A PHENOMENOLOGICAL STUDY OF CLINICAL TEACHERS' EXPERIENCES WITH BORDERLINE NURSING STUDENTS

by

MARY MARGARET BOYER

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We accept this thesis as conforming to the required standard

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Department of Nursing

The University of British Columbia
Vancouver, Canada

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ABSTRACT

The challenge of working with borderline students is a reality of the clinical teacher's role which had not been researched. Based on the review of the literature, it was apparent that more knowledge was needed to understand the experience of evaluating borderline nursing students from clinical teachers' perspectives. In order to present a description of how clinical teachers perceived their experiences with these learners, the phenomenological method of qualitative research was used to explore the experiential meaning of evaluating borderline students from the perspectives of eight diploma program-based teachers. The data were collected through the use of two unstructured audio-taped interviews with each informant. The concepts of role, perception, and decision-making provided direction for the trigger questions used in the first interviews. Data collection and analysis were done simultaneously. The themes and concepts which emerged from the data were validated and clarified with the teachers during their second interviews. From data analysis, three overlapping concepts emerged: ambiguity, student's self-awareness, and laborious decisions. It was concluded that clinical teachers' experiences with borderline students involve evaluating individuals with an ambiguous performance within an ambiguous process. The ambiguity of borderline performance amplifies the ambiguity inherent in clinical evaluation and in the nurse educator's dual responsibility
to students and to patients. Further, the experience of evaluating borderline students entails the time-consuming process of fostering borderline students' awareness of their performance problems. Students with insight accept their clinical standings and are less likely to appeal their clinical failures. It was concluded that dissonance and a variety of emotions, of which uncertainty is the most predominant, are associated with the decision-making process about borderline performance. Dissonance is reduced by using various forms of rationalization and peer support is essential for dealing with the feelings of uncertainty. Finally, it was concluded that clinical teachers use intuitive strategies during the laborious process of deciding a borderline student's final grade. These strategies include a sense of knowing, a sense of the student's whole performance, and a sense of whether or not the student can be trusted as a future co-worker and/or care-giver. The clinical teachers in this study did not value the use of intuition as a respectable element of evaluative decision-making. The research findings have implications for nurse educators, educational preparation for clinical teaching, and for nursing research specific to clinical evaluation.
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CHAPTER ONE

Introduction

Background to the Problem

Clinical teaching is a vital and complex part of nursing education (de Tornyay, 1985; Infante, 1985; McCabe, 1985). According to Carpenito and Duespohl (1985), clinical teaching is "the core of all nursing education" (p. 1). Although the complexity of clinical teaching precludes a detailed description, one of the most critical responsibilities of the teacher's role is that of supervising and evaluating students' clinical performance (Carpenito & Duespohl; de Tornyay & Thompson, 1987).

Clinical teaching involves accountability to students, consumers, the profession, clinical agencies, and educational institutions (Carpenito & Duespohl, 1985). Consequently, clinical evaluation of students' performance is a professional and legal obligation of clinical teachers. This obligation includes assigning failing grades to students who demonstrate unsatisfactory clinical performance (Majorowicz, 1986, p. 36).

For clinical teachers, failing a student in the clinical setting is described as a debilitating experience (Carpenito, 1983; Symanski, 1991) and as an emotionally taxing responsibility (Meisenhelder, 1982). Teachers face an even greater challenge when clinical evaluation involves a borderline student (Brozenec, Marshall, Thomas, & Walsh, 1987; Wood, 1971). This challenge results because the
clinical performance of a borderline student is inconsistent and does not clearly fall into a pass or fail pattern (Brozenec et al.). The decision to assign a passing or failing grade is problematic and, therefore, presents teachers with a stressful and emotional evaluative dilemma (Brozenec et al.; Welborn & Thompson, 1982). This dilemma is compounded by the subjective nature of clinical evaluation (Brozenec et al.; Carpenito & Duespohl, 1985; de Tornyay, 1985; Fowler & Heater, 1983; Infante, 1985; LeVeille Gaul, 1988; Meisenhelder; Poteet & Pollok, 1981; Reilly, 1980; Reilly & Oermann, 1985, 1990; Welborn & Thompson; Wood, 1982, 1986; Wood & Campbell, 1985; Wood & Wladyka, 1980: Woolley, 1977). Because of this subjectivity, teachers feel uncertain about the validity of their evaluative decisions (Meisenhelder). Furthermore, teachers wrestle with the decision to assign a failing grade knowing that: (a) a failure is emotionally difficult for the student (Brozenec et al.; Carpenito 1983; Majorowicz, 1986; Meisenhelder; Symanski, 1991; Turkett, 1987; Welborn & Thompson; (b) the student has the right to involve the educational institution in an appeal process (Carpenito; DeYoung, 1990; Fowler & Heater; Huston, 1986; Lenhart, 1980; Majorowicz; Meisenhelder; Welborn & Thompson; Wood, 1986; Wood & Campbell; Wood & Wladyka; and (c) responses of other faculty members may or may not be supportive (Carpenito; Majorowicz; Symanski).

The nursing literature addresses the emotional
difficulty of assigning failing clinical grades. Although two references (Brozenec et al., 1987; Wood, 1971) address the challenge of evaluating borderline students, a review of the literature did not reveal any research focusing on teachers' experiences with this phenomenon. Until the meaning of this experience is explored, it is difficult to understand and appreciate how clinical teachers perceive this evaluation process.

Statement of the Problem and Research Question

This study explored the difficult emotional dilemma that clinical teachers face in the clinical evaluation of borderline nursing students. Given that the clinical performance of a borderline student is inconsistent, and that clinical evaluation is subjective in nature, the teacher's decision to pass or fail the student is a stressful challenge. The challenge arises from the teacher's awareness of the consequences of assigning a failing grade. The teacher anticipates that there may be negative effects on the student, the educational institution, and relationships with faculty members.

Clinical teachers' perceptions of their experiences with the evaluation of borderline nursing students had not been studied. Thus, there was little known about how teachers viewed this experience which is inherent in their professional role. The research question the study addressed was: from the perspective of the clinical teacher, what was the experience of evaluating borderline
nursing students?

**Purpose of the Study**

The purpose of this study was to present a description of how clinical teachers perceived their "lived experiences" (Oiler, 1982, p. 178) of evaluating borderline nursing students.

**Conceptual Framework**

The concepts of role, perception, and decision-making formed the conceptual framework for this study. The concepts were selected based on the review of the literature and the researcher's own "tension-filled" experiences associated with the clinical evaluation of borderline nursing students. The concepts are generally accepted as elements in all clinical evaluation situations and, therefore, provided direction for the consideration of the challenges of evaluating borderline students.

Role is a complex concept. Two components of this concept are the inherent obligations and relations with people (Joos, Nelson, & Lyness, 1985; King, 1981). These components of role are central to the clinical evaluation process.

With respect to the first component, the role of clinical teacher involves a professional and legal obligation to evaluate students' clinical performance (Majorowicz, 1986). Teachers are obligated to determine if students' overall clinical performance is satisfactory or unsatisfactory. Fulfilling this obligation with borderline
students is difficult because these students exhibit both satisfactory and unsatisfactory clinical behaviors (Brozenec et al., 1987; Wood, 1971).

The second component of role, relations with people, is relevant to the teacher's evaluative role. Relations with people is relevant because the clinical evaluation process involves an interpersonal relationship with students (Kushnir, 1986; Reilly & Oermann, 1990) and students' clinical performance is a concern communicated amongst faculty members (Brozenec et al., 1987; Carpenito, 1983; Meisenhelder, 1982). Further, the clinical evaluation process, particularly with unsatisfactory students, has a direct effect on the teacher-student relationship (Carpenito; Meisenhelder). The student's potential for failure influences the interactive nature of the ongoing clinical evaluation process. Equally as important, the evaluation process with unsatisfactory students influences the teacher's relationships with fellow colleagues (Carpenito; Meisenhelder; Symanski, 1991). Although some faculty members will offer supportive input, others may offer only criticism which will heighten the teacher's uncertainty with respect to assigning the final clinical grade (Symanski).

"Perception gives meaning to one's experience, represents one's image of reality, and influences one's behavior" (King, 1981, p. 24). Perception is subjective and unique to each person. Teachers' perceptions, based on
their own set of values and beliefs, will influence the meaning they assign to their observations and interpretations of students' clinical performance (Fowler & Heater, 1983; Reilly & Oermann, 1985). Furthermore, teachers' perceptions of students' performance are influenced by their past experiences (Reilly & Oermann, 1985), role obligations, relationship with the student, and relationships with other faculty members (Meisenhelder, 1982).

Decision-making is the third concept that is intrinsic to the evaluation process. Clinical evaluation involves a series of decisions which teachers make about students' clinical behavior (Wood, 1986). The evaluation of a borderline student culminates in the teacher's final decision to award a passing or failing grade (Brozenec et al., 1987; Wood, 1971). This decision is influenced by the teacher's perception of the situation.

The concepts were used as the foci for exploring teachers' experiences and, therefore, provided a framework in the formulation of the interview questions used for data collection (Appendix A). Moreover, the concepts provided a partial structure for the organization of the literature review.

The researcher did not test the relevancy of the conceptual framework to clinical teachers' experiences of evaluating borderline nursing students, nor did she use the concepts as a guideline for data analysis. The data were
analyzed according to the information provided by the informants.

**Significance of the Study**

**Scientific Significance**

Clinical teachers are charged with the responsibility of determining if borderline students have mastered the expected level of clinical competency. Although the non-research-based literature described the experience of evaluating borderline students as problematic and stressful, the meaning of this experience from clinical teachers' perspectives had not been explored. It was clear that more knowledge was needed to understand how clinical teachers perceived their experiences with this phenomenon. Hence, the study's scientific significance was the advancement of nursing knowledge concerning clinical evaluation of borderline nursing students and the study's findings may stimulate further related research.

**Practical Significance**

A research-based description of clinical teachers' experiences of evaluating borderline students had practical significance for the following reasons: (a) it would enhance nurse educators' and administrators' understanding of the emotional challenge associated with this responsibility, (b) it would provide a basis for clinical teachers to validate their own experiences evaluating borderline students, and (c) it would provide clinical teachers and graduate nursing students preparing for this role with
insight and understanding into the complexities of this aspect of clinical evaluation.

**Definition of Terms**

**Clinical Nursing Teacher**

For the purpose of this study, a clinical nursing teacher is a registered nurse who has completed at least a baccalaureate degree in nursing. The teacher is presently employed in a diploma nursing program.

**Borderline Nursing Student**

For the purpose of this study, a borderline nursing student is enrolled in a diploma nursing program and has received an unsatisfactory appraisal or a failing grade prior to the final evaluation in a clinical course.

**Clinical Evaluation**

Clinical evaluation involves a series of decisions made by teachers about students' clinical performance. Based on observations and data collection, teachers are responsible for awarding the final clinical grade (Wood, 1986).

**Experience**

From the perspective of clinical nursing teachers, experience is the lived reality of being responsible for the clinical evaluation of borderline nursing students.

**Assumptions**

The study was based on the following assumptions:

1. Evaluating a borderline nursing student is a meaningful experience for the clinical teacher.
2. Perceptions of an experience lead to meaning. Human
beings can reflect on the past and verbally express their ideas (King, 1981).

3. The use of in-depth, unstructured interviews enhances the emergence of relevant and meaningful experiences from the informants (Schwartz & Jacobs, 1979).

Limitations

The limitations of the study were as follows:

1. The study was limited by the clinical teachers' willingness and ability to articulate their true perceptions of and feelings about their experiences.

2. Clinical teachers' perceptions of the phenomenon under investigation may have been limited by the time lag between the time of the experience and time of the study.

3. The informants who participated in the study were clinical teachers employed in a diploma nursing program. Therefore, the generalizability of the experiences may be limited to diploma program-based clinical teachers.

Research Method

The phenomenological method of qualitative research was selected for this study. "Phenomenology is the study of human experience from the actor's (actress's) particular perspective" (Knaack, 1984. p. 107). According to phenomenology, people have their individual, subjective realities which implies that experiences are considered unique to each person (Burns & Grove, 1987).

The phenomenological method enabled the researcher to explore, interpret, and describe the meaning (Bergum, 1989).
that clinical teachers assigned to their experiences with the clinical evaluation of borderline nursing students. Thus, phenomenology was the most suitable method to answer the study's research question. Furthermore, the literature review revealed that this experience had not been previously studied. The exploration of an unknown phenomenon supported the use of a phenomenological design (Sandelowski, Davis, & Harris, 1989). Chapter Three presents the specific details of the application of the phenomenological method in this study.

**Organization of the Thesis**

This chapter has introduced the study by addressing the background to the problem, problem statement, research question, purpose, conceptual framework, significance, assumptions, limitations, and research method.

Chapter Two presents a review of the related literature. This review includes both research- and non-research-based references.

The third chapter describes the application of the phenomenological design used in this study. It outlines the selection and characteristics of the informants, ethical considerations, data collection, data analysis, and reliability and validity.

Chapter Four presents a descriptive account of how the informants perceived their experiences with the evaluation of borderline nursing students. The findings were analyzed using relevant literature.
The fifth chapter includes a summary of the findings, conclusions, and implications for nursing education and research.

**Summary**

Clinical evaluation is a responsibility inherent in the clinical teacher role. Fulfilling this responsibility with borderline nursing students who demonstrate inconsistent performance is a stressful challenge. There was no research found which described how clinical teachers perceived the experience of evaluating these students.

This study used a phenomenological research method to investigate the experiences of clinical teachers who had evaluated borderline nursing students with the concepts of role, perception, and decision-making providing the conceptual foci. The study should contribute to the advancement of nursing knowledge and enhance appreciation of the complexities of evaluating borderline nursing students.
CHAPTER TWO

Literature Review

Introduction

This chapter reviews the research- and non-research-based literature which is pertinent to clinical teachers' experiences with the evaluation of borderline nursing students. Given that the references specific to borderline students are limited, the literature review applies primarily to failing or unsatisfactory clinical students. However, because borderline students receive an unsatisfactory appraisal or failing grade prior to their final clinical evaluation, this literature is directly applicable to the phenomenon under study.

This chapter is organized into three major sections. The initial section examines the essence of borderline students. It describes these students and addresses factors which may contribute to the development of performance problems. The second section focuses on clinical evaluation and the decision to pass or fail students. In particular, this section reflects the concepts of the study's framework. It relates to the concept of decision-making, the concept of perception which is inherent in the subjective nature of clinical evaluation, and obligations which are a component of the concept of role. The third section reviews literature regarding the relations with people component of the concept of role. It addresses clinical teachers' relationships with borderline students.
and with their colleagues during the evaluation process. Further, this section pertains to the concept of perception by addressing how teachers' perceptions of their relations with students and colleagues influence their evaluative decisions. Finally, the literature review is summarized and conclusions are drawn.

