with the ward. The ward was influenced by the attitude of the students so that "generally it was a positive learning environment if the students are motivated" (Leisa). Students were sometimes rewarded by offers of future employment if they fitted in:

> We had two students and one fitted in perfectly and the other one didn't. One just fitted, she was great and we said yes come back we'd love you to. And this girl who had so much problems with it at the beginning has turned out to be such an excellent nurse. So that's a reward, because she's really tried to work hard at her faults and really you can't fault her clinical work, her clinical work has always been good it was more her personality and her anxiety but she's really calmed down and grown up a lot (Alison).

It was thought that if students realised that the hospital was observing their performance as a potential employee, they might be motivated to "to show that they are really keen and motivated. If they know that this may influence their chances of future employment, it might make them pep up a little bit and think, I've really got to try hard" (Roslyn). Alison reported that her ward was using students' assessment forms to screen graduates and "if the ward is particularly happy with a student then they get the opportunity to come back here on their graduate program, which benefits us as well as the students."

The criteria for fitting in was subsequently defined as "being keen, motivated, willing to learn, and making the most of the opportunities that are presented to you" (Leisa), consistent with the understanding of learning through task mastery. It was observed that "some people fit in from the first day, some people just do. They have the personality that fits in and are really keen to do things and take the initiative" (Alison). Students who did not display these attitudes were seen as "obviously not going to have a good time, you're not going to learn

anything and you'll just be shutting everything out" (Jeanne). However, it was recognised that sometimes the ward environment also contributed to how welcome students were made to feel. This was attributed to the fact that "everyone has a good day and a bad day, and if you're put with someone who is constantly whingeing about what they have to do, then it is very hard for the students because they get a false sense of what it is all about" (Kim). Kim described that she was aware "some students were given the impression that they were not really wanted here, they had to tread carefully and not get in people's way, that is not the general idea". In particular, participants acknowledged that the "horizontal violence" which has marked nursing for many years was still present in some wards, which can be "quite judgmental, because nurses they talk, they are critical" (Alison).

Students who displayed initiative were regarded as getting more out of their clinical experience and subsequently as fitting in more easily than did students who appeared to be hesitant or lacking in assertiveness. In particular, Leisa considered that students in her ward needed to be more assertive otherwise they may find the ward "hard, and the students tend to be fairly quiet when they come out and don't have a lot of assertion skills." However, there was some appreciation of what students might be experiencing to cause them to be hesitant, particularly during stressful periods such as the handover report. Students' lack of knowledge of the many abbreviations which nurses use to communicate was acknowledged as a source of anxiety and discomfort. Roslyn remembered that

> It was terrible; I don't know how many months I was doing handover before
> I felt confident because you're so nervous. There's nothing worse than sitting
> there and listening to all the experts using these abbreviations and thinking
> 'What the hell is that'. A lot of students and new graduates won't speak up
> because they can easily be made to look stupid (Roslyn).

On the other hand, Alison admitted that she occasionally forgot how stressed students might be feeling. She related an incident in which a student admitted her ignorance, yet she had never realised that the student did not understand:

> One of the girls said to me "I've just heard something, I've just heard the
> PCA (Patient Controlled Analgesia) monitor go off. I've never heard that
> before". We all laughed and said, you've finally made it now, you've heard
> the PCA. She's never noticed it before because she has been so busy with
> everything else, and finally she's got everything else right. She's confident

with everything else and now she's heard the PCA. It was really funny. And yet we had never thought that she hadn't heard the alarm. She was so focused on everything else, that the PCA monitor was even beyond her comprehension. (Alison)

The incident appeared to help Alison to understand that it may take some students time to become comfortable and confident enough to learn in environments which may appear hostile to them. Nevertheless, despite this appreciation, these nurses continue to prioritise fitting in ahead of belonging, as their goal in socialising students.

4.4.2 Discussion of Fitting In

This theme of fitting in to the role of nurse was defined by these participants as "being keen, motivated, willing to learn and making the most of the opportunities that are presented to you". The role for these nurses was therefore to assist students "to acquire the skills, content, and sense of occupational identity characteristics of the profession" (Hixon, 1996, p. 34). Participants recognised that, as novices, their students need help in dealing with stressful or hostile environments before effective learning can take place (Gross et al., 1993). There was awareness that it was their role to assist the student as novices to learn the technology and language of the profession and so to internalise the professional culture (Hixon, 1996). However, it is of importance to examine what influences the respondents in their role of socialiser as they encourage students to fit in and "function like an ordinary RN".

Close examination of the language used by the respondents to describe their view of professional socialisation reveals concepts such as "should see that there are things to be done", "you are really busy" and, "the RN is behind in her work". These describe an understanding of the participants' world as busy and focused on 'getting things done'. The work setting of these nurses, a large, busy, metropolitan hospital thus clearly remains as a powerful determinant of their professional socialisation values. These concerns are reflective of the broader concerns of nurses as reported in the literature (Bick, 2000; Corey-Lisle et al.,

1999; MacCormick, 1995; Shindul-Rothschild et al., 1996). They also serve to raise questions about the value of the clinical learning environment when students are "forgotten" or "regarded as another set of hands" because of the busyness of the wards. The practice of "treating students like an RN" was an issue for these nurses. Yet some students have reported that are uncomfortable in their supernumerary role because staff perceive them as "lazy or a hindrance" and so would prefer to be seen as part of the workforce (Clark et al., 1997). Similarly, some students have described that "you want to be seen as part of the team. You don't want to use your (supernumerary) status" (Wilson-Barnett et al., 1995, p. 5). It was also observed that working with a team may provide greater opportunities for students to practise skills and observe new procedures (Wilson-Barnett et al., 1995). These reports serve to reinforce these participants' perceptions of clinical placement as a time for students to be learning how to fit into busy clinical environments.

The need to fit in is a very powerful influence on both students' and nurses' behaviour. A dichotomy is apparent between meeting the students' needs and those of the ward under these conditions; students who take the initiative to help out and reduce the nurses' workloads were viewed more positively. The need for students to fit in and be accepted by the ward is recognised as a common theme in nursing research (Hart & Rotem, 1995). However, a supernumerary status affords students the freedom to individualise their learning, although questions are raised (Moreton-Cooper & Palmer, 1993) about whether students alone have the insight and experience to recognise the teaching-learning opportunities of some clinical experiences. The rush and busyness of the clinical setting may serve to reduce the time available to fully explore learning opportunities. This finding raises questions about the educational value of such a placement, which is still regarded as satisfactory because the students used their initiative and so did not cause any extra work for their buddy nurse. It appears to be important for students to act in this manner (Twinn & Davies, 1996), because students who are more compliant, help out and generally reduce rather than increase the nurse's workload, are perceived as reducing the stress of having students. This finding concurs with the experiences of other nurses who identified that a difference between the values of the practice areas and those of the education areas led to

conflict and anxiety (Charnley, 1999). It is evident that the practice setting values those students who appear to be busy and show initiative.

Many hospitals have created what Moorhouse (1992) terms "the busyness cult", in which "most nurses seem to thrive on being seen to be busy; this has been ingrained into their work patterns since their first day on the job" (p. 66). In the context of this study, the comment from one participant that her role was not "just baby sitting" perhaps explains the perception of their role as socialiser into this busyness culture. One student, who was observed to be restocking supplies in the dressing room, was regarded as particularly 'good' because she was resonating with the values and beliefs of these nurses and the ward area by keeping busy. The need to be busy continued to be perpetuated by these participants.

In contrast, the professional socialisation of the tertiary student is chiefly influenced by philosophy of the school of nursing and curricula, which seek to encourage the professional ideals of critical thinking and independent learning (Faculty of Health Sciences, 1995). It is the potential conflict which may occur as the professional ideals of the student encounter the bureaucratic values of the work setting (Kramer, 1974) which may account for some students' failure to 'fit in' or to ever 'feel part of the team'. The transition from their own set of values to the hospital's set of values, however, is not an expectation of professional socialisation (Hixon, 1996). Rather, the expectation of a professional socialisation (Hixon, 1996; Kramer, 1974; Melia, 1987) is that students and novices will be assisted to integrate their own values and beliefs about nursing with the expectations of the organisation, in order to achieve a satisfactory resolution to this potential conflict.

However, it not evident that all participants see their role as facilitating such a conflict resolution that is based on the integration of students' ideals with the organisation's values (Kramer, 1974). The expectation that students should be motivated "to try really hard" in order to demonstrate their worth to the hospital and demonstrate why they should be employed after graduation, suggests that some participants believe that students would benefit by adopting the task mastery orientation of the hospital. Students who "don't take the initiative and just ask questions all the time" (Roslyn) were regarded as not achieving this

goal of socialisation and so not fitting in. However, if practical knowledge of nursing, which is contextual, can only be achieved by "active involvement in a situation" (Hixon, 1996, p. 41), then perhaps these nurses' perspectives of their role as socialiser may be more clearly understood and appreciated.

It is their own past experiences and active involvement with nursing which shapes these nurses' professional values and beliefs of nursing. The professional image of self is thus controlled on one hand by these belief systems and on the other hand by the context in which they operate (Butler, 1996). The bureaucratic context of these participants serves to ensure that the focus of professional development is on the mastery of new skills and technology in accordance with the policies and procedures of the relevant area (Butler, 1996). As a consequence, it is both their own beliefs about nursing and those of the bureaucratic work setting which impact on these nurses' perceptions of their role as socialiser. Their definition of that role is grounded in fitting in to the organisation's culture. These nurses do not envisage their role as change agents (Butler, 1996). Nevertheless, in order to be responsive to the changing needs of healthcare, nurses need to be aware of themselves as pivotal in the changing healthcare environment (Hixon, 1996; Porter-O'Grady, 1996). Professional socialisation based on opportunities for growth and development (Hixon, 1996) rather than on achieving task mastery may enhance nurses' abilities to meet the challenges of these evolutionary changes.

4.4.3 Learning the Realities of Practice

This theme defines the second element of how the respondents in this study perceive their role as socialiser- to assist the students in their transition to graduate nurse by coming to understand the realities of practice, before they graduate. Consequently, a number of similar sub-themes relating to the need for students to "learn the reality of practice", "understand shiftwork", and "take responsibility for a realistic patient load", were consistently found in the data. It was agreed that if students could meet these objectives of clinical practice, then it

would assist them to be better prepared to cope with the transition from student to graduate nurse. This was regarded as important because all participants agreed that "students should have a bit more clinical experience before they come out". The following quotation was representative of all participants' perceptions of their role as socialiser, particularly for final semester students:

> I think mainly towards the end of their training, making them realise what it is like. And rather than giving them just one patient, which is not a realistic view of what it's really going to be like, give them a full patient load and let them know that this is going to be the reality. This is how many patients they're going to have to be looking after. And even if they're not caring for them totally, they're still going to get an idea of the workload. But if you share it between the two of you and as they progress towards the end then they can slowly start to take over and then they would be doing everything for their patients and they will get a better idea of what it's like. And they're able to develop their time management skills a bit better. Because some people say you take this patient and I'll these patients. Fair enough it's giving the student a patient load, but it's not a realistic patient load. Then you find when they graduate they say, 'Oh I didn't know I would have to care for this many people'. They don't really know how to organise their time and what they're doing (Roslyn).

Participants explained that new graduates, who are struggling to cope with the increased expectations of them as clinical nurses, frequently attributed it to the fact that "they had never really had to look after this type of workload before". Thus it was felt that if students were given the boundaries during their clinical practice, they might develop more realistic expectations of their role as a graduate. Nevertheless, all participants were keen to reiterate that they enjoyed clinical teaching, particularly with the third year students whom they feel were sometimes not adequately prepared for the realities of nursing. Their task mastery view of learning again influenced their language: "we quite enjoy having the students here and getting in with them and saying this is how it happens" (Leisa). It was this initiation into the "real world" which summarised these participants' beliefs about their role in helping the students learn the realities of nursing.

Clinical practice was also seen as an opportunity to explain to students that things will always change and they need to be able to cope with that. This was difficult on occasions if students were anxious about their clinical experiences. Some students "expect that every day

there will be something to take out, something to put in, someone is going to theatre and they will be allowed to go. They are not thinking that the theatre nurses have had students for the last five days, and they really need a break" (Jeanne). Thus, participants viewed their role as introducing students to the "real world" as a constantly changing, dynamic environment.

Similarly, clinical placements were seen as important opportunities in assisting students develop their skills in time management. A common statement was: "That's an important thing, everything starts from your time management. If you can get that down pat as a student then you're not going to have problems in the transition of coming into the wards" (Roslyn). This feeling was also reflected in participants' expectations that students should use clinical placements to practise their skills so that "when they actually graduate that's not going to be a stepping stone, they're already comfortable with doing observations etc". Jeanne related an incident in which she was able to assist her third year student care for an elderly patient who suddenly required cardiopulmonary resuscitation. She and her student were working an evening shift together and so Jeanne had time to be able to explain the procedure in much more detail than she would have been able to "if it was a morning, busy, rush where you really probably wouldn't have picked it up. You might not have had the time. And I guess that's the advantage if you and the student you can work those shifts together" (Jeanne). This was given as an example of how important is for students to practise their clinical skills in the "real world", rather than "by the book".

Clinical placement therefore was also regarded as an opportunity for final semester students to understand the nature of shift work and rosters. Students usually were allocated to work early shifts that generally commence at 7am and conclude at 3pm. It was strongly regarded that this pattern represented an unrealistic expectation of nursing which was not helpful in assisting students understand the reality of nursing. Students should be working all shifts, including some night shifts. Roslyn recalled her own transition to registered nurse to comment that:

> I think that half the battle when I started was getting used to the shift work, it was so different to student life. Even though the early shift is good because there are things

that need to be done, on a late shift you have time to plan for discharges and other things that are equally important. And night duty is different again (Roslyn).

It was noted that students frequently only work early shifts perhaps because of other work commitments. However, participants remarked dryly that "there's not many jobs available where you only work earlys". Thus it was agreed that "towards the end of your 3rd year, the longer placement is really helpful." Students should therefore be "flexible" and able to work the same shifts as the nurse with whom they are buddied. This was regarded as one strategy to allow students to understand "how an RN works and what they do and so get a better idea of how they are progressing themselves over a period of time rather than just in an 8-hour shift" (Kim). Learning the culture of nursing through the varieties of shift work was also regarded as useful to show students how nurses adjust to a life of shift work.

> They would see that you can still have a social life, but sometimes you can't always go out on a Friday night, you've got to work a late or night duty. What's a public holiday? It's just another workday to us. Your weekend might be Monday, Tuesday. It's hard when they first start to realise that. I used to go out every weekend. We all tried it as a student, going out between a late and an early and trying to function the next day – it didn't really work! I think it's still a big culture shock when they graduate (Alison).

Leisa likened the transition from student to graduate nurse as "part of growing up really. We've got someone in our ward and he said, 'I didn't get Christmas off for the past two years'. And we laughed and said, this is the real world, you mightn't get it off for eight years." These comments were not made with any sense of malice. There was an element of pride in working at special occasions such as Christmas, when families and patients were more likely to interact with nurses on a personal level.

Some wards were attempting to develop solutions that will enable students to be buddied while working another nurse's shift roster. Leisa explained that her ward is presently attempting to negotiate a "ward based contract where the university facilitator does not need to be in the hospital grounds for the student to be there, that the ward would take responsibility for that student". Participants agreed that this model has the potential to assist students by allowing them to learn, "by doing the 3 shifts, the culture of nursing a little bit" (Leisa). It was thought that this would also make it easier to allocate students with a

preceptor. Some ward areas thus proposed this model, which presently is only offered to final semester students, as appropriate for all students. In particular, it would achieve some continuity of supervision, rather than the present situation where students may work with a different buddy nurse each day of their placement and "no-one's really got an idea of how they are going from week to week" (Leisa). Students may be better supervised under this model which might reduce some of the transition problems faced by some students who had "obviously been able to hide at prac when they've been out with the Uni, and now that they've graduated they can't hide anymore and they're really struggling" (Roslyn).

