STUDENTS' CONCEPTIONS OF THE EFFECTIVENESS OF CLINICAL TEACHERS IN NURSING

By

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"Students' Conceptions of Effective Clinical Teachers"

The purpose of this descriptive study was to determine: a) similarities and differences between conceptions of second and third year college-based nursing students regarding effective clinical teachers; b) if either groups' opinion was affected by the instructor's contractual agreement; and c) if students' conceptions could provide a theoretical framework for further empirical research into clinical teacher effectiveness.

Transcript analysis of the thirty interviews with second and third year students in a three year college based diploma nursing program revealed that students are capable of identifying factors which enhance their learning in the clinical area, although second and third year students differed somewhat in their perceptions of effective clinical teachers.

Lastly, a significantly greater number of full-time faculty than part-time faculty were described as most effective $[\chi^2=8.66 \text{ (df=1)} \ p.<.01]$. 
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Chapter One

CLINICAL TEACHER EFFECTIVENESS

Introduction

In recent years a number of nurse educators have taken an interest in comparing student and faculty perceptions of effective teacher behaviors in clinical nursing (Brown, 1981; Kiker, 1973; Knox & Mogan, 1987; O'Shea & Parsons, 1979; Pugh, 1986; Stafford & Graves, 1978; Stuebbe, 1980; Wong, 1978; Zimmerman, 1988). Results of these studies indicate that while students and faculty agree on certain factors which determine clinical teacher effectiveness, there is disagreement in many areas. In a study with university nursing students, for example, Mogan and Knox (1987), found that both faculty and students agreed that being a good role model was the highest rated characteristic for 'best' teachers and the lowest rated characteristic for 'worst' teachers. While faculty and students' perceptions were fairly similar regarding rated characteristics of 'best' teachers there was less agreement on rated characteristics of 'worst' teachers.
Comparisons of perceptions of university nursing students in an earlier study by Mogan and Knox (1982) indicated that students became more critical of clinical teachers as they moved through a program of study. They also found that students valued different characteristics of effective clinical teachers in each of the four years, although there was some overlap in values. 'Availability' for example, was mentioned by students in all four years, however more frequent comment was given to the promotion of independence ("not watching us like a hawk", "freedom to work independently") by second and fourth year students. Third year students' comments related mostly to the instructor's communication skills. Student values overlapped regarding the teacher's ability to evaluate, her interpersonal skills and her personality.

A teacher's ability to evaluate appeared important to students in all four years of the program, since approximately 25% of all of their comments related to this area. First and second year students wanted frequent if not continuous feedback with ample direction, whereas third and fourth year students focused on expectations. Senior level students preferred high but realistic expectations that were clearly spelled out.

The instructor's ability to relate to students and
others also received similar comments from all four years, however third year students appeared most concerned with this aspect of clinical teacher effectiveness. Most effective teachers were described as: approachable, supportive, helpful, empathetic and encouraging. Least effective teachers were described as non-supportive, unapproachable, intimidating and not empathetic to students' needs.

Although first year students commented least and third year students commented most on the instructor's personality, generally students appreciated the teacher who was enthusiastic, organized, flexible, cheerful and had a 'good sense of humor'.

On the whole, comparative analysis of studies in clinical nursing education has been difficult because researchers have not agreed on how to classify clinical teaching behaviors, nor on a definition of clinical teacher effectiveness. Attempts at classifying teacher behaviors has resulted in much confusion in the literature due to the lack of a universally accepted definition of effectiveness and an incongruent classification system.

The majority of existing studies are quantitative and are based on data collected from American undergraduate university students. It is indisputable that much research
is needed in this area to reflect teacher effectiveness in college based nursing programs.

Teaching is a complex skill, and there is no single variable that fully describes or explains the qualities of an effective teacher. Regardless of the perceived complexity of this task, nurse educators have a responsibility to their students, the profession, and their clients to identify and use the qualities of effective clinical teaching. 

(Zimmerman & Waltman, 1986, p.31).

It is debatable who is best suited to provide the data base for this much needed research. Some researchers have agreed that students, being the direct recipients of instruction, are in the best position to observe and evaluate the behaviors of their clinical instructors (Armington, 1972; Pratt & Magill, 1983; Zimmerman, 1986) while others have been concerned that students' tendency to rate teachers on personal qualities may result in a popularity contest rather than in instructor evaluation (MacKay, 1974; Mogan & Knox, 1987). 

In most instances, there is need for more than one source of data when evaluating a teacher's effectiveness. However, it is this researchers' belief that students are a vital source of data in the evaluation of clinical teachers. More importantly, it is essential to attempt to gain an understanding of how students perceive effective clinical instruction if nurse educators are to become increasingly accountable for their teaching.
That students' concern about the quality of their education is legitimate, and that they should be allowed to express their views on all matters of genuine concern to them is documented in a 1972 study by Armington. A 1987 study on the process of evaluating nursing faculty by Coleman and Thompson concludes: "When properly obtained, student ratings can be a valid and reliable component of the measurement of teaching effectiveness" (p. 27). Similarly, Dawson (1986) discusses how valid and reliable students' ratings of teachers are, as measures of their teaching effectiveness. She claims that there is empirical evidence to support both the validity and the reliability of students' ratings of effective teachers but does not cite specific studies as evidence of this. In a review of the literature of effective teacher behaviors for clinical nursing instructors, Zimmerman and Waltman (1986) reiterate that students, as direct recipients of instruction are in the best position to observe the behaviors of their clinical instructors.

It is also widely recognized that the paucity of research on clinical teacher effectiveness is at least partially due to unusual problems associated with clinical teacher evaluation. Evaluation techniques designed for classroom use are not universally applicable to the clinical
setting (Brown & Hayes, 1979). The difficulty with evaluating clinical teacher effectiveness is further complicated by the fact that many graduate programs do not provide individuals with basic information on clinical instruction.

In a survey conducted between 1983 and 1986 (Karuhije, 1986), a startling 78% of the 211 nurse educators sampled agreed with the statement: "...most graduate programs do not provide individuals with basic information on clinical instruction" (p. 138). They indicated that they had been prepared as clinical specialists but were frequently expected to assume the role of nurse educator for which they were inadequately prepared. Although the population surveyed consisted of volunteer nurse educators from 35 of the 50 states in the continental U.S., there is no evidence of a significant difference in Canada. Generally, the ability to teach in the classroom is considered sufficient preparation for clinical teaching.

Clinical instruction makes dual demands on teachers, since they are expected to maintain expertise in two fields. Naturally, one field must take precedence. Recent emphasis on clinical competence has determined that this is the priority for nurse educators. The clinical teacher is much more likely to be questioned regarding her clinical expertise than regarding her teaching expertise.
Employers and professional associations have recently attempted to define clinical competence. They have debated in fact whether clinical instruction in itself constitutes clinical practice. At the same time, classroom teaching has become a symbol of increased status, while clinical teaching is viewed as having lower status. This is reflected in the hiring practices of educational institutions, where increasing numbers of clinical instructors are employed on a part-time basis to teach exclusively within the clinical setting. What effect this practice has had on teacher effectiveness is unknown. Furthermore, based on data collected in her 1983-1986 survey, Karuhije makes the point that clinical teacher effectiveness is compromised by having two groups of nurse educators, one in the classroom, the other in the clinical setting. "Contrary to current trends and practices, the clinical teacher and the classroom teacher in undergraduate nursing education should always be the same person" (Karuhije, 1986, p. 143). Students may not benefit to the same extent from clinical practice when the instructor is not familiar with the theoretical content. In addition, the teacher who is not dealing with current theoretical content is poorly equipped to assist students with the integration of theory and practice.

Studying the effectiveness of having two separate groups
of nurse educators is further complicated when one takes student-faculty contact hours into account. The relationship between hours of contact and student evaluation of clinical instruction has only recently been studied and could have an impact on all of the factors mentioned (Dawson, 1986).

While several studies have compared students' and teachers' perceptions of effective clinical teachers, there appears to be a lack of research regarding students' conceptions of effective clinical teachers from college based diploma nursing programs. In addition, empirical studies into students' perceptions of effective clinical teachers tend to be comparative and focus on behaviors of clinical teachers.

**Purpose**

The purpose of this study was to determine similarities and differences between the perceptions of second and third year students regarding characteristics of effective clinical teachers. More specifically: How did second and third year students in a three year nursing diploma college program conceive clinical teacher effectiveness? Was either groups' opinion related to the instructor's contractual agreement and lastly, could the data collected from interviewing college based nursing students regarding their experiences with effective clinical teachers provide a
theoretical framework for future empirical research into clinical teacher effectiveness? When students from a college based nursing program were asked to recall an effective clinical instructor, were their conceptions similar to current findings reported in quantitative studies on effective clinical teachers carried out with university students? In addition, were teachers who also taught nursing theory concurrently with clinical practice viewed differently than clinical teachers who taught exclusively within the clinical arena?

Definitions

1. College based R.N. diploma student: student who is enrolled in a full time course of study in a community college and who will be eligible to write nursing registration examinations upon completion of the designated course of study.

2. College based R.N. diploma faculty: all of the nursing teachers who have clinical teaching responsibilities in a community college based Registered Nurse diploma program.
3. **Part time contractual agreement**: a contractual agreement whereby a faculty member is hired on an hourly, weekly or sessional basis to teach clinical practice on a part-time basis.

4. **Full time contractual agreement**: a contractual agreement whereby a faculty member is hired on an annual basis to teach both nursing theory and clinical practice on a full-time basis.

5. **Clinical teacher**: "one who instructs nursing students in the practice setting" (Brown, 1981, p.6).

6. **Characteristics of clinical teachers**: attributes observed by second and third year nursing students as stated in open-ended interviews.

**Assumptions**

The study is based upon three assumptions. Firstly, second and third year nursing students will have had enough experience with a variety of clinical teachers to be able to provide an account of their conceptions of effective clinical instructors. Secondly, different clinical settings have provided comparable opportunity for clinical teachers to demonstrate their teaching styles. The final assumption is that our understanding of clinical teaching effectiveness can be enhanced by studying students' conceptions of effective clinical teachers based on their own experiences.
Significance of Research

Due to the increasing scarcity of clinical resources, increasing student demands for instructor accountability, increasing student-faculty ratios and limited time for clinical practice in nursing programs, it is imperative that nurse educators learn more about effective clinical instruction. Achieving a universal definition of effective clinical teaching is only possible through repeated enquiry by nurse educators. What constitutes effective clinical teaching practice can be determined by systematic analysis of learners' conceptions of their experiences with effective clinical teachers. Research in this area will assist teachers in guiding students in the application of theory to practice and contribute to the formulation of measurable criteria for the clinical evaluation of nursing faculty.

A nursing teacher who wishes to be most effective with her clinical students must come to understand what it is that students value at various stages in their growth and development as students. Identification of those values enhances the potential for successful implementation of nursing practice and educational outcomes. If it could be shown that certain characteristics are valued more by one level of student, perhaps teachers could be assigned more appropriately to that level of student.
The effect of a recent trend toward the employment of two groups of nursing faculty, one to teach theory, the other to teach students clinically has not been evaluated. The outcome of such practice is a question which must be addressed by nurse educators as well as the search for a definition of clinical teacher effectiveness.

Similarly, the effect of contractual agreements between faculty and employers may provide guidance to employers in the management of this most valuable resource. If it could be shown that a clinical teachers' perceived effectiveness was not affected by the nature of her contractual agreement, administrators could more easily meet staffing requirements. If on the other hand, there was sufficient evidence to show that a clinical teacher was perceived by students as more effective when employed on a full-time basis, the trend to hiring more part-time staff may be questioned.

Limitations

There is one major limitation to the study. It has limited generalizability due to the student population from which the data were collected. Inferences from this study must therefore be limited to students from college-based nursing diploma programs.
Outline of Remaining Chapters

Chapter One has introduced the topic of clinical teacher effectiveness and outlined the purpose of this study. Terms used throughout the paper have been defined and assumptions upon which the study is based have been discussed. Chapter Two of this paper will review previous studies on clinical teacher effectiveness and explore the difficulties associated with the use of classroom teaching models to evaluate clinical teacher effectiveness. The methodology utilized for sample selection, collection and analysis of data is described in Chapter Three and is based upon a blend of phenomenography (Marton, 1984), a distinct field of inquiry aimed at analyzing students' descriptions of their clinical experiences and grounded theory (Glaser & Strauss, 1967; Glasser, 1978; Strauss, 1987). Chapter Four will present the findings and Chapter Five will discuss the findings, state conclusions and implications for nursing education as well as recommendations for further study.
Chapter Two

LITERATURE REVIEW

Introduction

Understanding clinical instructor effectiveness requires an overall view of teacher effectiveness in education. A review of the literature in this chapter therefore begins with a brief overview of studies in teacher effectiveness in general education and medical education. An in depth review of teacher effectiveness in nursing education follows, forming the basis for a discussion on the misuse of classroom teaching evaluation tools in the evaluation of clinical teaching. Lastly, five factors are suggested as reasons for the misuse of classroom evaluation tools in the evaluation of clinical teachers.

Teacher Effectiveness in General Education

Recent studies on teacher effectiveness in general education have focused on the teacher's thought processes and knowledge base in an attempt to determine what constitutes effective teaching. Some researchers (Wittrock,
1986; Calderhead, 1987; Pratt, 1983) have examined antecedent events and factors which influence the teacher's interactive decision making process. They have attempted to answer: "What constitutes effective decision making by a teacher?" and "What determines which approach teachers employ in teaching similar content to diverse groups?"

Other researchers (Wilson, Shulman and Richert, 1987) have begun to investigate the professional knowledge base of teachers. They have attempted to answer: "What do teachers need to know?" Their investigations have led them to view subject matter and pedagogy as two separate domains; both equally essential to effective teaching. They claim that effective teachers employ seven types of knowledge: a) knowledge of educational contexts; b) content knowledge; c) knowledge of other content; d) general pedagogical knowledge; e) knowledge of learners; f) knowledge of educational aims, goals and objectives; g) knowledge of curriculum. Shulman (1987) has further explored the capacity of a teacher to transform his or her content knowledge into forms that are suitable to a diverse group of learners, hence the process of information transformation from teacher to learner.

Transformations, according to Shulman, require some combination or ordering of the following processes:
preparation of materials, representation of ideas, selection of teaching methods, as well as adaptation and tailoring of the material to suit the characteristics of the students. He compares the teachers' thinking in relation to teaching to the manufacturing of a suit of clothing. Adaptation is like preparing a suit of a particular style, color, and size that can be hung on a rack. Once it is prepared for purchase by a particular customer, however, it must be tailored to fit perfectly (p.17).

Wittrock (1986) and others explored teachers' interactive decision making as a means of identifying behaviors of effective teachers. Based on three empirical studies which have attempted to describe thought processes of effective teachers during interactive teaching, a number of characteristics of effective teachers have been identified.

Other researchers (Peterson and Clark, 1978) explored teacher flexibility and found that teachers who had alternative teaching strategies in mind but who did not employ them (i.e. showed less flexibility in interactive decision making), were bound to the instructional objectives which they had established during planning. Doyle (1977) found that compared to unsuccessful teachers, successful teachers (those whose students scored the highest on examinations) had the following cognitive skills: rapid judgement, chunking and differentiation. In addition to
being able to make rapid decisions in a complex classroom environment, successful teachers had the ability to group events into units and could differentiate between the immediate and long-term significance of events. Differentiation, or what Corno (1981) called 'selectivity', is the ability to separate out important from incidental information during interactive teaching. This finding is similar to that of Morine and Vallance (1975) who reported that teachers with low student achievement gain scores tended to mention a larger number of items that they took into account during interactive decision-making indicating that unlike their more effective peers, they were not able to transform complexities from the environment into meaningful conceptual chunks and thereby anticipate the flow of events. This research is further substantiated by comparisons of interactive decision making of novice and expert teachers (Calderhead, 1981).