**Borderline Nursing Students**

Descriptions of students with clinical performance problems are found in the literature. These descriptions help to identify the essence of borderline students. In addition, the literature offers insight into why some students may develop performance problems.

**The Essence of Borderline Students**

The literature review reveals only two articles focusing specifically on borderline nursing students (Brozenec et al., 1987; Wood, 1971). Brozenec et al. describe borderline students as individuals who do not clearly fall into a pass or fail pattern. Their clinical performance is inconsistent and includes both strong and weak behaviors. Wood (1971) characterizes borderline students as having a marginal, unsatisfactory, or a deteriorating level of clinical competency. Welborn and Thompson (1982) describe that some students demonstrate progress toward mastering the expected level of clinical performance, yet their progress is not entirely satisfactory. This description may apply to borderline students. Because learners with borderline clinical
performance have a potential for failure, they fit Reed and Hudepohl's (1983) definition of high-risk nursing students. These authors define high-risk students as learners who are at risk for not completing their nursing education.

The description of learners who are at risk for not completing their nursing education because they exhibit an inconsistent, marginal level of clinical performance identifies the essence of borderline students. Borderline students, unlike learners who excel or whose performance is consistently unacceptable, "walk a fine line" between passing and failing. Therefore, these students may pose a distinct evaluative dilemma for clinical teachers.

**Borderline Students: Contributing Factors**

Although the literature does not outline specific factors which may contribute to individuals becoming borderline nursing students, it does identify factors which may contribute to students developing performance problems. These factors include admission standards and heterogeneity among nursing students.

In recent years nursing programs have experienced a declining enrollment (Campbell & Davis, 1990; Lenhart, 1980; Rosenfeld, 1987; Statistics Canada, 1990; Symanski, 1991). According to American authors, the decreased number of applicants is forcing some schools of nursing to lower their admission standards (Lenhart; Rosenfeld, 1987; Symanski). Symanski argues that because of the trend to lower admission standards, teachers "may encounter an increasing number of
marginally prepared students and fewer who excel" (p. 18).

Students who are enrolling in nursing education today are a heterogeneous group (Brown, 1991; Campbell & Davis, 1990; de Tornyay, 1985; de Tornyay & Thompson, 1987; Holtzclaw, 1983; Lenhart, 1980; Reilly & Oermann, 1990). Nursing students are women, men, high school graduates, older individuals who are seeking their first career or a career change, and they are from many cultures and ethnic minority groups (de Tornyay & Thompson; Lenhart). Holtzclaw asserts that, because more females are choosing other high-ranking professions, "nursing education is experiencing a 'brain drain' of the academically strong, leadership-oriented women" (p. 453). Because of the diverse student body, more students may experience academic difficulties, personal problems, (Rosenfeld, 1988; Welborn & Thompson, 1982), family pressures, and health-related problems (Reed & Hudepohl, 1988; Rosenfeld, 1988). These difficulties, problems, and pressures may explain why some individuals become borderline students.

Owing to lower admission standards in some nursing schools and the increased diversity amongst student nurses, the potential for borderline students in nursing education may increase. Thus, more clinical teachers may experience the dilemma of evaluating these students.

Clinical Evaluation: The Decision to Pass or Fail

This section reviews literature regarding the clinical evaluation process with borderline students. It examines
research into this phenomenon, the evaluation process as a stressful responsibility for clinical teachers, the subjective nature of clinical evaluation, and students' rights to academic due process.

Research Related to Evaluating Borderline Students

The literature review reveals an abundance of articles on clinical teaching and the process of clinical evaluation. Although this literature is consistent in labeling clinical evaluation as problematic (Karuhije, 1986; LeVeille Gaul, 1988; Mantle, 1982; Schneider, 1984; Wong & Wong, 1987; Wood, 1972, 1982, 1986; Wood & Campbell, 1985; Wood & Wladyka, 1980), there is a dearth of reported studies of clinical teaching in general or specific to the evaluation process (Daggett, Cassie, & Collins, 1979; de Tornyay, 1984; DeYoung, 1990; McCabe, 1985; Pugh, 1983; Windsor, 1987).

Three published reviews of research in nursing education do not identify any quantitative or qualitative studies which focus on clinical evaluation or on borderline students (Allemang & Cahoon, 1983; Andreoli & Musser, 1986; Baj & Clayton, 1991). Meleca, Schimpfhauser, Witteman, and Sachs's (1981) national survey of clinical teaching skills in nursing, medicine, and dentistry does not examine clinical evaluation or borderline students. Given that this review of research in nursing education reveals the paucity of studies addressing clinical evaluation and no studies focusing on borderline students, this section examines non-research-based literature and related studies.
Clinical Evaluation: Stressful Responsibility

The professional and legal obligation to evaluate the quality of students' clinical performance (Majorowicz, 1986) is a stressful component of the clinical teacher's role (Fry, 1975; Little & Carnevali, 1972; Majorowicz; Wood, 1986). Inherent in this obligation is the failing of incompetent students (Fowler & Heater, 1983; Majorowicz) and, with borderline students, deciding whether the marginal level of performance should be awarded a passing or failing grade (Brozenec et al., 1987; Wood, 1971). Being charged with the responsibility of evaluating students with performance problems intensifies the stress of the clinical teacher's role (Lenhart, 1980; Majorowicz; Symanski, 1991; Welborn & Thompson). In addition to being stressful, Symanski suggests that evaluating students who may fail is a devastating, debilitating, and demoralizing experience for clinical teachers.

Goldenberg and Waddell's (1990) research on stress and the use of coping strategies amongst 70 female baccalaureate nursing teachers substantiates the theory that clinical evaluation of unsatisfactory students is stressful in nature. These faculty members cited seeking peer support as their most often used coping strategy.

The literature identifies that the stress associated with the clinical teacher's evaluative role may be linked to the time involved, the element of risk in clinical teaching, burnout, and educational preparation. The literature
related to these areas is examined and discussed in relation to the clinical evaluation of borderline students.

Clinical evaluation is an enormously time-consuming component of the clinical teacher role (LeVeille Gaul, 1988; Little & Carnevali, 1972; Wood & Wladyka, 1980). The time devoted to clinical evaluation may contribute to the physical and emotional fatigue inherent in the stress of clinical teaching (Little & Carnevali). The added dimension of students with unsatisfactory or borderline clinical performance compounds the responsibility and, therefore, the stress and the time involved (Lenhart, 1980; Majorowicz, 1986; Symanski, 1991; Welborn & Thompson, 1982; Wood, 1971).

Given that student involvement in patient care has the potential for error and serious consequence to the patient, there is an element of risk in clinical teaching (de Tornyay & Thompson, 1987; Knox & Mogan, 1985; Little & Carnevali, 1972; Wong & Wong, 1987). This risk, particularly with unsatisfactory students, contributes to the stressful nature of clinical teaching. Unsatisfactory students, with their increased potential for error, require a closer degree of clinical supervision and more time and energy is needed to plan, evaluate, and document their learning experiences. Meanwhile, clinical teachers have less time and energy available to devote to more capable students and to other role responsibilities (Symanski, 1991; Welborn & Thompson, 1982). Teachers' lack of attention to other students and responsibilities may elicit feelings of guilt and resentment.
which may further increase the stress of the evaluation process (Welborn & Thompson).

According to Welborn and Thompson (1982), unsatisfactory students with their increased potential for error present teachers with a time-consuming, stressful decision-making process which tends to involve four overlapping phases. These phases are: problem identification, data collection and intensive supervision, discussing the problem with the student, and resolving the situation—the final decision to pass or fail. This final decision to pass or fail students is an emotional struggle for clinical teachers (Meisenhelder, 1982; Welborn & Thompson). Further, the literature indicates that the decision to pass or fail unsatisfactory students may add to teachers' burnout potential (Lenhart, 1980; Ray, 1984; Symanski, 1991; Zanecchia & Stephenson, 1988).

Burnout, a syndrome that develops in response to stress is "a state of physical, emotional, and attitudinal exhaustion" (Ray, 1984, p. 218). The potential consequences of faculty burnout include: the loss of experienced teachers, ineffective teaching behaviors (Ray), and "erosion of teaching standards" (Symanski, 1991, p. 18).

When clinical teachers are afflicted with burnout and continue to teach, they may abdicate their power and authority to maintain standards by choosing to avoid the challenges associated with clinical failure. Therefore, teachers with burnout may pass inept students along to other
faculty members (Lenhart, 1980, p. 425). The pressures and conflicting forces that teachers may encounter due to the declining enrollment in nursing programs may contribute to faculty burnout (Lenhart). Because of the declining enrollment, program administrators may pressure clinical teachers to pass or retain students. Thus, teachers may encounter conflicting forces when evaluating unsatisfactory students; their obligation to uphold professional and educational standards opposes the administrative pressure to retain students (Lenhart).

Although clinical evaluation is described as stressful, and teachers are obligated to decide whether to pass or fail borderline students, nursing studies which focus on faculty role and job satisfaction do not address teachers' experiences with the clinical evaluation of borderline or failing students (Fain, 1987; Marriner & Craigie, 1977; O'Shea, 1982).

The complex and stressful nature of clinical evaluation necessitates that clinical teachers have adequate educational preparation (Carpenito & Duespohl, 1985; Wood, 1986) and continuing education in order to be effective evaluators (Wood, 1986; Wong & Wong, 1987). Teachers who are ill-prepared for the demands and realities of clinical teaching may experience more frustrations with their role responsibilities (Carpenito & Duespohl). These frustrations may add to teachers' stress and burnout potential. Given that evaluating students with performance problems is a
stressful reality of the clinical teacher role (Carpenito & Duespohl), the evaluation process with borderline students warrants inclusion in education programs focused on clinical teaching. Hence, the stress and insecurity that new clinical teachers (Welborn & Thompson, 1982) experience during the evaluation process with unsatisfactory students may be decreased with adequate educational preparation. Further, Ray (1984) argues that nurse educators need to engage in professional development to enhance personal growth and increase tolerance to stress. Because evaluating borderline students is a stressful dilemma, clinical teachers may benefit from professional development programs focused on evaluating this kind of learner. The review of nursing research on the effective behaviors of clinical teachers reveals three studies in which evaluation is rated highly by students and teachers as an area in which proficiency is required (Brown, 1981; Knox & Mogan, 1985; O'Shea & Parsons, 1979). However, Karuhije's (1986) study of how 211 nursing faculty members perceive the adequacy of their graduate program in preparing them for the role of clinical teacher indicates that many nurse educators do not feel their education adequately prepared them for clinical teaching and their obligation to evaluate students' performance. This research supports the importance of educating teachers on the process of clinical evaluation.

Clinical evaluation is a stressful obligation of the clinical teacher's role. This obligation is even
more stressful when working with students with performance problems. These students intensify the time involved, the element of risk in clinical teaching, teachers' burnout potential, and teachers' need for an adequate educational foundation in clinical evaluation.

The subjective nature of clinical evaluation is one topic which needs to be considered. The next section explores the issues relating to this subjectivity with clinical evaluation of borderline students.

The Subjective Nature of Clinical Evaluation


Although the subjectivity in clinical evaluation cannot be removed, it can be minimized and the quality of fairness enhanced by using clearly stated clinical objectives (Reilly
& Oermann, 1985, 1990). Objectives prevent teachers' own personal desires and beliefs from becoming the focus of student evaluations. Through the use of clinical objectives, the expected level of performance is communicated to students (Carpenito & Duespohl, 1985; Guinee, 1978; Reilly & Oermann, 1985, 1990). Although objectives provide an explicit focus for clinical evaluation, teachers must render a subjective judgement which reflects their perceptions on whether these objectives have been achieved (Carpenito & Duespohl; Fowler & Heater, 1983; Reilly & Oermann, 1985; Wood & Campbell, 1985). In the end, teachers "must call it as they see it" (Meisenhelder, 1982, p. 348).

Because of the subjective nature of evaluative decisions, the clinical evaluation process "can evoke feelings of insecurity, inadequacy, and guilt on the part of nurse educators" (Reilly & Oermann, 1990, p. xiii). Therefore, the subjectivity in clinical evaluation is the impetus for investigating the accuracy and reliability of evaluative decisions. Results of a half-day faculty workshop which examined how 30 clinical teachers evaluated a student with borderline performance indicated that teachers did evaluate differently (Brozenec et al., 1987). Because some teachers evaluated the overall performance as passing and others as failing, Brozenec et al. assert that, due to the presence of subjectivity in clinical evaluation, the progression or dismissal of borderline students may actually
depend upon the assignment to a particular teacher. The findings from this workshop illustrate the subjective nature of clinical evaluation and the importance of nurse educators sharing and discussing their evaluative strategies and examining the clarity of their clinical course objectives (Brozenec et al.). Through the use of videotaped clinical performances, studies by Bondy (1984), Hayter (1973), and Loustau et al. (1980) compared how different teachers evaluated the same situations. These investigations show that, although teachers do evaluate differently, the accuracy and reliability of decision-making can be enhanced by using videotapes to train teachers in the clinical evaluation process. Findings from the faculty workshop and these studies further substantiate the need to educate teachers on the evaluation process with borderline students.

The literature describes two methods of clinical evaluation—normative-referenced evaluation and criterion-referenced evaluation (Bondy, 1983; Guinee, 1978; Krumme, 1975; Reilly & Oermann, 1985). The first method judges performance in relation to other individuals or some kind of ideal model. It ranks students and compares their standing to others. In contrast, criterion-referenced evaluation judges performance against specific behavioral criteria (Krumme). The trend today in nursing education is toward criterion-referenced evaluation (Krumme; Reilly & Oermann, 1990). Clinical objectives are written in terms of standard performance and learning outcomes (Guinee, 1975). According
to Krumme, because of the explicit performance criteria inherent in criterion-referenced evaluation, this method is superior to normative-referenced evaluation in fostering the accuracy and reliability of the evaluation process. However, with either method, teachers must render a subjective judgement which reflects their perceptions of students' performance.

The grading of students' clinical performance is an area of concern which relates to the subjectivity inherent in evaluation (Brozenec et al., 1987; Litwack, Linc, & Bower, 1985; Reilly & Oermann, 1985; Rines, 1963; Wood, 1982; Wood & Wladyka, 1980; Woolley, 1977). Although grading is separate from evaluation (Infante, 1985; Reilly & Oermann, 1985, 1990), it relates to summative or final evaluation and, therefore, is relevant to clinical teachers' experiences with borderline students.