4.4.4   Discussion of Learning the Realities of Practice

Analyses of the themes presented in this section reveal the tension which nurses experience in their role as socialiser, between assisting students learn to fit in to the culture of nursing and yet meeting the demands of the workplace. The economic clinical environment in which many patients are cared for ensures that the values of the practice arena remain dominant (Upton, 1999).

The expectation that clinical practice allows students to experience a process of socialisation into the culture of nursing is widely acknowledged in the literature (Bradby, 1990; Melia, 1987; A. Wilson & Startup, 1991). These nurses' beliefs that students should be working shiftwork in order to appreciate the differing nature and requirements of shifts is corroborated by Carlisle, Luker, Davies, Stilwell, and Wilson (1999) as being a vital method of ensuring that students are perceived as part of the "team", contributing to their acceptance and learning in the wards. Students generally do not feel part of the nursing team and so are "shielded" from the full breadth of the role of a nurse (Charnley, 1999). Learning the structure and geography of the organisation does help nurses become organised and familiar with the realities of practice (Charnley, 1999). The demands of the workplace result in insufficient time for students to be fully exposed to the social rules that govern the

organisational structure of work and consequently insufficient time to be able to integrate these social rules into their understanding of the nature of work (Carlisle et al., 1999).

These participants' beliefs that students should be taking a 'realistic' patient load has supported by one study in which staff regarded students as "lazy or a hindrance" if they did not become part of the workforce (Clark et al., 1997). In contrast, some students have been shown to prefer to be regarded as supernumerary and to focus on just one patient (Little, 1999). This provides them with opportunities to ask questions, think about the way things are being done for this patient and address their personal learning needs (Little, 1999). Some students are asking for extra time in the clinical setting to understand and question their practice rather than be expected by busy clinical settings to function as an extra set of hands or to perform like a registered nurse.

Tension has subsequently been reported when nurses in busy clinical settings experience a conflict between a commitment to the scientific rather than the holistic view of patient care (Hodges, 1997). Similarly, tension occurred when students, who have undergone a period of socialisation in the professionally-oriented, educational setting, face the more bureaucratic culture and values of the work setting (Goldenberg & Iwasiw, 1993; Hixon, 1996; Moorhouse, 1992). The nurses participating in this study appear to have resolved this conflict for themselves by adopting the values of the organisation (Kramer, 1974). Thus their beliefs about nursing, while focused on "delivery of total patient care" remains based in the need to be doing, to be busy, because as Leisa describes "there's no watching in our ward, there's only doing". Moorhouse (1992) concurred with this observation by noting that as a means of coping with increasing workloads, nurses were shifting to a task mastery approach to patient care, rather than a patient centred approach. This perspective was supported by Rolfe (1996) who argued that although nursing education has changed their values and beliefs, the dominant paradigm in healthcare remains the traditional, reductionistic, scientific view of nursing.

Subsequently, this represents the reality for these participants. Their increasingly, economically-driven, clinical environment ensures that the values of the practice area

remain dominant (Upton, 1999) despite the aims of new curricula to offer nurses a fresh perspective of nursing (Diekelmann, 1993). It is therefore not surprising to find that the participants construct their role as socialiser, as one of helping students to understand the realities of nursing in a technical-rational, oriented environment. Their nursing context is characterised by expectations that they will be busy (Moorhouse, 1992) and focused on doing more with less. When the importance of their working context is appreciated, this view of socialisation becomes congruent with their perceptions of their role. The participants do not see themselves as change agents (Butler, 1996). The lack of time in increasingly busy clinical settings and the dominant, technical-rational orientation of their work setting, may be factors influencing this perception. Further research into the factors which influence their understanding of socialisation and their ability to influence the values of their own environment may reveal ways in which nurses can be encouraged to become leaders.

4.5 ROLE AS ASSESSOR

The final major theme emanating from data analysis is a perception of these participants' role in clinical teacher as that of an assessor. Participants frequently discuss issues relating to 'being a gatekeeper', to having 'dialogue in assessment' and to 'changes in the clinical learning environment', to define their understanding of their role as assessor of students' performance while on clinical practice. Nurses' expectations of their role in the assessment and evaluation of students' learning have one main goal - to ensure that students can "function like an RN". Thus participants see their role as a gatekeeper for the profession.

4.5.1 Being a Gatekeeper

The concept of a gatekeeper role in assessment relates to the maintenance of the standards of a profession (Mahara, 1998). Participants perceived their role as gatekeeper to the profession very seriously and with great thought. All participants expressed regret at having to fail students, however there was strong support for their perception of their role as a gatekeeper. "We failed one student at the end of his third year and said, you just can't pass him, he's not safe. And it makes you wonder how that got to that stage" (Alison). This remained as an issue which participants found most problematic; how students could get to the end of their three-year course and then to be found unsafe and unsuitable to continue in the course. Failing students at this stage of their course presented two major challenges. The first was understanding why students were not recognised earlier as having problems, and the second was the consequences of failing a student at this stage of their course. Participants tended to respond to these challenges by asking themselves "am I the only one who has found problems with this student?" (Kim).

It was therefore believed that students should be failed earlier in their course if their clinical performance was unsatisfactory, even though "you might feel really mean in their

first year by saying, look you really haven't grasped it, but I think you need to" (Roslyn). To let students progress to the end of their third year and then assess them as unsafe or unsatisfactory was regarded as even more irresponsible. Even though participants admitted they "feel terrible", it was generally understood that such formative feedback should be given in time for students to attempt to redress their weaknesses "so that it's not on their last day that you tell them that they've been doing badly and I'm going to have to fail you" (Alison).

However, many participants appeared reluctant to offer give negative feedback, because of an apparent lack of confidence in their own abilities as a teacher. As a consequence, some participants also did not believe that it was their responsibility to fail students, even when the decision not to fail was in conflict with their own nursing practice values. "There's a feeling that I don't really have the right to do that, I'm not their facilitator and it's not my job to say no, that's way off track. But at the same time when they're caring for patients that I'm responsible for, well…" (Kim). Participants believed that as a consequence, this reluctance to take responsibility for students' progress "is perhaps why we have students in third year that shouldn't be there, because everyone's been reluctant to fail them" (Leisa). This reluctance was illustrated by the difference in perception with which some participants viewed assessment of students in comparison to assessment of new graduates:

> With the new grad you really have to get it into them. With the students you tend to say, oh well somewhere else down the track they will pick up on that, because they are not on the ward for long and you might not really see very much of them. And there is the facilitator who can have a go (Kim).

Kim was verbalising all participants' beliefs that students do not receive sufficient periods of clinical placements during their course. It could be argued that as a result of their shorter clinical placements in the first five semesters, students are not given sufficient opportunities to demonstrate how much, or indeed, how little, they understand and integrate into practice until their final semester placement which usually extends over a period of 320 hours. Consequently, students might proceed through the course with minimal opportunities to demonstrate mastery of the relevant nursing competencies (ANCI, 1994). Participants therefore displayed reluctance in failing these students who they believed "have not really

been able to practise independently because they are only on the ward for a short period of time" (Kim).

A second major factor influencing the participants reluctance to fail students was their perception of the consequences for the student. "Yes, it's a hard thing to do particularly when your decision will stop them from continuing in the course" (Roslyn). All participants confirmed this belief. Kim commented: "To be honest I don't like doing assessments. I don't like saying to someone, look I don't think you're ready, I don't think you're very good. Because it's very hard to knock someone's confidence, especially if her getting through is dependent on my assessment." Kim typified the reluctance of nurses to fail students when she admitted: "At the same time I did pass her. I didn't think she was too bad."

Likewise, participants doubted their own assessment abilities and clinical judgement when failing students responded that the participants have been the first nurses to be dissatisfied with the student's clinical performance. "And so it makes it really hard then when they say, 'Oh but I've done so well in my other pracs (practice) and in all my feedback.' And so you question yourself then and think, well maybe I've been too hard" (Roslyn). Participants' confidence in their abilities as an assessor were further challenged when schools of nursing faculty members also appear to question their assessments of students. One school of nursing response to a student's failure with the comment that "we've always had rave reviews about her and she's always done so well" (Jeanne), served to further undermine these participants confidence in their role as assessor. Such feedback from a school of nursing caused these nurses to doubt their clinical judgements. In one particular instance, the school of nursing was asked to assess the student and "they made the decision to pass her, we probably wouldn't have but they did. They worked with her for a week or two and they were happy, so that was their decision" (Jeanne). While participants did not always agree with others' assessment of difficult students, they acknowledged that:

> It can be sometimes beneficial to have someone else work with the student for a few days to also see whether they are of the same opinion as you. That way you know whether it's your opinion or whether it's something valid. Observations from other nurses are helpful, because the RNs are always looking at what the students are doing so you can often ask them how they feel the student is coping (Roslyn).

This strategy was successfully followed by one of the nurses with a third year student who was not performing well on clinical placement. When the participant realised that the student was experiencing some difficulty, she immediately spoke to a number of other staff in the ward to clarify her assessment and perceptions of the student, then contacted the relevant faculty member to discuss the issue. The student's history of under-performance on clinical placement reassured the participant that her assessment of the student was reliable and objective and reinforced her confidence in her clinical judgement.

However, it was agreed that some participants continued to exhibit a reluctance to fail students because of a perception that it was a personal reflection of their own abilities as a clinical teacher, again reflecting a lack of confidence in their abilities as assessor. On occasions participants' actions reflected this need to have their students pass the clinical placement. One incident that was observed to take place between a respondent and a final semester student, appeared to reinforce this desire to have students' successfully complete clinical placements. Unbeknown to her buddy nurse, the student had experienced difficulty in her previous two semesters' clinical placements, both of which she had been required to repeat in order to master the placements. On her first day on this placement, the student announced to her buddy nurse (Jeanne) that she had failed her last placements and asked if she would fail this one? Jeanne promptly answered; "no she wouldn't," without any basis for this prediction. As a consequence, Jeanne was obliged to give this student much more support than that required by her peers on the same placement, in order for her to indeed successfully complete the placement.

In discussions, Jeanne justified her approach by saying that she wanted to reward the student's honesty for admitting she had a problem. It was not obvious that she understood that the student had effectively manipulated her into supporting her until she passed the clinical placement. Other participants also reported that some students appeared to manipulate the clinical setting and buddy nurses in order to pass their clinical placements. In particular, some participants identified that students sometimes use their self-assessment opportunities to manipulate the buddy nurse to say "but you are doing really well, so they're

not really being very honest [in their self assessment]" (Roslyn). While these encounters with students caused some discomfort for participants they also acted to reinforce their lack of confidence in their assessment abilities. However, all participants recognise that despite feeling they would fail incompetent students, they had at some time, worked with a new graduate who perhaps should not have graduated.

"I think I have worked with a couple of those. Sometimes you notice it when the new grads come on. You think, how did they get through, and that's scary, because that's something we really struggle with. The fact that they have got this far and their basic nursing is way off the track" (Alison). Nevertheless, it was still agreed that "you do feel bad pulling up a 3rd year student. You do feel bad, because you don't want to come over like you think you're the big experienced nurse, but I've got enough experience to know when they have problems" (Roslyn). Subsequently, there existed some agreement that both students and participants need support in assessment to resolve some of these conflicting interpretations of assessment.

4.5.2   Discussion of Being a Gatekeeper

The concept of nurse as gatekeeper in the maintenance of standards of nursing has been reported in teacher education (Mayer & Austin, 1999) where teachers believe that their role is to uphold the standards of the profession. In particular, the dominant culture of the work setting appeared to influence these participants in their belief that their role is to maintain standards of "basic nursing" practice (Alison). Similarly, Paterson (1994) described a perspective of the gatekeeper role which reflected a very narrow view that is focused upon reproducing behaviours and patterns of behaviour which nurses believed were essential to nursing. Analysis of these participants' beliefs about their role as assessor therefore finds that it is the technical-rational culture of the work setting and a lack of confidence in their role as clinical teacher which continues to influence their behaviour and choice of strategies as assessor.

Earlier analysis of these respondents' beliefs about learning found that they experienced difficulty in perceiving learning as other than task mastery. Such a perception of learning may account for the evident conflict that these nurses demonstrate in their role as assessor. Furthermore, their inability to be able to explain the intricacies of their practice may also contribute to their reluctance to fail students. However, these participants are not alone. Nurses constantly make numerous decisions for which they have difficulty explaining the criteria and carry out interventions for which they cannot justify the rationale (James & Clarke, 1994). This was in fact, the subject of Benner's (1984) research which likewise concluded that nursing has been unable to articulate the uniqueness and richness of knowledge embedded within the practice of expert clinicians. Similarly Chinn and Kramer (1993) concurred that much of what is known in nursing cannot be fully described. This situation has been earlier recognised as 'tacit knowledge' (Polanyi, 1962), describing knowledge which professionals are unable to fully explain.

It has been suggested (Johns, 1995) that reflective practice presents practitioners with the opportunity to resolve any contradiction between that which they intend to implement and their actual nursing practice. Reflective practice therefore allows practitioners to learn through experience and to make explicit their tacit body of knowledge. Through reflective practice, nurses can then begin to understand their practice and to develop their own body of 'personal knowledge' (Johns, 1995). The development of such a body of personal knowledge may assist the nurses in this study to make explicit their own tacit knowledge. These participants are all experienced practitioners who possess a great deal of expert knowledge. Their inability to fully explain this knowledge when combined with a task-mastery focus appeared to prevent them from being able to see students' learning as more than the completion of skills. This served to restrict their assessment of students within a technical element of practice.

These participants are most concerned with the technical aspects of nursing practice. Their theory of nursing is associated with explaining and predicting patients' behaviours from a scientific perspective. Such a theory of nursing is associated with 'techniques', 'efficiency' and 'effectiveness' in nursing practice (James & Clarke, 1994). This position is consonant

with these participants' beliefs of learning as task mastery. As a consequence, their assessment of students' clinical practice is also focused on the student's successful mastery of particular procedures. Of particular concern is the belief expressed by some of the participants that they do not perceive their responsibility for teaching and assessment of the student to be as important as their responsibility towards ensuring that the new graduate is competent.

Subsequently, a conflict emerges between ensuring that students were exposed to as many learning opportunities as possible, "because they are not on the ward for long and you might not really see very much of them", and being more concerned with new graduates because, "you really have to get it into them" (Kim). These participants' rationales were that "somewhere else down the track they [the students] will pick up on that", a position that is supported by MacCormick (1995). Yet this perception is at odds with the views of some participants who believe that their primary role is to show the students as much as possible. The participants were motivated by the students' relatively short periods of clinical experience and consequently the beliefs that nurses must be competent in the basics of nursing (Carlisle et al., 1999). However, this incongruity perhaps illustrates the deep reluctance which some nurses have towards giving negative feedback to students, or indeed failing their clinical performance.

Nevertheless, while the participants believed that nursing should be holistic, they were chiefly concerned with the psychomotor skills of their students (Duke, 1996). Their own lack of reflective practice and relatively large bodies of tacit or unexplained knowledge was evident in the participants' difficulties in explaining the intricacies of their own practice to the students. A culture that does not reward questioning similarly inhibited participants' abilities to explain their actions. Thus while they experienced little conflict when assessing routine skills' performance, participants were stressed when asked to assess the student who showsedo real desire to learn by doing, or to fit in to the expected norms of the ward or hospital culture. Their lack of preparation for their teaching role may account for these respondents' difficulties in assessing the non-conforming student and their apparent unpreparedness for the complexities of their teaching role (Duke, 1996).