In Exploring Teachers' Thinking (1987), James Calderhead and others explore a variety of conceptions of the teachers' role held by educational experts from the United States, Canada and Western Europe. Although research on teachers' thinking doesn't provide a theoretical framework for studying the role of the teacher, it provides insight into how various educational tasks are approached. Teaching is described as an active process in which the teachers' knowledge provides the
source of identifying and interpreting professional situations and responding to them. How a teacher responds is based to some extent on 'common sense' in addition to a body of professional knowledge including: knowledge of learners, educational aims, subject matter, curriculum materials, teaching strategies and classroom processes (p.108). In earlier research, Calderhead (1981) compared descriptions of classroom incidents from beginning and experienced teachers. Based on that research, he believes that teachers' thinking changes in a fluid, interactive manner, based on competing personal and professional interests. Expert teachers are those who can employ and adapt routines sensitively to the situation at hand (Wittrock, 1986, p.230). Although expertise is not solely dependent on practice, experience can transform the teacher. For example, the beginning teacher's practices are more often constrained by the way the teachers' task is defined by the school, whereas experienced teachers who have reflected on their experience have developed metacognitive skills. They have become transformed by their experience and gradually became experts in their field.

Teacher's practices are also influenced by the context within which they work and the tasks they must accomplish. Getting through the syllabus may take precedence over assessing individual learners' difficulties and prescribing suitable remedial work. Similarly, the teacher's attempt at
controlling classroom behavior often results in a less than intellectually challenging curriculum. While much of a teacher's practice is based on preconceptions about teaching or knowledge base, professional education takes little account of these in training student teachers. Critical reflection on practice is required in order to avoid perpetuating existing poor practices. Professional development programs for teachers must call for reflective teacher education rather than being focussed on process. Much of a teachers' work must be aimed at understanding why even those students who were able to demonstrate mastery of a concept or skill appear to have forgotten it shortly after, or why apparent mastery of the curriculum cannot be related to previous existing knowledge. Our understanding of how professional knowledge base develops and how teachers' knowledge informs classroom behavior is limited. Continued attempts at exploring teachers' conceptualizations of their role will guide efforts to improve the quality of a teachers' practice.

Pratt (1988) discusses three perspectives of teacher effectiveness in adult education. The first and most dominant perspective since the 1950's is based on behavioral psychology and is one of the teacher as skilled manager and performer. This perspective is based on the belief that there exists a universal set of teaching principles and skills.
applicable to most learners in most situations. Adoption of this perspective leads to a misrepresentation of teaching as mechanical procedures and routines. It does not encompass the wisdom or insight which is prevalent in good teaching practice and resembles training rather than education (p. 247).

The second and most dominant perspective in the past decade compares teaching to problem-solving. The teacher is seen as a clinical practitioner and teacher effectiveness is a function of one's ability to solve complex, ambiguous and unpredictable problems within the learning environment.

An effective teacher is one who is able to interpret complex and diverse situations and is thereby able to derive rational strategies. In this perspective, judgements about effective teaching are based on the teacher's ability to predict common conceptions, misconceptions, difficulties and motivational orientations of entering students (p. 248).

The third and most recent perspective focuses on the relationship between implicit and explicit values and the teachers' thinking about what is taught, as well as how it is taught. Effectiveness is viewed as the level of critical awareness of the means and ends of one's teaching and acknowledgement of the link between teaching and personal and cultural values. An effective teacher is one who is able to critically examine his or her own values as they affect professional practice (p. 249). This teacher has a concern for the social conditions within which the process of teaching and learning is conducted, as well as the
relations of power and authority that structure and influence those conditions.

While each of these three perspectives has a place in practice, it is conceivable that teachers move through each of them as they gain experience. For novice teachers with experience in a content area who now wish to teach that content, appropriate emphasis must be given to guidelines, skills and procedures. Later in ones' teaching career, the emphasis may shift to deriving roles and functions from the variations in context. Lastly, the balance shifts even further for highly experienced and confident teachers as they emphasize relationships between values and professional practice. Movement through the perspectives, according to Pratt, is cyclical and regressive and should increase one's awareness of the relationship between perspectives. An appropriate conceptualization of teacher effectiveness is one that acknowledges the interdependence of all three perspectives.

As previously mentioned, Wilson, Shulman and Richert (1987) have provided a framework for understanding components of the professional knowledge base of teaching. They claim that effective teachers employ the following types of knowledge:

Knowledge of educational contexts.

General pedagogical knowledge.
Content knowledge.

Knowledge of learners.

Knowledge of other content.

Knowledge of curriculum/goals/objectives (p. 113).

Knowledge of educational contexts means that the teacher must be familiar with how that knowledge is to be used in the field. The teacher who is able to demonstrate "hands on" application of nursing principles and theories taught in the classroom is a powerful role model for students. When students experience theory in action, they are likely to recognize the value of augmenting their body of knowledge and the link between theory and practice. Knowledge then, is most meaningful when it can be shown to have direct and useful application.

Knowing how to teach is referred to as general pedagogical knowledge. It represents the blend of content and pedagogy into an understanding of how various topics, problems or issues are organized and represented to learners with highly varied interests and abilities, hence how "x" material can best be organized and represented to "x" student to achieve "x" outcome for both student and teacher.

Content knowledge is the subject matter which is to be mastered by the student. It is an understanding of facts and concepts within a domain, as well as how the fundamental principles are organized. In addition, content knowledge includes the scientific proofs that guide enquiry and practice.
Knowledge of learners and their characteristics includes knowledge of motivational and developmental aspects of how students learn. It is the acknowledgement of what students bring to the learning situation, including attitudes shaped by past experiences.

Knowledge of other content is that which is much broader than the field of practice or the scope of the discipline within which teachers teach. It addresses the teachers’ ability to draw upon many areas of indirectly related knowledge that serve to enrich the principal area of content under study.

Knowledge of curriculum and objectives contribute to the teacher’s pedagogical decisions and includes her understanding of the program and how particular subjects and topics at each level contribute to the achievement of desired outcomes. It includes knowledge of the logical or practical sequencing of content and of the desired achievement of learning.

That clinical teacher knowledge can be viewed in these broad categories is new to the study of clinical teacher effectiveness. Perhaps it has been the absence of such specific and clearly established categories that has impeded the analysis of data on clinical teacher effectiveness in previous research studies.
Teacher Effectiveness in Medical Education

Pioneering studies of clinical teaching in the education of medical students (Daggett, Cassie and Collins, 1979) indicated that "teachers might be major obstacles to student learning" (p. 158). Two similar studies (Stritter, Hain and Grimes, 1975; Mayberry, 1978) using rating scales of specific behaviors or teaching approaches asked medical and dentistry students which of them contributed most to their learning. Mayberry (1978) found that dentistry students valued communication skills, interpersonal skills, availability and instructor-student rapport. Similarly, Stritter, Hain and Grimes (1975) found that medical students placed emphasis on active student participation, preceptor attitude, applied problem-solving, student-centered instructional strategies on a humanistic orientation and on references as well as research.

In a much more comprehensive study of clinical teaching, Reichsman, Browning and Hinshaw (1964) observed 82 teaching sessions, (56 of which were medical floor rounds) and interviewed departmental chairmen, faculty and students. They concluded that teaching was haphazard, mediocre and lacking in intellectual excitement. Despite their observations no suggestions for change or improvement of teaching were made.
Bazuin and Yonke (1978) found similarities between teachers of medicine and nursing. Observation of videotapes of clinical faculty revealed that teachers were lecturing rather than being engaged with students in problem-solving activities. They also found that faculty experienced problems in role definition, utilization of teaching strategies, developing instructional objectives and dealing with interpersonal problems.

Recent information on clinical teaching in medicine by Irby (1986) outlines strengths and problems of clinical education. While the strengths of clinical education in medicine include a problem centered approach, experience based learning and combined individual and team learning, the limited emphasis on problem solving creates difficulties in clinical teaching. Other problems in the clinical teaching of physicians include: lack of clearly stated expectations, inadequate feedback and inappropriate role models. In spite of these difficulties within the clinical area, Irby found seven characteristics of excellence among outstanding clinical teachers in medicine. Outstanding teachers were knowledgeable, they presented ideas clearly and in a well organized fashion. They were enthusiastic, interacted skillfully with students, provided clinical supervision, demonstrated clinical skills and modelled professional characteristics. Irby viewed these characteristics within
the three key roles played by clinical teachers: "role model, clinical supervisor and instructional leader/scholar".

Teacher Effectiveness in Nursing Education

An historical overview of the literature associated with perceptions of faculty and students regarding effective clinical teaching in nursing reveals that studies conducted in the U.S. during the 1960's and the 1970's examined classroom and clinical teaching strategies jointly. Classifying effective teacher behaviors is a major problem since each researcher has ended up with different categories of behaviors.

Availability and accessibility of the instructor is valued by students (Armington, 1972; Jacobson, 1966; Karns & Schwab, 1982; Kiker, 1973). A teachers' interpersonal skills has been identified as critical to his/her effectiveness (Griffith, 1983; Jacobson, 1966; Karns & Schwab, 1982; Kiker, 1973; Mogan & Knox, 1987). General knowledge and professional competence are also frequently mentioned as valuable attributes (Armington, 1972; Jacobson, 1966; Karns & Schwab, 1982; Kiker, 1973). Other frequently mentioned attributes include: evaluation skills, personality traits such as enthusiasm and a non-judgemental attitude, ability to role model, taking the time to get to know
students individually and ability to motivate students or encourage them to think. However, categories of behaviors and/or characteristics are arbitrary because terms are poorly defined and a universal classification system is lacking. The systematic collection and analysis of data has been further complicated by the lack of agreement among researchers regarding the placement of findings within behavioral categories.

Although classification systems for effective teacher behaviors vary from researcher to researcher, in many studies three to five behavioral categories emerge from the data. For example, Kiker (1973) has three categories: (professional competence, relationships with students and personal attributes), whereas Mogan & Knox (1987) have five categories (teaching skills, nursing competence, interpersonal skills, evaluation skills and personality traits).

Student-teacher ratios and level of educational preparation have also been studied in relation to clinical teacher effectiveness. As early as 1966, Jacobson identified student-teacher ratios in the clinical area as a significant factor in determining teacher effectiveness." When data was treated on percentage basis, the % of ineffective incidents increased as the clinical faculty-student ratio increased " (p. 220).
Neither Jacobson nor any other researchers however, have shown any relationship between the preparation level of teachers and teacher effectiveness in the clinical setting. Even after more than a decade of investigation however, Brown & Hayes (1979) stated that there were no universally accepted models for evaluating effective classroom and clinical teaching (p. 778).

**Communication Models in Nursing Education**

A variety of communication models serve as tools used in educating health care professionals to prepare them as skilled helpers. Three models which have enjoyed popular use in curricula throughout the 1970’s and 1980’s include: Rober Carkuff’s counselling model, George Gazda’s human relations development model and Bandler and Grinder’s neurolinguistic programming (NLP) model. Each model offers a framework for understanding the steps or components of the communication process whereby health care workers assist clients with problem-solving.

Once students in health care programs become familiar with a communication model, they are able to apply it in therapeutic relationships with clients, ultimately enhancing the clients’ self awareness and problem solving skills.

Most therapeutic communication models in current use
are based on Carl Roger's theories about the conditions that facilitate positive interactions. Rogers identified three concepts - empathy, congruence and positive regard as critical dimensions of interpersonal relationships and of all human learning situations.

Rogers (1980) describes empathy as the ability to listen carefully to others for feelings and to reflect those feelings back (p. 138). He believes that a high degree of empathy in a relationship is possibly the most potent factor in bringing about change and learning (p. 139), and sees direct application of empathetic responses in educational situations as meaningful. When teachers show evidence that they understand the meaning of classroom experiences for their students, learning improves (p. 155).

An empathetic teacher therefore listens actively, reflects back her perceptions of student's feelings and conveys an appreciation of the student role in a caring manner.

Congruence, according to Rogers, is being real. It means having an awareness of what is going on within oneself as well as the ability to reflect on the inner self. It is a state of integration and genuineness. The congruent educator projects matching verbal and non-verbal cues to the learner, showing genuine pleasure and displeasure in day to day interactions with students. A congruent teacher also has the ability to self-disclose feelings and experiences.
The teacher with positive regard has a person-centered approach to education (Rogers, 1980, p. 307), always showing respect for the student as a person. The teacher with a high degree of self regard exhibits the following (compared with the teacher with low self regard): a) a more positive self concept; b) more self disclosure; c) responds more to student's feelings; d) gives more praise; e) is more responsive to student's ideas, and f) employs the lecturing method less in teaching. These attributes have not been studied in college level teachers, however nurse educators have recently become interested in studying the application of communication models in therapeutic relationships to student-teacher interaction (Griffith, 1983; Karns and Schwab, 1982).

Karns and Schwab (1982) found that although nursing educators teach Rogers' three critical dimensions of therapeutic communication and use them in patient care, they rarely apply them to their interactions with students in the clinical area. "In spite of knowledge of these concepts and some skill in using them, the literature describing student stress and anxiety suggest that clinical faculty do not use these skills when teaching" (Karns & Schwab, 1982, p. 41). Griffith and Bakanauskas (1983) came to a similar conclusion following a review of the literature on student-instructor relationships in nursing education. "The therapeutic
relationship between nurse and client is learned from nursing lectures and readings, and applied in clinical experiences. Student nurses, however, seldom experience this 'helping relationship' with a nursing instructor, although the same principles of a therapeutic relationship can be applied" (p. 105).

The literature in nursing education clearly raises important questions regarding the application of therapeutic communication models in day to day student-teacher interactions. Why, for example, are nurse educators who are skilled in the use of a therapeutic communication model not employing these same skills with their students?

Misuse of Classroom Teaching Evaluation Tools

The misuse of classroom tools to evaluate clinical teaching practice is well documented in both Canada and the U.S. (Brown & Hayes, 1979; Jacobson, 1966; Knox & Mogan, 1985). The relationship between student and faculty is more crucial in the clinical setting than it is in the classroom. Clinical teachers must possess different skills than classroom teachers. For example, their questioning skills, communication skills and ability to assess learners in small groups has a significant impact on their effectiveness.
Their ability to assist students with integration of theoretical and clinical knowledge is also important. Teaching students how to think while also showing them how to do, requires a good knowledge base as well.

The inappropriate use of classroom tools to evaluate clinical teaching can be attributed to five factors: 1) difficulty in conducting educational research in a work setting not designed primarily as a learning environment; 2) lack of emphasis on clinical teaching skills in nursing education programs; 3) emphasis on nursing skills over teaching skills; 4) lack of rewards for teaching excellence and 5) social role confusion.

Jacobson (1966) describes the difficulty with conducting educational research in a clinical setting. "In the clinical situation, the relationship of student to teacher is a significant one. The learning situation is often one that cannot be repeated, and the clinical learning milieu is not usually controlled specifically for the teaching of the nursing student only" (p. 218).

Opportunities for learning are to a large extent dictated by the patient population within each clinical area. Patients' needs must always take precedence over learning needs of students. Clinical instructors must exercise professional judgement to assist as many students as possible within a given clinical setting. Students and
teachers must maintain open lines of communication at all times in order to maximize learning in this complex and diverse work setting.

Lack of emphasis on clinical teaching skills in most graduate programs is not unique to nursing.

Although the practicing professions — teaching, social work, nursing, law, medicine, the ministry and clinical and counseling psychology require that the neophyte be trained in the skills of the practice as well as the theory, clinical instruction has been found to be quite problematical across all the disciplines (Daggett, Cassie & Collins, 1979).

Prompted by the preface in a book by Carpenito and Due & Pols (1980), that stated "...most graduate programs do not provide individuals with basic information on clinical instruction," Karuhije (1983) conducted a survey of 211 volunteer nurse educators from the United States. The purpose of the survey was to test empirically the validity of the statement. As mentioned earlier, a startling 78% of the respondents agreed with the forced-choice question: "...most graduate programs do not provide individuals with basic information on clinical instruction". Nurse teachers felt that they had been prepared as clinical specialists but were frequently expected to assume the role of nurse educator for which they were not prepared.

Emphasis on nursing competence rather than on teaching competence among nurse educators is less well documented. Rauen (1974) offers suggestions for nurse educators regarding
the maintenance of clinical competence.

The responsibility to be an effective role model should be stated in the clinical instructor job description, ...Employers need to enforce minimum staff nurse experience requirements for all clinical instructors. Another means of self-improvement would be to function as a staff nurse for a few weeks each year (p.38).

Although leaders of professional nursing associations have not dictated what constitutes "minimum staff nurse experience" for nurse educators, an instructor is generally considered clinically competent to the extent that she is able to perform the nursing functions which students are required to perform.