Grading is the subjective process by which a symbol is used to designate some degree of academic achievement (Infante, 1985; Reilly & Oermann, 1985). Grading may be based on a multidimensional system which uses five letter grades (A, B, C, D, or F for failure) or on a dichotomous system which uses either satisfactory/unsatisfactory or pass/fail (Reilly & Oermann, 1985; Rines, 1963; Wood & Wladyka, 1980; Woolley, 1977).

A controversial issue in nursing education is which system of grading best suits clinical courses (Wood, 1982; Wood & Wladyka, 1980; Woolley, 1977). Rines (1963) opposes
the multidimensional system. She argues that clinical performance involves human behavior which is too complex to permit the fine discriminations necessary with letter grades. Reilly and Oermann (1985) argue that although the pass/fail system reduces anxieties associated with grades, it does not distinguish between excellent and barely satisfactory performance. Further, these authors emphasize that, regardless of the system, grading is subjective.

Brozenec et al. (1987) and Wood (1971) acknowledge that, because borderline students exhibit both passing and failing clinical behaviors, awarding the final grade is a difficult task. However, the literature does not address how the method of grading influences teachers' decisions with respect to grading borderline performance. For example, with letter grades, teachers can indicate that students' performance is borderline by assigning the symbol "D," whereas with the dichotomous system clinical performance must be graded as either passing or failing (Reilly & Oermann, 1985). However, with the pass/fail format, unlike the multidimensional system, students who receive an unsatisfactory clinical grade and successfully repeat the course will not have their final grade point average influenced by the initial failure (Reilly & Oermann, 1985). A second issue which relates to grading and the subjective nature of clinical evaluation is what constitutes a failing clinical grade (Brozenec et al., 1987; Carpenito & Duespohl, 1985; Grant, 1989; Wood, 1972, 1982, 1986).
Wood's (1986) survey on the problems inherent in clinical evaluation identifies this issue as a major concern for clinical teachers. There is no fixed rule with respect to the number of errors or unmet objectives that will distinguish a failing grade from a borderline passing grade (Wood, 1982, 1986). According to Carpenito and Duespohl, teachers must render a judgment on such questions as:

1. How many incidents warrant failure?
2. What types of incidents warrant failure?
3. How much improvement warrants passing?
4. How many performance deficits can be permitted for anxiety (p. 221)?

Particularly with borderline students, deciding the answers to these questions poses a challenge for teachers during the evaluation process.

A review of the literature regarding the subjective nature of clinical evaluation supports perception as a concept relevant to a study focusing on evaluating borderline students. The entire evaluation process and decisions about whether to award these students borderline passing grades or failing grades reflects teachers' particular perceptions.

Although clinical evaluation is essentially subjective, it can be fair (Reilly & Oermann, 1985). The following section addresses students' rights to fair evaluation, or the concept of academic due process, and the feelings and fears that teachers share with respect to ensuring that
their evaluations are fair.

Students' Rights to Academic Due Process

Wood (1971) argues that nursing programs need to have policies and procedures which ensure positive, fair strategies to resolve the problems associated with borderline students. Although this advice is dated, it remains applicable today. Further, educational institutions should have clearly delineated policies and procedures for clinical evaluation, grading, grievances, and appeal processes (Carpenito, 1983; Darragh, Jacobson, Sloan, & Standquist, 1986; Grant, 1989; Miller, 1982; Wood, 1986; Wood & Campbell, 1985).

Given that students' rights to academic due process require that teachers' evaluative decisions be substantiated with documented evidence (Grant, 1989; Huston, 1986; Majorowicz, 1986; Wood, 1986; Wood & Campbell, 1985) and that students must be informed of their unsatisfactory clinical progress prior to the final evaluation (Carpenito & Duespohl, 1985; Fowler & Heater, 1983; Huston; Majorowicz; Poteet & Pollok, 1981; Wood, 1986, Wood & Campbell), nursing programs need an explicit policy regarding clinical evaluation procedures. Written evaluations support teachers' decisions and provide students with concrete feedback regarding their clinical standing to date. Therefore, with borderline students, teachers need adequate documentation to substantiate their evaluations and written evidence that students are aware of the possibility of
The fear of violating students' rights to academic due process, particularly when the possibility exists that students may fail, is a significant concern for clinical teachers. With feelings of uncertainty and frustration, teachers vacillate between believing that their decisions are valid and believing that perhaps their decisions are not quite fair (Welborn & Thompson, 1982). Borderline students with their marginal performance exacerbate teachers' uncertainty and frustration in making fair decisions (Brozenec et al., 1987; Welborn & Thompson).

To validate teachers' evaluative decisions, several authors recommend that nursing programs adopt the policy that a second teacher evaluate the clinical behaviors of failing students (Brozenec et al., 1987; Carpenito, 1983; de Tornyay, 1985; Meisenhelder, 1982; Welborn & Thompson, 1982; Wood & Campbell, 1985). According to de Tornyay (1985), seeking a second opinion is a sound, commendable practice which pools faculty expertise in understanding and evaluating students. The literature review did not reveal any references specific to second opinions with borderline students. However, observing students' clinical performance must be done over a period of time (Reilly & Oermann, 1990). With respect to second opinions, the teacher observes merely a sampling of behavior which may or may not be representative of true performance (Reilly & Oermann, 1990, p. 223). With the inconsistent performance of a borderline
student, the second evaluator may not observe the student's strong and weak behaviors. In addition, the second evaluator, who has not established a working relationship with the student, may enhance anxiety which results in a poorer than expected level of performance. According to Kushnir's (1986) study regarding the effects of clinical teachers' presence on students' behavior, teachers need to establish an effective interpersonal relationship with students to minimize their performance anxiety. Therefore, this study substantiates that second evaluators may not always observe students' true level of competency. Second evaluations must be viewed individually for their accuracy and reliability.

Students' rights to appeal teachers' evaluative decisions gives them an avenue to dispute treatment perceived as unfair (Carpenito, 1983; DeYoung, 1990; Fowler & Heater, 1983; Huston, 1986; Lenhart, 1980; Meisenhelder, 1982; Miller; Wood, 1986; Wood & Campbell, 1985; Wood & Wladyka, 1980). Clinical teachers share the fear of the appeal process and the legal ramifications if failed students were to sue (Fowler & Heater; Majorowicz, 1986; Meisenhelder; Ray, 1984; Wood, 1986) and teachers may question whether or not their documentation will adequately support the failing grade in the event that students appeal the decision (Welborn & Thompson, 1982).

In the case of a fourth year medical student dismissed for lack of clinical competency, the United States Supreme
Court ruled that the student had been accorded due process and upheld the rights of educators to exercise subjective judgement in the process of clinical evaluation (Fowler & Heater, 1983; Poteet & Pollok, 1981; Wood & Campbell, 1985). This case supports students' rights to due process and teachers' right to evaluate clinical performance as they see it. Furthermore, it substantiates the need for clinical teachers to support evaluative decisions with explicit documentation.

Wood and Campbell (1985) cite a Canadian case in which the court ruled on behalf of the student's right to due process. In this case, a nursing student failed the clinical experience without being given notice and the teacher's documentation lacked the clarity to support the failing grade. This case emphasizes the importance of having a clear grading policy and explicit documentation in the evaluation of borderline or failing clinical nursing students.

Findings from Orchard's (1991) study of administrative structures and procedures dealing with clinical failures in 94 Canadian nursing programs, indicate that teachers' decisions to fail students are (a) upheld in most grievance reviews within the nursing programs, (b) often modified in appeal hearings outside the nursing programs, and (c) upheld when they reach the courts in an external appeal. Furthermore, this study reveals that many nursing programs do not have written policies and procedures which address
clinical evaluation or the grievance and appeal processes. Orchard recommends that nursing programs can avoid having teachers' evaluative decisions modified in grievance or appeal processes by following prescribed institutional policies and procedures related to clinical evaluation. This recommendation supports the literature previously reviewed.

Each student's right to academic due process is a reality of the clinical teacher's evaluative role. Ensuring that clinical evaluation is fair and, therefore, does not violate this right is a significant concern for teachers when faced with the challenge of evaluating borderline performance.

According to Reilly and Oermann (1985, 1990), a requisite for a fair evaluation is a supportive climate. The following section includes a discussion of the psychosocial climate for clinical evaluation.

**Relationships with Students and Colleagues**

Clinical teachers' relationships with the student and with their colleagues during the evaluation process with unsatisfactory students are inherent in, and central to, the teacher's evaluative role. These relationships influence teachers' perceptions of the evaluation process. This section examines literature related to these two areas.

**Teacher-Student Relationships**

Clinical evaluation is a dynamic, interactive process which involves relationships between teachers and students
(Reilly & Oermann, 1990). The dynamics of the clinical evaluation process are influenced by perceptions. Clinical teachers' perceptions of their relationships with students may influence their evaluative decisions (Meisenhelder, 1982) and students' perceptions of their relationships with teachers may influence whether or not they value clinical evaluation as a process for personal growth and learning (Reilly & Oermann, 1985).

Teachers need to establish a positive, supportive, communicative relationship with each student which is characterized by mutual trust and respect (Meisenhelder, 1982; Reilly & Oermann, 1985). Majorowicz (1986) asserts that through effective communication teachers and students can attempt to understand each others' perceptions of their situations and work together to deal with any concerns.

Teacher-student relationships are intrinsic to the psychosocial climate for evaluation (Reilly & Oermann, 1985). Positive relationships between teachers and students facilitate a supportive learning climate. This climate is essential to students accepting clinical evaluations as fair (Reilly & Oermann, 1985), valuing teachers' evaluative feedback (Meisenhelder, 1982), and growing through both their successes and their failures (Carpenito & Duespohl, 1985).

In a supportive learning milieu teachers view students as individuals with their own learning needs (Reilly & Oermann, 1985). By completing comprehensive student
assessments, teachers are able to determine students' learning needs, identify potential performance problems, and plan individualized, facilitative teaching strategies (Reilly & Oermann, 1985; Wood, 1971).

Further, in a supportive learning milieu, students feel secure to evaluate their own clinical progress (Carpenito & Duespohl, 1985). Self-evaluation encourages students to examine their own strengths and weaknesses as well as providing a means for teachers and students to communicate their perceptions of the clinical experience (Brozenec et al., 1987; Carpenito & Duespohl; Majorowicz, 1986; Reilly & Oermann, 1985).

According to a study of nursing students' perceptions of unethical teaching behaviors in the classroom and clinical setting, students report lack of respect and sensitivity toward the learner as significant unethical teaching behaviors (Theis, 1988). In comparison, studies which focus on students' perceptions of effective teaching behaviors illustrate that respect, support, and concern for students are effective teaching behaviors that enhance learning (Brown, 1981; O'Shea & Parsons, 1979). A study of how diploma nursing students explain their successes and failures in the clinical setting shows that students view teachers as the most important factor underlying both their successes and their failures (Davidhizar & McBride, 1988). These studies verify the importance of the teacher-student relationship and the need for a "supportive learning milieu"
(Reilly & Oermann, 1985, p. 96) in the clinical setting.

Teacher-student relationships and a supportive learning milieu are especially important when working with students with performance problems (Majorowicz, 1986; Meisenhelder, 1982). Although it is important that teachers remain positive and supportive, the clinical evaluation process with unsatisfactory students has a direct effect on teacher-student relationships (Carpenito, 1983; Meisenhelder). There is a qualitative difference in how the individuals respond to each other. Students may respond with denial, grief, anger, and hostility (Brozenec et al., 1987; Carpenito; Meisenhelder) while teachers may respond with anger, frustration, and guilt, or by emotionally and physically distancing themselves from students (Carpenito; Meisenhelder). According to Meisenhelder, teachers need patience and self-control to retain a caring approach with hostile students.

Clinical teachers wrestle with the decision to assign failing grades knowing that failing is emotionally difficult for students (Carpenito, 1983; Majorowicz, 1986; Meisenhelder, 1982; Symanski, 1990; Turkett, 1987; Welborn & Thompson, 1982). A failing grade may threaten students' self-esteem and shatter their dreams (Brozenec et al., 1987; Carpenito; Meisenhelder). Teachers' awareness of their own fallibility may influence the assigning of a failing grade and the severe judgement implied by clinical failure may conflict with teachers' beliefs about caring for, and
nurturing, learners (Meisenhelder, p. 348). Thus, teachers' perceptions of the meaning of failing may influence the evaluation process (Meisenhelder).

Inherent in the clinical teacher's evaluative role is an interpersonal relationship with each of their students (Kushnir, 1986). Given that learners with performance problems can influence the dynamics of and teachers' perceptions of the evaluation process, relationships are an essential element of the teacher's evaluative role with borderline students.

Relationships With Colleagues

The dynamics of evaluating borderline students and teachers' perceptions of the evaluation process may be influenced by relationships with colleagues (Meisenhelder, 1982). The decision to fail a borderline clinical student may or may not be supported by a teacher's colleagues (Carpenito, 1983; Majorowicz, 1986; Symanski, 1991).

According to Carpenito (1983), faculty members may view clinical teachers who fail students as cruel and uncaring. Furthermore, some faculty members may be labeled as "failing teachers" by their peers who have never assigned a failing grade. Brown (1991) argues that the increased number of grade appeals in recent years has led to more scrutiny of evaluative data by colleagues. Teachers may perceive this scrutiny as lack of respect and support.

Symanski (1991) asserts that teachers "should seek support from like-minded colleagues and temporarily ignore
the rest" (p. 21). However, ignoring one's peers appears to be an impermanent solution which does not reconcile the differences in teachers' philosophies with respect to clinical evaluation. In contrast to Symanski, Brozenec et al. (1987) encourage teachers to openly exchange ideas and share philosophies about the clinical evaluation process.

If colleagues are supportive, their understanding and input may assist clinical teachers in coping with the challenge of evaluating unsatisfactory students (Brozenec et al., 1987; Goldenberg & Waddell, 1990; Meisenhelder, 1982; Symanski, 1990; Welborn & Thompson, 1982). Furthermore, by seeking the support of their peers, clinical teachers pool their expertise in understanding and evaluating students (de Tornyay, 1985). Although the validity of having a colleague evaluate an unsatisfactory student's performance was previously addressed, this procedure may promote faculty support (Brozenec et al.; Carpenito, 1983; Welborn & Thompson). According to Carpenito, colleagues should view the actions of teachers who award failing grades as a higher form of caring which demonstrates responsibility and accountability to the student, the clients, and the profession (p. 33).

The fact that the literature outlines that peer support is valuable, yet not always given, when evaluating students with performance problems, justified the inclusion of relations with faculty as a focus of clinical teachers' experiences with borderline students.
Summary and Conclusions

The review of the literature is summarized and concludes with an outline of how the concepts of role, decision-making, and perception formed an applicable framework for this study. Conclusions are drawn regarding how the current state of knowledge supported the rationale for this study.