A recurring theme for all participants was their perception that failure of the students was their fault and that they had not done enough to assist the student to learn and subsequently pass the placement. The tendency for some nurses to question their own competency when a student fails clinical placement has been described in the literature (Duke, 1996). It has been reported that some nurses believe that students' failure is linked to their own professional competence and so equate failure of a student to failure of the preceptor (Bowles, 1995). Such a lack of confidence in their teaching and assessing capabilities is not confined to buddy nurses or preceptors, but has also been identified in sessional clinical teachers (Duke, 1996). Low self esteem which is evident in the doubting of their abilities as a clinical teacher, may be a result of a socialisation into a work setting which remains dominated by the patriarchal medical model (Moorhouse, 1992). While not all participants have experienced the apprenticeship model of nursing training, their adoption of the technical-rational culture of the work setting may be influencing their perception of their role as assessor: "It's not my job to say no, that's way off track" (Kim). Dyck et al. (1991) suggested that nurses continued to value the traditional feminine characteristics of helping and showing concern for others, which may explain the conflict which these participants demonstrated when faced with assessment situations in which they must be assertive and not nurturing towards the student. Some authors have similarly identified a role conflict between the nurse's nurturing role as a mentor/preceptor and the need to be involved in formal, summative assessment of the student (Burnard, 1988; Atkins & Williams, 1995).

The role conflict subsequently experienced by these participants has also been expressed by school teachers who describe guilt and distress over failing their student teachers, particularly when they believe they are "ruining someone's career" (Mayer & Austin, 1999, p. 73). Similarly, the desire to cause the student no harm (Duke, 1996) is congruent with the participants' reluctance to fail students and so interrupt their progression through their course. As a consequence, some nurses have highlighted the need to give positive feedback to students when possible in order to maintain their self-confidence (Atkins & Williams, 1995). Furthermore, the encouragement which participants gave to students to self assess their own clinical performance was reported as a strategy which reduces the

stress and conflict experienced by registered nurses in the assessment of students whom they were mentoring (Atkins & Williams, 1995).

The issue of whether preceptors should be engaged in the evaluation of their students is complex. Evaluation of students is difficult because of the complex nature of nursing practice and the unpredictable impact of the clinical context on the student's performance (Twinn & Davies, 1996). Much of the clinical context in which assessment takes place is beyond the control of both the assessing nurse and the student. The dual nature of assessment as being both formative and summative (Mahara, 1998) was recognised by the participants who acknowledged that even though they do not enjoy this aspect of their clinical teaching role, feedback should be given to allow students the opportunity to address inadequacies in their practice. Assessment of students is threatening to many nurses (Duke, 1996; Mahara, 1998) who, although confident of their clinical expertise, continue to doubt their objectivity and reliability in making decisions about failing students: "because you don't want to come over like you think you're the big experienced nurse, but I've got enough experience to know when they have problems" (Roslyn). It is suggested that professional education may assist nurses overcome such assessment anxiety (Mahara, 1998). Professional development may also serve to assist the participants to uncover their tacit knowledge and so increase their awareness of the contradictions evident within their practice (James & Clarke, 1994).

4.5.3 Dialogue in Assessment

The theme of dialogue in assessment encompasses issues that the participants related to a perceived need for their role in assessment of students to be broader and based in dialogue between buddy nurses, students and schools of nursing staff. In particular, the assessment performed by university clinical facilitators of the students whom they supervise in a group, was regarded as problematic. Participants generally described the individual support that they receive in addressing issues relating to assessment as reasonable. However, they

questioned the validity and reliability of assessments performed by clinical facilitators and expressed the desire to contribute to the assessment of all students. It is highly unlikely that one clinical facilitator is able to adequately observe and assess the eight or so students in their group, who are usually placed in a number of different wards throughout the hospital. Clinical facilitators were reported to "really have no idea what they're doing. They just waltz in, the ones that I've seen, and say 'Is everything going well?' Of course the student is going to say, yes we're fine" (Alison). Students were frequently reluctant to reveal to their facilitator that they were experiencing difficulty. Consequently, facilitators were not able to gain a realistic impression of the students' progress. It is the experience of participants, that while many clinical facilitators may come to the ward and ask the buddy nurses about the student's progress,

> I really don't think that they are listening. I know that if you start to tell them a lot of information about how the student has been going, particularly if they have been having problems, then they don't write it down, they just listen to you. Now if they do that for every one of their eight students they're not going to remember all that information on each student (Kim).

Participants stressed that while not all facilitators act in this manner, they have little confidence in the assessment results of those who do. Alison concluded that the student also feels better supported if they are working with the one nurse for their whole placement. This allowed both the buddy nurse and student to collaboratively assess the student's progress over the full extent of the clinical placement. "You can also evaluate them properly rather than the facilitator walking in and only seeing them for 5-10 minutes a day" (Jeanne). Participants added that this issue was not totally the fault of the facilitator, although Jeanne described an experience in which:

> The facilitator left the student with eight patients, but in the whole week she never asked me how the student was going or anything like that. She might have come to see him do one dressing or whatever, and that was it and that was the basis of her assessment. How could she assess him? (Jeanne).

Since clinical facilitators have up to eight students in various wards of the hospital for whom they are responsible, they "physically can't be everywhere at once" (Jeanne). However, clinical facilitators should be seeking greater feedback from the buddy nurses

as the basis of their assessment of the students. "Because we're the ones who have seen what's going on and whether they are taking initiative and going ahead, or asking if they don't have any ideas about taking any risks. I think we do need to have some sort of say in how they go" (Leisa). In Alison's experience, "you'll get a couple [of clinical facilitators] who have said, 'what do you think about this person, how do you think she's going?', but that's about it. When you're only working with them one day a week, everyone can be good for one day, do you know what I mean?"

Subsequently, participants suggested that students should be encouraged to work the same shifts as one or two buddy nurses to increase the reliability of the feedback and assessment of their clinical performance. The nurse and student may be able to develop and implement appropriate strategies to assist the student meet their individual learning needs. Alison cited an example of a student who worked with one nurse for four weeks then with another nurse for two weeks. The student was then able to utilise the first nurse as a support person during the remainder of her clinical placement and the two precepting nurses were able to collaborate in the student's assessment. This model was regarded as preferable to having students buddied with a different nurse each shift, which usually resulted in a situation in which "no-one's really got an idea of how they are going from week to week" (Alison). Leisa described how one of her present students had admitted that she has always been able to hide during their clinical practice. "She always got her assessments done on the last day so there was no time to improve." Increased dialogue between nurses, the university and students was therefore regarded as a valuable solution to these issues.

Roslyn also believed that students should be encouraged to undertake regular self-assessments, not only to be compared with their buddy nurse's assessment of them, but also to increase their self awareness and understanding of their own learning needs. "I think that this gives them a broader overview of where they're going" (Roslyn). This may also encourage students to feel comfortable enough to voice any personal concerns about their nursing practice. Roslyn's suggestion arose from her experiences with many final year students who "are really scared and say, 'Oh I don't know as much as that nurse and I'll

never know that much'. But I think everyone thinks that, but obviously some people voice it and others don't." Participants recognised that undertaking this amount of assessment for every student may be time consuming, particularly if they are required to write anecdotal notes to support their assessment, however it "gave the student more guidance, if you've got examples there, they can work from that" (Leisa). Support and dialogue during assessment was therefore regarded as necessary for both student and nurse.

Several options, including the relevant university lecturer or clinical coordinator or other clinical colleagues, were frequently accessed for support. Nevertheless, while assessment was a significant issue for nurses, participants did not report many problems with students' clinical practice when compared to the total number of student hours during which the hospital hosts students for clinical placements. Many problems particularly those relating to clinical skills, were dealt with by the participants themselves. However, issues relating to patient safety and lack of professionalism that cause nurses to fail students, were more frequently referred to the university. Alison described one student who "had so many problems, she didn't want to take responsibility for her care basically. We ended having to call in the uni representatives and getting them to work with her. Her problems were beyond our experience." Support from the university was helpful in reducing the extra workload which students, particularly those requiring intensive support, engender.

Kim viewed that extra support as vital because the clinical facilitator can take the time to work with students in the areas in which they might require more practice. While it was suggested that assessment, "was a matter of using your head" and "it's something you get to learn more about as you're going along" (Roslyn), the nurses in this study all agreed that support and preparation from the universities for assessment was necessary. Several topics were most commonly nominated as being important components of preparatory workshops including conflict resolution, communication techniques, and assessment. It was therefore agreed that while the responsibility for ensuring appropriate preceptoring or supervision of students lay firmly with the university, dialogue between the stakeholders was equally important.

4.5.4 Discussion of Dialogue in Assessment

While earlier analysis reveals a conflict within the role of assessor as gatekeeper, it is also evident that the nurses in this study are seeking an increased dialogue with their students regarding assessment. There is an acknowledgment that university-appointed clinical facilitators experience difficulty in adequately supervising or assessing their entire student group, which concurs with the experience of these nurses (Grant et al., 1996). In particular, facilitators who were unfamiliar with a clinical area were also regarded by other nurses as requiring extra support in assessing students and in some cases are perceived as "incompetent" (Brammer, 1999), thus increasing the pressure on these nurses' responsibility for clinical assessments. As a consequence, these participants expressed a desire to be further involved with the assessment of students with whom they have been buddied, through dialogue with the university clinical facilitator and the students.

The participants' desire to work jointly with students and clinical facilitators to collaboratively assess students' clinical performance, is one tenet of fourth generation evaluation (Guba & Lincoln, 1989). Clinical assessment within fourth generation evaluation methodology does acknowledge the authority and power of the nurse as clinical teacher (Mahara, 1998) who is then able to assist students take more responsibility for their own learning. This approach was evident in comments from some participants who suggested that students should be involved in their own assessment, with the purpose of increasing their self awareness and understanding of their own learning needs. This dialogue is congruent with the view of assessment as having a formative function and is catalytic in the establishment and maintenance of an assessment relationship (Guba & Lincoln, 1989).

Similarly, the proposal from a number of participants in this study for an increase in the utilisation of the preceptorship model of clinical supervision appears to be based in this desire to establish a longer-term relationship with students. Participants suggested that this

model would advantage students' learning. Student assessment would be more consistent, the precepting nurse would be able to take into account the contextual and changing nature of the clinical learning environment and preceptoring nurses would be more likely, having established a relationship with their students, to negotiate and resolve conflicting views of teaching (Mahara, 1998). In keeping with these intentions, the dialogue that these nurses initiate with schools of nursing to resolve conflict in assessment is also consistent with the aims of fourth generation evaluation (Robinson et al., 1999).

However, increased workloads within complex clinical settings are impacting on the ability and willingness of nurses to undertake objective clinical assessment of their students (Twinn & Davies, 1996). The supernumerary nature of students means that clinical nurses may fail to accept the responsibility for ensuring students' clinical competencies, particularly as the wards become busier and nurses prioritise patients' needs ahead of students' needs (MacCormick, 1995). Questions have been raised (Twinn & Davies, 1996) about the appropriateness of some clinical learning environments when nurses cannot pay sufficient attention to their role in student learning and assessment. The lack of time available for assessment does support the participants' calls for the wider utilisation of preceptorship models of clinical supervision, as a method that allows students and nurses to work together for an extended period and increases the validity of the assessment process. Fourth generation evaluation, in its valuing of the relationship between stakeholders (Mahara, 1998) offers support for these nurses in their quest to be more involved with student assessment.

Therefore, while there is evidence on one hand that participants are seeking to extend dialogue with students in assessment in order to provide feedback and increase self awareness, on the other hand, there also appears to be some contradiction in their perception of what constitutes assessment. Assessment "within a positivist tradition is based on an assumption that learning involves the acquisition of information that exists independently of context" (D. Willis, 1993, p. 396). Evidence of the influence of the positivist work culture can be found in some participants' comments such as "if they pitch in like everybody else, I think they learn a fair bit" (Alison). This begs the question, what do students learn in such an environment? Students assessed on this expectation of learning may be able to demonstrate

that they have met the behavioural criteria of the workplace by 'fitting in' and 'showing initiative'. However, this does not necessarily mean that they will have made the qualitative changes in their thinking and understanding (D. Willis, 1993). It is these qualitative changes in understanding and reorganisation of knowledge that are the foci of new curricula as they seek to develop the reflective practitioner and critical thinker (Diekelmann, 1993; Faculty of Health Sciences, 1995). Lack of evidence in these participants' understanding of teaching and learning may contribute to students' perceptions of learning on clinical placements as being focused on assessment, rather than as an opportunity to develop the attributes of a life long learner.

While these conclusions confirm the research findings that clinical teaching is a source of stress and potential conflict (Atkins & Williams, 1995), it is well documented that many experienced nurses do enjoy clinical teaching (Grealish & Carroll, 1998). Nevertheless, the rapid changes being experienced within healthcare environments may contribute to difficulties which these nurses experienced in assessment of students because of the changes in clinical learning and assessment opportunities. Conflict appears to exist between meeting the students' needs through assessment and the imperative to ensure that they are safe and competent future practitioners. The next section presents relevant data reporting participants' understanding of the impact of change on their role as a clinical teacher, particularly their role as assessor.

4.5.5   Change in the Clinical Learning Environment

A number of common themes were identified by all participants in their description of the factors contributing to the increased pressure and stress which they are experiencing in their clinical environments. Changes in the nature and profile of their patient population, change in learning opportunities and the impact of change on staffing and morale, all combined to increase the pressure on the clinical nurse to meet their commitment to the student's need for assessment of their clinical performance. Within this environment, participants identifyied

some specific examples of how they perceive that learning opportunities may be affected, many of which are corroborated in the literature as becomes evident in the following discussion.

One common feature of all participants' experience was change in the nature of patients being cared for in the hospital and subsequently, change in the care required by these patients. The fact that patients are staying in hospital for shorter periods of time due to improved pharmacotherapeutic and other treatment options was identified as a common issue. These trends are supported Venegoni (1996) who reports significant increases in patient acuity. Barbara described that in her unit, the needs of patients were changing because of an increase in the number of acutely ill patients, as well as more violent and aggressive patients who are admitted, in some cases for longer periods than previously had occurred:

> But you get all those quite aggressive people who tended to once be spread out more. But now you are getting two thirds of the people who are highly demanding and the other one third is settled. Because people aren't coming in so soon, they are being looked after in the community now (Barbara).

Higher readmission rates resulting from earlier discharge were contributing to an increase in the number and acuity of patients. Jeanne agreed that in her unit "we think we are getting more dependent patients. It's taking its toll on everybody because of the staffing and the patients who aren't so sick are getting woken up every night because of the patient who is screaming and yelling and wetting the bed and falling out of bed."

While the needs of patients in each unit are becoming more acute, participants also described that this has increased the pressure on them because, "nursing care has become more specialised now, it is not so general any more" (Kim). This change requires that all nurses have advanced assessment and treatment skills. However, Roslyn felt that this made it difficult for students, particularly as novice learners, to access more "routine" teaching and learning opportunities. Participants agreed that the change in their patient profile has subsequently increased the need for both students and nurses to be more fully aware of the whole patient and their environment. Students were now required to be able

to liaise with other health professionals to adequately plan and co-ordinate their patient's care after discharge from the ward. The nurses in this study acknowledged that this could be a positive change as it increases the student's perspective of the whole patient.