Probably it is not necessary for instructors of the novice to be able to perform clinically at the advanced levels. But as the students advance in clinical specialization, they need teachers who can themselves demonstrate advanced levels of clinical judgement (Benner, 1984, p.186).

All instructors are expected to be familiar with the clinical routines and particular clinical expertise for the area within which they teach. Professional development time is provided for teachers who are employed full-time in order to allow them to maintain their clinical expertise by returning to practice in a hospital setting annually. Although no such provision exists for most faculty employed on a part-time basis, many are concurrently employed by hospitals within the field of expertise in which they teach clinically.
The instructor's clinical competence may be rewarded since formative and summative evaluations generally draw attention to the teachers' clinical skills, however that does not occur with teaching skills. There appears to be no standard for practice related to clinical teacher expertise. Perhaps this is not surprising given the lack of a reward system to recognize teaching excellence (Karns and Schwab, 1982) and the social role confusion that exists when nurses are educators within a clinical setting. That teaching is the primary mission in all non-research educational institutions means that it must be reflected in the reward structure of those institutions (Van Ort & Longman, 1986). In addition to the lack of rewards for excellence in clinical teaching, nursing faculty receive mixed messages from employers regarding desirable characteristics of instructors (Stafford & Graves, 1978). Decisions regarding the promotion of faculty members appear to be based on a variety of non-teaching functions including committee membership, volunteering for various tasks, attending faculty and professional group meetings and generally "fitting into the group".

Pugh, (1986) studied the role confusion that exists for nurse educators in the clinical area within the last decade and discovered that there were three distinct patterns of faculty behavior. "Nurse, Teacher, and Nurse-Teacher."
Nurses enact primarily nurse behaviors; Teachers enact
teacher behaviors; and Nurse-Teachers appear comfortable
using both roles. Faculty role identity does not in itself
predict the observed behavior of faculty".

Pratt and Magill (1983), describe clinical teachers as
adopting three basic roles: "expert, model and facilitator".
Learners too adopt three basic roles: "dependent, competitive
and participant". Difficulty arises in the absence of role
clarification. "The teacher's decision to adopt a particular
role should be made in response to a diagnosis of the
learner's current role, developmental stage, circumstantial
constraints, and needs" (p. 464). They believe that lack of
agreement about social role expectation is as important a
source of conflict as is deficient role performance.

Role conflict can be in part attributed to the lack of
a theoretical basis for teaching and guiding would-be
teachers during the socialization process from one expected
role to another.

Becoming a nurse educator is not an additive process;
that is, it is not a matter of adding the role of
educator to that of nurse. It requires a change in
knowledge, skills, behaviors, and values to prepare
for newly assimilated roles, settings and goals shared
by new reference groups (Infante, 1986, p. 94).

The clinical setting provides a source of role conflict.
While staff nurses and head nurses view the clinical area as
a setting to provide quality care where problem-solving is
rapid, and client needs are met, nurse educators view the clinical setting as a place where students meet clients and their families to acquire intellectual and psychomotor skills. The teacher values collecting and analyzing data, hypothesizing, testing hunches and appraising outcomes, while the practitioner values efficiency and technical skills. Educational activities take place in numerous and varied places, therefore the nurse educator must be prepared to maintain clinical competence in a number of clinical specialties. Clinical instructors move frequently through a number of settings, sometimes never having achieved a high degree of comfort there (Infante, 1986, p. 95).

Summary

Studies on teacher effectiveness apply to classroom teaching for the most part. While they offer some insight into the complexity of teacher effectiveness, studies in the education of physicians are more akin to studies on teacher effectiveness in clinical nursing. Seven characteristics of excellent clinical teachers in medicine identified by Irby (1986) include: a sound knowledge base, clearly presented ideas, enthusiasm, skillful interaction with students, clinical supervision with demonstrated clinical expertise
and role modelling of professional characteristics.

Comparison of effective clinical teacher behaviors in nursing education is still impossible due to the lack of a universally accepted classification system. Researchers agree however on certain student values. Students value: availability and accessibility of the instructor, her interpersonal skills, her general knowledge and professional competence. Other attributes appreciated by students include the teacher's ability to: evaluate student performance, maintain enthusiasm and portray a non-judgemental attitude, role model appropriate nurse behaviors, individualize her teaching and motivate students.

The impact of certain environmental factors on clinical teachers has also been studied. For example, Jacobson (1966) studied the effects of student teacher ratios and years of formal teacher preparation on teacher effectiveness in nursing. Studies on environmental factors have also been impeded by the lack of a universally accepted classification system for effective clinical teacher characteristics.

Inappropriate use of classroom evaluation tools within the clinical setting to evaluate teacher effectiveness is due to the following five factors: 1) difficulty in conducting educational research in a practice setting; 2) lack of emphasis on teaching skills in graduate nursing
programs; 3) emphasis on clinical skills rather than on teaching skills; 4) the lack of a reward system for recognizing excellence for teachers in undergraduate nursing programs and 5) role confusion for nurse educators teaching within the clinical setting.
Chapter Three

METHODOLOGY

Introduction

The purpose of this study was to determine the conceptions of second and third year nursing diploma students enrolled in a three year college program regarding effective clinical instructors. The research was guided by the following questions: a) What do students value in a clinical instructor; b) to what extent are the conceptions of second and third year students similar; c) are their conceptions related to the nature of the instructor's contractual agreement; and d) can second and third year nursing students' conceptions of effective clinical teachers provide a theoretical basis for the further empirical study of clinical teacher effectiveness?

This chapter outlines a rationale for the study, a discussion of methodology, a description of the subjects, how data were collected, ethical considerations and the data analysis procedures that were followed.
Rationale

The need to combine qualitative and quantitative methods of investigation into students' conceptions of effective clinical instructors is due in part to the difficulty that researchers have experienced in establishing a universally accepted classification system for teacher effectiveness. More importantly however, the uniqueness of students' conceptions has been set aside when students are asked to categorize behaviors. Rather than suggesting discrete attributes and characteristics of effective clinical teachers therefore, the researcher explored second and third year nursing students' recall of all of the factors associated with their most effective clinical instructor to date.

Methodology

A qualitative approach based on phenomenography allows for the description, analysis and understanding of logical relations existing between conceptions. The study was designed to seek an understanding of the students' conceptions of effective clinical teachers from their descriptions of past experiences with effective teachers. In the study, students'
conceptions were the object of analysis. Transcripts generated from an audiotaped semi-structured interview yielded categories of conceptions currently held by second and third year college-based nursing students regarding effective clinical instructors. It is the interrelationship of conceptual categories that was most significant to the researcher in acquiring a better understanding of the essential components of effective clinical instruction. Simultaneously, data generated by the rank ordering of responses to open-ended items allowed the researcher to add a quantitative dimension to the analysis of the data. This enabled the researcher to attach relative values to students' comments. This is in accord with recent recommendations by Knafl (1988), which calls for the development of creative, new approaches to research design and emphasized the desirability of combining diverse techniques if this is what is needed to answer a particular research question.

Description of Subjects

Respondents for this study were randomly selected from a population of 47 second year and 67 third year nursing students enrolled in a three year college based diploma nursing program. Sixteen Registered Psychiatric Nurse (RPN)
students who joined the third year of the diploma program in September, 1987 and who graduated in March, 1988 were deleted from the population. The 16 R.P.N. students were excluded because they were in a modified program designed to enable them to reenter the workplace. This R.P.N. group joined the 51 third year students in the fifth semester of the program in September, 1987. They graduated in March 1988, approximately one month before the "regular" third year students graduated. Their previous experiences with clinical instructors were therefore uncharacteristic of the general population of nursing students. Students in the winter semester of each of those years would have had four to eight clinical instructors in a variety of clinical settings. Fifteen students in each of the second and third years of the program provided the data base regarding conceptions of effective clinical instructors. Although clinical instructors were not directly involved, they were informed of the nature of the study.

The setting for the study was a three year college based nursing program with an average enrolment of 60 students per year. The nursing department consisted of eleven full-time and eighteen part-time female faculty, one full-time and two part-time laboratory demonstrators as well as one administrative chairperson. Full-time faculty were assigned
classroom and clinical teaching duties as well as responsibility for the implementation and evaluation of the program. Part-time faculty were employed exclusively to teach within the clinical setting.

Students were assigned primarily to one 200 bed extended care hospital and one 350 bed active treatment hospital until the last semester of the program. During the last twelve to fourteen weeks of the program students were encouraged to choose one of eight to ten small hospitals within the region (ranging from 45-150 beds) for a four to six-week clinical experience. Although students were working with nursing 'buddies' within hospital settings, third year faculty maintained liaison with the agencies and assumed responsibility for student evaluation at all times. One faculty member was also available at all times for consultation by staff or students. Instructor-student ratios within the clinical area varied depending on the level of the student but the average ratio of student to faculty was 8:1. The program was divided into six semesters of equal duration.

Each semester consisted of two weeks of classroom theory and two six-week rotations during which students were in the clinical area two or three clinical days or evenings per week combined with two days per week of classroom study. Students
in the final semester had two weeks of theory combined with twelve weeks of clinical duty during which they assumed a leadership role in preparation for entry into the workplace. Sixth semester students' clinical hours were scheduled to coincide with those of their "buddy"; usually 12-hour shifts scheduled throughout a seven day workweek. For one to two weeks within the final semester, students selected a clinical specialty in order to gain exposure to a variety of clinical areas which were otherwise often unaccessible to them. Such areas included: the operating room, post-anesthetic recovery room, delivery room, adult and neonatal intensive care units.

Data Collection

Students were selected to take part in the study by use of a random table. All students who were initially contacted volunteered to take part in the study. The purpose of the study was explained and agreement for participation sought one week prior to the scheduled interview. Taped interviews required 30-40 minutes and were held prior to the end of the term. Second-year students were interviewed during the fourth semester whereas third-year students were interviewed during the sixth and final semester of the program. A semi-structured interview schedule was developed to gain insight
into the students' conceptions of effective clinical instructors (see Appendix A). Interviews were conducted over a one month period. All interviews were taped with students' consent to allow for transcript analysis. Audiotape equipment did not appear to affect students' responses. Interviews were scheduled at the student's convenience outside of classroom activities in a quiet, private environment. Twenty eight of the interviews were held in the researcher's office; two were held in conference rooms in the clinical area in order to coincide with students' clinical hours.

There were three minor irregularities in conducting interviews. One male student who arrived for the interview complaining of a headache was given the choice of rescheduling or cancelling the interview but he chose to carry on as planned. Approximately half way through the 35 minute interview, the researcher once more offered him the option of cancelling the interview and once again, he chose to continue to completion. Two female students requested permission from the researcher to be interviewed in the clinical area. Both interviews were successfully completed in private conference rooms without any noticeable difference in the quality of the interviews.

Open-ended questions allowed for the collection of qualitative data. For example, the first question asked
respondents: "Please recall the most effective clinical instructor you’ve had recently or one you’ve had at anytime throughout your clinical experience. Tell me [the interviewer] about your experiences with that instructor". Closed questions were used to ask respondents to rank order their responses to open ended items and to provide demographic data. The interview schedule was first pilot-tested in January, 1988, with four second year students who were dropped from the target population for the study. Piloting resulted in refinement of the questions and allowed the researcher to critique her interviewing style. Second year students were chosen to pilot the interviews because they were more readily accessible to the researcher.

Following each interview, the researcher summarized salient thoughts, feelings and reactions to the interview. This allowed the researcher to begin data analysis while data collection was ongoing. Each audiotaped interview was transcribed verbatim. Original transcripts were stored in a secure place and photocopies of the originals were used as working copies from which data analysis was carried out.

**Ethical Considerations**

Written consent was obtained from students and permission to conduct the study was obtained from college
administration as well as from the University of British Columbia Behavioral Sciences Screening Committee For Research and Other Studies Involving Human Subjects, prior to the scheduled interviews (see Appendix B).

Student anonymity was guaranteed by removing all identifying data from transcripts. Once the author had transcribed the tapes, they were erased. Students were provided with copies of their individual transcripts by mail one month to six weeks following taping of the interviews in order to verify the content of each interview. Many students expressed interest in the findings of the study when it was completed. Several subjects admitted that although they had never given much thought to this topic, they had definite opinions about effective clinical teachers and were grateful for the opportunity to express their views.

Data Analysis

A modified grounded theory approach to analysis of the data was carried out (Glasser & Strauss, 1967; Glasser, 1978, & Strauss, 1987). This is the constant comparative method whereby comparisons of data are made between and among groups of subjects sampled. The grounded theory approach presumes that fundamental patterns exist within social systems. The
researcher arrives at a final integrative idea or core category through discovery by constantly comparing and sorting the data.

Grounded theory is not a specific method or technique (Strauss, 1986); it is a style of doing qualitative analysis including a number of distinct features, such as theoretical sampling and certain methodological guidelines (e.g. constant comparisons and coding procedures) to ensure conceptual development and density (p. 5). Through a series of detailed analysis and interpretations of the data, the grounded theorist captures the complexity of the reality of the experience under study.

The qualitative analysis of data is termed grounded theory "because of its emphasis on the generation of theory and the data in which the theory is grounded" (Strauss, 1986, p. 23). Data analysis involves repeated transcript analysis, sentence by sentence and then phrase by phrase seeking constant comparisons and linkages of ideas.

It is not the aim of the researcher to prove a theory in a causal sense but rather to demonstrate the plausibility of a concept or belief. This occurs gradually as core categories emerge and relational aspects are uncovered. The theory which emerges is the product of systematic coding, sorting and integration of ideas and accounts for frequent
changes in the researcher's point of view during the entire analytical process. Analytic description is the result of repeated active inspection of the data.

Coding of transcripts took place in two separate processes. Initially, brief summaries of thoughts, feelings and reactions to each interview were reviewed to reflect on what appeared to be emerging from the data. Memos were written for each interview, outlining what appeared to be salient points from each transcript. Secondly, all transcripts were reviewed. Key ideas were jotted in margins; recurrent themes were circled and important sections were highlighted. Transcript analysis of the 30 interviews yielded a list of 30 substantive codes which constituted all of the possible behaviors and attributes of effective clinical teachers perceived by informants of this study. When students referred to more than one characteristic in a single statement each of the perceived characteristics constituted a substantive code. See Appendix C for the list of substantive codes generated.

Once open coding was completed, frequencies of each of the characteristics were tabulated and compared for second and third year students. Comparisons of responses to open-ended and closed questions were carried out. When all of the data had been coded and compared five conceptual codes emerged from the data.
Quantitative analysis of the data consisted of a nonparametric statistical test, the chi-square, to determine observed and expected frequencies of respondents choosing full-time and part-time clinical teachers as most effective.
Chapter Four

PRESENTATION OF STUDENTS' CONCEPTIONS OF EFFECTIVE TEACHERS

Introduction

The purposes of this study were to investigate the characteristics of effective clinical teachers in nursing as perceived by second and third year students of a three-year college nursing program, to determine to what extent their conceptions were similar and/or whether the instructor's contractual agreement influenced their choice of most effective teacher. In addition, could the student's conceptions of effective clinical teachers provide a theoretical basis for assessing clinical teacher effectiveness? The results of this study are presented in this chapter in two major sections.

Section I is a presentation of findings related to background information including: frequencies of conceptual categories chosen by second and third year nursing students, timing of student's choices of most effective clinical instructor, and contractual agreements of instructors recalled by students as most effective.

The second section is a presentation of the four conceptual categories of effective clinical teachers (Table 2, p. 56).
It is divided into the following subsections: knowledge, feedback, communication skills, and environmental factors. Whereas the first three categories include factors which are within the control of clinical teachers (internally controlled), this is not the case with environmental factors which are externally controlled.

**Timing of Most Effective Teachers**

Of the 30 responses regarding the student’s most effective clinical teachers, the majority recalled an instructor in the second year or the first half of the third year (fifth semester) of the program. The rotation in which they experienced their most effective clinical teacher is represented in Table 1.

Table 1.