Summary

The limited literature specific to borderline nursing students described the difficult challenge that clinical teachers face when evaluating these individuals' inconsistent clinical performance. Because these students "walk a fine line" between passing and failing, they present teachers with an evaluative dilemma different from those learners who excel or consistently perform poorly. The American literature indicated that, due to lower admission standards and a diverse student body, there is a possibility that clinical teachers may encounter an increased number of students with borderline performance.

According to the literature, evaluating the quality of students' clinical performance is an obligation inherent in the role of clinical teacher. With a borderline student, teachers are obligated to decide whether the marginal level of performance warrants a passing or failing grade. Because students with unsatisfactory performance exacerbate the complex problems and stress involved in the evaluation process, fulfilling this obligation with these students was
described as debilitating, demoralizing, devastating, and frustrating. Furthermore, the literature indicated that clinical evaluation of unsatisfactory students may contribute to the development of faculty burnout.

The complexity of clinical evaluation was discussed by a number of authors as being linked to its subjective nature. Teachers' subjective perceptions influence their interpretations of students' clinical performance. This subjectivity is an issue of concern for clinical teachers during the process of deciding if a clinical failure would be fair and justified. The literature identified the many factors that teachers take into consideration when deciding the final grade of students with performance problems. These factors included: the amount and type of documented evidence gathered on students' performance, students' rights to due process, the standards of the profession, the legal ramifications, and the overall consequences associated with clinical failures. The importance of educational preparation for clinical teachers with respect to this complex evaluation process was outlined in the literature and supported with research.

The literature documented that evaluating students with performance problems influences the teacher-student relationship and further emphasized that, although the relationship changes, it is imperative that teachers remain positive and supportive. Studies which examined teacher-student relationships confirmed the importance of teachers
having a supportive approach with learners in all situations.

According to the literature, during the process of evaluating unsatisfactory students, teachers' colleagues vary in their attitude and support. The process of evaluating these students may put a strain on teachers' relationships with some of their peers while others may prove to be a valuable resource.

Inherent in this overview of the related literature were the concepts of role, decision-making, and perception. Hence, the literature supported the relevancy of these concepts as the framework for this study. In brief, the role of clinical teachers includes the obligation to evaluate the quality of students' clinical performance. With borderline students, who exhibit a marginal level of performance, teachers wrestle with their decisions to award either passing or failing grades. This decision-making process reflects teachers' perceptions and influences their relationships with students and peers.

Conclusion

Based on review of the related literature, it was evident that a study exploring the meaning clinical teachers give to their experiences of evaluating borderline students was justified. The literature that was available on this topic was anecdotal in nature, focused primarily on failing students, and had not been presented from clinical teachers' viewpoints.
Although the literature described the challenging subjective decisions that clinical teachers encounter while evaluating borderline nursing students, how clinical teachers perceived this experience has not been studied. In addition, there was an absence of research that explored how the evaluation process with these learners influences teachers' relationships with students and peers. Thus, there was a lack of understanding of how teachers viewed their experiences with borderline students; experiences which encompass a challenging decision-making process and relationships with borderline students and colleagues. This lack of insight, combined with the fact that evaluating students' performance is a fundamental responsibility for clinical teachers, underscored the necessity of researching this phenomenon.

The application of the phenomenological research method used in this study is described in the following chapter.
CHAPTER THREE
Methodology

Introduction
This study used a phenomenological research method to investigate and describe clinical teachers' perceptions of evaluating borderline nursing students. In this chapter the selection and characteristics of the informants, ethical considerations, data collection, data analysis, and reliability and validity are considered.

Selection of the Informants
The selection of the informants was consistent with the phenomenological method. The sampling method, selection criteria, and selection procedures will be described.

Sampling Method
The informants were selected based on the criterion that they were willing and able to speak to the phenomenon. This method of sample selection is known as theoretical sampling (Omery, 1983; Sandelowski et al., 1989). The principles of random or representative sampling were not applicable to this study's qualitative research design (Field & Morse, 1985). Given that qualitative research is directed toward obtaining data that are "comprehensive, relevant, and detailed" (Morse, 1986, p. 183), the sample size was limited. The researcher selected informants until theoretical saturation was achieved. Morse explains theoretical saturation as the point in data collection when the information is complete, makes sense, and is confirmed
with the informants. Thus, an adequate sample size could not be predetermined. However, the researcher estimated that between six to eight informants would probably be needed to achieve theoretical saturation.

Criteria for Selection

In accordance with theoretical sampling, the clinical teachers who participated in this study were selected based on their willingness to share their experiences of evaluating borderline students. In addition, the clinical teachers were required to be registered nurses with at least a baccalaureate degree in nursing and employed in a diploma nursing program. The selection of informants who were interested and able to illuminate the phenomenon (Omery, 1983) minimized the possibility of having informants who were unwilling or unable to articulate their experiences. The rationale for stipulating diploma program-based clinical teachers related to the high number of accessible diploma nursing programs in the Vancouver area. To recruit enough willing informants and avoid agency-specific data, three nursing programs were used.

Selection Procedures

The director of each nursing program was sent an explanatory letter (Appendix B) for agency consent (Appendix C) and a brief overview of the proposed study (Appendix D). Once agency consent from the three directors was obtained, and approval from the University of British Columbia Screening Committee for Research Involving Human Subjects
was granted, an introductory letter was distributed to the clinical teachers (Appendix E). Enclosed with this introductory letter was a brief overview of the proposed study. Within two weeks of distributing these letters, the researcher presented the study to the entire nursing faculty in two agencies and to interested clinical teachers in the third agency. These presentations provided an opportunity for clinical teachers to meet the researcher, learn more about the study, and ask questions. Nine clinical teachers contacted the researcher and volunteered to participate. All nine teachers met the selection criteria, expressed a keen interest in the research topic, and disclosed that they would value the opportunity to share their perceptions of the phenomenon. In addition, the teachers asserted that their recent evaluations of borderline students would facilitate recalling these experiences. Later, one teacher withdrew from participating due to time commitments and illness. After the researcher had interviewed the first eight informants, another clinical teacher volunteered to participate. Given that sufficient data had been collected and theoretical saturation obtained, this person was not included in the sample.

**Characteristics of the Informants**

Eight female clinical teachers from three different diploma nursing programs participated in this study. The distribution per program was four, three, and one.

A baccalaureate degree in nursing was the highest level
of education for three informants. Five informants had masters degrees distributed as follows: two in nursing, two in education, and one in counselling psychology.

The informants' years of experience in nursing ranged from 11 to 31 with the average being 19 years. Primarily, the informants' nursing experiences prior to clinical teaching took place in medical-surgical and/or intensive care units. In addition, one informant had worked as a community health nurse, one informant had been a pediatric nurse, two informants had practiced as psychiatric nurses, and three informants had been nursing administrators.

Presently, all informants taught in medical-surgical clinical areas and their number of years as nurse educators were respectively: 1, 1, 2.5, 10, 10, 12, 17, and 18. Two of the veteran teachers had previously taught in a psychiatric setting.

Seven clinical teachers spoke to their experiences of evaluating borderline students at various levels of the program. The most recent clinical teaching responsibility for two of the informants involved evaluating students in a final preceptorship semester. One inexperienced informant had only taught in the middle stage of the program.

The following indicates how many borderline students each informant had evaluated: 3, 4, 7, 10, 20, 25, 42, and 100. As the informants' number of years of teaching increased, so did the number of borderline students evaluated. At the time of the interviews, four of the
informants were in the process of evaluating a borderline student.

**Ethical Considerations**

This researcher ensured protection of the rights of informants by:

1. Obtaining consent from the three agencies (Appendix C), and obtaining approval from and adhering to the standards set by the University of British Columbia Screening Committee for Research Involving Human Subjects.

2. Explaining to the informants in writing the study's purpose, the benefits of participating, and the expectations for informants (Appendix E).

3. Obtaining written consent from each informant prior to conducting the initial interview (Appendix G), and by obtaining verbal consent from each informant at the initiation of the second interview. The written and verbal consents addressed voluntary participation, the audio-taping of each interview, the informant's rights to withdraw from the study upon request, to refuse to answer any questions, and to ask that disclosed data not be included in the study.

4. Assuring the informants that their participation, their place of employment, the audio-tapes and the transcriptions of the interviews would be kept confidential and anonymous. Therefore, each informant was assigned a letter and the audio-tapes and transcripts were coded accordingly. The informants' consents and personal information were kept in a locked drawer. Further,
identifying data were deleted from the transcripts.

5. Assuring the informants that the only people who might listen to the audio-tapes were the researcher and possibly the thesis advisors. In addition, they were told that the audio-tapes would be erased and the transcripts would be destroyed upon completion of the study.

6. Requesting that the informants not disclose the names or any identifying information regarding the identities of the borderline nursing students who were involved in their experiences.

Data Collection

In order to collect data which were "comprehensive, relevant, and detailed" (Morse, 1986, p. 183), the researcher completed in-depth interviews with each informant. The interviews were audio-taped, unstructured, and lasted approximately one hour. The interviews were conducted in a quiet setting of the informant's choice. Four of the teachers chose to be interviewed in their offices and four requested their homes. Each informant was interviewed twice and the time between interviews varied from three to five weeks. Two interviews with each informant were sufficient to collect data which adequately described, clarified, and validated the phenomenon under consideration.

The initial interviews were guided by basic trigger questions (Appendix A). These questions were open-ended and related to the framework's concepts of role, perception, and
decision-making. The first question addressed the informant's overall experience. The second question focused on decision-making. Given that evaluative decisions are inherent in the obligations associated with the clinical teacher role and are influenced by the teacher's perception of the student's clinical performance, this question pertained to all three concepts. The final two questions explored relationships, a component of the concept of role. The trigger questions served as a guideline and were modified according to the data elicited from the informants. During each interview, additional questions were posed as they naturally emerged from the informant's responses. This unstructured format facilitated the formulation of significant questions which in turn promoted a range of meaningful answers from the informants (Schwartz & Jacobs, 1979). In addition, the first interview included basic questions concerning the informants' academic and nursing backgrounds. This information provided the data needed to describe the informants who participated in this study (Appendix F).

During the second interview, the questions posed were more structured and were directed toward expanding, clarifying, and validating informants' accounts. Expanding on and clarifying previously collected data minimized the discrepancy between what informants had said and what they had meant to disclose (Schwartz & Jacobs, 1979). The validation questions ensured that the researcher's
interpretation of the data faithfully portrayed the informants' perceptions.

Data Analysis

In phenomenological research data collection and data analysis occur concurrently (Morse, 1986). The audio-tapes were transcribed verbatim by the researcher and then, with direction from Giorgi's (1975a,b) approach to data analysis, the transcripts were analyzed. The steps used for data analysis were as follows:

1. The transcripts were read to grasp a sense of the whole.
2. The transcripts were thoroughly reexamined to identify the natural transitions in meaning, called meaning units.
3. The similar meaning units from all the interviews were compared, contrasted, combined, and categorized into themes which were clarified and elaborated on by relating them to each other and to the whole.
4. The themes were reflected on and grouped into abstract concepts.
5. These insights were synthesized and integrated into a written description of the phenomenon.

Reliability and Validity

In this qualitative study, the rules for achieving reliability and validity in quantitative research did not apply. (Sandelowski, 1986; Yonge & Stewin, 1988). This study followed the criteria of rigor in qualitative research
which include credibility, fittingness, auditability, and confirmability (Guba & Lincoln, 1981).

According to Sandelowski (1986), a qualitative study is credible when the findings faithfully portray the informants' experiences. To ensure credible findings, the researcher searched for the meaning of this experience from the informants' cognitive, subjective perspectives without any preconceptions about what this meaning might be (Omery, 1983). Therefore, in order to describe the phenomenon from the informants' perspectives, the researcher's beliefs and assumptions about what the experience may mean were bracketed (Knaack, 1984; Swanson-Kauffman & Schonwald, 1988). The researcher's exposure to the related literature assisted in consolidating and bracketing her experiences and beliefs (Munhall, 1982; Swanson-Kauffman & Schonwald). The process of validating the emerging themes and concepts during the second interviews and the use of transcript excerpts in data presentation enhanced the credibility of the study's findings.

Guba and Lincoln (1981) propose that fittingness be the criterion used to evaluate the applicability of qualitative research findings. Fittingness was established by selecting the informants from several nursing programs. The use of more than one agency minimized obtaining data particular to one nursing program which would have limited applicability. In addition, fittingness was ensured by including both typical and atypical data in the findings.
Auditability is the criterion of consistency or reliability in qualitative research (Guba & Lincoln, 1981). The findings are auditable when the reader can clearly follow the researcher's decision trail (Sandelowski, 1986). An explicit decision trail supports the method of data analysis and, therefore, the validity of the findings (Field & Morse, 1985). Throughout the research process, the researcher's decision trail was confirmed with her thesis committee.

The criterion of confirmability is the freedom from bias in the research process (Guba & Lincoln, 1981). Confirmability was ensured by the establishment of credibility, fittingness, and auditability (Yonge & Stewin, 1988).

**Summary**

This chapter outlined the research design used in this study. The selection of informants, procedures of data collection and analysis, ethical considerations, and reliability and validity were described.

The use of a phenomenological design enabled the researcher to search for the meaning that eight clinical teachers assigned to their experiences of evaluating borderline nursing students. The data were collected through the use of unstructured interviews which were guided by three trigger questions, reflecting the concepts of role, perception, and decision-making.

With direction from Giorgi's (1975 a,b) method of data
analysis, the informants' accounts were analyzed. The following chapter presents a detailed discussion of the concepts and themes which emerged from the data. This presentation includes a comparison to the literature and concludes with a summary of the phenomenon's central characteristics.
CHAPTER FOUR
Presentation and Discussion of Accounts

Introduction

From the analysis of the data emerged an intricate network of interrelated themes. These themes were reflected on and then grouped into three overlapping concepts. The concepts are ambiguity, student's self-awareness, and laborious decisions. These concepts and their inherent themes are depicted in Figure 1.

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Figure 1. Clinical Teachers' Experiences--Concepts and Themes.
This chapter is an in-depth presentation and discussion of the concepts, themes, and their interrelationships. Given that ambiguity was a recurring concept, its linkage to other relevant themes is considered. Included in this presentation are references to the relevant literature and transcript excerpts in which the letter "I" refers to the informant and the letter "R" to the researcher. This chapter concludes with a summary of the informants' accounts.