Economic and budgetary constraints were also identified as contributing to reduced teaching and learning opportunities for students. Leisa described that in her area, protocols for certain procedures were being reviewed because, for example "we must be the only idiots who change monthly catheters fortnightly". However, such changes result in a decrease in the number of opportunities for students to practise and subsequently be assessed, in such skills as catheterisation, particularly when these interventions were usually being performed on the weekends when the ward routine is less busy, but there were fewer students. Jeanne confirmed that this trend was also occurring in her unit where protocols have been altered so that certain procedures, particularly complex, time-consuming skills, are only performed on certain days to reduce time and staffing expenditure. She noted that this frequently meant that students miss out on participating in or even observing these procedures, which were more likely to be scheduled at quiet times such as evenings or weekends when students were less likely to be on clinical placements.

A further example of the effect of the economic constraint on students' learning opportunities, was an incident in which students were not permitted to use a ward's sterile gown packs to practise their gowning and gloving technique. The ward nurses explained that since responsibility for budgets had been devolved to the ward level, they could not justify the cost of multiple sterile gown and gloves for students' practice sessions. As a consequence, students were unable to be assessed in either their gowning and gloving technique or in the process of catheterisation. However, Jeanne attempted to justify these reduced learning opportunities by arguing that, "IDC is only a glorified aseptic technique anyway and as a new grad they will be walked through it. It's far better for them to consolidate their skills in aseptic technique, that's what they will be doing as an RN". Jeanne's rationalisation of the reduced learning opportunities for such skills as catheterisation was in direct contrast to the stated commitment of other participants to developing sound, foundational skills and an understanding of the basics through repetitive

practice as explained by Leisa: "the hard thing for me is to try and get across to them that the more they do it, the more comfortable they'll be". It is clear that such comments reflect a pragmatic approach to change in their clinical environment by these nurses.

In Alison's unit, staff were involved in numerous trials of new equipment as well as various teaching projects, all of which created a degree of pressure which she expected that students are not even aware of. Multiple models of facilitation, different student year levels, different universities and expectations, new graduates, re-entry and overseas students were all factors creating stress in the ward. Alison explained:

> It is a lot of work, and I think what the problem is, is that we've got three preceptorship programs. We've also got an exchange student coming from England, we've got a re-entry student at the moment and then we've had second years, who are being facilitated as well. So you've got lots of different models operating at once, we've got so much going on; it's to the point where it's too much (Alison).

Kim and Roslyn also perceived that the expectations of them to be involved in clinical teaching further contributed to their stress: "I don't think that the hospital gives us any support really, clinical teaching is just something that is expected of you. You arrive at work and they say, you've got a student for the next two weeks." Roslyn described how she had returned from leave to be told that she was preceptoring a student for the next eight weeks:

> It gets a bit draining when you're doing it every day. I enjoy working with the students but two months is a long time, having to explain everything that I was doing and making sure that she was learning. Even simple things like how to flush an IV line, you've got to take your time to let her have a go and sometimes you feel like pulling your hair out by the end of a day. I think that if we had a break between students that RNs would find it more rewarding, rather than it being expected of us that we have to do it (Roslyn).

The time and effort required to adequately meet students' learning needs and carry out formative assessments "to make sure she is learning" was described as "just too much" (Roslyn). Subsequently experienced nurses were leaving the ward areas, which further exacerbated the pressures on remaining staff. Barbara confirmed that similar events were occurring in her area.

> We are very short in numbers of experienced staff. I was talking to one of the others yesterday and she said 'I just know that I'm going to be asked to act up as Level Two and I don't want to do that'. There is a lot of pressure on staff to do that. And a lot of people are agency staff or casual staff, so we can work a shift with two of our own staff and everybody else from outside (agency staff). I imagine that very shortly there will be no Level Two's left in the ward. And so we are all thinking I just want to get out of here (Barbara).

Likewise, Jeanne confirmed that she was considering leaving her ward because of the increased pressure caused by understaffing.

> That's true, because the more people that leave and the more short staffed you are, then it starts the ball rolling and everyone thinks, 'well if this is how bad it's going to be then I'm not staying either'. I know in our ward a whole lot of people have just left and now we are all leaving. It's too hard, when we were all there it wasn't so bad, but now it's too hard (Jeanne).

All participants shared the view that these events were impacting on students and clinical teaching opportunities. "Yes, it's a stressful time and it's not good for the students either to just pass them around from RN to RN. But at the same time they are going to learn more effectively from somebody who is fresh and wants to be teaching because we're burnt out" (Roslyn). Reliability in assessments is compromised under these conditions. However, while the nurses in this study did note that "a phone call from the uni would have been nice" to acknowledge their role as a preceptor, they did not perceive that there were "insufficient" benefits to the role (Dibert & Goldenberg, 1995), but rather based their reasons for leaving on workload pressures.

4.5.6   Discussion of Change in the Clinical Learning Environment

The extent and speed of change in healthcare delivery is undoubtedly exerting an enormous impact on both the role of the nurse and on the clinical learning environment. While opportunities for students to be more involved in activities such as discharge planning and patient education are occurring, the increased busyness of the wards is contributing to a general perception that opportunities for quality teaching and learning are diminishing. This theme is reported by Charnley, (1999) and Forrest et al. (1996) that students and

experienced nurses agree that effective clinical learning environments are being adversely affected by staff shortages and an increasingly demanding workload. The value of learning taking place in these changing contexts is also questioned (Gross et al., 1993) by suggestions that students may be too insecure to learn within such complex clinical environments. These participants' concerns about the loss of quality clinical learning environments and opportunities concur with an analysis of healthcare reforms in the United Kingdom (Forrest et al., 1996). A change in patient population and the decreased length of stay of patients is an issue of concern for these participants. However, their concerns about the loss of opportunities for students to repeatedly practice various skills, is answered in the literature by the acknowledgment that repetitious practice of skills is not the only way to achieve competency as a nurse. Venegoni (1996) describes changes to the nature of patient population that are occurring as a result of advanced technological care, treatment options and case management models. As a consequence, these patients simply do not require multiple invasive interventions. Oermann (1994) subsequently challenges nurses to create new learning opportunities for student nurses to learn advanced clinical decision-making skills in this changing environment.

It is therefore important to this study to analyse and discuss how the participants in this research understand the nature of assessment, in order to understand why changes in the clinical environment present such barriers to effective supervision and assessment of their students. Ramsden (1988, p. 15) suggested that one reason for "students' failure to learn effectively can probably be found in the ways that teachers and other educators think about teaching and learning". Similarly, it could be suggested that one reason why these nurses express difficulty in assessment could be related to the ways in which they think about learning and assessment. Examination of the discussion in sections 4.5.2 and 4.5.4 points to an interesting contradiction in these nurses' perceptions of assessment.

On one hand their view of learning as task mastery means that they perceive assessment as a measure of competency within this task mastery approach to learning. Subsequently, being a gatekeeper in assessment is measuring whether students meet professional standards (Mayer & Austin, 1999). These participants are particularly concerned with

assessment of their students' psychomotor skills (Duke, 1996). In contrast, they also express a desire to be involved though dialogue with their students and with schools of nursing, in order to facilitate students' understanding and awareness of their own learning needs. This approach is comparable to fourth generation evaluation (Guba & Lincoln, 1989; Robinson et al., 1999). However, examination of the respondents' descriptions of the impact of change in healthcare on their own nursing context, suggests a number of responses to this tension between learning for task mastery and assessment for growth and development.

Some participants appear to be overwhelmed by the pace and extent of change. In particular, Jeanne is actively searching for another position outside acute nursing and comments: "it's too hard. When we were all there it wasn't so bad, but now it's too hard". It appears that Jeanne has chosen to adopt Kramer's (1974) choice of behaviour capitulation, and rather than give up her ideals and values about nursing to adopt those of the work setting, she has chosen to leave the clinical area. Jeanne's perception that the clinical environment is now "too busy", so that learning can only be achieved by doing, and that opportunities for appropriate assessment are compromised, is supported in the literature (Twinn & Davies, 1996). There is conflict for her between meeting the needs of the patients and the imperative to facilitate students' learning and assessment (Corey-Lisle et al., 1999) in increasingly busy clinical settings.

Until now, Jeanne has drawn on her belief of learning as task mastery to facilitate students' learning, utilising various strategies such as stepping students through new skills and encouraging them to learn by doing. (See section 4.3). Assessment for Jeanne has been based on her observations of students' completions of tasks and the extent to which they have fitted in to the team environment. Changes to nursing protocols in Jeanne's ward so that certain procedures are now performed during the quieter times of the weekend, mean that students cannot participate in, or even observe certain procedures. Jeanne interprets this as a worrying loss in her ability to be able to facilitate learning through showing students new tasks and unusual procedures. However, this dissatisfaction is not supported within the literature, which suggests that nurses must be

able to develop a broader view of the patient and their environment (Oermann, 1994). The emergence of primary healthcare models is reducing patients' length of stay, increasing patient acuity and the nurse-patient ratio, increasing workloads in tertiary care settings (Shindul-Rothschild et al., 1996). However, such changes in healthcare delivery also increase the need for nurses to be involved with patient education (Porter-O'Grady, 1990). Jeanne does not appear to interpret these changes to her work setting as an "opportunity for individual growth or growth of the profession" (Corey-Lisle et al., 1999, p. 35) because of her technical-rational beliefs about learning and subsequently about assessment.

Similarly Barbara described the loss of experienced staff from her ward areas as being the greatest source of her concern in her ability to be an effective clinical teacher. The increased use of casual or agency staff is placing pressure on remaining nurses to supervise other staff who may be unfamiliar with the ward area. It is acknowledged by Glen and Clark (1999, p. 14) that this reduction in the numbers of permanent, experienced staff is increasing "demands in terms of time and responsibility of teaching and supervising students". Barbara viewed her role in facilitating learning as a process of role modeling her philosophy of nursing based in an empathic, holistic view of the individual. Having students with her, watching, observing, listening and talking until students feel comfortable enough to take on their own patient load, describes Barbara's approach to facilitating learning. Further trends noted by Barbara such as the increased acuity of patients and significantly higher levels of readmission of psychiatric patients as a direct result of earlier discharge, are also reported in the literature (Shindul-Rothschild et al., 1996). As a consequence, the increased busyness and loss of time which she was able to spend with the students, particularly in providing formative feedback, caused her some concern, so that she too was questioning whether she wanted to remain in such a working environment. She confided that "we are all thinking we want to get out". Barbara's proposed resolution to the conflict she was experiencing exemplifies Kramer's (1974) option for behaviour capitulation.

Change in clinical environments was also a source of stress for the remainder of the participants. However, while Roslyn feels like "pulling your hair out at the end of the day"

and Alison noted that "it's to the point where it is too much", none of the remaining participants anticipated leaving nursing in the foreseeable future. However, they shared the view that clinical teaching has become more stressful, increasing the risk of 'burnout' (Dibert & Goldenberg, 1995). The lack of acknowledgment from schools of nursing, "even a phone call would have been nice" (Roslyn), of the increased pressure placed on nurses in fulfilling their teaching, supervision and assessment responsibilities, was recognised as potentially leading to a situation where preceptorship ceases to be a viable clinical teaching model (Bain, 1996). Similar expectations from the hospital that experienced nurses should be involved with teaching and assessing students despite the escalating demands of patient care, were also corroborated by Wilson-Barnett et al. (1995). This is regarded as part of 'doing more with less'.

All participants in this study expressed numerous concerns about the negative effects which reduced staffing levels and falling staff morale are exerting on their ability to fulfil their role as a nurse and clinical teacher. Like two of these participants, many nurses have reported leaving their positions because of increased patient load and acuity (Corey-Lisle et al., 1999). There is more pressure on clinicians with many nurses complaining of noisy, chaotic, and uncertain workplaces (Bick, 2000; Forrest et al., 1996). Nevertheless, while some of these participants appear to perceive the impact of change on their work setting as particularly stressful and so contemplate leaving clinical nursing, there are suggestions in the literature (Oermann, 1994) that nurses should be taking advantage of the emergence of primary healthcare models in order to assist students develop the broader perspective which will be required of them in these new models of care. Curricula that aim to prepare nurses capable of working in these new environments support these goals (Faculty of Health Sciences, 1995).

Primary healthcare places emphasis on the role of the nurse who will be expected to be capable of interacting with clients, medical practitioners and other colleagues to develop client-focused health management and education programs (Scott, 1998). The objectives for primary models of care consist of an increased emphasis on wellness that encompasses health screening programs to accelerate the early detection of disease, immunisation and

other prophylactic programs to prevent disease and planning to reduce risk factors for disease (Hickey, 1996; Porter-O'Grady, 1996). As the nature of nursing changes due to economic globalisation, nursing education must be sufficiently flexible to meet the challenge of preparing the kinds of nurses who will be safe and competent practitioners in the future (Hills et al., 1994).

The literature confirms that nurses need to be exposed to an educational and clinical program that will adequately prepare them to work in the 'new' healthcare environment (Clayton, 1995). Such new curricula also make the assumption that students' clinical placements will provide opportunities for the type of learning that will facilitate this learning. The respondents in the study may need to be aware of the influence which their own worldview (Butler, 1996) of nursing and, in particular, of learning and assessment, exerts on their perception of their role as assessor. The participants do not seem to deliberately incorporate reflection into their nursing practice; thus it is suggested that they may not be fully aware of the powerful influence which their worldview exerts on their perceptions. (See section 4.3). Butler (1996) proposes that professionals need to take into account their own world view as the lens through which their world is viewed and interpreted.

As a consequence, it could be concluded that the lens through which the participants view their role as clinical teacher, and in particular, as assessor, is one shaped by the bureaucratic, technical-rational culture of their work setting. In this context, assessment is more likely to be perceived as focused on task mastery (D. Willis, 1993). Assumptions by schools of nursing, that assessment of the student will take a broad account of the whole student, utilising a comprehensive framework, may present conflict for nurses more comfortable with a technical-rational view of learning (Atkins & Williams, 1995).

4.6   SUMMARY OF DISCUSSION

Through the process of comparative analysis, it was concluded that the participants interpret their role in clinical teaching as comprising of three main elements: a role as facilitator of learning; a role as socialiser and a role as assessor. Further analysis of the data also revealed a number of related themes; learning as task mastery, learning from experience, fitting in, learning the realities of practice, being a gatekeeper, dialogue in assessment and change in the clinical learning environment.

These participants described one element of their clinical teaching role as being a facilitator of learning. While learning was chiefly regarded as being achieved through a task mastery approach, these nurses do not draw on their past experiences in order to facilitate students' learning. All participants shared a contemporary view of nursing as holistic, yet they also were required to meet the demand for increasingly complex, technical levels of care. It is the continued dominance of the traditional scientific paradigm of nursing that appeared to influence participants' perceptions of learning as doing, more strongly than does their holistic view of nursing. As a consequence, their selection of learning strategies remained focused on having the students achieving task mastery. This scientific paradigm supported these nurses' approaches to clinical teaching as they urged students "to find all the things to do and just get it over with". Their own past experiences of nursing, particularly of teaching and learning, also provided a basis of understanding from which their role as facilitator of learning was drawn. Thus, on one hand, respondents reflected on their own experiences to "remember what it was like when I was a student…I try to do things differently". Yet on the other hand, they relied on their past experiences to support their task mastery approach to learning, because "when I did my training you didn't have a choice…it was there and you had to do it".

As a consequence there was some conflict between these nurses' behaviouristic perspective of learning and the expectations of new curricular approaches to nursing education, which focus on the development of the critical thinking, reflective practitioner. Some participants appeared to engage in questioning of students prior to the implementation of new procedures. However, the purpose of such questioning was not to encourage critical thinking

and reflection, but rather was based in the need to prevent students making mistakes through a rehearsal of the procedure.