**Timing of Most Effective Teachers**

<table>
<thead>
<tr>
<th>Semester</th>
<th>Year</th>
<th>Rotation 1</th>
<th>Rotation 2</th>
<th>Timing of Interview</th>
</tr>
</thead>
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<tr>
<td>Sem. 1</td>
<td>1</td>
<td>SS</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sem. 2</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Sem. 3</td>
<td>2</td>
<td>SSSS TT</td>
<td>SSS</td>
<td></td>
</tr>
<tr>
<td>Sem. 4</td>
<td>2</td>
<td>SSS TT</td>
<td>SSS TT</td>
<td>S</td>
</tr>
<tr>
<td>Sem. 5</td>
<td>3</td>
<td>TTTTT</td>
<td>TTTT</td>
<td></td>
</tr>
<tr>
<td>Sem. 6</td>
<td>3</td>
<td></td>
<td></td>
<td>T</td>
</tr>
</tbody>
</table>

n=30  S=second year students; T=third year students
Analysis by Instructor's Contractual Agreement

A significantly greater number of full-time faculty (n=24) than part-time faculty (n=6) were described as most effective \( \chi^2 = 8.66 \) (df=1) \( p < .01 \). There was a significant relationship between the instructor's contractual agreement and her perceived effectiveness in the clinical area.

Student's Conceptions of Effective Clinical Teachers

Cumulative frequencies of behaviors selected by both groups of students repeatedly revealed choices of effective teacher characteristics and behaviors related to knowledge, feedback and communication skills. These factors were viewed as internally controlled in that the teacher had full control over the ability to display each of them.

Of the 166 references to the teachers' knowledge base, the majority alluded to four kinds of knowledge: a) knowledge of educational contexts; b) pedagogical knowledge; c) content knowledge; and d) knowledge of learners. Knowledge of other content, curriculum, goals and objectives were mentioned infrequently.
There were 140 references to the teachers' feedback skills, most of which were comments regarding the teachers' skill in providing positive and negative feedback. A number of responses within this category referred to the levels of trust and honesty that existed between student and teacher.

References to the teacher's communication skills numbered 127. Virtually one half of their comments related to the teachers' ability to display empathy, while the remainder of their comments alluded to congruence in the instructors' verbal and non-verbal communication and her ability to become a student advocate when the situation demanded it.

Given the opportunity to comment on external factors (i.e. those that may be outside the control of the teacher) affecting their clinical performance, students in this study identified three factors. Those external factors were: a) availability of the instructor; b) emotional climate in the clinical setting; and c) staff acceptance of students. Of the 27 references to externally controlled factors, one half of them related to the availability of the teacher both within and outside of the clinical setting. These factors are not mentioned in other studies on clinical teacher effectiveness except that numerous studies mention the availability of an instructor within the clinical setting (Armington, 1972; Barham, 1965; Karns & Schwab, 1982; Jacobson, 1966; Kiker, 1973; Mogan & Knox, 1983; O'Shea & Parsons, 1979).
<table>
<thead>
<tr>
<th>Categories</th>
<th>Second Year</th>
<th>Third Year</th>
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</thead>
<tbody>
<tr>
<td>KNOWLEDGE</td>
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<td></td>
</tr>
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<td>Knowledge of educational contexts</td>
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<td>20</td>
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<td>Pedagogical knowledge</td>
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<td>Content knowledge</td>
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<td>11</td>
</tr>
<tr>
<td>Knowledge of other content</td>
<td>9</td>
<td>8</td>
</tr>
<tr>
<td>Knowledge of curriculum/goals/objectives</td>
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<td>15</td>
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How Students View "Knowledge"

Comparative analysis of student transcripts revealed that twenty eight of the thirty students interviewed made direct reference to the instructor's "knowledge base". Most of the students in fact viewed "knowledge" as the most important determinant of teacher effectiveness in the clinical setting.

Students viewed types of knowledge very differently and ascribed values to teacher knowledge accordingly. Their comments frequently alluded to content knowledge, knowledge of educational contexts, pedagogical knowledge and knowledge of learners. Knowledge of other content and knowledge of educational aims, goals and objectives and curricular knowledge were mentioned less frequently. Indirectly, they referred to the latter two types of knowledge when speaking of the instructor's ability to individualize her teaching in order to meet their learning needs and when they spoke of the teacher's expectations.

A third year student who was asked to name the three most critical qualities of clinical instructors responded:

R 27: Knowledge, you have to have authority, the knowledge and authority so that people are going to respect you and I think if they're an instructor, they should have the knowledge in order to be able to role model [appropriate nurse behaviors].
Another third year student asked to describe her most effective instructor said:

R 28: I think her knowledge base impressed me, she had such a depth for the different prototypes, such an understanding of pulling together all the lab. [laboratory] results and it all fit. She knew what you were trying [to do] and she would add knowledge to that or add experience to that.

I: What do you think are the three most critical qualities of any clinical instructor?

R 28: I want a smart teacher, I've gotta have a smart teacher and as much knowledge as she has, I want it!

When given the opportunity to elaborate, students usually specified that knowledge meant both theory and clinical application of theory. They did not perceive one as more important than the other but rather saw a need for both kinds of knowledge at work. Students also elaborated on how an instructor's knowledge level impacted directly on them:

R 3: Her knowledge level will affect your ability to learn.

***************

R 4: An instructor has to have knowledge, I've run across a couple of instructors who if you asked them a question, they kind of, well they don't even attempt to think it out. Like perhaps they don't really know what the answer is.

As previously mentioned, they provided detailed and specific descriptions of the types of knowledge which they considered vital for effective clinical instruction. Their comments clearly demonstrated how effective clinical teachers employ seven types of knowledge (Wilson, Shulman and Richert, 1987).
Knowledge of Educational Contexts

Knowledge of educational contexts in clinical teaching means that the teacher must be familiar with the practice setting and must be able to role model appropriate nurse behaviors. Knowledge must have practical application to be of value to the learner. Students noted the impact that a teacher's years of clinical experience had on their learning, and they had certain expectations regarding an instructor's clinical background. Instructors were most effective when they had extensive clinical experience in the area in which they taught students or when they had a sound orientation to the area. A few student comments illustrated this point.

R 2: If the instructor is familiar with the place she is working it helps. The instructor is the one who sets the tone for everything.

***************

R 4: The instructor comes with quite a few years of experience. You expect them to be knowledgeable, especially in the field that they work in and to be able to look more into the future.

***************

R 6: She knew the floor, she was able to put it to real work. She really knew what she was doing.

The teacher's knowledge of the clinical area affected her ability to role model, and students perceived an instructor's ability to role model desirable 'nurse behaviors' as essential
to her clinical effectiveness. They saw a direct link between role modelling and knowledge level.

R 28: She was very well organized and she knew the floor and the patients inside out. It didn’t matter who [what patient] she gave you, her homework was done and because of that I think that she never looked haphazard, she never looked stupid or she never looked like she wasn’t aware of what was happening all the time.

**********

R 2: You need someone who can show you how things can be done. The kind of nurse I’d like to be someday.

A third year student stated her view of the instructor who was a powerful role model:

R: 28: She was a real good role model, not one of us didn’t feel that [she] wasn’t the ideal. We were very proud of her, like little chicks [who] walked behind her with great pride. She’s a very strong and good role model and I have to respect her.

The instructor’s ability to relate theoretical knowledge to everyday occurrences in the clinical area was vital in assisting students to integrate theory with practice. One student explained it this way:

R 3: [I liked] the way she integrated things, she would tell me things about these particular patients that were related to their illness and it’s something you remember, because you’re there at the time and it sticks in your head.

Other references to integration follow:

R 11: The thing that really impressed me was her knowledge level and the way she incorporated it into use, put it into practice. The second thing is to be able to integrate practical with theory and labs. She’s got to be able to put the whole thing together because everything is so complicated and each patient even
though it's a standard kind of assessment, each person is different and you've got to be able to treat that difference [she could do this] with her expertise and the fact that she can incorporate and integrate all this.

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I: [Is there] anything else about this person that was really helpful to you as a student?

R 19: [She] makes you think about things, dig into your patient's condition and why they're on certain drugs.

Students who perceived that their clinical instructor lacked expertise in a particular clinical setting experienced negative consequences. Two students explained their concerns about inadequately prepared instructors.

R 1: Looking back at different instructors in some of the areas there's not as much confidence or let's say you need help with a skill, and sometimes they didn't know a whole lot more than we did... which was understandable because they hadn't been to the area for a while, but I found that quite hard because it didn't help me as much.

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R 14: If I'm not too sure that they know what they're telling me, then I'm not too comfortable.

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A third year student expressed similar concerns when she stated that a good teacher is someone who knows what she is doing. She went on to say:

R 30: Knowledge level means the ability to apply it in practical situations, the ability to be a leader and ability to role model. It's more than knowledge level, you shouldn't have somebody that just is nervous or that doesn't know the system and knows just about as much as you [the student] going out to teach. They can't guide you.
In summary, the instructor's knowledge of the clinical area is a key determinant of the student's view of that area. Students were best served by an instructor who had either extensive experience in the area or a good orientation to the area; an instructor who was viewed as being knowledgeable and who provided a good role model for them. Their learning was enhanced by someone who could help them with the integration of their theoretical and clinical knowledge; someone who could help them 'pull it all together'.

Pedagogical Knowledge

Pedagogical knowledge is that which is not subject bound and refers to the 'how to' of teaching. The instructor's pedagogical knowledge is a major concern to students. They appreciate the instructor who is able to get ideas across clearly, and who is able to help with integration of theory. Her questioning skills are also very important in assisting students with integration of knowledge. Students also value the teacher who is able to admit outright when she is unable to answer a question and can suggest alternative resources.

Three students alluded to their pragmatic need for knowledge and to their need for clearly stated explanations:

R 30: She was a good teacher. She was practical rather than just logical.
R 20: Some instructors don’t express it [knowledge] that well and she did, so that would be super important for any instructor. I’m there to learn because someday I won’t have that person and I don’t want to look like an idiot.

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R 21: There was no hesitation in her ability to teach you the skill because some people may be very proficient in how they do things but they don’t have the ability to pass on that knowledge.

Many students attested to the fact that the instructor’s pedagogical knowledge was responsible for helping them to integrate their knowledge, hence these five statements from different interviews:

R 3: The way she integrated things, she would tell me things about this particular patient that were related to their illness, so what she was doing was augmenting your knowledge of the total picture of the patient you were looking after.

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R 14: When I went to the chart it was to look up the lab results and anything on there that was abnormal, I would have to find out why and I learned the whole overall situation.

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R 19: She makes you think about things, dig into your patient’s condition and why they’re on certain drugs, why they’re having certain tests done.

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R 28: Conference time is very very important in the day. You’re bringing the stuff that you had in the classroom into the clinical area and the conference time is the time you’re taking the clinical patient into there and putting it all together.
R 29: We do learn, but whether we can recall it or not, that seems to be the problem, so it seemed if you didn't know it, it was amazing how she could make you [recall information].

The instructor's pedagogical knowledge was also manifested in her questioning skills. Students responded best to a teacher who could question them without intimidation and who used questioning techniques to get to know them as individuals in order to tailor the clinical assignment to meet their learning needs. Many students required ongoing questioning to stay motivated. For example, three students stated:

R 11: She helped you learn, asked you questions and then if you didn't know the answers she made you look them up.

***************

R 14: I was questioned constantly on my knowledge base. After a while, I appreciated her making me use my knowledge.

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R 17: She asked a lot of questions almost every day and it could be anything from drug profiles to prototypes, pathophysiology and nursing interventions.

Another referred to the instructor's questioning skills as a tool for helping her integrate her knowledge:

R 7: She applied the clinical experiences that you were experiencing. She tied in the theory with that, she questioned you so that you could remember. You could associate principles with something that you had actually done.

A few students acknowledged that the teacher's pedagogical knowledge was directly responsible for their growth.
R 22: The one thing I really felt was her knowledge and her ability always made me go to my full potential rather than just getting by or just getting by without having to know exactly what this drug does.

I: You said the instructor had a lot of knowledge, what made you say that?

R 22: Just because when she'd ask questions, it [the answer] was right there, she didn't have to think about it too long whereas other instructors had to think about it.

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R 9: She gave me a drug quizz and her drug quizz was typical of her. You'd think I know this one and she'd take you that much further until you finally had to say I don't know then you had to go back and that's what she wanted. She wanted to bring you to a point to get you to go on, to go look it up.

In certain situations it is essential for an instructor to admit that she doesn't have the knowledge required by the situation at hand. Part of any instructor's pedagogical skill is learning to say: "I don't know the answer to this off hand, but let's try to come up with the answer as a group", or at least to be able to point the student to the appropriate resources. Three examples of this follow:

R 11: If you ask a question you need an honest answer whether they know something about it, not try to fake it which is really embarrassing, and if she doesn't have the answer she can tell you where you might find it or refer you to someone who could know.

A second year student expressed similar concerns:

R 12: You know that if you have problems and you ask them hopefully, and even if they don't know the answer they'll say well let's go and look here, or here's a book.
The same concern was echoed by yet another second year student:

R 21: Her knowledge and capabilities were top notch but if a situation arose where she didn’t know the answer, it didn’t stop her from saying I don’t know the answer.

An instructor’s pedagogical knowledge then is best described as the ability to maintain a pragmatic approach to teaching, using every opportunity to bring theory into the clinical setting and helping the student to see the whole rather than fragments of patient care. A teacher who can guide the student through problem solving by example rather than by taking over the student’s problem has enhanced the student’s problem solving skills. Questioning skills appear to be the key to successfully assisting learners with integration but above all, student nurses value an honest response to their questions. They respect the teacher who deals with their requests for help openly, especially in situations where the instructor lacks the necessary skill or knowledge to be of assistance but is able to direct the student to an appropriate resource.

Content Knowledge

Content knowledge includes an understanding of the facts or concepts within a field as well as the ways in which fundamental principles are organized (Wilson, Shulman and Richert, 1987,
To a large extent an instructor's content knowledge determines her effectiveness in the clinical area. Student interviews revealed a relationship between the instructor's content knowledge and her questioning skills. In addition, the clinical teacher who is able to carry content forward from the classroom into the clinical setting is most effective in assisting students with integration of content knowledge and in motivating them to study. Generally, students' comments attested to the fact that the teacher with sound content knowledge was the most effective.

I: You felt really comfortable with her knowledge base, can you expand on that?

R 1: I think she had a lot of experience with teaching and with the material we were working on.

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I: Can you think of anything else that made her particularly effective in terms of your learning?

R 6: She gave me the impression of knowing everything.

***************

I: What are the three most critical qualities of a clinical instructor?

R 26: A good grasp of the knowledge is essential so that they are able to teach. You can't know the clinical if you don't know the theory.

***************

I: Can you think of anything else that has been really helpful to you?

R 8: She's really good in class. I think when I hear her lectures in class and I had her as an instructor it all comes together.
A second year student who was asked to rank order the five characteristics which described her most effective instructor replied:

R 6: I think knowledgeable has to be number one because through that comes respect. I like a capable knowledgeable instructor who has her basics down so I don’t feel any hesitation when I ask questions.

The instructor’s content knowledge motivates student learning and is closely associated with the instructor’s expectations and her questioning skills. Two third year students commented:

R 29: She has a good knowledge base. We thought she expected us to become real doctors, but she didn’t.

***************

R 17: She is fairly tough so you really did respect her and you didn’t dare come to clinical unprepared with all the answers to any possible question that you could think of. She asked a lot of questions almost every day. You could never pull the wool over this person’s eyes, you could never BS your way out of it.

In summary then, students believe that the teacher’s ability to motivate them and her expectations are directly related to her level of content knowledge. A teacher with sound content knowledge is able to question students effectively and assists them with integration of theory and practice. Her content knowledge provides the basis for her contextual knowledge, therefore her expectations are also a reflection of her content knowledge.
Knowledge of Learners

Knowledge of learners includes among other things, knowing students' characteristics and their cognitive maps as well as motivational and developmental levels. Throughout the interviews students referred to the importance of the instructor's ability to get to know them as individuals, of tailoring learning opportunities to meet their needs, of offering support in difficult situations and of acting on their behalf when the need arose.

Students valued the instructor who went out of her way to meet their learning needs by providing them with as many new learning opportunities as possible. When asked at the end of the interview if anything else affected her learning in the clinical setting, a third year student responded:

R 13: The instructor who gives you a good array of clinical situations to work with, a wide variety [of experiences] is most helpful.

Offering them support in difficult situations is also important. A third year student recalled what that kind of support meant to her.