**Ambiguity**

The predominant concept that emerged from the data was ambiguity. According to Webster's Dictionary, "ambiguous" means not clear, uncertain, vague, or open to interpretation (Guralnik, 1980). The informants used, or implied, these terms in reference to borderline performance, the clinical evaluation process, and their dual responsibility to students and to patients. According to the informants, this ambiguity contributed to their dilemma of evaluating borderline students.

**Ambiguous Nature of Borderline Performance**

The ambiguous nature of borderline performance surfaced from the data as a common theme. This ambiguity related to the informants' difficulty in isolating borderline students' performance problems and to their inconsistent pattern of clinical behavior. It became particularly evident when the informants compared borderline students to failing students.

*Enigmatic performance problems.* One similarity
apparent among the informants' perceptions was their difficulty pinpointing the problems underlying students' borderline performance. Because students' performance problems were unclear, identifying them was difficult. One informant described these problems as "vague" whereas, another informant stated, "The borderline student is the person who can go either way; you can see some really good strengths and some other things that are a bit of an enigma." The following three transcript excerpts further support that borderline students had enigmatic performance problems.

I: I think the borderline student, to me, is the one ... I spend a lot of time identifying what is going wrong ... the "whys," why did it happen this way ... trying to figure out what it is that has gone wrong ... why can't this student pull it together? ... they are just not clear cut ... they are hard, because it is so hard to figure out what the problem is.

I: ... it's hard to pinpoint exactly what it is they're doing wrong and what they need to do to fix it. It's not always clear.

I: ... usually when somebody is a borderline student there's a whole lot of things ... a whole constellation of incompetencies ... it's usually never
really really clear, it's a collection of things ... it's all this kind of subtle stuff and it's isolated incidents and you have to connect them and it's a lot of work.

Inherent in these quotations were the perceptions that problem identification was hard work, time-consuming, and involved connecting many "things" which were unclear or subtle. Further, the rationale for the performance problem often remained shrouded in uncertainty--"Why can't this student pull it together"? In addition, various informants described how borderline students exhibit "patterns of behavior" and the reasons underlying their performance problems were so diverse and individualized that isolating the contributing factors was "never easy."

The idea that students' clinical behaviors may result from a "collection of things" was expressed by the informants when they listed the possible determinants of borderline performance. This list included concerns regarding their level of motivation, attitude, knowledge base, application of theory to practice, organization skills, communication skills, and psychomotor skills. An additional reason, mentioned by many informants, was the problem of "personal baggage," "more appendages," or "more commitments." For instance, one informant said ...

I: I also find that students come with a whole lot of
baggage, tons and tons of baggage that has nothing to do with school ... but it sure does impact it.

This informant went on to say that the number of students carrying personal "baggage" had increased and cited the following reason for this ...

I: ... part of it could be that we get older students now. We don't have so many young students ... which means they have experienced life to a greater degree.  
R: They have more time to gather baggage?  
I: Right, more time to gather baggage. They have more appendages to their lives like children, husbands and boyfriends ...

Likewise, another informant asserted ...

I: ... another problem ... we are running into with borderline students is that, since we have so many mature students, they may have a lot of other commitments in their life ... so they are not able to put so much as they really should into their studies / then we see the consequence of it ... you don't see as good of a performance as you should.

The interrelationships between students with "personal baggage," performance problems, and a more mature and
diverse student population were identified by many informants. One teacher asserted that "the caliber of students" had decreased because of this diversity. Similarly, the increased number of students with personal problems caused by a diversified student population was addressed in the nursing literature (Reed & Hudepohl, 1988; Rosenfeld, 1988; Welborn & Thompson, 1982). Further, the informants stated that they were often unaware that students had personal problems, yet they saw the consequences of them.

According to informants, the factors which contributed to the development of borderline performance were unclear or "a bit of an enigma." Although the rationale for borderline performance was unclear, the informants agreed that these students exhibited an inconsistent pattern of clinical behavior.

**Inconsistent behavior.** The informants described the inconsistency of borderline performance using antipodal terms like: "up and down" and "strong and weak." In the following three narratives, the informants referred to the vagueness, uncertainty, and unpredictability of this inconsistent behavior.

I: ... their performance is vague ... sometimes passing, sometimes failing ...

I: ... one week fine, one week not fine, and up and
down. I guess never knowing, not being able to predict that the student will do something right the next week ... even though the student did it this week alright.

I: ... they are up and down; they are okay at times and not okay at other times. You are never really sure where they are at. It makes it really hard.

According to the informants, borderline students' inconsistent patterns of performance distinguished these learners from those that were failing.

**Borderline versus failing students.** When asked about the difference between borderline and failing students, most informants explained that failing students consistently exhibit unsatisfactory behaviors resulting in a clear-cut performance and a simplified clinical evaluation process. The narratives below illustrate this viewpoint.

R: How would you distinguish between borderline and failing students?
I: Failing students don't meet any of the objectives, they are clearly not at the satisfactory level. They are much easier to evaluate ... straightforward ...

I: if someone is unsafe, I don't think it is that difficult of a decision.
R: How come it's not as difficult of a decision if the
student is unsafe?

I: Well, it is definitely more clear ... it is more clear that they are not meeting the objectives ...  

I: I guess the distinguishing thing is that a student who's failing ... it's much more clear-cut and perhaps less energy goes into that student ...  

In contrast to failing students, borderline students' inconsistent performance resulted in a complex evaluation process. Given that the term borderline contains the words border and line, it was not surprising that some informants described these students as "on the border" or "walking a thin line." Moreover, descriptions like "on the brink," "on the edge," and "on the fence" were used. One teacher used an analogy to distinguish between failing and borderline students. This analogy and the other descriptions inferred that borderline students could potentially "fall" to the failing side.  

I: ... the borderline student as opposed to the failing student is the student who has his/her foot on the banana peel, the failing one is falling down.  

Owing to the fact that borderline students were viewed as stepping "on a banana peel" or "walking a thin line," the outcome of their performance was perceived as not clear or
certain. Most informants outlined how these students may "pass or fail;" "scrape through or not scrape through."

The essence of borderline performance. Based on enigmatic performance problems and the inconsistent behaviors of borderline students, the essence of their performance was conceptualized as ambiguous. This conceptualization was validated during the second interviews. Although for a few informants ambiguous was a new way of depicting borderline performance, they all agreed that the term was appropriate and most stated that "ambiguous" was a good word.

In the literature, the ambiguous nature of borderline performance was not captured in the two articles specific to borderline students (Brozenec et al., 1987; Wood, 1971). However, Brozenec et al. referred to the unclear nature of borderline performance by stating, "More problematic is the borderline student who does not clearly fall into a pass or fail pattern" (p. 42). Further, like the informants, these authors described borderline performance as inconsistent and they addressed the difficulty of isolating the reason for the unsatisfactory clinical behavior.

Summary. According to the informants, inconsistent, uncertain, unpredictable, enigmatic, and "on the border" behavior characterized the ambiguous nature of borderline performance. This ambiguous performance contributed to the difficulty of evaluating these students.
Ambiguous Nature of Clinical Evaluation

Wong and Wong (1987) described clinical evaluation as "highly ambiguous" (p. 508). The ambiguous nature of clinical evaluation was a common theme expressed or inferred by the informants during their first interviews. One informant used the adjective "ambiguous" while others frequently commented on how aspects of clinical evaluation were unclear, vague, uncertain, and open to interpretation. The ambiguous aspects of clinical evaluation identified by the teachers were its subjective nature, the definition of consistent, and learning versus evaluation time. The ambiguity of clinical evaluation assumed greater importance in the face of borderline performance rather than with passing or failing performance.

Subjectivity. The informants shared the view that the subjective element of clinical evaluation contributed to its ambiguous nature. The transcript excerpts below typified how informants referred to this subjectivity.

I: Individualistic evaluations based on individual perceptions.

I: ... as objective as we try to make it, it is still subjective.

I: ... there is no set policy on how many errors / up
to your own individual decision-making.

In these quotes, the informants asserted that the interpretation of evaluative data was based on subjective perceptions. The third transcript excerpt outlined how an evaluation policy was left open to one's interpretation. Most informants described evaluation policies, criteria, and parameters as either vague, unclear, or implicit. According to the informants, this vagueness intensified the subjectivity and, thereby, the ambiguous nature of clinical evaluation. The following sections expand on the ambiguity inherent in clinical evaluation.

**Defining consistent.** The informants reported that they were expected to evaluate whether or not borderline students had consistently met the objectives. The consensus amongst the informants was that the term "consistently" was open to interpretation.

I: ... it is based on whether or not they have consistently met the objectives. Consistent is the really core word that we certainly need to look at / because meeting the objectives can be very ambiguous and so subjective.

I... consistency is not defined ... the criteria for this term is not explicit in any way.
I: In our program in order for someone to meet the objectives they are supposed to consistently meet the objective / so even though someone is meeting the objectives some of the time they are on today and off tomorrow and on the next day and off the next day and they are not being consistent ... and consistent is open to interpretation ... everyone has a bad day even your best student may have a bad day ... So is consistent 90% of the time, 80% of the time, is it 70% of the time?

----------------------------------------

One informant discussed the definition of "consistent" in relation to a policy regarding clinical failure. Again, the term consistent was open to interpretation.

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I: We have a policy ... it talks about students who consistently display unsafe behaviors in the clinical setting may be asked to leave ... the word consistently is not defined anywhere / and if you have a room full of instructors and asked them what does consistently tell you ... once, twice, seven times you get different answers ... so what is the definition of consistency no one has defined it for me ...

----------------------------------------

Thus, the informants shared the view that "consistent," a term used extensively in clinical evaluation, was left open to their subjective interpretations. This lack of clarity
Teaching time versus evaluating time. Another ambiguous aspect of clinical evaluation articulated by a few informants and documented extensively in the literature concerned the unclear distinction between teaching time and evaluating time (Brozenec et al., 1987; Carpenito & Duespohl, 1985; Infante, 1985; MacKay, 1974; Morgan, Luke, & Herbert, 1979; Rines, 1963; Van Hoozer et al., 1987; Wood, 1982; Wood & Wladyka, 1980).

I: There is also that terrible dilemma ... deciding how long is teaching and how long is evaluation and unfortunately we tend to think to be ready to defend our decision ... how do you do that if you're not documenting and in fact evaluating right from day one.

According to Van Hoozer et al., "Failure to recognize the dichotomy between formative (ongoing evaluative feedback) and summative (final) evaluation often causes the greatest difficulty for clinical instructors ... (they) must develop strategies that clearly differentiate the promotion of learning from the assessment of terminal behavior" (p. 1982). In the previous transcript, the informant implied that the division between teaching and evaluating was ambiguous. Moreover, she referred to supporting evaluative decisions with evidence. The need of clinical teachers to gather evaluative data to both support their decisions and
show evidence of academic due process may further blur the dichotomy between formative and summative evaluations. This lack of a clear dichotomy was a component of clinical evaluation perceived as ambiguous.

**Validation: Ambiguous process.** During the second interviews the informants were asked if they viewed clinical evaluation as ambiguous. They concurred with this description and elaborated on things such as its "subjectivity," its "fuzzy nature," "vague objectives," "the lack of firm objective criteria," and how things are not "cut and dried." One informant responded that the process was "very ambiguous" and asserted that because terms, like consistent, were so "loose" ...

I: ... anyone can make a case for passing or failing depending on the data they want ... the process is so unclear ... the process of evaluating is not clear and the criteria is not clear ...

In the above narrative, the repeated use of the word unclear further supported the ambiguous nature of clinical evaluation. During this validation process one of the inexperienced informants commented on how viewing the evaluation process as ambiguous was insightful ...

I: it is kind of reassuring to feel that maybe something with the process is ambiguous ... I had never
really looked at the process.

This section was introduced with a reference which described clinical evaluation as "highly ambiguous" (Wong & Wong, 1987, p. 508). In addition, other authors implied this ambiguity in reference to clinical evaluation's unclear and subjective nature (Brozenec et al., 1987; Meisenhelder, 1982; Welborn & Thompson, 1982)

Ambiguity: Performance and process. During the second interview, the informants were asked about the ambiguities of borderline performance and the evaluation process. The informants agreed that borderline performance amplified the ambiguity inherent in clinical evaluation. One informant reported, "It is very difficult and very unclear and it puts the instructor in a real dilemma of not knowing what to do." The following transcript excerpt typified the process of ascertaining the relationship between these two themes.

R: ... so the fact that you have a process that is ambiguous ...
I: Yeah.
R: ... and then you have the student whose performance is ambiguous ... do think these two things together make evaluating borderline students difficult?
I: Definitely, very definitely ... yes that is right ...
... I hadn't thought of it like this / very interesting.
R: Whereas, if you have the ambiguous process with a failing student or a student who excels it is easier? I: Absolutely ... yes ... because in either those case the student is clear-cut. One way or the other their performance says yes they are passing or no they are not.

This quotation illustrated how evaluating an ambiguous performance within an ambiguous process was perceived to be at the root of the difficulty in evaluating borderline students. The narrative addressed how the ambiguity of clinical evaluation came to the fore when working with borderline students. In addition to this informant, other teachers shared the sentiment that conceptualizing their dilemmas in this way was interesting or insightful.

**Summary.** Because of the subjectivity, implicit criteria, and the unclear distinction between teaching and evaluating, the informants viewed clinical evaluation as ambiguous. The ambiguity of clinical evaluation was augmented for the informants when working with students who were not clearly passing or failing.

**Ambiguity: Dual Responsibility**

A thematic category which surfaced from the data pertained to the ambiguity of the informants' responsibilities as nurse educators to students and to patients. Two aspects were viewed as ambiguous. First, borderline students challenged the informants' simultaneous
responsibilities to enhance students' learning and to ensure patients' rights to competent care. Second, the informants indicated that their responsibility changed focus from being student-oriented in the earlier semesters to patient-centred in the later semesters. According to the informants, when this change in focus occurred was not clearly defined and, therefore, ambiguous.

**Dual responsibility: The fine line.** Consistent with the literature, the informants referred to a dual responsibility (Brown, 1991; Joos et al., 1985; Langemo, 1988; LeVeille Gaul, 1988; O'Shea, 1982; Redman, 1965; Sleightholm, 1985). Generally, the first area of responsibility encompassed students and the second area concerned patients. The two narratives below illustrate this viewpoint.

---

**I:** On one hand you have the student's future and on the other hand you have to uphold professional standards of nursing practice ... and the responsibility to protect the public from people who are unsafe.

---

**I:** ... I have a professional responsibility as a nurse to ensure patient safety and I have an instructor's responsibility to enhance learning.