Consequently, the second element of these nurses' perceptions of their role as clinical teacher was their role as socialiser in order to assist students learn to fit in to the ward environment and to learn the realities of nursing practice. The need to fit in was observed to be a very powerful determinant of both students' and nurses' behaviour. Students were frequently faced with a conflict between "acting like an RN" and so meeting the expectations of the ward, or preserving their supernumerary status and seeking opportunities for learning experiences. As a consequence, students who took initiative to help reduce their buddy nurses' workloads were regarded more positively by staff than were students who "just ask questions all the time". The technical-rational approach of the clinical setting influenced these nurses' beliefs about their role as socialiser. Students were encouraged "to try really hard" in order to demonstrate to the hospital that they have adopted the task mastery values of the workplace and subsequently would be valuable employees.

Furthermore, these nurses' expectations that students should be working all shifts, was based in the perception that their role as socialiser was concerned with showing students the realities of nursing. It was believed that this would give students a sense of being part of the nursing team and encourage them to take responsibility for a "realistic" patient load in order to prepare them for the transition from student to graduate nurse. This belief contrasts with other research, which reports that students would prefer to be regarded as students and be able to focus on one patient in order to have opportunities to think more critically about patient care. The beliefs of the nurses participating in this study, while focused on the delivery of total patient care, appear to be anchored in the need to be busy. This is supported by the literature which observes that as a means of coping with increasing workloads, nurses are adopting a task mastery approach to nursing care, rather than a patient centred approach.

The assessment of students was difficult because of the complex nature of nursing practice and the unpredictable impact of the clinical context on the student's performance. The dual nature of assessment as being both formative and summative was recognised by the

participants in this study who acknowledged that even though they did not enjoy their role as assessor, feedback should be given to allow students to redress any inadequacies in their practice. Conflict was experienced in this gatekeeper role as they described guilt and distress over failing students, particularly when they felt they were "ruining someone's career". Assessment of students was threatening to these nurses who, although confident of their clinical expertise, continued to doubt their objectivity and reliability in making decisions about failing students. This conflict may be made more apparent because of the difficulty that these nurses experienced in making explicit the frameworks for their nursing practice. Professional education may assist participants to overcome such assessment anxiety and may also serve to assist these nurses uncover their tacit knowledge and so increase their awareness of the influences on their practice. However, the lens through which these nurses construct their beliefs about nursing and subsequently their role as clinical teacher, is one that is influenced by the positivist values of their clinical context.

Hodges (1997) described nursing as operating within dialectic between a positivist work culture bound by the rules and regulations of bureaucracy and a world of human experience and meaning. She further defines the positivist culture as one in which "the scientific world of empirical facts…includes a commitment to the ultimate validity of objectification, logical positivism, empiricism, scientism, and linear thinking. Its language is non-personal and standardized terminology. This domain contains the precise "doing" of nursing practice including quantitative analysis of observable data and searching for cause and effect" (Hodges, 1997, p. 349).

As a consequence, the respondents do not always perceive any tension between the demands of the positivist work setting and their own values and beliefs about learning. The majority of the participants appear to have adopted the values inherent in a positivist paradigm within their role as clinical teacher. Although they find their workload is increasing and they are being asked to do more with less, they perceive that their role as clinical teacher is to assist students learn by doing, to assist them learn the realities of practice and to assess students' competency in mastering the tasks which they will be required to perform as graduate nurses. While the remaining participants share some of these values of their cohort group,

they experience greater conflict between having sufficient time to meet the students' learning needs and meeting the demands of their increasingly complex and rapidly changing environment. Accordingly, some participants choose to resolve this conflict by planning to leave the clinical setting.

A further examination of how these two contextual factors, the positivist culture of their clinical environment and their own beliefs about nursing, exert influence on these nurses' construction of their role as clinical teachers is presented with a synthesis and review of the research in Chapter 5.

CHAPTER 5:   REVIEW AND CONCLUSIONS

5.1   INTRODUCTION

The purpose of this chapter is to review and provide conclusions related to the perception of experienced nurses of their role as clinical teachers. Despite the transition of nurse education to the higher education sector, the preparation of individuals as competent professional nursing practitioners by necessity, demands that student nurses spend a regulated number of hours on field or clinical placements, integrating theory with practice. Nurses within almost every nursing environment, from community and hospice care, to acute tertiary hospitals, interact almost daily with a number of student nurses on clinical practica. While the models of clinical teaching vary from school to school, students are generally supervised under some model of clinical supervision. However, it is the nurse in the clinical setting who is paired or buddied to work with the student nurse and thus who bears the brunt of students' queries and complaints; who implicitly acts as a role model, teacher and socialising agent. The aim of this research was to explore the perceptions of those nurses who either formally take on a preceptorship role, or informally are buddied with undergraduate students, about their role as clinical teachers. This is important because it has been acknowledged that it is those interactions which take place between the clinical nurse or their colleagues in the clinical setting and the students which contribute to the development of students' professional values about nursing (Ahern, 1999).

Healthcare settings are experiencing major economic constraints that have lead to the development of healthcare models characterised by rapid patient turnover rates, increased patient acuity levels both in hospitals and in community care, and increased expectations of customer satisfaction and quality outcomes (Venegoni, 1996). The pressures experienced by clinical settings as a result of these changes may be impacting on experienced nurses' willingness and ability to adequately fulfil their role as clinical teachers. The study was set within the clinical environment of one healthcare agency in which the six research

participants were all experienced nurses involved with clinical teaching of undergraduate students as part of their role as nurses.

5.2   DESIGN OF THE RESEARCH

Since this study was exploring perceptions of nurses towards their role as clinical teachers, it invited a qualitative research design which offered opportunities for the researcher to share in the participants' lives, in order to observe, listen, question, hear and interpret the significance they give to their experiences. The epistemological position of constructionism was adopted because it takes into account the impact which engagement with the research exerts on participants' construction of meaning (Crotty, 1998). An interpretivist theoretical perspective served to structure the research in a manner that was congruent with the philosophical underpinnings of the research questions. The utilisation of two research orientations, hermeneutic phenomenology and symbolic interactionism, have been justified as appropriate guides for the research because they share the common principle that meaning and interpretation of the phenomena must be understood by listening to the voices and perspectives of the participants (Strauss & Corbin, 1994). Similarly, both approaches acknowledge that the meanings which participants give to experiences is shaped by their situation, so that it is necessary to observe the participant in context (Crotty, 1998).

A case study approach was utilised in this study in order to orchestrate or organise "the collection and presentation of detailed, relatively unstructured information from a range of sources about a particular…group" (Hammersley, cited in Hitchcock & Hughes, 1995, p. 318). It appeared appropriate to use case study for this research because it provided not only the means by which existing beliefs and theories about clinical teaching can be tested, but also the opportunity and ability for the researcher and participants to develop new theoretical positions on clinical teaching (Sturman, 1997).

Data were collected through participant observation and a series of semi-structured interviews and informal interviews, supported by field notes and the researcher's diary. The time period for data collection was between July 1998 and August 1999. Participants' availability and periods of involvement with clinical teaching of students, determined the time period for collection of data from each participant. The procedure for data collection and subsequent analysis was embedded within the need to engage the participants in a process of interpretation and reinterpretation of data as it were collected, consistent with the underlying principles of the hermeneutic circle and the orientation of symbolic interactionism.

Findings from the analysis were presented and discussed under the following themes and sub-themes:

1   Role as Facilitator of Learning

- Learning as Task Mastery

- Learning from Experience

2   Role as Socialiser

- Fitting In

- Learning the Realities of Practice

3   Role as Assessor

- Being a Gatekeeper

- Dialogue in Assessment

- Change in the Clinical Learning Environment

The research subsequently concluded that it is the positivist culture of the work setting and their own experiences and meanings of nursing grounded within that culture, which served to influence these participants' perceptions of their role as clinical teachers. The increased busyness of the clinical environment combined with the participants' inability to articulate nursing knowledge in a way from which students can learn to create a clinical environment which fostered learning through busywork and repetitive practice, rather than through critical thinking and reflective practice. It was subsequently important that the three research

questions were re-examined to determine to what extent they have been answered by the findings of this study.

5.3 RESEARCH QUESTIONS ADDRESSED

5.3.1 Identification of the Research Questions

Three research questions emerged which focused the conduct of this study. These questions emanated from the purpose of the study, yet took an evolving form and were shaped as the research unfolded by the experiences of the researcher, the ongoing interaction with relevant literature and dialogue with the participants. The research questions were:

Research Question One:
How do experienced nurses create positive clinical learning environments for student nurses?

Research Question Two
How do experienced nurses resolve the often-contradictory demands of nursing students and those of the practice setting?

Research Question Three
How do changes in the healthcare environment impact on the experienced nurse's role as a clinical teacher?

These questions have been utilised as a framework to present the summary of the findings. However, it is evident that there is a close interrelationship between each question so that the questions should not be viewed in isolation. The usefulness of the research therefore lies in the extent to which the responses to the questions achieve credibility with the reader (Janesick, 1994). The contentious issue of generalisability of one case study to a wider context was addressed by Sturman (1997) who suggested that the reader may be able to

draw some generalisations from a case study if the researcher has been able to document all the characteristics of the known case so that the reader has full knowledge of the context of the case. Therefore it is emphasised that the responses to the questions have been presented to provide some understanding of the perceptions of clinical teaching as described by a small group of experienced nurses. The responses do not claim to represent particular solutions to the many issues surrounding the clinical education of student nurses within healthcare agencies. Rather, they serve to assist in the understanding of these particular nurses' perspectives so that the reader may more fully understand the complexity of the concept of clinical teaching and the impact which changes in nursing practice are having on clinical teaching environments.

5.3.2   Research Question One

The research question is:

How do experienced nurses create positive clinical learning environments for student nurses?

Participants viewed the creation of positive clinical learning environments as the result of a number of contributing factors, rather than as their sole responsibility. The six participants were all committed to their role as clinical teachers of student nurses and frequently expressed their desire to be involved with assisting students learn to be nurses. Thus, they perceived that their very willingness to be clinical teachers played a major role in the creation of positive clinical learning environments. It was their belief that most nurses were similarly oriented towards students, although they did acknowledge that there were occasions on which some wards appear 'unfriendly'. This was largely attributed to increased pressures within the hospital and excessive demands on a small number of experienced nurses to constantly precept or buddy with students, leading to a sense of 'burnout'. However, there was some frustration with students who were regarded as inappropriately placed within a particular area. In such cases, participants found it difficult to create a positive learning environment because they perceived the students as requiring more support

and assistance to cope with the increased diversity and complexity of patient care required in some specialty areas than that which they could give. This finding appears to be based in the belief that students should be 'learning the basics' of nursing care, particularly through the repetition of nursing skills so that they become confident with the everyday tasks which they will be completing as graduate nurses.

Thus, the university was also regarded as partly responsible for the learning environment by ensuring that students who were allocated to various areas within the hospital were adequately prepared to be able to work without excessive support and supervision in the particular environment. As a consequence, some clinical areas were perceived to be too demanding of, for example second year students, who, because of their need as novice learners for rule-governed behaviour, may not have the ability to analyse the patient's needs and to adapt their nursing care accordingly. Similarly, the university's clinical facilitator who may be supervising the clinical placement of up to eight students, was also expected to contribute to the learning environment by being clinically competent and interested in the area rather than just 'dumping' the students for the ward staff to teach. Clinical facilitators were regarded as 'excellent' if they also asked questions, sought learning opportunities for the students and actually observed their students' clinical performance when possible. However there was an acknowledgment that one clinical facilitator cannot adequately supervise eight or so students and therefore clinical teaching, by default, largely becomes the responsibility of buddy nurses. This was a particular problem when the university's facilitator was not perceived to be competent in the clinical areas accessed. As a consequence, the participants expected to be involved in the assessment of their student, rather than have only the university facilitator, whom they perceived to have gained minimal knowledge of the student's real performance, assess the student.

However, participants also expected students to contribute to their own positive clinical learning environment by being interested, motivated and willing to 'pitch in'. Students who displayed such characteristics of showing initiative in helping and an interest in the ward were generally regarded more positively by participants who were then motivated to assist these particular students in their learning. When participants perceived the students as being

interested in learning, they actively sought out learning opportunities for their students, either in other wards or in related areas such as the operating theatre. This pursuit of learning opportunities was based in their belief that students should be 'doing' as many practical clinical skills as possible in order to achieve beginning level competency as a nurse. Therefore students who met these behaviouristic expectations of the ward were rewarded by their buddy nurse with opportunities to 'do' a variety of clinical skills. The participants' consistent focus on behavioural pedagogical approaches such as learning by doing was regarded by most as contributing to the creation of a clinical environment which presents multiple opportunities for students to learn how to be a nurse. This repetition of tasks and skills was perceived as assisting in the reduction of the stress commonly experienced by new graduates in their transition to graduate nurse.

Conversely, students who appeared unmotivated, to be just filling in the time, or uninterested in the learning experiences available, were regarded as not assisting in the creation of positive clinical environments. Consequently, such students were not supported in their learning endeavours, particularly if they were perceived to have not fulfilled their professional obligations to the ward by being motivated, punctual and present for the whole clinical placement. Participants experienced no conflict in failing such students because they were not perceived to have made a positive contribution to their own clinical learning opportunities. Students who do contribute to their learning environment, particularly by doing as many clinical skills as possible, presented a greater conflict for participants if the student was not mastering the clinical placement. Subjective responses that focus on students' personality and whether they 'fit in', rather that their clinical competence, influenced participants' perception of whether students should be assessed as competent or not and subsequently presented significant conflict for them in the decision to fail or non-master the student.

Participants described a number of other strategies that they regard as assisting in the creation of a positive clinical environment. These varied from preparatory activities such as reading and reviewing of pharmacology at home, to discussing difficult issues with other nurses in order to gain a broader understanding of the problem. Thus participants described

strategies which can be broadly related to experiential learning theories as shaping their approaches to teaching and learning. They recognised that although they were occasionally frustrated by students who 'ask questions all the time' this questioning of their own practice did allow them the opportunity to think about their own nursing practice. They discussed how to complete procedure and skills with the students, however this did not extend to encouraging in students a critical thinking, reflective process in their nursing practice.

The respondents' own past learning experiences as students were particularly important influences on their approaches to teaching and learning. Teaching strategies which "worked for us" were thus adopted by these nurses and implemented in their clinical teaching activities. It was evident that these nurses utilised their past experiences both as a student and as a clinical teacher in order to develop and refine their approaches to teaching the student. While the issue of time appears to preclude opportunity for reflection, these nurses acknowledged that their teaching styles were greatly influenced by their own experiences and how they would have liked to be treated as a student. However, it was not evident that they engaged in any formal or planned process of self-reflection or evaluation of their teaching. This may be due to the increasing demands on their time; nevertheless it was also apparent that these participants did not describe their personal beliefs about teaching and learning in terms of any formal theories. Consequently, it could be concluded that a lack of knowledge of formal theories of teaching and learning makes it difficult for these nurses to articulate meaningful reflection on their clinical teaching practices.

However, the busyness of the clinical environment, occurring largely as a result of changes to healthcare delivery models and economic constraints, has also contributed to the participants' conflict between meeting the needs of the ward and meeting the learning needs of the student, as they seek to create positive clinical learning environments. This issue is answered in more depth in response to questions two and three.

5.3.3 Research Question Two

The second research question is:

How do experienced nurses resolve the often-contradictory demands of nursing students and those of the practice setting?

While participants have some empathy for the students' difficulties in combining university studies with part-time work and personal commitments, their essential belief was that clinical placement represents an opportunity for students to practise basic skills as much as possible. Frequent repetition of basic skills means that these students' transition to graduate nurses will not be delayed by having to practice these basic skills. Participants' belief that students should be receiving more clinical experience than is currently offered in tertiary courses, consequently reinforced their expectation of clinical placements as a time for 'doing'. Hence, they did not perceive that this approach may be contradictory to the expectations of new curricular approaches to nursing education which would have the students "involved with the problem solving approaches to care, that is, to learn through the experience by reflecting on and discussing aspects of each intervention and then doing" (Marrow & Tatum, 1994, p. 1251).