R: 8: One of my patients died and she [the instructor] was really good. She was there for me. He died right there when I was looking after him and she went through everything with me, she came into the room and helped me get him ready to take him to the morgue, went down and got the morgue stretcher, brought it back up, went through all the paper work with me and before we took him down she sat me down and talked with me about how I felt about
it and helped me get all the feelings out. That really helped and she was there through the whole thing.

There were many references to the need for instructors to get to know students as individuals in order to meet their learning needs. A third year student recalled:

R 5: She had to know whether I was up to that level or not. The reason she was effective was due to this ability to take a moment for each student and say 'who are you and where are you going?' let's take a look at you, never mind everybody else and this particular instructor did take the time.

Another third year student recalled her most effective instructor for much the same reason when she said:

R 9: The most important thing that I found with her was that she individualized for everyone in our group she found out how we learned the best, where we were at in our knowledge base and tried to get us to be the best that we could be. She didn’t just generalize and get all eight of us to do the same things. She really took the time too!

Similarly, yet another third year student expressed the need for individualization:

R 28: She took the time to get to do that too [know us individually], I think subtly too. It wasn’t that she talked to you for hours about your personal life or anything but there were little quick questions and she’d find out where you were at and what was happening with you and I think maybe that’s good psychology because I know that she handled each one of us differently, so differently. The individualizing is really important because some instructors say these are my six students and they all get the same, meanwhile, you’ve got someone like me who is pushing forty and someone who just graduated from grade twelve so our experiences are so different, so it’s really important because I have been put in the same can as my peers.
A third year student was motivated and impressed by the teacher who went out of her way to note her theory grades and commented on her progress or lack thereof regularly.

R 24: This instructor would look into our theory marks as well as notice how we were working in the clinical area and if she felt that the two weren’t corresponding, the marks were low or your clinical wasn’t showing the knowledge, then she’d work on an almost threatening way to tell you how to make you work harder and then you’d reach your potential.

Other students appreciated the instructor who took a general interest in them as people outside of the clinical situation, taking the time to enquire about future plans and family relationships.

R 11: She seemed to want to know us as a person as well as just a student. In our coffee breaks some of us would go down with her and she’d always ask how you guys doing right now? She’d ask where we were from and different things about our background, which really made you want to do well to please her.

In summary, taking time to get to know learners has rewards for instructors and benefits for students as well. Knowledge of learners means that instructors must take interest in each student as an individual, tailoring the learning situation to meet each person’s needs and being sensitive to the student’s changing needs. It means offering support to students in difficult situations, and taking an interest in their scholastic achievements.
Knowledge of Other Content

Knowledge of other content implies a broad understanding of subject matter not directly related to the field of study - that which makes one a 'well rounded' person. Students value the instructor who has a broad knowledge base and who can deal with a variety of problems as they arise. They learn vicariously from the teacher who is able to share her diverse theoretical and clinical background. A second year student stated her views on the instructor's knowledge of other content:

R 6: She had enough world wide experience. She knew what was important, what could be left out, so it's being knowledgeable, but realistic too.

Several students commented on the need for teachers to be knowledgeable in many areas outside of the clinical specialty in which they worked with students. One student commented:

R 4: I'm thinking of that instructor that we talked about earlier, I notice a lot of times, we wouldn't even be asking a question, it might just be a topic that came up and she still knew a lot about the other areas of nursing, not just what she focused on as a specialty. She had the ability to reason out other areas.

The same third year respondent spoke of the need for instructors to demonstrate problem solving skills:

R 4: I think the body of knowledge would be helpful, but if you've got the ability to sit down and say: well, this is the problem, what might be outside interferences that don't relate? You [the instructor] don't just focus on the complaint that has brought things to the surface. She has the ability to say perhaps there's some underlying problem.
An instructor's ability to help the student problem solve, requires the ability to step back and give the student some guidance to allow her to come up with the answers as illustrated in these three statements:

R 5: When I run into a problem I want some backup and I want to know where I'm going to go, how I'm going to solve this problem and I don't want her to give me the answer but I want her to clue me into how I'm going to come up with the answers, whether I'm going [about it] right or wrong so that I can solve it. She has to let me know when the potential for a problem is coming up if she can foresee it.

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R 18: She had a lot of knowledge to offer and yet she didn't just give you the answer, each of us had to find out something, so she urged us to find things out for ourselves.

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R 30: I need somebody to guide me. When I need a question answered I don't need everything done for me, but I do need somebody that when I'm having a problem, I can go to them and say: "now what?"

The teacher who brings knowledge from the sciences and humanities and whose knowledge is based on a variety of clinical experiences has a sound resource base upon which to draw in solving clinical problems. The broader the teacher's knowledge base, the greater is her potential to assist the student with day to day problem solving in the clinical setting.
Knowledge of Educational Aims, Purposes and Curriculum

Knowledge of educational aims, goals and objectives implies a clear vision of the outcomes of learning and contributes to pedagogical decisions. Knowledge of curriculum, on the other hand is the understanding of program materials designed for teaching particular topics at given levels. Students referred to the teacher's knowledge of educational aims, purposes and curriculum when they spoke of her expectations. The instructor who spelled out expectations early in the rotation was considered effective by most students. The following are examples:

R 1: Some of the things instructors did were good, especially a good orientation in first year was important.

I: What's a good orientation?

R 1: First day, going through the ward and explaining some of the things that are expected and direction with care plans I felt was really important in first year.

R 24: [It's helpful to] have the instructor sit you down and say this is what I like to do with my students; this is how it's going to be. If you don't like it come and talk to me.

R 28: She was there so that you would grow and that was her main objective, she was going to see growth in her students and she got it! If you knew that you were going to be discussing principles of chest trauma it was good to at least read up so that you could talk on her level 'cause she didn't have time for you if you didn't do your homework. Her expectations were high but not unrealistic.
R 30: It's very important to know the expectations. Clearly establish the expectations! Laying the ground rules because every clinical instructor is so different. She has to lay it on the line and then that helps with trust.

The instructor's expectations should not be biased negatively, however because that may have a detrimental impact on the learner according to the following third year students.

I: Is there anything else that affects your learning in the clinical area?

R 23: preconceived notions

I: On the part of the instructor?

R 23: Yes, she already has something at the back of her mind about me and how I'm going to do before I even get there.

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I: What kinds of things have helped you to establish rapport with an instructor?

R 30: Well, trusting me, immediately not assuming that I'm out to be stupid and make mistakes

I: assuming the best about you?

R 30: Assuming the best yeah, before judging me.

The teacher's expectations determined the level of motivation for many students. Many felt that the instructor did not expect enough from them. One third year student feared that part time instructors may have lower expectations than full time instructors.

R 9: They [part time teachers] don't have the same expectations as full timers and I found that for me I felt apprehensive that the part timers weren't expecting as much as the full timers and I would suffer later on and maybe we got off too easy.
R 24: Some hadn't pushed me hard enough.

Many appreciated the instructor who was "tough" or "strict", with high expectations.

R 17: She is fairly tough so you really did respect her. You didn't dare come to clinical unprepared with all the answers to any possible question you could think of.

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R 28: She was such a perfectionist and her expectations were so high that you thought if I can please her I can do anything!

***************

R 29: Her expectations may have been a bit high so to keep up to that standard we would put in a good eight hours in clinical and more at night.

I: You said she had high expectations. How did she convey that to you?

R 29: She seemed isolated, and I guess we felt in order to shorten the distance we'd have to come up in our knowledge.

"Those high expectations made me go to my full potential" stated three students, while one third year student stated:

R 28: Not being spoon fed was important to me.

A few appreciated the fact that the instructors' expectations were tempered by the reality that they were still students.

R 15: She had high expectations of us but on the other hand, she also realized that we were students.

Part of the teachers' realism in her expectations were based on the view that she should not expect anything she was not capable of doing herself.
R 9: If she practices what she preaches to me that's an important aspect. We're looking at them for what we're going to be when we graduate. You can't expect your students to do what you can't.

Questioning skills and expectations were closely tied in the student's mind. A student spoke of her motivation being affected by the instructor's questioning skills.

R 2: She helped you learn, asked you questions and then if you didn't know the answers she made you look them up.

Students' conceptions of how their clinical teacher's knowledge of curriculum and educational goals affected their learning included thoughts on clearly stated expectations. Instructors who were able to clearly state their expectations early in the clinical rotation and who maintained high but realistic standards without having preconceived negative bias were considered most effective. Lastly, the instructor should not expect students to perform duties which she was not capable or willing to carry out herself. Her expectations were also reflected in her questioning skills.

In conclusion, students perceived theoretical and clinical knowledge as being equally important. Utilizing Wilson, Shulman and Richert's (1987) model of teacher knowledges, students appeared to attach the greatest significance to the teacher's knowledge of: the clinical setting, how to teach and knowledge of the learner. Secondly, they valued the teacher's knowledge of content within a specialized area of nursing. They appreciated a
teacher who possessed a broad base of knowledge from which to draw in order to enhance student learning. Lastly, they perceived consequences of the teacher's knowledge of curriculum and of educational goals and objectives insofar as she was able to individualize her teaching and to state her expectations clearly, early in the clinical rotation.

Feedback

Introduction

According to students interviewed, the second most important characteristic of an effective clinical instructor is the ability to give feedback. Nursing studies on clinical teacher effectiveness often include students' ratings of the teacher's ability to give feedback, however, those comments tend to be general. Researchers have not attempted to describe what constitutes the teacher's ability to provide feedback. Zimmerman (1986) for example, ranks "provides useful feedback on student progress" among the five highest rated characteristics of most effective clinical teachers by students and faculty without further elaboration. Similarly, Griffith (1983) refers to the teacher's ability to "give honest appraisal and evaluation" as one of the nine strategies that nurse-teachers employ to increase student learning. She does not state however what
constitutes "honest appraisal and evaluation". Students in this study indicated that positive and negative feedback must be given on an ongoing basis and in a balanced fashion to be most effective. They also mentioned the need for immediate feedback as well as the trust that ensues from honest feedback. This section on feedback is therefore divided into the following three subsections: honesty and trust, positive feedback and negative feedback.

Honesty and Trust

The instructor who is capable of giving feedback is perceived as being honest and trustworthy. For example one third year student described her instructor as follows:

R 8: She's very straightforward and honest and she lets you know where you stand. The number one characteristic of any clinical instructor is preferably honesty, that is letting them [students] know where they stand.

A second year student recalled how ongoing positive feedback increased her level of trust with instructors:

R 12: They [instructors] appreciated the fact that I could help that student, that I was understanding of the other students. That's the word that was used, and that to me was sort of supportive because that made me sort of feel like the person [instructor] trusted me. It was reinforcement for what I had done.

Students generally agreed that without honesty on the part of both student and instructor, their learning was compromised. A second year student stated:
R 2: Without honesty, you have nothing, it's number one!

Several students referred to the need for the instructor to "give it to you straight". Instructors demonstrate honesty by being able to say they're sorry, they don't know the answer to a question or by demonstrating a genuine interest in the student's career or problems whether they are related to school or not. A third year student explained:

I: Tell me what it is about this instructor that was particularly helpful.

R24: her ability to notice the potential in you

I: How did she go about doing that?

R24: She'd come up to you and say I don't think you're working to your full potential. She's very honest, very frank, which is really good and if you don't buckle down, you're going to fail. Either I'm going to fail you or you're going to fail your test. You have a choice! Then you say yes I'm going to show her. If you're the kind of person that's intimidated which I was it really worked well with me. Later she said: I knew you could do it. It really opened up my respect for her and understanding how she was working.

The instructor who did not give ongoing feedback was reducing the trust between herself and her student. The uncertainty that came from not knowing how one was doing left much doubt in the student's mind about her ability to succeed.

R 9: I'd rather have constant ongoing feedback. I never found that I had a situation where I had to go and ask where I was at or got a big surprise at the end, and that to me is critical because it breaks the bond of trust if all of a sudden you think you're not doing well out of the blue.
The teacher who was conscientious about giving both positive and negative feedback on a consistent basis was establishing a bond of trust with her students. Her ability to provide feedback on an ongoing basis in spite of the busy pace in a hospital setting was vital to the student's success within the clinical area.

Positive Feedback

While the need for consistent, ongoing and immediate positive feedback has long been recognized, students in this study raised interesting concerns about what is considered ideal timing and frequency for positive feedback. The notion that praise may be detrimental to learning when given too soon or indiscriminately appeared to be linked with student's perceptions of themselves. The student who was given positive feedback without having "earned" the praise did not benefit to the same extent as the student who believed she had earned it. Similarly, the amount of praise given early in the clinical rotation may have an adverse effect on the student's motivation.

Positive feedback was a motivator for many students. They frequently commented on the need for consistent, genuine and ongoing positive feedback.

R 5: Good positive input, once again genuine input [I mean] positive feedback on a consistent basis too. Not on an inconsistent basis. I discovered lots of times when I wasn't getting the input I needed. Remember I'm the student.
Students disagreed on ideal timing and frequency of positive feedback. Some suggested that occasional positive feedback may have more value than frequent praise. Others felt that it should be given sparingly and perhaps not too early in the clinical rotation.

I: Is there anything that influences your learning that we haven't talked about?

R 15: Making you feel that what you are doing is good, giving you positive feedback, just occasionally. I wouldn't like it all the time, but when you deserve it.

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R 24: You can't really use praise at the beginning. You have to get to know them a little first until you see what they can do. If you praise them too soon they're not going to try to improve clinically.

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R 28: If she was impressed you'd know about it but it had to be something that really impressed her...the fact that you got through eight hours wasn't very impressive!

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R 24: She knew when to praise you, not too much. She did a bit of sandwich technique, where a bit of positive and a bit of negative with a little more positive so that oh good! you've learned this but you still need to get this so it's coming a bit smoother, and then something else positive.

In summary, positive feedback is a motivator when it is given in the right amount, at the right time. The crucial factor in determining the optimal amount and timing of positive feedback for each student appears to be based on the student's perception of having earned it.
Negative Feedback

"A good teacher is someone who can evaluate you and see your weaknesses" stated a third year student. Negative feedback was most effective when given immediately after the alleged error or misbehavior. It should be tempered with positive comments kept in perspective and caring must be conveyed as strongly as disappointment.

R 10: When I did something that wasn’t right she didn’t come down hard on me, she didn’t jump on you if you made a mistake, and I think first of all the positives, you [the student] need to get some positive.

The instructor’s ability to give negative feedback was a factor some students recalled first when asked to describe their most effective instructor. A third year student explained:

I: Tell me what it is about this instructor that has been particularly helpful.

R 8: She’s very straightforward and honest. She lets you know where you stand.

I: What exactly do you mean by that?

R 8: She’ll tell you right off. She’ll say look I don’t think you’re going to make it so do something about it and she doesn’t beat around the bush.

Immediacy in receiving feedback was of importance to students.

R 12: If I’m not doing something right I need to know about it and I need to know right then and there, not six weeks later.

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R 13: After every skill she always said what you did wrong or asked how you felt about it.

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R 28: If she saw a skill that she thought that you should be above that, of making a mess out of it, she would let you know how disappointed she was.

Students recognized that giving negative feedback was the most difficult part of an instructor's role and valued the teacher who had acquired the skill to deliver genuine negative feedback in a positive manner. The instructor who gave negative feedback without embarrassing or belittling the student did so privately and didn't blow the problem all out of proportion.

R15: She would explain anything that she felt that you should know about, tips that she learned, anything that she felt you weren't doing quite correctly she would take you aside afterward and point it out to you. It takes courage to tell someone if something needs to be taught over.

Students gained much respect for instructors who were able to give negative feedback in a positive manner and who strived to maintain a balance in giving both types of feedback. Students described the need for balance in receiving positive and negative feedback.

R 22: If I did get negative feedback, she did tell me when I did something wrong but it wasn't a big major thing.

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R 20: She gave lots of feedback, a lot of positive feedback but even when she had something negative to say it was said in a positive way.
R 14: She's giving positive feedback, on everything that you did. If you did something that you needed [help with] an error, she'd say that's ok you can correct that error the next time. If I was doing something wrong I was made aware of my error in a way that I didn't feel put down. She'd say you've done this but this isn't quite right, next time you can do it.

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R 18: The main thing about this instructor is that she is very good as far as letting you know right away when she didn't think you were doing something right and she didn't beat around the bush. She said ok, I don't think you did this right. This is how you should do it and yet at the same time when you did something right, she was very quick to compliment you on that and say why she liked what you did, so she was very balanced as far as feedback goes.