---

When faced with unclear, inconsistent performance, clinical teachers were responsible for enhancing students'
learning while simultaneously protecting patients from the increased risk of incompetent care. Many of the informants described their responsibility to "remove or withdraw unsafe students" from the clinical setting. However, the decision whether or not to remove a student who was borderline and not assuredly unsafe, was not as clear or straightforward. In the next narrative, the informant described how the "fine line" between supporting the student and protecting the patient was "anxiety producing."

I: I walk that fine line between supporting the student and wanting to keep them in clinical and looking at the risk factors of keeping them there. Have I put a patient at risk by keeping them there? Is the potential for risk too great to keep the student there? That creates a lot of anxiety, because that is really making a high level judgement on somebody else's behavior.

Other informants described this "fine line" as evoking feelings of ambivalence or uncertainty. Thus, borderline students' with their ambiguous performance precipitated negative feelings related to the informants' concurrent responsibilities to students and to patients.

I: I often tell a student your performance at this point in time is unsafe. I have a professional
obligation to remove you so that you don't jeopardize patient safety ... when the student's behavior is clearly unsafe ... the problem is that the borderline student ... you can see that there's a potential for safety errors ... a calculated risk factor ... do I leave the student in or do I bring the student out based on my responsibilities?

This quote illustrated how a clinical teacher's decision whether or not to withdraw a borderline student was uncertain. To "leave in" versus "bring out" was a quandary.

Change in responsibility focus. It became apparent during data analysis that the informants' view of their responsibilities varied depending on the student's level in the program. Seemingly, the focus of responsibility changed from students in the earlier semesters to patients and the profession in the later semesters. Each informant validated this change in responsibility focus and some informants asserted that clinical evaluation of a borderline student would be influenced by "the semester they are at." Although the teachers agreed that the focus changed, they emphasized that they always have a responsibility to "it all."

Concerning the earlier stage of the program, the informants explained that clinical teachers could "afford the luxury" of hoping students improve," "giving the student another kick at the can," and of "knowing that the student will be supervised by subsequent teachers." Another aspect
of evaluating learners in the early semesters pertained to the socialization process. The following two quotes exemplified this viewpoint. The first transcript excerpt implied the notion of student-centred responsibility and the second insinuated the need to give the student the benefit of the doubt.

I: ... in the earlier semesters they (teachers) are really trying hard to socialize the student to nursing and they need to be loving, caring, and nurturing of the students.

I: ... at the beginning you think well maybe it's the socialization process ... it's a socialization issue ... give the student another term and see what happens, maybe it's culture shock or you know the student just hasn't quite caught on ... you don't know ...

In contrast, the informants' sense of responsibility in the later semesters was oriented more toward patients and the profession. One teacher stated, "In the later terms you feel more of a professional, moral, or an ethical obligation to do something." Similarly, another informant asserted ...

I: If someone who is going to pass and graduate ... to me the responsibility to the public and to the profession is much heavier because there isn't another
The degree of perceived clarity or ambiguity related to the responsibility shift between the early and late semesters was a question the researcher posed. Basically, they perceived this change in responsibility focus to be either ambiguous in itself but clear to them, or ambiguous in both ways. The informants who viewed it as clear elucidated how they had taught at "both ends of the program."

In addition, two of the responses included an explanation about the need for teachers, at different levels of the program, to communicate their concerns and to discuss their different emphasis of responsibility. The informants discussed how this communication would enhance understanding amongst clinical teachers—"issues might be less contentious if you knew the underlying dynamics."

Further, one person spoke of an additional factor which may affect the direction of clinical teachers' focus of responsibility; a "knee-jerk reaction" or a "chain reaction."

I: ... if a lot of students exit in one semester, the semester before does a careful examination of what they are doing ... this starts a chain reaction down the line ... the previous semesters exits more ... maybe you become tighter with borderline students because
they are failing in the next semester ... knee-jerk reaction ... bumping down the semesters ... where you feel responsible not only to the institution but to your colleagues as well.

Unlike the other informants, this teacher affirmed a responsibility to her colleagues. This responsibility entailed the hesitancy to pass borderline students on to peers who had recently experienced clinical failures.

Finally, responses from two inexperienced informants included a discussion of "passing students on." One teacher felt angry toward earlier colleagues for allowing borderline students to pass. This person articulated how this change in responsibility focus may explain why some borderline students progressed—"because of this responsibility to the student there is always that hope." In comparison, the other informant outlined how, before she had taught at the lower levels, she used to feel "angry" for this same reason. But with first hand experience, she had a new appreciation of "where they are coming from." Although, the other informants did not address "passing borderline students on" in this context, they did discuss these learners "getting so far," and how some colleagues "never fail." The notion of "passing students on" will be addressed further in the section focused on the emotional challenge inherent in the experience of evaluating borderline students.
A review of the literature did not reveal any references which explicitly detailed how a change in responsibility focus occurred between the early and late stages of a nursing program. However, with respect to failing a nursing student, Mantle (1982) stated that first year faculty often say they have too little data while the final year faculty assert that steps should have been taken earlier. Mantle did not offer a solution, but posed the question—"How do you resolve this dilemma" (p. 61)? O'Shea (1982) researched role conflict and role ambiguity by looking at whether nurse educators' role orientation was to students or patients. Although the findings left no clear impression, they indicated that teachers tended to be slightly more student-oriented than patient-oriented. Because this study failed to differentiate between beginning term teachers and advanced term teachers, this variant was not considered as an influence in the discussion of role orientation.

Summary. Evaluating students whose performance was borderline challenged the informants' dual responsibility to students and to patients. The responsibility for teaching the student while ensuring competent care created an ambiguous situation and precipitated negative feelings. The informants' focus of responsibility changed from being student-centred in the earlier semesters to patient and profession-oriented in the later semesters. The timing of this shift in responsibility focus was viewed by the
informants to be open to interpretation.

Student's Self-Awareness

It became evident during data analysis that a recurrent theme was borderline students' limited awareness of their clinical competency. This theme emerged in relation to the student's degree of insight or self-awareness, the teacher-student relationship, the informants' discomfort about clinical failure, and the informants' fear of an appeal. Because enhanced insight would be conducive to a positive teacher-student relationship and it would facilitate the student's acceptance of his/her clinical status, the informants were concerned with fostering the development of this self-awareness. A possible and optimal outcome would be the avoidance of an appeal.

The Degree of Insight

The informants contended that borderline students tended to lack insight or awareness of their own strengths and weaknesses. They described how these learners—"have no self-awareness," "no insight," "see themselves better than they are," "are poor self-evaluators," and "don't hear what you are saying." Limited insight was perceived as a contributing factor to the difficulty of working with these students. The informants asserted that borderline students who lacked self-awareness "were the hardest ones to work with," "complicated the issue," or were the "the biggest challenge." Similarly, the literature described the challenge of working with unsatisfactory students who tend
to overestimate their clinical abilities (Meisenhelder, 1982; Woolf, 1984).

The informants viewed insight as fundamental to borderline students' clinical progress. The following two narratives illustrate this viewpoint.

I: ... a very major part of the whole problem is that they are not able to self-evaluate, they have limited or no insight and that is why they aren't able to improve to meet the objectives ...

I: ... insight is a key factor to students ... and usually the crux to whether they pass or fail.

In addition to being perceived as a detriment to the learner's success, a lack of self-awareness negatively influenced the teacher-student relationship.

Teacher-Student Relationship

According to the informants, the student's degree of self-awareness affected the interactive nature of the clinical evaluation process. Generally, the greater the degree of self-awareness, the more positive the teacher-student relationship. One informant expressed this idea as follows.

I: ... how much the student is going to allow us to get into that teaching-learning type of relationship ...
allow themselves to be open enough to hear the feedback, do something with it, set some objectives, and change their behavior.

If the student lacked self-awareness, the informants described an inability to develop a relationship based on mutual trust. They spoke of not trusting the student to seek appropriate assistance when giving patient care--"I wouldn't trust these people to do things on their own." Thus, decreased self-awareness seemed to correlate with decreased trust.

Further, the informants found that students who lacked insight into their capabilities responded to negative feedback in a defensive manner. This defensive behavior encompassed "denial," "anger," and "hostility" which were typically characterized by blaming their clinical teachers or some external force for their performance problems.

I: I think that all borderline students go through some sort of denial where they push me away, deny that there's a problem ... they are going to blame to some degree ... blame somebody ... self-preservation .... because to accept it all themselves is pretty hard.

This quote linked students' defensive response to "self-preservation" while other informants related it to students'
self-esteem, self-image, or self-integrity.

I: I really think that their self-esteem is low and so they have these defenses to protect their low self-esteem. They try to convince themselves that they are doing well ... the instructor just doesn't like them and really their performance is okay ... they are protecting their self-esteem.

I: I think it really depends on their own self-esteem and their image of themselves and their self-integrity.

The literature supported the informants' perceptions that clinical failure would threaten a student's self-esteem and result in defensive behavior (Brozenec et al., 1987; Carpenito, 1983; Hill, 1965; Meisenhelder, 1982).

The suggestion that an external locus of control contributed to students' defensive behavior was made by one informant.

I: ... because they have an external locus of control they don't see themselves as being fully responsible for their performance and they blame the situation for being too difficult and they blame ...

This informant's referral to an external locus of control and assertion that students blame others for their
unsatisfactory performance may fit with Rotter's (1954) social learning theory. This theory described individuals in terms of their tendencies to ascribe success or failure to external or internal causes.

Students' defensive behavior in turn engendered an emotive response from the informants. They spoke of feeling "frustrated," "disappointed," "powerless," "helpless," and "angry." Moreover, one informant disclosed how she "wouldn't feel as positive about them either." The following transcript excerpt illustrated some of the informants' emotions generated by borderline students' limited insight.

I: ... there would be frustration with students not recognizing their weaknesses ... the three of them that I had did not recognize that there was anything wrong ... they had problems ... very frustrating.

I: You feel frustrated and it comes from a sense of powerlessness ... because I thought sometimes if I could videotape them in action ... maybe that would help them to see how they were coming across ... you try different things so they gain insight and if they don't you feel helpless and disappointed.

Like the informants, Meisenhelder (1982) described how the dynamics of the clinical evaluation process can be
disrupted by students' defensive behavior. This author outlined the emotional chain reaction implied by the informants--students reacting defensively and clinical teachers responding to this behavior with emotional distancing, frustration, and anger.

According to the informants, students who had or developed insight responded in a manner which was motivating and accepting. In these cases, the teacher-student relationships were viewed as more positive and the informants felt "better" about their experiences.

I: ... makes a difference when the student has insight makes me feel like I have done a better job of helping them work through it.

The Student's Decision

The informants emphasized the importance of having students develop an "honest, realistic" view of their performance to the point that they would withdraw if clinical failures were inevitable. The student's self-withdrawal would reduce the clinical teacher's discomfort of issuing a failing grade and it would eliminate the possibility of an appeal. Students who voluntarily quit a clinical course waive their rights to claim unfair treatment. The following quote illustrates this idea of insightful students making the decision. Further, it
outlines how fostering insight was perceived as hard work.

I: ... it is much better if you can give students enough feedback so that they can make the decision that yes I am meeting the objectives or no I am not really ready to go on. That is the best scenario ... most times with borderline students, I have been able to provide them with enough information so that they don't leave feeling angry like someone did this to them ... they come around to the view that I've done this ... that takes a lot of work an awful lot of work.

This quote explained how students leaving on their own accord was viewed as a better scenario than "students leaving angry." The informants found that students who left in a state of denial or anger were more likely to appeal their final grades.

I: ... if the students are in denial they're the ones that are most likely to appeal ... they think you're wrong.

Concerning the appeal process the informants spoke of its "emotional," "stressful," "difficult," and "time-consuming" nature. The literature's description of the appeal process was consistent with the informants' outlooks. (Carpenito, 1983; Huston, 1986; Majorowicz, 1986; Robinson &
Bridgewater, 1979). The informants viewed the enhancement of a student's self-awareness as a means to eliminate the threat of a "stressful" appeal.

**Fostering Self-Awareness**

Often the informants described the frustration and time involved in enhancing the development of students' awareness of their clinical abilities. To foster this awareness, many informants elaborated on how they examined the student's feelings, gave verbal feedback, wrote anecdotal notes, and set learning contracts. These mechanisms were employed to promote insight and to ensure that the student was aware of his/her clinical status and afforded the opportunity to improve. The informants' perceptions of how they attempted to enhance self-awareness were outlined in the quotations below.

I: ... examine how they feel in the setting ... do you feel scared, fearful ... getting students to recognize that those feelings are precipitated by their lack of ability, confidence, and lack of knowledge ...

I: ... feedback ... you say I'm really concerned about this and use the word fail .... we used to use the expression you're not meeting the objectives and I don't think students hear that, that means you will fail or might fail ... be clear with the student.
I: ... sometimes you get frustrated because you've documented to the ying yang and this person doesn't develop awareness ... anecdotal note writing, contract writing, student self-evaluations, the evaluation of the contract. Like all the documenting and documenting requires a lot of time.

Summary

The concept of student's self-awareness was viewed as a significant factor in the quality of the informants' relationship with the borderline student. Lack of insight strained the teacher-student relationship, evoking emotional responses from the informants and defensiveness from the student. Regardless of the time and effort involved, fostering the development of insight was perceived as essential to the student's acceptance of their clinical standing. Additionally, it was viewed as reducing the risk of an appeal if the student was to fail.

Laborious Decisions

The informants' experiences with borderline students encompassed making evaluative decisions which were predominantly described as difficult. These difficult decisions required "personal investment" of time, "effort," "energy," and "hard work." To capture the notion of both difficult and hard work while remaining true to the informants' perceptions, this component of their experience was conceptualized as laborious decisions. The sentiment
that working with unsatisfactory students was hard work requiring a commitment of time and personal energy was also documented in the literature (Lenhart, 1980; Majorowicz, 1986; Symanski, 1991; Wood & Wladyka, 1980).

The concept of laborious decisions had five inherent themes. Two themes pertained to the emotive dimension of making evaluative decisions. The informants found that evaluating borderline students generated numerous feelings, including a sense of uncertainty, and was emotionally challenging. The remaining three themes related to the informants' decision-making strategies. These strategies included a sense of the student's whole performance, intuition, and a sense of whether or not the student could be trusted as a future co-worker and/or care-giver.

A Sense of Uncertainty: Self-Doubt

The informants disclosed that making evaluative decisions about borderline students was riddled with uncertainty and self-doubt. Recurrently, they spoke of "waffling," "worry," "anxiety," "stress," questioning themselves, and of questioning their "perceptions." Uncertainty and self-doubt were so common to this experience that they were often the first feelings verbalized in response to the initial interview question.

R: What was it like for you to evaluate borderline students?
I: very stressful, questioning, I question my judgement
quite a lot as to whether I was seeing the student the right way.