Rather, these participants' understanding of clinical teaching was that their role was firstly as a facilitator of learning, to assist students to access clinical skills in order to develop their basic level of skills competency; secondly as assessor to ensure students met the standard competencies of a beginning registered nurse; and finally as socialiser, to assist the students develop the beginning principles of time management. They perceived that these skills would facilitate students' transition to graduate nurse practice and the 'real world'. As a consequence of such a nurturative socialisation, participants expected that the students would experience less conflict between the demands of the clinical environment and their expectations of their role as graduate nurses, because they have already been exposed to this reality during their clinical placements. Their own personal experiences and meanings of nursing influenced them to believe that by fulfilling these roles of teacher, assessor and socialiser, they would decrease the stress of transition to graduate nurse.

Of particular concern was the belief expressed by some participants that they did not perceive their responsibility for teaching and assessment of the student to be as important as their responsibility towards ensuring the new graduate was competent. These participants' rationale was that on another placement, another clinician will meet the student's learning needs. The students' relatively short periods of clinical practice in the wards offered participants some justification for evading some of their responsibilities to the students' learning. As a consequence, participants identified some ambiguity in the perception of their role as teacher and assessor. On one hand, they want to ensure that students are basic competent practitioners through the repeated practise of their clinical skills and on the other hand, believe that students will be guided through tasks as a new graduate. This reinforced their beliefs that the clinical nurse's time was more appropriately expended on teaching the new graduates. There was a similar conflict for participants between showing students unusual procedures which they 'may never see again' and focussing the students on the everyday tasks which will be expected of them as a new graduate. The participants resolved these conflicts in varying ways. Some participants chose to focus students' attention on learning and practising the basics. Some participants chose to 'reward' students by offering extra learning opportunities, particularly focussing on the unusual and unexpected procedures. It was evident that neither one approach could be termed more appropriate than the other, particularly as some participants attempted to combine these approaches, acknowledging that this had the potential to cause further conflict for them.

5.3.4   Research Question Three

The final research question is:

How do changes in the healthcare environment impact on the experienced nurse's role as a clinical teacher?

While all participants were willing to be involved with the clinical education of student nurses, they acknowledged that changes to their working environment were influencing their teaching role. In particular, participants described how understaffing and an imbalance between permanent staff and casual or agency staff were increasing their workload. Not only

were they required to meet their own patients' needs, but they were also required to take responsibility for the increasing numbers of relief staff unfamiliar to the working of the ward area. Other factors such as the increasing numbers of students, students from different universities and courses and various clinical supervision models, were all perceived to be contributing to the increased stress being experienced by nurses. Consequently, the expectation that the participants would also be responsible for ensuring appropriate clinical learning and teaching opportunities for students, led them to occasionally regard teaching as 'too hard' or 'just too much'.

Therefore, it was expected that students should recognise that clinical teaching impacts on the buddy nurse's time and ability to complete their own patient cares. Students subsequently were regarded as fitting in if they 'act like an RN' and so helped to reduce the workload of their buddy nurse. Participants experienced conflict between their responsibility to helping the students' learn by completing patient care themselves and the pressure to meet the patient's needs in the minimum of time. Thus, these participants expressed most satisfaction with teaching in busy environments when students were perceived to have shown initiative and anticipated their patients' requirements, rather than asking questions and seeking direction.

Subsequently, participants expressed some conflict between the understood need to treat students as supernumerary and the demands of busy wards that sometimes required that they 'basically treat the students like RNs'. Hence, while they recognised that they should be pulling back and letting the student make some decisions, the busyness of the ward presented a conflict for them between facilitating the student's learning needs and meeting the needs of their clinical environment. This was resolved in a variety of ways, all of which appeared to create further conflict either for the student or for the participant. Participants sometimes decided to intervene and assist the student in order to reduce the time taken, causing stress for the student; or they left the student to complete the procedure unassisted, yet experienced frustration because the student was taking an excessive period of time. Again, those students who fitted in and took the initiative for their patient care resolved this

conflict. These students were regarded most positively because they assisted to reduce the pressures within the ward.

Participants also expressed some concern at the loss of clinical learning opportunities available to students as a result of the changes in patient turnover rates and reduced treatment interventions. This further justified their task mastery approach to learning during clinical placements, because they believed that students encounter fewer opportunities to practise skills. If students indicated a desire to observe rather than attempt new procedures, participants expressed concern that the student may not gain another opportunity.. Consequently, participants attempted to 'find' other clinical experiences for their students, even if it required taking the student to another ward to practise, for example, intravenous therapy care. However, this strategy again appears to be in conflict with curricular and professional expectations of clinical practice as a period of integrating theory with practice in a reflective, inquiring, problem-solving approach.

In particular, the increasingly busy and complex clinical environment has created tension for two participants. These two nurses expressed frustration at their diminishing ability to have time to meet both their patients' and their students' needs because of the demands of the clinical environment. Changes to the skillmix of the ward, occurring as a result of economic rationalist trends, were impacting on these participants' personal satisfaction with their work. As a consequence, Barbara and Jeanne were preparing to leave the clinical setting, rather than, as Kramer suggested (1974), integrate their values and beliefs with the technical-rational orientation of the hospital. Both participants intended to remain practising as nurses, however they anticipated moving to primary care roles.

5.4 CONCLUSIONS OF THE RESEARCH

The following conclusions represent an attempt to better understand the perceptions of six nurses about their role in the clinical education of student nurses. It is acknowledged that such conclusions are drawn in the understanding that participants' perceptions of clinical teaching are not fixed, but rather are subject to constant change as a result of their continuing interaction with students and the clinical environment.

This study concluded that nurses value their roles in clinical teaching. However, several contextual factors emerged which participants identified as important in shaping their perceptions of their role. As a consequence, the research also concluded that clinical teaching represents a tension for nurses between their commitment to the positivist work culture of the clinical setting and the expectations of the profession and new nursing curricula in an environment that is marked by change in the models and management of healthcare. The positivist work culture of the clinical setting and nurses' own human experience and meaning of nursing exerted significant influence on their beliefs and values towards clinical teaching.

Accordingly, the following model (Figure 5.1) has been proposed to describe the concept of clinical nurse as teacher and to present the conclusions of the research. This model illustrates the inter-relationship between the roles of nurse as clinical practitioner, facilitator of learning, assessor and socialiser. The importance of the context in which nurses are situated is also represented by acknowledging the positivist work culture of the clinical setting and nurses' own experiences and meaning of nursing from which they derive their practice.
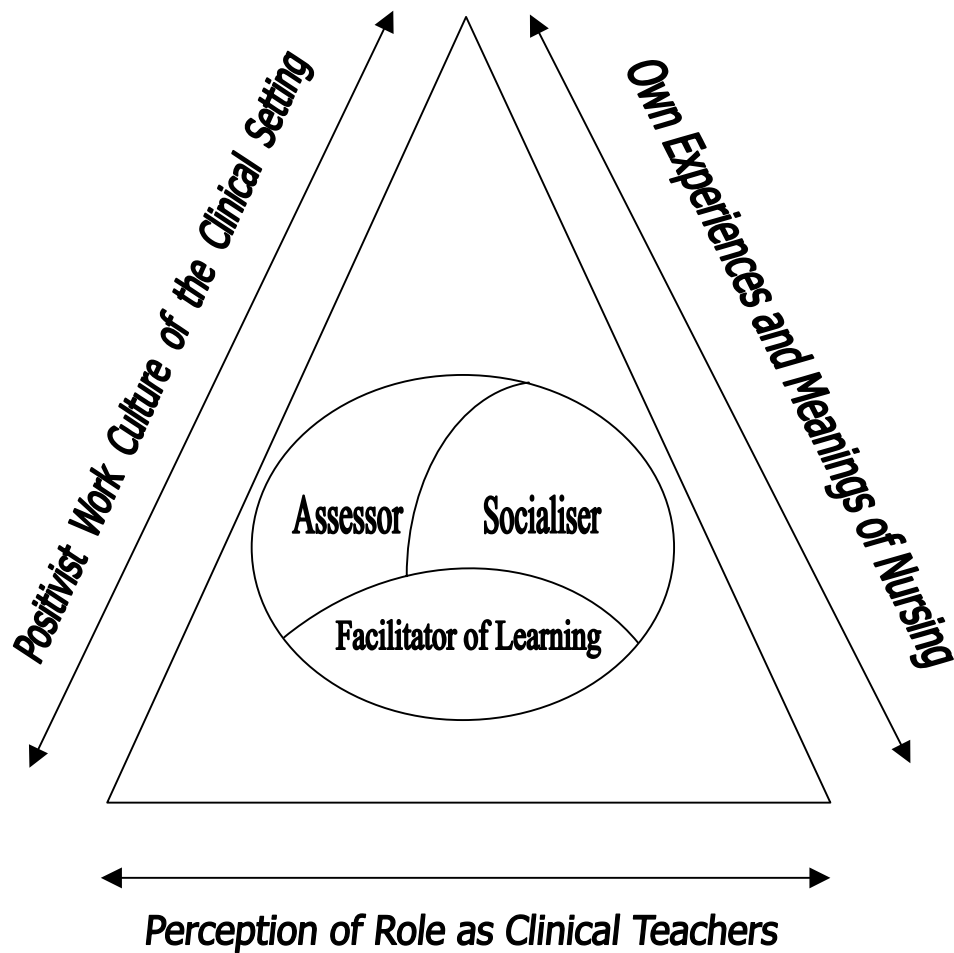
Figure 5.1   Model of Nurse as Clinical Teacher

5.4.1   Positivist Work Culture of the Clinical Setting

The worldwide adoption of economic rationalist healthcare policies that increasingly view health as a commodity to be marketed has been explored in section 2.4. The impact of such policies is evident in the continued dominance of economically-driven, positivist methodologies in practice settings. For example, competency-based training standards have been adopted through the ANCI competency standards which have been set as the

benchmark for minimum standards of nursing practice in Australia (ANCI, 1994. It has been argued (Cordery, 1995) that nursing has rushed to accept the limitations of a competency-based training grounded in positivist methodologies, despite the fact that worldwide literature criticises this philosophy as inappropriate for holistic nursing practice. The more recent introduction of the management models of casemix and DRGs reinforce this focus on an economically-driven, task mastery approach to nursing practice (Cordery, 1995). Current emphases on evidence-based practice have also arisen from the need of health authorities to identify quality indicators which reward efficiency and economy (Upton, 1999). Thus, nurses continue to face a dichotomy between the need to provide holistic care and the need to demonstrate economic accountability and efficiency. In the face of such pressures to be economically accountable, it is evident that nurses remain drawn towards positivist methodologies to guide their practice in order to provide the evidence made necessary by management based healthcare models, that their nursing interventions are clinically effective and do contribute to patient outcomes.

Subsequently, these participants expressed pride and pleasure in fulfilling their role, particularly when the student was also perceived to have similarly fulfilled the reciprocal positivist expectations of the student's role. Students who fitted in and met the expectations of the ward were therefore viewed more positively and enhanced the self-identity of the participant as an effective clinical teacher. Students who asked to be reassigned to a particular ward following graduation and subsequent employment, also served to reinforce participants' perceptions of themselves as clinical teachers and role models because the students' positive learning outcomes reinforced their positivist beliefs about learning (Guskey, 1986). As a consequence, the rationale for the adoption of such learning strategies, which tends to be focused in the expectation that students will learn how to be a nurse by repeatedly 'doing' those skills and tasks which will be expected of them in the 'real world', was not challenged (Guskey, 1986). Hence, participants continued to adhere to a technical-rational model of nursing that is characteristic of the positivist work culture of the clinical setting. The perception of clinical practice in busy clinical environments, as a learning opportunity if students 'pitch in like everybody else, I think they learn a fair bit', rather than as a period of observation, questioning and thinking, is consequently perceived as

inappropriate. However, Jarvis (1992) suggested that the busyness of present healthcare settings which reinforces this perception of clinical practice as an opportunity to 'do things' has similarly been driven by the technical-rational approach of today's practice settings.

The influence of the positivist culture of the work setting can subsequently be understood as a factor in how these participants perceived their role as clinical teacher. Their beliefs and meanings of nursing gained through their own socialisation and nursing experiences similarly influenced their perceptions of their role as clinical teachers. However, as Butler (1996) warned, it is apparent that these very experiences of the participants cannot be separated from the positivist influences of their work setting because this is the lens through which they view their world.

5.4.2 Nurses' Own Experiences and Meanings of Nursing

"The greatest leverage in the development of professional practice is the reading of one's own actions" (Butler, 1996, p. 269). Yet the continued adherence by the nurses in this study to a technical-rational model of nursing as evidenced by their beliefs of learning by doing, may be explained by their apparent lack of any formal knowledge of the principles of teaching and learning. Consequently, while participants all expressed a positive desire to be involved with clinical teaching, it was concluded that they lack a formal, conceptual framework of supervision and teaching. This may present a barrier to a deep, reflective examination of their own teaching actions that could allow these nurses to achieve an understanding of the intricacies of learning. Such an understanding may serve to assist nurses in the creation of reflective learning opportunities that fulfil the expectations of new nursing curricula.

Frustration at both students' unwillingness to repeatedly practise tasks and skills and at students' questioning of their practices, indicates little appreciation by the participants of the principles of adult learning which are embedded within new curricular approaches to

nursing education and serves to support this conclusion. Thus, while participants described their personal beliefs of teaching and learning using a number of popular theories, they experienced difficulty in relating their beliefs to any formal theories of teaching and learning. The participants do draw on their own experiences of learning and engage in discussion with other nurses or university faculty staff in their approaches to clinical teaching. However, it is evident that while they do think about their own teaching and learning experiences, a critical reflective framework does not support this thinking. Rather, the lack of time to create positive clinical learning environments in such a busy chaotic environment precluded both participants and learners from taking time to reflect on their practice and critically examining the influence of the positivist lens through which they view the world. These conclusions are of significance because they do impact on nursing education and clinical teaching. It is subsequently important to address the implications of these conclusions on nursing education and clinical teaching, particularly within the context of the researcher and participants.

5.5   IMPLICATIONS FOR NURSING

This research holds implications for the profession of nursing and hence is significant for a number of reasons. Firstly, it contributes to nursing's store of knowledge of clinical teaching and the perspective's of nurses towards their role as clinical teachers and so assists to fill the lacuna of knowledge in this under-theorised area. Secondly, this research offers some insights into the relationship between nursing education and nursing service. Finally, there is value in the extent to which the involvement with the research does increase the participants' awareness of their professional responsibility towards clinical teaching.

It is evident that these participant nurses hold positive attitudes towards their role as clinical teachers. However, their construction of their role is grounded in a task-mastery belief of learning that is reinforced by the increasing busyness of their clinical contexts and its focus on economic management of healthcare. Furthermore, this focus on learning as task mastery

has been shown to be, in part, resulting from both their inability's to articulate their tacit knowledge and from the lack of time which busy work settings offer nurses to practise reflectivity. Subsequently, it has been found that while the participants can describe their nursing practice in informal ways, they lack a conceptual framework of teaching and learning.

The lack of a conceptual framework to guide these nurses' practice may be a factor contributing to their emphasis on procedural-based nursing practice with its origins in the narrow, empiricist basis of positivist methodologies (Grossman & Hooton, 1993). Articulating professional knowledge in nursing is extremely difficult because of its complex interactions. However, this is not an acceptable rationale for participants' failure to be able to explain what they do in such a way that students can learn from their explanation (James, 1995).