Although giving negative feedback required courage on the part of the instructor, the student did not internalize negative feedback unnecessarily if it was given in a caring manner. A third year student stated:

R 9: You always got the feeling that she genuinely cared even if she was giving you [negative feedback], just reeming you out. When you get in heck you need to know that it's not personal.

Lastly, when the teacher failed to give students any kind of feedback, it kept them guessing about their performance. Not telling them anything made them wonder what was going on.

R 19: I'd say giving positive feedback is important; ongoing feedback to let the students know how they're doing, or it could be any feedback. Not telling them makes them wonder what is going on.

On the other hand, the teacher who failed to balance negative
feedback with some positives soon destroyed student confidence.

R 3: If there's nothing positive and all you hear is the negative things, they never say the things that you're doing really great, but they say oh that's good in their mind but they don't tell you and then you feel like oh! I can't do anything right because you know all you've heard is the bad things.

Negative feedback was most effective when it was immediate and given in a positive manner, ensuring that the student was not embarrassed or belittled in the process. Although students recognized that giving negative feedback was a difficult part of the teacher's role, they valued the instructor who could do this skillfully. A balanced approach to feedback, required that negative feedback was accompanied by positive feedback. This approach went a long way in conveying a caring attitude to students.

In conclusion, how, as well as when, feedback was given were two critical factors in determining students' perceptions of effective clinical instructors. It would appear that for some students at least, too much positive feedback, given too soon may have had a negative impact on their learning in the clinical setting.

The need for honesty and immediacy in providing feedback as well as providing balanced positive and negative feedback must be uppermost in the minds of all effective clinical teachers. In addition, maintaining privacy and ensuring that caring comes across at all times are important when giving negative feedback.
The teacher who failed to provide any feedback at all, or who tended to give primarily negative feedback was creating great uncertainty at best and destroying student motivation at worst.

Communication Skills

Introduction

Students interviewed believe that the third most important characteristic of effective clinical instructors, is her ability to communicate effectively with others. Nurse researchers have frequently reported the importance of the clinical teacher's interpersonal skills (Karns & Schwab, 1982; Kiker, 1973; Knox & Mogan, 1986). Pugh (1983) described the ideal teacher-student relationship as one which involves good or excellent communication in a peer relationship.

Students in this study indicated that the clinical teacher acted as a role model to the extent that she demonstrated the very same communication skills that they learned in theory.

How Students View Communication

Based on student interviews the instructor's communication skills are the third most important factor in
determining teacher effectiveness in the clinical area. Students placed a high degree of importance on the instructor's ability to communicate. A second year student associated communication skills with role modelling, while a third year student described rapport with her instructor as the most important ingredient in a learning situation.

R 12: [The most important would be] good communication skills because I think if you have good communication skills the other ones are going to follow through.

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R 18: Communications comes strongly into role modelling.

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R 30: The rapport with your instructor is more important than anything else. The rapport with the instructor is the most important influencing factor [in determining success].

The instructor with good communication skills was more likely to hear from a student in difficulty, and thus could provide her with the opportunity for input into her own learning. One third year student commented that the clinical teacher's busy schedule was no excuse for poor communication.

R 13: If something went wrong or if you had a problem, she was really good to talk to.

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R 4: I'm sure the instructor's busy with eight students but if you have the ability to communicate effectively you should be able to do so in a short time.

Carl Roger's cornerstones of therapeutic communication:
empathy, congruence and positive regard have provided clearly established categories for the study of clinical teacher's interpersonal skills. According to subjects in this study, the teachers' ability to display empathy was dependent on her active listening skills and in how she demonstrated a caring attitude. The empathetic teacher was known for her ability to remain calm under all circumstances. Congruence was demonstrated by the teachers' genuineness, her ability to self-disclose and her sense of humor. An instructor showed positive regard for her students in her approachability, in her willingness to be a student advocate and to maintain a positive attitude. The teacher who showed a joy of teaching also demonstrated positive regard for others.

**Empathy**

The clinical teacher who actively listened to her students, stated her observations, confirming her perceptions of events and gathered all of the facts, rather than jumping to conclusions. She was skilled at eliciting student's feelings regarding their clinical experiences and related to them at their level. A third year student stated:

R 4: When she communicates with the students she's on their level. If there's a problem she'll say to you: "this is what I'm seeing, is it true?" She doesn't jump to conclusions.
Another student said:

R 23: She would listen to what you had to say and offer suggestions as to whether it's appropriate or this is how you should correct it, she tried to get an understanding of what you were experiencing.

Students appreciated the teacher who observed their non-verbal cues, stated her observations and recalled what it was like being a student.

R 12: What was helpful was the feeling that the instructor knew that I got really nervous if someone was hanging over me.

I: How did she know that?

R 12: She said: you get nervous if somebody is watching you.

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R 18: By the end she could point out your day doesn't seem to be going as smoothly as in the past. She's very in tune.

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R 7: They can empathize with your learning needs because you don't have the same level of knowledge as they do. They remember what it was like being a student too.

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R 24: She'd come across as a person too, like she's a student too working on some degree so she's a student like us and we'd try to help her too. She knew when to be an instructor; she knew when she could be just a peer too.

Displaying a caring attitude was described by two students as being more important than having a good knowledge base and the second most important after honesty.
R 8: I think the most important is to be honest and actually her concern about students is next.

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I: Can you rank those three most critical qualities of any clinical instructor?

R 21: Honesty first, caring attitude second and then knowledge base is third.

When asked how the teacher displayed a caring attitude, respondents generally mentioned the fact that it was someone who showed a personal interest in them and their problems and someone who could be supportive in all situations. The following is a description of the instructor with a caring attitude.

R 12: Say if something happened that you could go to them and say, like if something horrible happened at home, and I'm not up to par today so give me two patients? They would do that. It would be someone comfortable going to with personal things.

The instructor who stayed calm under all circumstances, maintained an "even keel" and never appeared rushed did much to promote a positive learning environment. Students felt that a calm environment enhanced learning and increased their self-esteem.

R 4: What I really found helpful with her was that she was very calm and relaxed. I like a calm approach because if you have an instructor who is really uptight or unpredictable, it really reflects back on the students too. They pick up the same vibrations.
R 9: Patience is critical because I’m sure they’ve [instructors] got better things to do than stand there for ages while you give your first needle. Not rushing you is not belittling what you’re doing.

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R 23: It was more relaxed than usual, she was calm and she also created a calm atmosphere. When something was going wrong she would stay there with you and help you work it through and not get excited about it. She was so calm, that you couldn’t get excited, the calmness carried over to her conferences.

Congruence

The instructor’s ability to communicate genuine concern for students was dependent on how congruent her verbal and non-verbal messages were. Third year students discussed their feelings about congruence.

R 5: [It] is the non-verbal expressions that the instructor portrayed, the great emphasis is on learning to do a good job but if you made an error, they might say oh, that’s not too bad but the non-verbal look would be: what the hell are you doing? I told you three times not to [do this].

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R 25: Displaying a warm and caring attitude [is conveyed through] non-verbal cues and just the facial expressions to you so the non-verbals. Just the way they communicate with you, you can tell when they care.

According to students, self-disclosure on the part of the teacher helped them learn vicariously and enhanced the bond
between student and instructor. The ability to self-disclose effectively included congruent verbal and non-verbal messages.

Six students verbalized the need for self disclosure on the part of instructors when stating characteristics of their most effective teacher. Many other students indicated that self disclosure was very beneficial to them in that they learned vicariously from the instructor who shared her experiences thereby helping them to avoid errors and omissions in the delivery of nursing care.

R 4: She’s willing to give a bit of history of herself. She can say you handled it this way, perhaps you can try this approach, or I found this worked.

I: How does that help you?

R 4: It’s quite good because you can see another point of view. A lot of times it’s very helpful if someone can do that.

The teacher who was able to use self disclosure was demonstrating respect for them. She was perceived as "more human".

R 30: She’s empathetic, understands where people are coming from. She exposed her own vulnerabilities, she was able to express herself.

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R 2: She’s willing to share her own background and her own feelings so you can get a better understanding about what life is about.

I: How does that help you as the learner?
R 2: I'm just a young pup so I haven't lived through much so it really gave me an idea of someone else's perception and it makes you feel like you really know her, it makes her more human.

Of the three students who mentioned the instructor's sense of humor as being a critical ingredient in her clinical performance, two explained that the humor made the instructor more "human" and that their relationship with the instructor was thereby enhanced. One of them offers this account:

I: Is there anything else that this person is doing?
R 19: [She has a] sense of humor!
I: How is that [a sense of humor] important to you as a student?
R 19: It's just good and there is humor to nursing in general. It's not always just really serious but there's still a light side to it.
I: How does that enhance your learning?
R 19: It does! I don't know how but it does. If an instructor has a sense of humor, you know that they're human too, it brings them down to your level.

Positive Regard

The instructor's approachability was a major concern to both second and third year students. Several spoke of the need to approach their instructor regardless of their level of knowledge, with the assurance that they would not be put down or made to feel stupid.
R 4: She was very approachable. It really makes you feel comfortable because if you’re having a problem of any sort you can approach her without feeling it’s going to be frowned on or commented on.

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R 6: She seemed very approachable. If I had a problem, I could go to her and she wouldn’t make me feel stupid.

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R 21: I never felt that if I didn’t know something I would be afraid to go to her and say: "I'm sorry I don’t know this. "I always felt comfortable to go and say: "I don’t have a clue here."

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R 26: I found her very approachable. I could go to her with a problem and know that I wasn’t going to be put down.

Others gauged the instructors’ approachability by how well she empathized with them as students and didn’t put herself above them. Ten students rated approachability in the top three characteristics of all effective clinical instructors. Four students (two from each year) felt that approachability was the most important factor in instructor student relationships. They rank ordered approachability ahead of knowledge and feedback skills. One second year student stated:

R 1: The main thing is to be able to express yourself to that instructor and she made it known that we were to feel free to come to her with problems.

A second year student described the importance of approachability as a team building tactic and the impact that it had on her learning.
R 20: She's very approachable. You felt more like a team rather than instructor and student. That way when you went to do your skills, you went as a team as opposed to "I'm watching what you're doing," and you weren't afraid to make a mistake in front of her. You still made them but it was no big deal and you certainly learned from your mistakes.

How approachable the teacher was, determined learning outcomes when there was student conflict within a clinical group according to one student.

R 24: Sometimes there's a student on the floor that you don't get along with or don't work well with. It's hard for an instructor to pick up on I'm sure. But if you have an openness with your instructor then you'll be able to tell her [about the problem]. When you're a student trying to learn, you need that openness with your instructor.

Little insight was gained into why certain instructors were more approachable than others. Two students speculated on what accounted for a teachers' approachability. One felt that it was due to her non-threatening way of questioning while the other wondered if it was due to her personality. A third attributed the instructor's approachability to her personality.

R 3: It was her non threatening way of putting questions that helped.

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R 4: I'm not sure what makes her that approachable, I think it's just her nature. That's the way she is. She's just like that.
R 11: [Approachability] has to do with personality as well but I guess at the beginning I asked a lot of questions and I find it’s really important to have rapport with your instructor so that you can feel comfortable enough to tell them I’ve never done an NG [naso-gastric] tube insertion before, would you like to be there in case I need you?

The instructor’s willingness to intervene on behalf of her students did not go unnoticed. Students felt that when their instructor acted as a buffer between the staff and themselves in difficult situations, their working relationships with everyone improved.

R 14: You can see when the instructor’s been the mediator and the staff seem to accept the students much better when that happens.

R 18: The way she reacted with the staff and acted as intervener between the staff and the students [was helpful]. She didn’t underplay the students, saying: "Oh well, they’re just students," or: "Sorry about my student."

A second year student explained the teachers’ ability to deal with conflict in the clinical setting.

R 21: When there was some sort of incongruence or conflict where a student was involved, she always gave you the opportunity to say: "This is the situation as I saw it and this is why I’m doing this and she always backed us up.

Two third year students expressed similar views:

R 28: As an advocate, the instructor affects staff attitudes towards students. I have yet to see an instructor that didn’t. That’s what’s so good about our place because the instructors go to bat or they will say: "This is unrealistic here, and I saw this [the teachers’ observations] in here and then how could she be there?"
R 30: She protects, she's a student advocate and if she's good she doesn't say: "Well, we're in a political situation and we have to deal with the hospital." She says: "OK, let's have a look and let's be fair."

Another third year student spoke of the pride she had in being a student in this program and the respect she had for her instructor as a result of the advocacy her teacher demonstrated.

R 28: She wouldn't let the staff or the head nurse push her students around and so we then had a really strong bond there. At one point when we were short handed, they didn't need to call for any more nurses because they had students. She stood up for us and said: "My students are here to learn, they're not here to staff the ward" and we loved it! At times we thought that on such a busy floor we were being used as staff. It's nice not to be pushed around because I think as students we don't stick up for ourselves.

The optimistic teacher, the one who could think positively and who always conveyed the message "you can do it" instilled a sense of pride and confidence in her students. They found this positive attitude conducive to success.

R 14: If I was doing something wrong, I was made aware of my error in a way that I didn't feel put down. She'd say next time you can do it. You didn't feel inadequate or bad because you hadn't done it right. She made me feel proud to be in nursing.

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R 30: Someone who is able to see things in positive terms helps us with our confidence.
Four students spoke of the teacher who really appeared to enjoy her work. They described this instructor as someone who really enjoyed what she was doing, who especially enjoyed them as students and who brought a sense of renewal to her work. An example follows:

R 19: They like what they're doing not just that they enjoy teaching.

I: How is that manifested?

R 19: It's not always routine for them. Teaching isn't a routine job that they're doing every year but they might bring new things to their teaching and keep stimulated for themselves, not just a job that they go to for the money or whatever. They keep themselves up to date and they really enjoy being with the students.

In conclusion, the empathetic teacher listened to her students, observing their non-verbal cues prior to arriving at conclusions. She appraised situations carefully before making decisions. Above all else, she demonstrated a caring attitude by showing a personal interest in them and their goals. Her ability to stick by them in difficulties and to remain calm at all times was further evidence of her empathy for students.

The teacher who displayed congruence between her verbal and non-verbal messages demonstrated genuine concern for her students. Congruence was enhanced by her ability to self-disclose. The clinical teacher who used self-disclosure appropriately was perceived as "more human". Similarly, the
instructor appeared more human to students when she acknowledged the humor in situations appropriately.

Lastly, the clinical teacher demonstrated positive regard for her student when she was approachable, acted as a student advocate and maintained a positive attitude. Students felt that approachability was a key factor in teacher-student relationships. The more approachable the clinical teacher, the more successfully she would role model team building and conflict resolution. Students were less certain about what determines a teacher's approachability. Similarly, when the situation demanded it, ensuring that their learning needs took priority over institutional needs for service was vital. Ultimately, the instructor who maintained a positive attitude and joy of teaching instilled a sense of pride and confidence in her students.

Environmental Factors

Introduction

Once the thirty interviewees had responded to the two open ended questions regarding teacher effectiveness in the clinical area, they were posed with this question: "Other than all of the things that we have just talked about, is there anything else that affects your learning clinically"?
Answers to this question were varied, ranging from frequent responses related to how well students are accepted by staff and the climate on the ward, to singular responses referring to the instructor's communication skills vis a vis the staff, the instructor's ability to empathize with them, her level of enthusiasm and the rapport that student and teacher had established in the classroom. Only one respondent had no new information to add at this point.

College-based nursing students recognized the impact of a teacher's availability, the staff's willingness to assist them, and the general climate in the clinical area on their learning. They generally agreed that while the teacher influenced all of these factors, in many instances she had little control over these. Availability, for example, may be due to the nature of the teacher's contractual agreement with the college, whereas acceptance by staff and the emotional climate in the clinical setting may be due to morale, staff workloads, expectations or leadership within the workplace. Both of these factors are highly variable and are affected by the frequency with which instructors are expected to move through a variety of clinical settings, as well as the level of students assigned for clinical supervision. Third year students are understandably more highly valued clinical resources than first year students regardless of the effectiveness of their clinical instructor.
Availability

Availability was not a major concern to most of the students interviewed. Only one mentioned that she felt availability was affected by group size and one stated that she spent needless time seeking the instructor’s assistance.