R: Based on your experiences, what was it like for you to evaluate borderline nursing students?
I: There's a lot of doubt / a lot of self-doubt about what I was doing because students of course catastrophizes the whole thing ... the end of their lives ... students actually say that and although intellectually I know that is ridiculous I feel some doubt about it ... am I really sure, am I really confident about what I am doing? So there's doubt in that sense.

The last quote illustrated feelings of self-doubt and anxious uncertainty. The repercussions that a failing grade would have on the student formed the basis of this informant's emotions. Similarly, the literature addressed clinical teachers' uncertainty associated with evaluating borderline students (Brozenec et al., 1987; Welborn & Thompson, 1982) and the consequences of assigning a failing clinical grade (Brozenec et al.; LeVeille Gaul, 1988; Meisenhelder, 1982; Symanski, 1991; Welborn & Thompson). Feelings associated with giving a failing grade will be addressed in the following section.

Welborn and Thompson (1982) asserted that unsatisfactory students exacerbated the existing uncertainty
and self-doubt that new clinical teachers experience with their evaluator role. Likewise, two of the novice informants expressed that some of their uncertainty stemmed from their lack of experience—"I don't think I have enough experience to really feel comfortable with my judgements." However, because evaluating borderline students was viewed as an ambiguous situation, a sense of uncertainty was experienced by both the new and veteran teachers.

Ambiguity and a sense of uncertainty. Throughout the presentation on ambiguity, the informants' feelings of uncertainty and self-doubt were discussed or implied. The pairing of an ambiguous performance with an ambiguous evaluation process created the sense of uncertainty and self-doubt experienced by the informants.

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I: With this student who's doing well you never question yourself / you don't question yourself as much as you do when you have a student who's on the edge.

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I: When things are vague / it is very unsettling and I feel really indecisive about it / what my ultimate decision might be about that student.

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Because ambiguity was inherent in the informants' experiences, making evaluative decisions was haunted with uncertainty and doubt. A "stressful" and "difficult" process of evaluating borderline students resulted from the
informants' feelings of uncertainty. The following section describes how these feelings were overcome in order to decide the final clinical grade.

Coping with uncertainty. To cope with their uncertainty and self-doubt, arrest their vacillation, and reduce their stress, the informants articulated how they would informally seek their colleagues' "input," "advice," "reassurance," and "support." They spoke of: "checking with instructors," "drawing on their peers' experiences," "talking things out," and "hashing out their decisions." Similar to the informants, the literature outlined how clinical teachers' doubts concerning their evaluative decisions may be dissipated by seeking peer support (Brozenec et al., 1987; Meisenhelder, 1982; Symanski, 1991; Welborn & Thompson, 1982). Goldenberg and Waddell's (1990) study of faculty stress substantiated peer support as the most significant coping strategy used to deal with the stress of evaluating problem students. However, other research on the same or related topics did not explore the stressful uncertainty of evaluating unsatisfactory students (Pain, 1987; Fong, 1990; Langemo, 1988; O'Shea, 1982; Sleightholm, 1985).

In contrast to the literature, the general consensus amongst the informants was that their peers were a valuable source of support (Carpenito, 1983; Majorowicz, 1986; Symanski, 1991). According to the informants, they received assistance because they "knew who to speak to," "were
selective in who they asked," and relied on those they "respected." The informants avoided faculty members whose views of clinical failure, heavy workloads, or interests, would not be helpful. "Knowing who to ask" paralleled Symanski's assertion that "teachers should seek support from like-minded colleagues" (p. 21).

In addition to "checking with instructors" on an informal basis, each informant mentioned seeking support in team meetings. For some informants the decision to pass or fail the student was their independent responsibility while for others the decision was formally approved by a team or a committee. Team meetings were outlined as a formal means to validate their concerns, discuss their perceptions, and solicit input on teaching strategies. However, one informant implied that the team's subjective input was inconsistent. This inconsistency could compound the ambiguity inherent in clinical evaluation.

I: I've decided that this is not uncommon to have a lot of difficulty making the decision and although I had found the semester team supportive, they were not consistent in their opinions ...

During the discussions concerning "checking with instructors," many informants identified teaching in the clinical setting as a contextual barrier to peer support. Working in a health care agency, a reality of the clinical
teaching role, was viewed by the informants as an influential factor in their experiences. They spoke of "isolation," "loneliness," and the "hunger to share experiences." Further, the informants referred to the frequently cited idea that nurse educators are "guests" or "visitors" in the clinical agency (Brown, 1991; Christy, 1980; Johnson, 1980; Sleightholm, 1985; Smith, 1988).

I: I believe very much in the importance of conversation with colleagues and teaching clinical is a very lonely job ... you are representing another agency while you're working in another one ... you can be in the clinical setting all day and not see anyone you can really bounce heads with / teaching issues / so there is this hunger; I believe that teachers have to share experiences.

I: I do feel isolated and I have always felt very isolated in the clinical setting who you work for is not who the RNs on the floor work for ... isolated and if I have a borderline student ... it is my judgement that they are borderline so I feel on my own ... I have called people when I got home because I have been so upset it can be so stressful ... it is a very lonely life ...

I: One thing I have found about teaching is that it can
be a very lonely job. You are a guest in these agencies you are isolated from your peers ... you develop short term relationships with your students but that is not the same as bouncing ideas off with another instructor. It takes awhile for the staff to know you and accept you as a teacher and as a nurse ... you have to show them you know what you are doing before they will start to trust you and I have been in three different hospitals since I've been teaching ... so it's hard. I think sometimes you feel lonely when evaluating students with problems.

The last quote described the need to develop a trusting, respectful relationship with the clinical staff which longevity would facilitate. However, this informant had worked in three agencies in her first year of teaching. The importance of establishing trusting relationships with clinical staff and familiarity with the setting were identified by many informants. For example ...

I: If you go back to the same agency you get a sense of trust between the staff and you get used to the clinical setting and it is a lot easier to assess students in a setting where you're comfortable.

In contrast, one informant denied feelings of loneliness in the clinical area because of her familiarity with the area.
and the staff.

R: Do you feel alone?
I: No, I don't feel alone. I have worked in a lot of the agencies. I know a lot of the staff...

The view that working in an outside agency may generate feelings of isolation and loneliness for clinical teachers was addressed in the literature (Ray, 1984; Wong & Wong, 1987). For instance, Wong and Wong outlined how these teachers, unlike their colleagues on campus, cannot seek advice and assistance from their peers as needed. Furthermore, these authors asserted that clinical teachers' feelings of isolation may be so pervasive that they may face a period of anxious uncertainty.

The feelings of isolation and uncertainty could be reduced by having a second teacher present in the clinical setting to provide support and/or evaluative input. Although having this second person was a strategy well documented in the literature, (Brozenec et al. 1987; Carpenito, 1983; de Tornyay, 1985; Meisenhelder, 1982; Welborn & Thompson, 1982; Wood & Campbell, 1982), only three informants mentioned this idea. Further, they disclosed how they had minimal or no experience with it.

Most informants identified that they solicited evaluative input from the staff nurses working alongside borderline students. This input would help validate
teachers' perceptions and interpretations of students' clinical behaviors. Further, nurses' viewpoints were an additional source of feedback used to foster students' self-awareness.

I: ... but I think another resource for clinical instructors are practicing nurses ... very helpful to an instructor ... I could say what do you think of so and so and they would say s/he does this, this and that. I could confirm with them and I felt very confident in their assessment.

Similar to the above narrative, Symanski (1991) stated, "It is a validating experience to have a staff nurse confirm your assessment that a student is not up to par" (p. 20).

The need to "check with instructors" to dissipate uncertainty, may not end with making the final evaluative decision. Peer support may be required to deal with teachers' post-decision uncertainty.

Post-decision uncertainty. Even when the final evaluative decision was made, the uncertainty and self-doubt did not dissipate. Post-decision uncertainty centred on the question--"Did I make the right decision"?

I: Making the decision is really difficult and there is always a little bit of ambiguity after you have made the decision wondering if you have made the right
I: ... difficult and unsatisfying because even after the decision is made, I'm not sure that you don't have a sense that it was necessarily always the right decision. I think it is going to be uncertain in the end anyway because I think the ambiguity will be there period ... even when you say yes the student will pass or no the student will fail ...

With respect to passing a borderline student, the uncertainty related to the student's future success in the next semester—"will the student improve," "were my perceptions correct?" With an individual who fails, the uncertainty rests with the student's right to appeal the decision. If the appeal process was initiated, the experience with the student would not end. According to the informants, it would continue in a new "stressful," "difficult," "unpleasant" and "time-consuming" direction.

Summary. The evaluation experience with borderline students was shrouded with uncertainty and self-doubt that did not end with the awarding of the final grade. The informants coped with this uncertainty by seeking peer and staff nurses' support and validation that their evaluative perceptions were correct. Although uncertainty and self-doubt were two feelings engendered from making evaluative decisions, the informants reported on numerous other
emotions.

**Emotional Challenge**

Emerging from the data analysis was the theme that making the laborious decision to pass or fail borderline students was an emotional challenge—a challenge encompassing a range of emotions, some of which were conflicting. The informants' conflicting emotions created dissonance which was reduced through the use of rationalization.

**Shared emotions.** Repeated references to the emotive aspects of making evaluative decisions were found in the data. The informants described their experiences as: "challenging," "unsatisfying," "unhappy," "uncomfortable," "frustrating," "heart-wrenching," "gut wrenching," "painful," "emotionally draining," "always emotional," "very difficult," "never easy," "no easier with experience," "anxiety producing," "time-consuming," and "very stressful."

Disclosures of a more positive nature were infrequent and limited to the occasional comment concerning the decision to pass the borderline student. However, due to the post-decision uncertainty associated with passing borderline students, this scenario was not perceived as positive by all informants.

Comparable to the informants, the literature addressed the emotional side of evaluating unsatisfactory or failing students. Wood and Wladyka (1980) labeled the clinical teacher's experience as difficult, time consuming, and
frustrating. Meisenhelder (1983) described it as an emotionally taxing responsibility which was difficult, uncomfortable, painful, and never pure or easy. Similarly, Symanski (1991) characterized the experience as stressful, emotionally draining, devastating, debilitating, and demoralizing.

In addition, the informants shared similar emotions in relation to evaluating borderline students within the context of the clinical group. Like the literature, the informants disclosed how the additional time spent with borderline students evoked feelings of "guilt," "resentment," inadequacy," and "anger" (Symanski, 1991; Welborn & Thompson, 1982). They asserted how "the good students suffered," and "if the borderline student failed, it was a waste of good teaching time."

To grasp the essence of the informants' experiences, the researcher asked them to summarize their perceptions of evaluating borderline students in either a word or a phrase. Their responses were similar and many inferred the concept of laborious decisions. Some of the informants reiterated their emotions while others adopted a personal standpoint to elaborate on their experiences. Their accounts cited: "an ambiguous process," "really difficult," "challenging," "ominous and necessary task," "frustrating and time-consuming," "stressful," and "anxious uncertainty." One clinical teacher explained the essence of her experience
as follows:

I: I think borderline students just got to be the hardest decision of the teacher ... they create more anxiety ... endless amount of work in all sorts of ways and they impact not only our work life but the rest of our life as well. They are just really difficult to make a decision on ... difficult because they are inconsistent and ambiguous ... not clear cut ... they are hard because it so hard to figure out what the problem is.

This transcript excerpt made reference to ambiguity and the sentiments that making evaluative decisions generated anxious uncertainty, was difficult, hard work, and would influence the teacher's personal life. Thus, this quotation exemplified the concept of laborious decisions. In the next narrative the informant alluded to the post-decision uncertainty and discussed how, regardless of the outcome, the experience was unrewarding and dissatisfying.

I: ... it is challenging either way ... pass or fail there isn't a lot of reward in it ... it is not a satisfying thing ... you can feel good in that I suppose that you have protected the public and the profession ... it is not like having a student who has done really well ... whereas with the borderline
student ... either way ... if you let them go on you worry about how they are going to do in the future and if they don't you feel badly ... 

This quote identified another emotive dimension of making evaluative decisions. Like many informants, this teacher used rationalization to deal with her feelings--"you can feel good in that you protected the public and the profession." Seemingly, this rationalization was employed to reduce the dissonance experienced in evaluating borderline students.

Dissonance and rationalization. Festinger (1957) proposed a theory of cognitive dissonance which stated that if a person held two incompatible cognitions dissonance was experienced. Because this dissonance is psychologically uncomfortable, the person would be motivated to reduce the discomfort. Deci (1975) described dissonance as a challenging motivator. According to Festinger, making difficult decisions may result in dissonance which people tend to reduce by justifying or rationalizing their choice. This notion of dissonance was relevant to the informants' accounts. They spoke of guilt and of a difficult, emotional, personal challenge which involved two opposing perceptions. Their desires for a successful student were challenged by their visions of possible clinical failure. Further, most of the informants used rationalization when they discussed their perceptions about making evaluative
decisions with borderline students.

Concerning their desires for a successful student, some informants disclosed "wanting the borderline student to make it," others worried that they were "too hard on the student," and a few teachers spoke of their "personal investment"—their personal investment in terms of time, energy, and effort to help the student to pass...

I: I think part of what makes it really difficult with a borderline student is you invest a lot of yourself into helping them to reach a satisfactory level...

Similarly, another informant stated...

I: ... difficult from the personal sense you are feeling for your students you want them to do well. You want each one to have the best chance to do well.

The implications of a clinical failure resulted in the informants' longing to pass the student. For instance one teacher disclosed that....

I: ... I feel like this person's future is resting in my hands ... my decision effects student's life so dramatically...
Likewise, another informant expressed that ...

I: ... your judgement of the student / you're greatly affecting their education if you should fail them.

Wanting the student "to do well" and appreciating the consequences of a failure, the teacher would favor a passing grade. However, these feelings were opposed by their views that the student's performance was borderline and the risk of failure existed. Meanwhile, the situation was perceived as ambiguous. Deciding to give a failing grade would be a severe judgement based on ambiguous data because the student's performance was not clear-cut.

Generally, the informants' opposing views were expressed concurrently and immediately followed by a rationalization or justification which took a variety of forms. These various forms will be discussed.

Two of the inexperienced informants described blaming themselves for the student's failure while some of the veteran teachers declared that they used to feel more responsible for the student's downfall. Nurse educators blaming themselves for the student's clinical incompetence was cited in the literature (Hill, 1965; Turkett, 1987). The following two transcript excerpts illustrate the use of self-blame to rationalize the student's failure.

I: ... you almost feel like you have failed if they
don't reach the level especially when inexperienced.