It is of concern that participants appear to rely solely on their own past experiences as students to develop a theory of teaching and learning, yet universities are being urged to select nurses who possess competent clinical teaching skills and a sound knowledge of the curricula and its philosophies to act as clinical teachers. Professional experience of nursing may teach about nursing, it is acknowledged that professional experience of nursing does not necessarily teach about teaching. Nevertheless, if nurses are to see themselves as change agents, professional development opportunities should offer nurses an understanding of the philosophies underpinning new curricular approaches to nursing education, the principles of adult learning, experiential learning and assessment, through a problem solving approach. It is tempting for schools of nursing to use the increasing busyness of clinical settings to explain nurses' difficulties in articulating their knowledge to students. However, it is evident that some responsibility for the appropriate preparation and support of nurses in their role as teachers and assessors lies with schools of nursing. This raises the issue of the relationship between nursing education and nursing service.

Secondly, this research offers some insights into the relationship between nursing education and nursing service. This research concluded that experienced nurses were willing to be

involved with clinical teaching, yet their perception of the role, shaped by the positivist paradigm of their work environment, remains in conflict with expectations of the school of nursing. Given the strength and extent of the reforms that are currently influencing models of healthcare worldwide, it may appear that the holistic principles of one nursing curriculum may be of little impact in assisting nurses to comprehend that learning is not mere busywork that is determined by business concerns. Nevertheless, if nursing were to advance as a profession, then it would appear to be implicit in the role of the school of nursing to contribute to experienced nurses' professional development. To suggest that schools of nursing are preparing students for a professional environment that does not exist (Carlisle et al., 1999), is to accept the positivist environment as the outcome into which the products of the curriculum must neatly fit. This presents a paradox for nursing education and the curricula- how on one hand, nurses can be assisted in their professional development endeavours that may increase their awareness and valuing of reflective, critical approaches to nursing practice, yet, on the other hand, do not set students up for failure in the economically driven reality of the clinical environment.

The conclusions reached in this study therefore raise a number of questions important for nursing eduction to consider. If experienced nurses are committed, as are the participants in this study, to their role as clinical teachers, what is the role and responsibility of the school of nursing towards supporting these nurses in what are clearly difficult teaching and learning environments? Heidegger (1962) suggests that the learner requires the presence of a teacher who can assist the learner to "comprehend" the real meaning of learning and not merely supervise repetitive practice. If this basic premise of the role of the teacher is accepted, as indeed it must be from the holistic, phenomenological perspective underpinning the research, then the question can thus be reframed as: what is the role of the school of nursing in assisting clinical teachers, who have been found to lack a conceptual framework of teaching and learning, to likewise "comprehend" the craft of teaching?

This finding therefore holds implications for the selection and preparation of nurses as clinical teachers. It is acknowledged that the busyness and altered skill mix of the clinical environment do present obstructions to removing potential clinical teachers from the clinical

setting for any lengthy period of professional development. Nevertheless, it is imperative that schools of nursing cooperate with clinical environments to provide professional development opportunities for nurses, particularly those experienced clinicians who express interest in clinical teaching. The context of the clinical setting is the environment in which experienced nurses will be implementing the knowledge gained through professional development. Therefore the focus of the professional development must take into account the social and historical context of the practitioner (Butler, 1996) who remains 'shackled' by their past heritage to the masculine traditions of medicine (Antrobus, 1997). Consequently, the positivist culture of these nurses' environment continues to exert an influence over how they will implement any changes achieved through professional and personal development.

Support for nurses involved with clinical teaching should consequently be available from both university faculty and university appointed facilitators. However, it is important that this support be appropriate and adequate. This requires that faculty staff and facilitators are both clinically and educationally competent to provide appropriate guidance in the selection of clinical learning opportunities and in the utilisation of higher level thinking and reflective processes with students. It is clear that this ideal situation does not occur in all situations at present. Instances were reported in this study of facilitators being engaged who are unfamiliar with clinical areas and thus require almost as much support as the students do. Participants in their role as buddy nurses also commented on a lack of contact with university faculty. This is of particular concern when these nurses require support in the assessment of students in order to address their well-documented reluctance to fail students because of its impact on progress through the course.

Consequently, in accord with the final issue of significance, the value of this research may lie in the extent to which involvement with the research increases the participants' awareness of their professional responsibility towards clinical teaching. The discussion and conclusions reached both challenge and support the participants to reframe their role as clinical teachers to one of true facilitators of learning. While their working environment generally rewards efficiency of outcomes, participants need support from the school of nursing if they are to confront the paradox between the realities of practice and the

expectations and ideals of the school of nursing. It is therefore important that this support be evident in a number of ways.

Firstly, support is needed through the vigorous and sustained implementation of clinical teaching workshops for interested and potential buddy nurses and preceptors. The current trend towards a casualisation of the nursing workforce is resulting in diminishing numbers of full-time, experienced nurses, who are consistently available to be involved in teaching, so that there is a reduction in the number of staff who possess prior experience in precepting. In an environment characterised by rapid patient turnover and increased patient acuity, clinical nurses need assistance in how to select teaching and learning strategies for their students that will maximise their integration of theory into practice. However, as reported in this study and in the literature, many experienced nurses are not aware of current theories of teaching and learning and subsequently are unable to draw on recognised principles of teaching and learning, other than those generated through their own experience, to guide their practice. It is therefore suggested that both undergraduate students and postgraduate nurses need an increased awareness of ways in which teaching and learning theories can offer guidance to their interactions not only with students or other nurses, but also with their patients.

One further way in which this outcome may be achieved, is through an increased interaction between faculty members and experienced nurses. Such interaction has the potential to allow faculty, as experienced nurses and teachers, to provide support to clinical nurses in their role as clinical teachers. This could offer opportunities for nurses to discuss problematic issues such as assessment, with more experienced teachers and so assist them to develop their knowledge of theories of teaching and learning. While there is wide support for this suggestion in the literature (Carlisle et al., 1999; Forrest et al., 1996; Grealish & Carroll, 1998), these authors also acknowledge that such a reframing of faculty members' roles has not always been supported by universities who remain committed to the "publish or perish" doctrine. This study therefore challenges schools of nursing to demonstrate their professional commitment to experienced nurses as co-teachers of students in the clinical environment.

5.6   AREAS FOR FURTHER RESEARCH

The value of this study lays not only in its findings but also in the involvement in collaborative study with nurses within one clinical area. This involvement offers opportunities for increased understanding of the clinical setting and the impact of contextual factors on the role of the nurse as clinical teacher. Therefore research that involves the broader teaching and learning environment is highly recommended. This study raises several issues that appear to warrant further investigation and research. The following areas are suggested:

- Inquiry into the perceptions of clinical teaching by nurses working within a variety of clinical settings. The research reported in this thesis explored clinical teaching within one large metropolitan hospital. It is acknowledged that the experiences of the nurses in this study may differ from the experiences of nurses within other hospitals and different clinical settings. Nevertheless, some similarities have been shown with other nurses' experiences of change. Rural nurses (McCarthy, Hegney, & Pearson, 2000) described a revolutionary change in their environment characterised by amalgamations, downgrading or closure of healthcare services and a shift in focus from acute to primary health and aged care. Rural and remote clinical settings and community agencies are utilised by schools of nursing as clinical learning environments. Consequently, it is suggested that the perceptions of nurses working in these areas be sought towards their role in clinical teaching and learning. This may provide insights into how positive clinical learning environments are achieved in other settings.

- Collaborative trials of different models of clinical supervision including the use of preceptorship models for students other than final semester students. Such trials may provide information about the impact on different models of supervision on the development of student learning and lead to further understanding about how

students' integration of theoretical and practical knowledge can be better facilitated.

- Further exploration of the nature of nurses' approaches to teaching and learning and their impact on students' learning. This may be facilitated through exploration of students' perceptions of clinical teaching and learning. Providing written reflections and critical analysis of their teaching practice may also provide opportunities for professional development for nurses.

- Inquiry into the epistemological bases of faculty members and how this influences their transmission of the culture of nursing in education. Such an understanding may illuminate the professional socialisation which nursing students experience during their education and assist the profession to develop ways in which nurses of the future can be in the forefront of changing healthcare.

- Comparative type studies with faculty members in relation to their understanding of the nature of clinical teaching and learning and their role in assisting nurses develop and maintain positive clinical learning environments. This may provide opportunities for further collaborative research between clinical areas and education areas.

- Exploration into ways in which experienced nurses could be encouraged to 'tease out' a complex, implicit skill. Such a capacity appears highly relevant to their role as clinical teachers and may promote an increased awareness of the value of reflection in understanding the principles, attitudes and beliefs underpinning their practice. Furthermore, such research would serve to document something of what it is that nurses do and so contribute to a greater clarity in understanding of the role of the nurse.

5.7 CONCLUSION

The literature confirms that in economically driven health services, nurses are expected to increase their productivity despite loss of resources (McCarthy et al., 2000). Students are expected to be able to use their initiative, time management and advanced problem solving skills to generally act like registered nurses and to fit in with the positivist work culture of many large healthcare settings. Such an expectation of new graduates has been colloquially described as asking them to "hit the ground running". While schools of nursing emphasise patient-centred nursing, the practice of nursing in hospitals frequently prioritises the completion of tasks (Charnley, 1999; Hodges, 1997). Although nursing education has changed, clinical practice appears to have remained focused on task mastery so that the expectation of clinical practice remains as 'learning by doing'. A clinical environment under increasing pressure demands that students be attempting to practise as many tasks as possible without increasing the workload for their buddy nurses. These findings corroborate forecasts that it will be workplace requirements rather than educational needs of the student, which will become more paramount in the future (Sellers & Deans, 1999).

The nature of conflicting roles and expectations within nursing is well documented (Kramer, 1974). The major source of conflict still remains as the disparity between the service needs of the profession and the educational needs of the university (Yong, 1996). The economic clinical environment in which patients are cared for ensures that the values of the practice setting have remained dominant (Upton, 1999). Despite the transition of nursing into the higher education sector, universities and hospitals "still do not have a common agenda for nursing education" (Napthine, 1996, p. 22). This is a matter of particular concern for nursing education in Australia, where the complete transfer of nursing education to the tertiary sector was, in part, driven by the acknowledgment that "nurses needed a broader base than that provided by on-the-job education (dominated by clinical requirements and workforce organisation)" (DHSH, 1994, p. 4).

While nurses may continue to prioritise the service needs of the clinical area against the educational needs of the student, schools of nursing are equally challenged to consider whether they are "preparing students for a clinical environment which does not exist in some organisations" (Carlisle et al., 1999, p. 9). Nursing remains essentially a practice discipline. It is argued that education curricula must therefore reflect the clinical needs of the graduate nurse in practice (Charnley, 1999). Changing roles of the nurse provide an opportunity to re-examine the content of pre-registration courses so that nurses are being adequately prepared to work within changing healthcare settings. The expectation that students will be supported in their endeavours to be critically thinking, problem solving and reflective practitioners may, in fact, be unrealistic in the current, economically constrained, clinical environment. It is evident that experienced nurses, despite being willing to be involved with clinical teaching, have to function in rapidly changing environments, where doing more with less has become a common expectation. The increasing demands of the clinical environment do not offer opportunities for nurses to reflect on their practice. Understaffing and changes in skill mix of nursing staff, combined with economically driven models of patient care have resulted in an environment that places increased responsibility on experienced nurses. The quality of learning provided by some organisations continues to be questioned. Increasing stress within clinical settings is impacting on the amount of time which busy nurses have to spend with students or newly qualified staff, "at the moment it is the supervision, the mentorship, the preceptorship…whatever you call it – that we are struggling with. For whatever reason it is almost as if we are failing them at the supervisory level" (Carlisle et al., 1999, p. 9).

Heidegger's (1962) description of thinking is offered as a challenge to reconsider the role of nurse as clinical teacher within the current economic-rationalist paradigm of healthcare:

> A cabinetmaker's apprentice, someone who is learning to build cabinets and the like, will serve as an example. His learning is not mere practice, to gain facility in the use of tools. Nor does he merely gather knowledge about the customary forms of things he is to build. If he is to be a true cabinetmaker, he makes himself answer and respond above all to the different kinds of wood and to the shapes slumbering within wood - to wood as it enters into man's dwelling with all the hidden riches of its nature. In fact, the relatedness to wood is what maintains the whole craft. Without that relatedness, the craft will never be anything but empty busywork, any occupation with it will be

determined exclusively by business concerns. Every handicraft, all human dealings are constantly in that danger…Whether or not a cabinetmaker's apprentice, while he is learning, will come to respond to wood and wooden things, depends obviously on the presence of some teacher who can make the apprentice comprehend (pp. 14-15).

The creation of positive clinical learning environments in these circumstances requires more than the existing goodwill of experienced nurses. It also requires an increased understanding and appreciation by schools of nursing and their students of the impact of change on these nurses and their clinical environment. This appreciation may result in more effective collaboration between nursing education and nursing service to assist student nurses learn not merely through practice and busywork, or to gain facility in the use of tools, but to answer and respond to people in order to learn the whole craft of nursing.

Summation

This research concludes that it is the positivist culture of the work setting and their own experiences and meanings of nursing grounded within that culture, which serve to influence nurses' perceptions of their role as clinical teachers. The increased busyness of the clinical environment combines with nurses' inability to articulate nursing knowledge in a way from which students can learn, to create a clinical environment which fosters learning through busywork and repetitive practice, rather than through critical thinking and reflective practice.

This study has confirmed for the researcher, the contributions of experienced nurses and of the clinical context towards assisting students to integrate theory with practice. A model of nurse as clinical teacher has been proposed to demonstrate the variables which nurses identify as impacting on their perception of the role as clinical teachers. This research was undertaken from a philosophical perspective which recognises and values the construction of the participants' world. However, it is also acknowledged, that this research can only be offered on the understanding that:

When I disclose what I have seen, my results [will] invite other researchers to look where I did and to see what I saw. My ideas are candidates for others to entertain, not necessarily as truth, let alone the truth, but as positions about the nature and the meaning of a phenomenon that may fit their sensibility and shape their thinking about their own inquiries (Peshkin 1985, p. 280).

APPENDIX 1

Consent form and

Letter of Information to Participants

SUBMISSION TO PRINCESS ALEXANDRA HOSPITAL RESEARCH ETHICS COMMITTEE.

1.   PROJECT TITLE:

Clinical teaching and learning: A case study of registered nurses' perceptions of clinical teaching and learning.

2.   INVESTIGATORS:

Chief Investigator:

Heather Beattie.   RN, Diploma Applied Science (Nursing Education), Master of Education, Doctor of Education candidate.

Lecturer
School of Nursing
Australian Catholic University,
Queensland.

Supervisor:

Dr Denis McLaughlin
School of Education
Australian Catholic University,
Queensland.

On-Site Sponsor:

Ms Judith Sprenger,
Executive Director, Nursing Services
Princess Alexandra Hospital.

3.   LOCATION OF THE RESEARCH:

The research will involve six registered clinical nurses who have had experience with clinical teaching of Bachelor of Nursing students, during their clinical placements at the Princess Alexandra Hospital.

4.   PROJECT RATIONALE AND OBJECTIVES:

This study forms an important and vital part of a Doctorate in Education that I am currently undertaking. I have been awarded six months study leave from Australian Catholic University, in order to further this research.

Purpose of the research:

The purpose of the research is to identify and understand the impact which the transition of nursing education from a hospital based training to the higher education sector, is having on experienced registered nurses. Specifically, it seeks to understand registered nurses' perceptions about their role in the creation of positive learning environments and their role in the clinical education of student nurses.