R 24: Just being available on the floor [is a problem]. I feel that our clinical groups are just too large. You’re looking for her [the teacher], she’s not available and the team leader is busy so you wait. It’s really frustrating.

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R 13: The one thing that we find hard as students is how available she [the instructor] is 'cause looking for your instructor to do something can be a problem.

On the whole however, those who commented found teachers always available and never too busy to help them.

R 6: She had that kind of presence. She was always around you and if she wasn’t with you she was easy to track down. She was always available.

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R 13: She made herself available for supervision. She didn’t let something pass by. If there was an opportunity to do something she didn’t say I’m too busy.

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R 16: I like the way she lets you do things on your own but if you needed her instruction she’d be there. She’s there when you need her.

How the instructor made herself available was of greater concern as stated by this second year respondent:
R 26: She's always available. It seemed like every time I needed her she was right there.

I: How did she do that?

R 26: She'd come around and check on me frequently but I didn't feel like she was spying on me, not like one other instructor. I thought oh, she's checking on me.

It would appear then that the manner in which the instructor made herself available to students was as significant as how frequently she was available.

Acceptance by Staff

Acceptance by staff meant being assisted by them when the need arose, and being allowed to carry out nursing care independently.

R 8: How the staff makes students feel [is important]. If they welcome students and try to help them out, and don't try to take over I think it's a lot better.

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R 25: The staff's attitude towards us as students [affects our learning]. If a problem arises in the beginning, you don't get shut off.

Helpful staff members gave students positive feedback and thanked them for their help when the day was over.

R 2: [It is helpful to work with] staff who are encouraging and willing to thank you for your help, staff that can give you the vibes that hey, you're ok, we really appreciate you, how would we survive without you?
A second year student aptly described helpful staff:

R 3: I mean they're willing to show you anything or let you do things that maybe they would be doing. I can think of a particular experience where she [the R.N.] was going to go hang some blood and she said come with me and I'll show you how to hang this blood so I went in and it was interesting.

I: If she hadn't taken the initiative you would have missed out on it.

R 3: Oh, I wouldn't have got to see it and then on the other hand, I've been on the floors where she just said: "get out of the way" you know like you can just feel that they don't want you to be there or you're in the room already doing something and they just sort of come in and take over and say: "Oh well, we have to get this done!"

A few students mentioned that staff acceptance meant being considered part of the team and having their opinions valued. A second year student said:

R 24: I learned most where the staff treated me like part of them, included me and valued my opinion.

A third year student felt that acceptance by staff was dependent on timing in the program.

I: That's one thing, can you think of anything else? [affecting your learning clinically]

R 28: Oh, I think the staff! If they don't want you there. It depends what year you're in too, if they think that you can't do anything and that you're in the way and they have to show you every blinking thing, you can sense that they're not happy.

Their acceptance by staff, they felt, was largely the result of how well their instructor was accepted by nursing staff. Her familiarity with the area and rapport with staff
were viewed as significant factors influencing the instructor's acceptance.

I: Do you think the instructor has any bearing on the staff's willingness to help you out?

R 2: If the instructor is familiar with the place she is working in, it helps.

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I: What is the instructor's role if any, in the staff's willingness to help students?

R 3: If she has a good relationship with the staff, that helps.

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R 29: The staff's attitude has to do with how well she speaks up for students, combined with her credibility.

There was a direct relationship in student's minds between how knowledgeable the instructor was and the staff's willingness to assist them when the instructor was unavailable to answer their questions or when new learning opportunities arose.

R 21: Where I learned the most or where I felt like I was progressing, were the wards where the staff treated me like I was a part of them and they included me in things, they valued my opinion.

I: Do you think the instructor has a role to play in that?

R 21: Yes, because they really respected her.

I: How do you see that happening?
R 21: I think because she’s honest and they can see that and also because they know that she’s not going to make a decision to put a student where a student can’t be left alone. They trust her knowledge base, they know that as students we have learned from her.

Three students offered more complex explanations regarding the staff’s attitude to them. The first felt that the willingness of staff to get involved was dependent on how well the instructor got along with the staff, how long she had been on that ward and how good her orientation was.

R 11: How they get along with the staff and I’ve noticed a lot of difference when an instructor comes onto the floor cold turkey, we feel like outsiders rather than part of the team. That makes it harder for the student to build rapport with the staff. If they’re familiar with the routine then it’s a lot easier because every floor runs differently.

The second student explained how receptive the staff was towards them was based on the instructor’s communication skills, her approachability and the behavior of the students themselves.

In response to the question: "Do you think the clinical instructor has anything to do with the climate on the ward"? a respondent commented:

R 12: Yes, by her communication skills and by the fact that she’s approachable and of course by the behavior of the students, that is going to influence how the staff feel about having you [the students] there.

One student felt that if the instructor was actively involved in patient care, the staff would be more willing to assist them when the need arose.
R 20: If the staff see that the instructor pulls her weight, they think this is great and they'll be more free to help students.

General consensus was, however, that if the instructor was respected by the staff, they would be more willing to involve the students and to assist them whatever their needs may be.

Climate

Most of the comments regarding the climate in the clinical setting related to the instructor's rapport with the staff. A few students saw a direct relationship between their behavior in the clinical setting and the emotional climate on the ward. How much the instructor was able to alter that was debatable.

I: What enhances your learning?

R 12: The climate on the ward [does].

I: Do you think the instructor has anything to do with that?

R 12: Yeah, but sometimes the instructor can't change that. I mean she can go to the head nurse and talk to her about things that are happening like if there were a lot of nurses who didn't like students there.

I: How does she impact on that?

R 12: By her communication skills and again by the fact that she's approachable and if something's really happening you could go to her and say: "I'm really having a rough time."
I: Outside of the instructor's communication skills, is there anything else that you think influences the climate on the ward when you're there?

R 12: The behaviour of the students is going to influence how the staff feel about having you there.

***************

I: Is there anything else that affects your learning clinically, other than the things we've discussed?

R 17: the atmosphere on the floor

I: Does the instructor have anything to do with that do you think?

R 17: Sometimes, but I don't really think you can lay that on the instructor, because they [staff] are individuals and it depends on how receptive they are to students.

***************

I: Do you think that the instructor has any control over the climate on the ward?

R 18: I don't know if she has a great amount of control over that, but I think she can influence it. If staff are having a hard time with students, making it better, but I don't know how you go about doing that!

I: You see that as within her realm?

R 18: Yeah, if they respect you as an instructor, they'll be more receptive to students.

Of the twenty nine students who chose to provide information on additional factors affecting their learning in the clinical setting, the majority chose to discuss how well they were accepted by staff, the climate on the ward and availability of the instructor.
How often the instructor was available did not appear to be a major concern of the student perhaps because most instructors appeared to be readily available to students. How this was achieved, however, was a matter that warrants further investigation. What causes certain students to feel that they are being "spied on" during clinical supervision for example, while others are more comfortable in the presence of their instructor? Perhaps the student’s conception is related to the rapport the teacher has established with the student or perhaps the conception is linked with the instructor’s expectations.

Acceptance by staff meant being given the freedom to carry out nursing interventions independently and being offered assistance when the instructor was not available. It meant being considered as a team member with worthwhile opinions and input into planning patient care. How well students were accepted by staff appeared to be dependent on two factors: what stage the student was at in the program (third year students being the most valued by staff) and how well the teacher was accepted in the area. Familiarity with the area, rapport with staff, knowledge level, level of honesty, problem solving skills and willingness to assist with patient care were all considered possible influences on staff’s acceptance of the clinical teacher.
Students recognized that their behavior altered the emotional climate on the ward but the instructor’s communication skills also had the potential to change the situation, especially if the teacher was willing to speak out on behalf of her students.
Chapter Five

SUMMARY CONCLUSIONS AND IMPLICATIONS

Introduction

The purpose of this study was threefold, to determine: a) similarities and differences between the conceptions of second and third year students regarding characteristics of effective clinical teachers; b) whether there was a relationship between individual conceptions of effective clinical teachers and the instructor's contractual agreement and c) whether students' conceptions of effective clinical teachers could provide a theoretical basis for future studies on clinical teacher effectiveness in nursing.

Chapter V is a summary of the findings regarding the timing of student's choices of effective instructors and apparent effect of contractual agreements on teacher effectiveness followed by comparisons of second and third year students' conceptions of most effective clinical teachers. A theoretical framework for further study of clinical teacher effectiveness is proposed. Conclusions are drawn from the findings and implications are discussed. Lastly, the researcher makes recommendations for further study.
Timing of Students’ Choices of Effective Instructors

Although one would expect students to recall most recent experiences when asked an open-ended question regarding most effective teachers, one can only speculate why second year students did not recall most effective instructors from the second rotation of the first semester or any effective instructor from the second semester. Perhaps extraneous factors contributed to this finding. For example, they may not have been preferred clinical areas by students or staff attitude toward students in those areas may not have been as conducive to learning.

It is less surprising that third year students did not recall most effective teachers from the sixth semester since they work more closely with preceptors than with instructors during that semester. The nature of their relationship with instructors changes during that semester. One can only speculate whether a researcher asking the same question of second and third year students in a similar college based nursing diploma program would experience similar findings. Since other nurse researchers have not reported on the "timing" of students' choices regarding effective clinical teachers, one can only speculate that this finding is unique to this group of students.
Instructors' Contractual Agreement

The ratio of full-time to part-time instructors as most effective was significant ($\chi^2 = 8.66 p,<.01$) for second and third year students. Given the full-time part-time ratios of clinical teachers involved in teaching second and third year students (13:18 and 17:19) one would have expected a much higher number of part-time instructors to be selected as most effective. Students perceived full-time instructors as more readily available and as having greater expectations than those employed on a part-time basis to teach exclusively in the clinical setting. This finding has not been reported in other studies on clinical teacher effectiveness, however Dawson (1986) reported a positive relationship between the number of contact hours and the students' evaluation of instructors. In this study, students concerns regarding part-time instructors offers insight into their preference for full-time instructors who are more readily available and who appear to have higher expectations than part-time teachers.

Comparisons of Second and Third Year Students' Conceptions

Teacher and student come to the learning situation with their own past experiences, cognitive maps, expectations and personalities. Conceptions of effective clinical teachers
among the subjects in this study consisted of the teacher's knowledge and the ways in which she facilitated learning. The teacher's ability to provide feedback and her communication skills were also perceived as important determinants of the effectiveness of clinical instructors. In addition, the learning environment itself was perceived to have significant impact on the learner.

Second-year students valued trust, approachability and availability far more than did the third-year students, whereas third-year students valued expectations, problem solving skills and self disclosure far more than did their juniors. This indicates that there were some similarities with the Knox and Mogan study (1986) in that second-year university students valued the teacher who demonstrated: promotion of independence (trust), availability, stated explanations clearly (expectations), established a pleasant learning environment and was a good resource person. Third-year university students in the same study valued the teacher who: stated expectations clearly, was available, provided guidance as necessary, was a good resource person, and facilitated growth of the student. Perhaps these differences are due to student-teacher ratios at various levels in each of these programs or due to a difference in research methodology.
Second and third-year students valued the teacher’s knowledge base equally except that third year students commented more than twice as frequently as second year students regarding the teacher’s knowledge of curriculum, goals and objectives. This perception may well be due to the nature of senior student’s clinical experience. Since they are approaching graduation, they may well show more need for individualization in meeting their educational goals at this time. It is not possible to compare these findings with other second and third year nursing students, since they are not reported in the nursing literature on clinical teacher effectiveness.

Second and third-year students differed in their perceptions of the teacher’s feedback skills in two areas. Although they commented equally on the teacher’s ability to provide positive and negative feedback, second year students commented two and a half times more frequently regarding the trust level they and instructors held but had no comments regarding the teachers’ level of honesty. Third-year students commented occasionally on the teacher’s level of honesty but were far less concerned about establishing trust with the teacher. Reasons for these findings are purely speculative. The researcher suspects that once again, their comments are tied to the nature of their clinical experiences at the time of the interviews.
Second and third year students shared similar concerns regarding the teacher's communication skills and stated similar views on the instructors' ability to demonstrate empathy, congruence and positive regard.

Communication skills were a major concern for third-year students in the Mogan and Knox study whereas findings of this study show that to be a greater concern of second-year students. This may be due to the timing of communication content in each program. It is possible that students who are learning content related to communication skills tend to emphasize this aspect of clinical teacher effectiveness. For example, subjects in this study learn most of the content related to communication skills during the first two years of the program.

Second and third-year students shared equal concerns regarding external factors (availability of the teacher, emotional climate in the clinical setting and acceptance of students by staff in the clinical area), except regarding the teacher's availability. Second year students mentioned availability more than three times as frequently as third year students did. This is not surprising for two reasons: a) third year students work more closely with preceptors; and b) second year students require a higher degree of supervision and guidance than do senior level students.
Other studies in clinical teaching mention the teacher's availability as a key factor in determining her effectiveness (Barham, 1965; Jacobson, 1966; Kiker, 1973; Karns & Schwab, 1982; Mogan & Knox, 1986), however few comparisons are drawn regarding perceptions of students at various levels within each program.

Clinical Teacher Effectiveness: A Theoretical Framework

Based on respondents in this study, clinical teacher effectiveness is dependent on the teacher's knowledge, feedback and communication skills as well as on extraneous factors within the clinical setting. Findings related to the instructor's knowledge level are somewhat consistent with studies in clinical medicine. Irby (1978) lists knowledge as one of six key factors in clinical teacher effectiveness with students in medicine.

Findings are also consistent with Wilson, Shulman and Richert's (1987) research into teacher effectiveness in general education. Their research stresses the teacher's knowledge base and provides a useful theoretical framework for the analysis of clinical teacher effectiveness. While previous nursing studies on clinical teacher effectiveness mention the teacher's knowledge as a determinant of her
effectiveness (Armington, 1972; Griffith, 1983; Karns & Schwab, 1982; Karuhije, 1986; Mogan & Knox, 1986; Wong, 1978), those references tend to be broad. For example, while Armington (1972) states that clinical instructors who are "experts in their field" and who "encourage students to think" are rated above average by their students (p. 791), Karns and Schwab (1982) refer to the clinical teacher's knowledge base as an attribute valued by nursing students. Mogan and Knox (1986) found that while students placed little emphasis on the instructor's knowledge in nursing, they valued an expert clinician and role model. Wong (1978) found that first year students were especially sensitive to how teachers made them feel while second year students were more concerned with the teacher's competency in teaching.

Students in this study value the clinical teacher who:

a) is a content expert; b) knows the clinical area well;
c) knows how to teach and d) goes out of her way to get to know them as learners and as individuals. They are less concerned with the clinical teacher's knowledge of content outside the field of clinical nursing and with her knowledge of curriculum or educational goals and objectives.

Feedback skills, according to respondents, are dependent on the teacher's ability to provide balanced positive and negative feedback and to maintain a trusting and honest
relationship with students. Their comments regarding an effective teacher's feedback skills were analyzed on that basis and findings were similar to those of other studies in nursing education. Mogan and Knox (1987) found that students ranked the teacher's ability to evaluate them, as well as a non-judgmental attitude among the top three characteristics of effective clinical teachers. O'Shea and Parsons (1979) described ineffective clinical teachers as those who criticized students in front of others and who only provided negative feedback or not enough feedback.

Students in this study raised concerns about the ideal timing and frequency of positive feedback. That too much positive feedback given too soon in the clinical rotation may be detrimental to the motivation of students has not previously been documented in the literature on clinical teacher effectiveness. Questions regarding the effect of positive feedback on students' conceptions of effective clinical teachers warrants further investigation. Determining the optimal timing and amount of feedback required by each student poses an interesting problem for clinical instructors. Perhaps each student's need for positive feedback is linked to her personality type or to her preferred learning style.

There are numerous general references to the teacher's interpersonal skills in the nursing literature on clinical

In this study, Carl Rogers provided a framework for the analysis of teachers' communication skills. Students value the teacher's ability to display empathy, congruence and positive regard. Unlike Karns and Schwab (1982) and Griffith and Bakanauskas (1983), this researcher found that effective clinical teachers employed Rogers three critical dimensions of therapeutic communication in daily interactions with students. Once again, these findings may have differed due to the nature of student populations studied or due to dissimilar research methodologies.

There were similarities and differences in conceptions of teacher characteristics favored by university students in the Knox and Mogan study (1986) and the college students in this study. College students did not appear as concerned regarding their clinical teacher's organizational skills or flexibility as university students, but they shared similar views on the effectiveness of the teacher who demonstrated enthusiasm, cheerfulness, a calm manner and a sense of humor.
Previous studies on clinical teacher effectiveness do not differentiate between factors influencing teacher effectiveness which are outside the realm of her control and those over which the teacher has full control. Students in this study made a distinction between those factors which are controlled by the instructor (knowledge, feedback and communication skills), and those which are only partially affected by her behavior in the clinical setting. Availability of the instructor is one such factor, since student-teacher ratios and contact hours are a direct result of the instructor's contractual agreement with her employer. Similarly, the emotional climate and acceptance of students by staff cannot be directly attributed to the clinical teacher. These three factors then, availability, emotional climate and acceptance of students by staff, constitute external factors influencing clinical teacher effectiveness.

In conclusion, based on the comments of respondents in this study, a theoretical framework for the evaluation of clinical teachers must include criteria in the following four areas: knowledge base, ability to provide feedback, communication skills and environmental factors. Each of these constitutes a major category of factors to consider in evaluating clinical teacher effectiveness in nursing.
Conclusions

Based on the findings in this study it is reasonable to arrive at four conclusions. The first conclusion is that given an opportunity to recall past experiences with effective clinical teachers, students are capable of identifying factors which enhanced the effectiveness of those teachers within a clinical setting. In addition, students are capable of ranking these factors in terms of importance or significance to their learning.

Secondly, students in the second and third years of a three-year college based nursing diploma program differ somewhat in their conceptions of effective clinical teachers. Second-year students are more concerned with a teacher that they trust, is approachable and available to them. Third year students on the other hand, value the teacher who states expectations clearly, demonstrates problem-solving skills and uses self-disclosure in assisting them.

The third conclusion is that effective clinical teachers are knowledgeable in a number of areas and are skilled at providing feedback as well as at communicating with staff and students. Four types of teacher knowledge are particularly significant to students. The teacher who possesses both content knowledge as well as contextual knowledge is highly valued.
Those two types of knowledge, combined with knowledge of how to teach (pedagogical knowledge) and knowledge of the learner, to a large extent constituted these students' conceptions of clinical teacher effectiveness. Nursing students placed less importance on the clinical teacher's knowledge of curriculum, goals and objectives.

The clinical teacher's ability to provide feedback is dependent on her ability to provide positive and negative feedback in an honest and caring manner. A trusting relationship between student and teacher is at least partially due to the teacher's feedback skills. According to this study, effective clinical instructors role model the three cornerstones of therapeutic communication in their daily interactions with students: empathy, congruence and positive regard.

Fourthly, clinical teacher effectiveness is also affected by extraneous factors which may be outside the realm of the teacher's control. Availability, for example, may be determined primarily by the number of contact hours and instructor-student ratios. These are a function of the teacher's contractual agreement which in turn is based on administrative decisions and subject to budgetary constraints. The emotional climate and the staff's attitude toward students are similarly affected by extraneous forces
over which the clinical teacher has little control. Students are keenly aware of the impact that these forces have on their clinical experiences.

Some of these conclusions are consistent with findings in nursing and medicine on clinical teacher effectiveness however, due to the homogeneous group in this study, generalizability of findings is limited.

Implications

The findings of this study have several implications for curriculum and program planners of schools of nursing, for clinical instructors and for college administrators.

First, since second and third-year college nursing students value knowledge, feedback and communication skills, preparatory educational programs for nurse educators at both the graduate and undergraduate levels must focus on developing skills in these areas. Inservice planners for schools of nursing can design workshops to help faculty improve their clinical teaching skills. Orientation programs for new instructors should include information about characteristics of effective clinical teachers. College administrators must ensure that evaluation of clinical instructors reflects this focus.

Since students emphasized characteristics related to
knowledge, communication skills, and feedback skills, clinical instructors must make a conscious effort to maintain current theoretical and clinical knowledge and to employ effective interpersonal skills in their interactions with students. Application of therapeutic communication with students in the clinical setting may reduce stress on students and increase their self-confidence, thus positively affecting their learning.

Secondly, second and third-year nursing students valued different characteristics. Therefore, unless clinical teachers have an awareness of these values, they may not be as effective as possible and student learning in the clinical setting may be compromised. Discussions between students and faculty on expectations and evaluation at the onset of each clinical rotation might be useful. Faculty must become aware of the conceptions of their students in order to attempt to change their behaviors or to at least facilitate discussion in order to enhance rapport with their students.

Thirdly, students prefer clinical teachers who are employed on a full-time basis. Therefore it is important to address students' concerns regarding the availability and expectations of part-time instructors. Orientation programs for new staff should include an orientation to the appropriate theoretical content as well as to the clinical setting. Part-time faculty may be able to overcome the problem of availability once it is recognized as an essential
component of effective clinical instruction. While providing greater faculty access for students by modifying collective agreements of part-time staff, college administrators can support clinical teacher effectiveness.

Lastly, the question of what is considered optimal timing and amount of positive feedback for each clinical student is a concern of nursing faculty. The relationship between preferred learning styles and the effect of feedback on the learner needs to be explored.

Recommendations for Further Study

It is useful to continue to explore conceptions of students as a basis for the evaluation of clinical teacher effectiveness. It is only through continued study of the similarities and differences in conceptions of different student populations that a full understanding of what constitutes effective clinical teaching can be obtained. Further comparisons of student’s conceptions is therefore recommended.

Exploring the effect of the instructors’ contractual agreement should also be explored further. Indications from this study show a significant relationship between the effectiveness of the clinical teacher and her contractual agreement. Quantitative studies with various nursing student populations are recommended.
Lastly, the conceptual framework provided in this study may be tested in future quantitative studies on clinical teacher effectiveness in the hope that the role of the nurse educator may be enhanced in the clinical setting and that students receive the best education to which they are entitled.
REFERENCES


Thank you for agreeing to be interviewed. I am working on a research project that looks at nursing students' thoughts about teacher effectiveness in the clinical area. I'm going to ask you questions about your own experiences with instructors in the clinical setting and how you view an effective clinical instructor.

The whole interview should take 20 - 30 minutes. I'd also like to tape record it so that I can listen to you more carefully now and review what you said later on. Are you agreeable to that?

QUESTION 1

Please recall the most effective clinical instructor you’ve had over the last 2 - 3 years. It may be an instructor you've had recently or one you've had at anytime throughout your clinical experience. Tell me about your experiences with that instructor.

a. (If not able to recall the most effective instructor) use these probes;
   - sticks out in your mind
   - has left a favorable impression

b. What were the specific characteristics of this instructor which enhanced your learning?
   (1) Tell me what you mean by......
   (2) Could you expand on......
   (3) How did that make you feel?

c. Of the characteristics you've mentioned, and I'll review them for you. (You mentioned the following:______,______, and ______). Which of these do you consider to be the most important to your learning?

I'd like to move on to the next question......
QUESTION 2

I'd like to ask a few questions regarding specific circumstances related to the clinical situation you have just recalled for me. Is that all right with you?

a. What was the clinical area?
   (If unable to recall the clinical area) use these probes;
   -medical  -long-term care  -pediatric
   -surgical  -psychiatry  -other
   -obstetrics  -critical care

b. Tell me about your assigned workload.
   (If unable to recall the assigned workload) use these probes;
   -team leading on a unit? on a team?
   -how many patients assigned?
   -level of care required by assigned patients?
   -degree of assistance available with the care?

c. What was the size of your clinical group?

d. What was the timing in the program? (semester & rotation)

e. Was your clinical instructor a part-time or a full-time instructor? i.e. Did she also teach classroom content?

I'd like to conclude this interview with a few general questions.

QUESTION 3

You have been to a number of clinical areas by now and have had a minimum of three clinical instructors. I'm going to ask you about your opinion regarding the teaching characteristics of these instructors.
a. In your opinion, what 3 qualities of those instructors was most critical to your learning? (These may differ somewhat from the ones you identified earlier or they may be the same).
   1.
   2.
   3.

b. Please rank those qualities from most to least important.

c. Other than all of the factors you've mentioned is there anything else that affected your learning clinically?

THANK YOU!
responsible for determining student-instructor ratios and for assigning faculty to clinical areas with students requiring various levels of supervision. It will also determine whether teaching effectiveness is enhanced by assigning faculty to teach nursing theory and clinical practice concurrently since faculty employed on a part-time seasonal basis do not concurrently teach nursing theory.
Summary of methodology and procedures.

The methodology for this study is phenomenographic, which is a variation of phenomenology (Marton et. al). It is designed to describe student nurses' perceptions of effective clinical instructors based on their own unique clinical experiences.

Random samples of students currently enrolled in the second and third years of a community college nursing program will be interviewed using a semi-structured interview schedule. The interview will consist of three broad questions including some demographic data in order to facilitate uniform data collection for analysis.

Respondent profiles will be gathered within each interview to facilitate the collection of demographic data. Audiotaped interviews will be transcribed and students will be provided with a copy of their transcript for content verification.

Content analyses of the transcripts will be carried out via the constant comparative methodology. Categories of descriptions will be generated from the empirical data. Descriptive categories will then be collapsed to yield an analytical map of students' perceptions of teacher effectiveness in various clinical areas at varying stages in their growth and development as student nurses. Descriptive statistics will be used to analyse the data generated from the respondent profile section of the interviews.

DESCRIPTION OF POPULATION

13 How many subjects will be used? 30

How many in the control group? N/A

14 Who is being recruited and what are the criteria for their selection?

- second and third year nursing students enrolled in the Cariboo college diploma nursing program during the winter semester (Jan.-April) of 1988.

- fifteen randomly selected students from second and third year.
15 What subjects will be excluded from participation?

Sixteen RPN (registered psychiatric nurse) access students who joined the third year of the Cariboo College diploma program in Sept. 1987 and who graduate in March 1988.

16 How are the subjects being recruited? (If initial contact is by letter or if a recruitment notice is to be posted, attach a copy.) NOTE that UBC policy absolutely prohibits initial contact by telephone.

-fifteen students from each year (second and third) will be randomly selected by use of a table of random numbers. Those selected will be invited by letter to participate in the study.

17 If a control group is involved, and if their selection and/or recruitment differs from the above, provide details.

N/A

PROJECT DETAILS

18 Where will the project be conducted? (room or area)

Interviews will take place in the researchers office S007 at Cariboo college, Science Building, Kamloops, B.C. phone:828-5436

19 Who will actually conduct the study?

Claudette Kelly

20 Will the group of subjects have any problems giving informed consent on their own behalf? Consider physical or mental condition, age, language, or other barriers.

No

21 If the subjects are not competent to give fully informed consent, who will consent on their behalf?

N/A

22 What is known about the risks and benefits of the proposed research? Do you have additional opinions on this issue?

This researcher is unaware of any risks of the proposed research. Benefits of the proposed research are previously outlined (see #8 of this form).
<table>
<thead>
<tr>
<th>Question</th>
<th>Answer</th>
</tr>
</thead>
<tbody>
<tr>
<td>23 What discomfort or incapacity are the subjects likely to endure as a result of the experimental procedures?</td>
<td>None</td>
</tr>
<tr>
<td>24 If monetary compensation is to be offered the subjects, provide details of amounts and payment schedules.</td>
<td>N/A</td>
</tr>
<tr>
<td>25 How much time will a subject have to dedicate to the project?</td>
<td>20 - 30 minutes</td>
</tr>
<tr>
<td>26 How much time will a member of the control group (if any) have to dedicate to the project?</td>
<td>N/A</td>
</tr>
<tr>
<td>27 Who will have access to the data?</td>
<td>Only the researcher and her supervising committee at U.B.C. have access to the taped interviews and transcripts. Students will be given a copy of their transcripts.</td>
</tr>
<tr>
<td>28 How will confidentiality of the data be maintained?</td>
<td>Subjects will be identified by number only. All data will be coded and stored in the computer.</td>
</tr>
<tr>
<td>29 What are the plans for future use of the data (beyond that described in this protocol)? How and when will the data be destroyed?</td>
<td>Data may eventually be made available, with identification deleted, to other research groups.</td>
</tr>
<tr>
<td>30 Will any data which identifies individuals be available to persons or agencies outside the University?</td>
<td>No</td>
</tr>
</tbody>
</table>
### CHECKLISTS

31 Will your project use: (check)

- [ ] Questionnaires (submit a copy)
- [x] Interviews (submit a sample of questions)
- [ ] Observations (submit a brief description)
- [ ] Tests (submit a brief description)

### INFORMED CONSENT

32 Who will consent? (check)

- [x] Subject
- [ ] Parent/Guardian
- [ ] Agency Official(s)

In the case of projects carried out at other institutions, the Committee requires written proof that agency consent has been received. Please specify below:

- [ ] Research carried out in a hospital - approval of hospital research or ethics committee.
- [ ] Research carried out in a school - approval of School Board and/or Principal. (Exact requirements depend on individual school boards; check with Faculty of Education Committee members for details)
- [ ] Research carried out in a Provincial Health Agency - approval of Deputy Minister
- [x] Other, specify: Cariboo College Administration (see attached letter of permission from Dr. D. Cane, Vice-President, Cariboo College)

33 UBC Policy requires written subject consent in all cases other than questionnaires which are completed by the subject. (see item #34 for consent requirements) Please check each item in the following list before submission of this form to ensure that the written consent form attached contains all necessary items.

- [x] Title of project
- [x] Identification of investigators (including a telephone number)
- [x] Brief but complete description IN LAY LANGUAGE of the purpose of the project and of all procedures to be carried out in which the subjects are involved.
- [x] Assurance that identity of the subject will be kept confidential and description of how this will be accomplished
- [x] Statement of the total amount of time that will be required of a subject
- [N/A] Details of monetary compensation, if any, to be offered to subjects.
- [x] An offer to answer any inquiries concerning the procedures to ensure that they are fully understood by the subject and to provide debriefing if appropriate
- [x] A statement of the subject's right to refuse to participate or withdraw at any time and a statement that withdrawal or refusal to participate will not jeopardize further treatment, medical care or influence class standing as applicable. NOTE: This statement must also appear on letters of initial contact.
- [x] A place for signature of subject CONSENTING to participate in the research project, investigation or study and ACKNOWLEDGING receipt of a copy of the consent form including all attachments.
- [N/A] Parental consent forms must contain a statement of choice providing an option for refusal to participate. (e.g. "I consent/I do not consent to my child's participation in this study.")
Questionnaires should contain an introductory paragraph which includes the following information. Please check each item in the following list before submission of this form to ensure that the introduction contains all necessary items.

- Title of project
- Identification of investigators (including a telephone number)
- A brief summary that indicates the purpose of the project
- The benefits to be derived
- A full description of the procedures to be carried out in which the subjects are involved
- A statement of the subject's right to refuse to participate or withdraw at any time without jeopardizing further treatment, medical care or class standing as applicable. NOTE: This statement must also appear on explanatory letters involving questionnaires.
- The amount of time required of the subject must be stated
- The statement that if the questionnaire is completed it will be assumed that consent has been given
- Assurance that identity of the subject will be kept confidential and description of how this will be accomplished.
- For surveys circulated by mail submit a copy of the explanatory letter as well as a copy of the questionnaire

Attachments

Check items attached to this submission if applicable. (Incomplete submissions will not be reviewed)

- Letter of initial contact (item 16)
- Advertisement for volunteer subjects (item 16)
- Subject consent form (item 33)
- Control group consent form (if different from above)
- Parent/guardian consent form (if different from above)
- Agency consent (item 32)
- Questionnaires, tests, interviews, etc. (item 31)
- Explanatory letter with questionnaire (item 34)
- Other, specify:
APPENDIX C

SUBSTANTIVE CODES GENERATED FROM DATA

Approachability
Availability
Calm manner
Caring attitude
Communication skills
Confidentiality
Congruence
Empathy
Enthusiasm
Expectations
Fairness
Feedback
Follow up
Honesty
Individualization
Integration
Intimidating manner
Joy of teaching
Knowledge
Personality

Positive Regard
Positive attitude
Questioning
Role modelling
Sense of humor
Self disclosure
Student advocate
Teaching skills
Trust