Nursing education in Australia has undergone vast changes since its legislated transfer in 1984, from a hospital-based, apprenticeship training, to the higher education sector. Whilst nursing education has thus become regarded to be the responsibility of the university, nursing is essentially and totally a practice discipline. It is recognised that student nurses, in common with students of other practical professions such as teaching, medicine, physiotherapy and speech therapy, need appropriate and adequate field experiences in order to develop their practical knowledge as well as integrate the theory of nursing with professional experience. Therefore, Schools of Nursing rely heavily on a wide variety of health care settings to provide the clinical experience and teaching necessary to assist students develop competency in their nursing practice. The Princess Alexandra Hospital is one important site for nursing students' clinical experience.

However, the separation of nursing education from nursing practice is perceived to have contributed to the exacerbation of a 'theory-practice gap' in nursing. One solution to this issue has been the recommendation that Schools of Nursing focus on the development of clinical teaching models which have the potential to increase the collaboration between nursing education and nursing service.

The Review of Nursing Education in the Tertiary Sector - 1994 and beyond, in 1994, concluded of the theory-practice disalignment that 'the key to bringing the respective expectations and realities into line with each other was the establishment of a more co-operative framework in which higher education and health agencies both contributed to improvement in clinical practice' (Reid 1994:5). The research thus aims to understand the beliefs and expectations of registered nurses about their role in clinical education of student nurses, so that a more co-operative framework for clinical practice might be envisioned between the hospital and the university. It is anticipated that this study will acknowledge and reaffirm the role of experienced registered nurses in the clinical teaching of student nurses.

Significance of the Research:

The research is significant for a number of reasons. Firstly, this study is significant because it has the potential to contribute to the development of co-operative relationships between the School of Nursing at ACU and the Princess Alexandra Hospital, by understanding the attitudes, values and beliefs of clinicians towards nursing education. Furthermore, this research is significant because it offers important insights into the practice of nursing, particularly in the relationship between nursing education and service. One of the major factors which influenced the transition of nursing into the tertiary sector was the need to establish a greater alignment between nursing education and service (Davies, 1991).

Secondly, this study is of significance to the quality of teaching and learning environments. It is anticipated that the participant registered nurses, because of their involvement within the study, may become more aware of their professional responsibility towards the education of student nurses. Insight into their own strengths as clinical teachers and subsequently into their practice, gained as a result of participation in this study, provides opportunities for these clinicians to become role models both to their peers and to students. This personal development has the potential to assist in the creation of positive clinical learning environments.

Thirdly, undergraduate nursing students expect to learn how to be a nurse through the educational experiences, both on campus and off campus, which are developed and offered during their course. This expectation demands that Schools of Nursing seek to develop and offer optimum clinical learning experiences that will assist their students transfer theory into practice. It is therefore important for the continued development of positive learning environments in which student learning can be optimised, and the goals of the new Bachelor of Nursing curriculum can be achieved, that appropriate models of clinical teaching are explored. The results of this study have the potential to assist the School of Nursing at Australian Catholic University, to develop alternative models of clinical teaching, which recognise the unique nature of the hospital and the contributions which clinical nurses within the hospital can make to the creation of quality learning environments, in which students learn to be a nurse.

Finally, the understanding of the processes of clinical teaching and learning is a largely under-theorised area; this research therefore contributes to the development of nursing theory and expands our understanding of the complex process of clinical teaching. It has been acknowledged that insufficient research has been undertaken into clinical teaching and learning, particularly research that examines the attitudes and views of clinicians.

Whilst there have been a number of studies which examine the 'best' and 'worst' attributes of clinical teachers, there are few studies which examine the effect of being a clinical nurse teacher once they have been engaged in that role. The research aims to fill this gap in the literature by seeking to understand the attitudes and beliefs of registered clinical nurses towards the clinical teaching of undergraduate student nurses.

5.   METHODS:

Design of the research:

This research will take the form of a case study of a particular group of registered nurses, working in wards of the hospital, who have been involved in the clinical teaching of student nurses. The case study will therefore be an examination of the registered nurse participants' involvement with clinical teaching and their perspective of the factors that influence them in clinical teaching.

A case study is appropriate because it will allow the researcher to observe, document, analyse and interpret the situation and events in order to gain a deep understanding of the experience of the participants.

Data Collection:

Data will be collected through a combination of four methods:

1. Guided focus group interviews:

Participants who accept the invitation to be involved in this study will be interviewed on three occasions. The first will be a guided interview prior to the commencement of the study in order to establish rapport between the participants and the researcher, and to explore the participants' perceptions and perspective about clinical teaching. Further guided interviews will be conducted during the study to allow participants to reflect on the experience and explore new insights into clinical teaching. The interview times will be mutually agreed upon and will be tape recorded with the participants' permission. It is anticipated each focus group interview will take about one hour.

2. Informal individual interviews:

The second form of interviewing to be used is the open ended, informal, or conversational interview. These informal conversations will take place throughout the course of the study, between participant and researcher. The main advantage of the informal interview is its use in spontaneous situations that may yield rich detail about the interviewee's perception of an incident, during the natural flow of the interaction. Informal interviewing will allow the researcher to take advantage of particular events and of the participants' availability and willingness to share insights into their understanding of clinical teaching. It is expected that each participant may be involved in at least three informal interviews, which would take approximately ten to fifteen minutes.

3. Participant observation:

Participant observation requires that the researcher share as closely as possible in the daily life of the participants within the case study. This has been described as a challenge to combine participation and observation so as to become capable of understanding the

program as an insider, while describing the program for outsiders. The researcher will meet this challenge by spending time immersed in the context, developing rapport and close relationships with the participants. The degree of rapport that develops over time allows the participant observer to gain access to confidential information and situations that would be unavailable to other researchers.

4. Field notes:

Field notes will be kept during participant observation and informal interviews to record descriptions of what participants were observed to do during any interaction with the student nurses, and quotations wherever possible of what was said by the participants during observed activities and later during informal conversational interviews. Comparisons may thus be able to be made between what participants are actually observed to do in relation to clinical teaching, non-verbal behaviour related to clinical teaching and verbal descriptions of their perceptions.

Transcripts of the taped interviews and field notes will be made available to all participants in order to confirm the accuracy of the data. Therefore, participants will be given the opportunity to reflect on and clarify interview transcripts; this will provide further important evidence as participants reflect on and validate initial insights.

Duration of the study:

Initial data collection will occur during a period when nursing students are on clinical placement on the participating wards at the hospital. It is expected that this time frame will have to be negotiated with each participant. It may also be necessary for the researcher to return to the participants on an informal basis, over the next eighteen months, in order to corroborate data and clarify understandings and perspectives with the participants as part of the process of data analysis. The times will be at the convenience of the participants and the hospital.

Participant Selection:

Initial discussions have been held with the Executive Director of Nursing, Assistant Directors of Nursing, and Clinical Nurses Consultants, who have identified interested wards. Discussions will be held on 22nd July with approximately six to eight registered nurses from these wards in order to acquaint them with the purpose of the study and to invite their participation. Prospective participants who would be available during the time period will then be given a letter inviting their participation and outlining the process of the study.

This information is set out in detail in Section 9 and 10 of this submission. Participants will be assured that they have the right to withdraw from the study at any time, without any consequences.

Data Analysis:

The analysis of qualitative data requires the researcher to tread a fine line between the imposition of some structure that makes management of the data easier, and the need to listen to all the voices participating in the research. Subsequently, an approach developed by Colaizzi, which sets out the steps involved in phenomenological data analysis, will be followed. This framework will ensure that major themes from the data are identified, which then form an organising structure that allows the research to remain true to the voices of the participants. The framework is reproduced below.

Colaizzi's Phenomenological Data Analysis Framework.

1. <u>Protocols</u> – All of the participants' descriptions, or protocols, are read in order to acquire a sense of the whole.
2. <u>Extracting significant statements</u> - Significant statements and phrases that relate to the topic are extracted from each transcript.
3. <u>Formulating meanings</u> – The meaning of each significant statement is spelt out. Care is taken to ensure that the meanings arrived at are close to the original protocols. Creative insight is required move from what the participants said to what they mean.
4. <u>Clusters of themes</u> – the above activities are repeated for each protocol and the aggregated formulated meanings are organised into clusters of themes that are common to all of the participants' protocols. The clusters of themes are referred back to the original protocols in order to validate them. If it is found that clusters of themes cannot be validated then the preceding procedures are re-examined or recommenced.
5. <u>Exhaustive description</u> – an exhaustive description of the investigated topic is integrated from the results of everything discovered so far.
6. <u>Formulation of a description of the phenomenon in a statement of identification</u> – An effort is made to formulate an exhaustive description of the researched phenomenon in as unequivocal a statement of identification of its fundamental structure as possible.
7. <u>Final validating step</u> – the researcher returns to each participant, and asks each participant about the validity of the findings. If any new data emerges at this point, then it must be worked into the final product of the research. (Colaizzi, 1978:48-71)

This process of data analysis forces the researcher to constantly compare theme with theme and to search for the relationship among the themes. Through this process of data analysis, it is anticipated that an indepth interpretation of the experience of registered nurses participating in this study will be achieved.

6   CLINICAL DRUG TRIALS: Not Applicable.

7   PROCEDURES: No invasive procedures are involved.

8   ASSESSMENT OF PATIENTS: Not Applicable

9   ADMINISTRATIVE ASPECTS:

No funding is required for this study. The chief researcher is on six months study leave from Australian Catholic University, in order to carry out this research, which forms an important component of a Doctorate in Education.

10   PARTICIPANT INFORMATION:

The following information and letter of consent will be sent to all participants.

PROJECT:

CLINICAL TEACHING AND LEARNING: A CASE STUDY OF REGISTERED NURSES' PERCEPTIONS OF THEIR ROLE IN THE CLINICAL EDUCATION OF UNDERGRADUATE STUDENT NURSES.

INVESTIGATOR: HEATHER BEATTIE

PURPOSE OF THE STUDY:

My name is Heather Beattie, and I am a lecturer in nursing at the School of Nursing at Australian Catholic University, Queensland. As part of my doctoral studies, I am interested in understanding the experiences, beliefs and perceptions of registered nurses in the clinical teaching of student nurses.

If you have previously been involved with student nurses during their clinical experience placements, I would like to invite you to participate in this study. Your participation will require you to be interviewed in small groups, on three occasions. Each interview will take about one hour. I would like to tape record the interviews to assist with the accurate collection and analysis of the data. The dates, times and location of the interviews will be mutually agreed upon, but it is likely that the Princess Alexandra Hospital could be suggested as a suitable venue. It may be the most central location and you would have no difficulty finding your way around!

Whilst you are working with students during their clinical experience, I would like to feel free to observe interactions between you and the students, and also to have informal conversations with you. These informal discussions will give us both an opportunity to explore some of your beliefs

and understandings about clinical teaching and learning. I anticipate that these discussions and observations will occur on a random, spontaneous basis, to be initiated by either of us, and last for only a matter of ten to fifteen minutes.

In order to gather accurate data, I will be making field notes during these periods of observation. Please be assured that I am not seeking to make judgements about your nursing practice. As a registered nurse myself, I am aware that it can be disconcerting to be observed, however, I am only interested in your experience and understanding of clinical teaching.

In order to ensure that I have interpreted and analysed your comments and insights accurately, I will be returning to the unit, at an agreed time and date, to allow you to read the transcripts of the taped interviews and field notes. I would like you to read these and discuss or comment on the data, as you desire. Confidentiality will be maintained by the use of pseudonyms in the writing up of the data.

As a lecturer, I am acutely aware that the universities and hospitals need to work together to develop collaborative approaches to clinical teaching. I believe that your participation in this research will be of great significance in assisting in the development of closer links between nursing education and nursing service. I anticipate that the information collected in this study, will allow collaborative models of clinical teaching to be developed between the hospital and ACU, which recognise the unique nature of the hospital and the contributions which clinical nurses make to the creation of quality learning environments, in which students learn to be a nurse.

You may withdraw from the study at any time without any consequences. This study also has the approval of the Princess Alexandra Hospital Research Ethics Committee.
If you have any questions either now or during the study, please feel free to contact my university supervisor, Denis McLaughlin, or me:

Dr Denis McLaughlin
Head, Department of Educational Leadership
Australian Catholic University
PO Box 247
Everton Park.   4053   Phone: 3855 7154

Heather Beattie
Lecturer in Nursing
School of Nursing
Australian Catholic University
PO Box 247
Everton Park.   4053.   Phone: 3855 7240   Fax: 3856 4988

If you now indicate a willingness to participate in this study, I ask you to carefully consider the Informed Consent Form, of which there are two copies. Please sign both copies, retain one for your records and return the other in the stamped addressed enveloped provided.

Yours sincerely

Heather Beattie

11   CONSENT:

The following letter of consent will be sent to all prospective participants.

CLINICAL TEACHING AND LEARNING: A CASE STUDY OF REGISTERED NURSES' PERCEPTIONS OF THEIR ROLE IN THE CLINICAL EDUCATION OF UNDERGRADUATE STUDENT NURSES.

INVESTIGATOR   HEATHER BEATTIE

I _____ *have* read *and understood the information*

provided in the Letter to the Participants and any questions I have asked have been answered to

my satisfaction. I agree to participate in this activity, realising that I can withdraw at any time

I agree that research data collected for the study may be published or provided to other researchers in a form that does not identify me in any way.

NAME OF PARTICIPANT ─────────────────────────────────
                                        (block letters)
SIGNATURE ──────────────────────────── DATE ───────────────

NAME OF WITNESS (independent of the study) ────────────────────
SIGNATURE ──────────────────────────── DATE ───────────────
NAME OF RESEARCHER   HEATHER BEATTIE

SIGNATURE ──────────────────────────── DATE ───────────────

12   ETHICAL CONSIDERATIONS:

Benefits:

The benefits of this study can be described in terms of benefits to the participants, to the hospital, to the university, and overall to the future of nursing education.

Participants will benefit from being able to contribute their experiences, beliefs and understanding about clinical teaching and know that they will be directly contributing to increasing our understanding of the phenomenon of clinical teaching. Participation will increase their self-awareness as clinical teachers and will have benefits for their future performance in this role.

The hospital and university will benefit from the increased collaboration and cooperation that is expected to develop as a result of this study. Such a relationship will result in an increased awareness of the changing needs of nursing eduction and nursing service, and has the potential to contribute to the development of creative models of nursing education and clinical teaching which will benefit both hospital and university.

The nature of nursing has experienced, and continues to experience, changes and challenges presented by economic, social and technological pressures on health care and its delivery. Calls for the 'revisioning' of nursing education to provide an educational base which will meet these changes, have seen a decrease in the traditional emphasis on a behavioural pedagogy, and a recognition that nursing practice is now characterised by ambiguity, uncertainty, complexity, and rapid change. The overall benefit of this study to nursing education is its real potential to contribute to the development of creative models of clinical education which recognise the changing nature of nursing and the need to develop student nurses who will be capable of practising competently in this changing world.

Protection of Privacy:

Participants will be allocated pseudonyms that will be used in all transcripts of the data, to protect their identity. The participants' right of access to the transcripts of their interviews, conversations and field notes, is acknowledged. This access forms an important part of the approach to data analysis to be utilised in this study, therefore access to this data is inherent in this process.

Only the researcher and the participants during the study will access recorded tapes and written transcripts of interviews, informal conversations and field notes. All recordings and written material will be stored securely in a locked cabinet in the researcher's office, throughout the study. These materials will be kept locked for a period of five years following completion of the project, in accordance with the ethical requirements of the Australian Catholic University Research Projects Ethics Committee. These materials will

then be disposed of by shredding all written data and erasing all audio recordings and relevant computer disks.

13   ADDITIONAL INFORMATION:

All recruiting of participant registered nurses is being conducted with the full approval and support of the on-site sponsor, Ms J.A. Sprenger. Initial meetings have been held with Ms Sprenger and interested registered nurses. From these meetings it is expected that participants will volunteer and be selected as soon as ethical approval for the study is obtained.

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