I: ... when I was a brand new instructor, I felt that it was my problem when students failed ...

A notion previously addressed and mentioned primarily by the novice informants involved blaming the student's former teachers for their dilemma.

I: ... why didn't someone deal with this sooner? ... frustrating if you feel that you have been left with something no one else has wanted to deal with ...

The experienced informants spoke of how they have developed an attitude that they "will do their best work," or "do all that they could," yet ultimately they viewed the student, not themselves, as responsible for the final decision ...

I: I'll do the best ... I'll work with you as long as I can or to whatever extent I can ... I've come to the realization, over time, that students have a big stake in this ... they can either choose to use the help that they're being offered and work with it and pass or they cannot ...

I: ... the student has a large part in this ... I have
resolved that the student has a big responsibility in this ... I can do what I can do to direct the student and help ... if the student doesn't do it well ... 

This view that clinical teachers were not personally responsible for nursing students' failure (Turkett, 1987) or for learners' personal lives (Symanski, 1991) was emphasized in the literature.

Some informants seemed to deal with the dissonance by protecting their identities as "nice people" despite possibly rendering a failing grade. The informants wanted to ensure that borderline students saw them as "sincere," "helpful," "their ally," and "on their side." Most teachers outlined how they would ask the student if there was "anything more they could do," or if they were "impacting on their success in any way."

According to the Jourard (1974), the informants need to be regarded as "sincere" or as "an ally" related to protecting their public self. Jourard described public self as "the identity a person wishes to have in others" (p. 162) or the "subjective side of one's social role" (p. 152). Seeking the approval of others or constructing the impression others may have of you would relate to constructing one's public self. Similarly, Allen (1990) described the "tendency to present oneself in a positive light" (p. 83).

Two forms of coping with the dissonance were linked to
the informants' dual responsibility to students and to patients. First, to help justify clinical failure, the informants spoke of how "it was necessary," how they had "protected the public," or how they could "rationalize that the student was unsafe."

I: I think I have come to the realization that if a borderline student fails our ultimate responsibility is to provide safe care to patients and if that student's performance to this point does not demonstrate that, then I think that I am also doing the right thing.

Second, a form of dissonance reduction corresponded to the change in responsibility focus that was previously addressed. This form related to the informants' suggestions that early semester teachers can afford to give the "student the benefit of the doubt" or "a second chance." By giving the student a "second chance," teachers avoid the discomfort of clinical failure.

The final way of dealing with the dissonance was linked to the concept of student's self-awareness. If a borderline student developed self-awareness and withdrew from the course, the informant's clinical evaluation process was "a lot easier." Hence, the student's withdrawal reduced the teacher's discomfort of having to award the final grade. When the informants discussed this withdrawal, they made reference to how it was "easier on the student," "best
scenario if the student decides," "much easier if the student admits," and "easier if student voluntarily makes the decision." The student's willingness to self-withdraw benefitted the teacher insofar as it eliminated an uncomfortable evaluative responsibility.

Blaming oneself, blaming one's peers, protecting one's identity, giving the responsibility to the student, protecting the public, giving the student a second chance, and having the student make the decision were the different ways that the informants dealt with their dissonance when confronted with borderline students. Newer teachers tended to blame themselves and their colleagues. Veteran teachers seemed better able to separate themselves from the situation and give the onus back to the student.

Like the informants, Meisenhelder (1982) described how evaluating unsatisfactory students creates conflicting emotions. This author described "external and internal forces that pull the instructor toward both passing and failing grades" (p. 348). According to Meisenhelder, assigning a failing grade may conflict with the teacher's nurturing self-concept. Further, the teacher "may anticipate the student's hurt and humiliation and feel guilty about inflicting pain by confronting the student's weaknesses" (p. 349).

Summary. Clinical evaluation of borderline students was an emotional challenge. Because some emotions were conflicting, dissonance developed which the informants
seemed to deal with through various forms of rationalization. This emotional challenge contributed to the difficulty inherent in their laborious decisions.

A Sense of The Whole: Gestalt View

The school of gestalt psychology views things as a whole, with the whole being greater than the sum of the constituent parts (Hinchliff, 1979). The informants shared the notion that evaluating borderline students required having a sense of the whole or the gestalt view of the situation. This gestalt view was one facet of making laborious decisions with borderline students. One informant made explicit the use of this view when evaluating the quality of borderline performance.

I: ... sometimes the whole concept that we have of student and the performance is sometimes a greater indicator than the individual data ... the sum of the parts does not equal the whole; the whole is sometimes quite a bit greater ... as I work through more borderline students, I have to keep in mind what is the whole, not just the individual data ...

Painting the whole picture. The literature described a sense of the whole as a requisite of clinical evaluation. For instance, authors emphasized the necessity of looking at the overall picture of students' clinical performance (Majorowicz, 1986; Robinson & Bridgewater, 1979; Wood &
With respect to looking at the complete performance, the informants spoke of taking isolated incidents and connecting them together to paint the whole picture. The three narratives below implied this need to grasp a sense of the whole picture.

I: ... it's collection of things or an accumulation of events, not just one event or two events ... isolated little incidents which you have to connect them and it's a lot of work ... try to not see little incidents as little incidents but come up with ... what's the learning problems.

I: You have a vague sense and little bits of data about things that on their own they don't mean very much but you have to put them all together and sometimes it takes awhile to put it all together to realize what you are dealing with as being poor performance.

I: ... look at whole patterns of behavior ... piecing together the little bit of data here and this little bit of data there ...

The last transcript excerpt illustrated how a gestalt view enabled informants to grasp a better understanding of performance patterns. This need to look at the whole picture to see "patterns of behavior" was also addressed in
the literature (Mantle, 1982; Welborn & Thompson, 1982). According to Mantle, a few pieces of data may not constitute sufficient evidence of a behavior pattern, but may when combined with other data gathered overtime.

The informants' need to paint an overall picture of the student's performance was linked to the concept of ambiguity. A sense of the whole facilitated decision-making within an ambiguous situation.

Ambiguity and a gestalt view. During the second interviews the informants were questioned about the relationship between a gestalt view and the themes of ambiguous performance and ambiguous process. The following quotation typified this questioning.

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R: ... if the process is ambiguous and the student's performance is ambiguous and you have mentioned in the interviews the need to look at the whole picture ... so I am wondering if you need to look at the whole picture because of the ambiguity?
I: Yes, I think so and I think with borderline students because they sometimes do things alright and then the next time they don't you don't get clear messages all the time / so it is difficult to know what you are dealing with and I think that is why you need to look at the whole picture. You need as much information as possible in order that you can make the best decision that you can ... It makes a lot of sense why you need
This quote outlined the relationship between a sense of the whole and ambiguity. Further, this narrative illustrated how many informants were unaware of why they looked at a gestalt view.

**Summary.** One aspect of the evaluation experience shared by the informants was the need to look at the whole picture; the student's overall performance. The ambiguous nature of both borderline performance and the clinical evaluation process heightened the necessity of having a sense of the whole in making their laborious decisions with these students.

**A Sense of Knowing: Intuition**

Given that all eight informants recognized either a sense of knowing or intuition as a component of making evaluative decisions, this topic became a thematic category in data analysis. Blomquist (1985) supported intuition as a valuable component of evaluating clinical nursing students. The author linked both a sense of the whole and the use of intuition in clinical evaluation by stating, "Evaluation is the making of subjective judgement about the meaningfulness of the whole both from the parts that are measurable and from those the must be assessed intuitively" (p. 11). In the following section, intuition will be explored in terms of how the informants described and used it, how it linked to the sense of the whole, and how it related to the
ambiguity of borderline performance and clinical evaluation.

**Knowing and feeling.** The informants either identified their intuition in terms of knowing, feeling, or as both knowing and feeling—"I feel that I just know." Although the informants referred to a: "sense," "sense of knowing," "sixth sense," "gut feeling," "gut reaction," "intuitive thing," or "you just know," they all agreed that either a sense of knowing or intuition fit for them as a way to describe these notions.

The informants spoke of their intuition as something that was "innate," "intangible," "not concrete," "difficult to articulate," "difficult to document," and "just like in nursing." This comparison between the use of intuition in nursing practice and clinical teaching was done by most informants ...

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I: ... you know it is like that sixth sense, it is like when you are caring for patients / I know there is something not right about them ... while that is kind of how it is with a student too.

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Rew's (1988) research on the use of intuition in clinical decision-making also found that nurses identified their intuition in terms of either feelings or knowing. According to Rew (1988), experienced individuals comfortable with the use of intuition may view it as knowledge rather than as emotion. However, in this study there was no apparent
connection between how the informants identified their intuition and their clinical teaching experience. The informants' inability to articulate or document their intuition or a sense of knowing was also described in the literature. For example, Polanyi (1966) stated, "We can know more than we can tell" (p. 4).

Experience and exposure. Most informants shared the view that their ability to evaluate using intuition was based on both "exposure" and "experience." Experience in terms of teaching was strongly advocated by those informants who were veteran teachers. The following quote typified this viewpoint.

I: ... I think it takes exposure and experience ... I think it does have a lot to do with experience in teaching and I think you just get better at identifying more quickly those behaviors that could be problematic and hopefully then you are able to help the student earlier.

Two of the informants, new to clinical teaching, did not discuss their intuition in relation to teaching experience. Instead, these informants advocated that their intuition was "based on their past nursing experience." In comparison, the third inexperienced informant found that, although she brought her intuitive abilities from nursing practice into her new role, it had taken teaching experience
to "transfer" and "adapt" it.

The literature documented experience as a definite prerequisite to intuition. Intuitive abilities were associated with experts (Benner, 1984), "seasoned" veterans, (Benner & Tanner, 1987), and connoisseurs, or qualified individuals who can make discriminating judgements (Polanyi, 1962). According to Bruner (1965), the effectiveness of a "good intuiter" rests upon familiarity and a solid knowledge of the subject. Likewise, Benner's (1984) research found that the use of intuition in clinical practice was reserved for the expert nurse with an enormous background of experience.

Intuition and a gestalt view. Most informants asserted that their use of intuition related to a gestalt view of the situation—"You get a sense ... is this really what this whole picture tells me"? One informant suggested that one's vision of the whole picture was grounded in an intuitive understanding of how smaller pieces of data interrelate. Likewise, another informant spoke of intuition in terms of this ability ...

I: ... your intuition ... is your abilities to look and put all the pieces of the puzzle together.

The relationship between the gestalt view of a situation and the use of intuition was documented in the literature. For instance, Rew (1986) identified one of the defining
attributes of intuition as knowledge perceived as a whole. Polanyi (1966) linked intuition, or what he termed tacit knowledge, to a sense of the whole by stating, "Tacit knowledge dwells in our awareness of particulars while bearing on an entity which the particulars jointly constitute" (p. 61). Similarly, Blomquist (1985) referred to intuition as the ability to grasp a situation as a whole and separate relevant from irrelevant information.

The use of intuition. The majority of the informants spoke of using intuition early in the clinical process with borderline students. They would get a "gut feeling" or a "sense" that "something was wrong." One informant described how she experienced a "sense" or how "little warning bells" would go off in her head which indicated that "something was not quite right." Another informant stated ...

I: I use intuition when I'm trying to identify a problem ... try to pursue those things in order to get more facts.

Regarding making the final evaluative decision, the majority of informants acknowledged that they used intuition which they would substantiate with "hard data" or "documented evidence." The informants spoke of knowing that a borderline student had the "potential," "could improve with another chance or another block of time," or they sensed that the student "just wasn't ready." The following
two quotations were examples of how informants viewed intuition in relation to the final decision.

R: Do you use intuition in making the final decision?
I: Oh yeah, I think we do, I think we try to justify it by a bunch of facts and bunch of examples ... I have a sense but we'll go through all the rest of the hoops until the end of it.

I: Instructors may have an intuitive feeling that the student shouldn't go on and won't do well in the future semesters but they don't have the hard data to support these intuitive feelings so they can't go on intuition alone you have to say you did this and this ... if there is an appeal you want to be able to support your decision ... I think maybe the decision you make to a large degree is intuitive but once you have made the decision you then look to see if you have the data to back it up.

The informants described "down playing" their use of intuition. According to the informants, intuition was not a respectable way of making evaluative decisions. For example one informant stated ...

I: We make such a big deal at school out of being objective that I'm down playing, I'm saying no this is
not intuitive, this is based on these facts because
that's what pushed a lot ... it could be
intuitive but we have a little way of wrapping it up so
that it doesn't look intuitive. ... I would never say
that it's an intuitive sense because first of all, I
don't think that intuition is a very respected
commodity anywhere ...

In contrast to the informants, the literature substantiated
the use of intuition as an essential element of the
decision-making process. According to the French
philosopher Bergson (1946/1968), intuition is an essential
component in higher intellectual activities. Likewise,
Ferguson (1987) described intuition as a superior form of
knowing that encompasses the intellect. Cosier and Alpin's
(1982) study of managerial problem-solving found that people
with high levels of intuitive ability made better decisions
than those with low levels. Marquis and Huston's
(1987) description of the decision-making process included
intuition as an intrinsic element. Rew and Barrow (1987)
recognized intuition as a "component of the perceived view
of science and a legitimate way of knowing in nursing" (p.
50). Further, these authors addressed how clinically-based
nurses refer to their reliance on intuition as an essential
component of the decision-making process.

Like the informants, the literature addressed the need
to substantiate intuition with "confirming evidence"
(Benner, 1984, p. xix). Bruner (1965) explained how intuition must be validated through analytical thinking which is more concrete and characteristically proceeds in explicit steps. The informants' analysis of their "anecdotal notes," "hard data," or "documented evidence" would correspond to this type of thinking.

Intuition and ambiguity. During the second interviews the informants were asked if they perceived a link between their use of intuition and the ambiguous nature of borderline performance and the evaluation process. Most informants agreed that they heavily relied on intuition when working with borderline students and acknowledged that this was due to the student's ambiguous performance being evaluated with a subjective or ambiguous process.

I: If those things (borderline performance and clinical evaluation process) weren't ambiguous, things would be much more clear-cut and you wouldn't have to rely on your intuition or gut feeling.

The use of intuition in decision-making with incomplete or ambiguous data (Rew, 1988; Rew & Barrow, 1987) or in situations which involve uncertainty, uniqueness, and unpredictability (Schon, 1983) was substantiated in the literature. Given that borderline students' performance has been characterized as ambiguous with unpredictable, uncertain, individualized behavior and that making
evaluative decisions involved an ambiguous process, intuition as a valuable component of this experience fits with the literature.

Summary. The informants used intuition or a sense of knowing to make evaluative decisions with borderline students. Due to the ambiguous nature of borderline performance and the clinical evaluation process, the informants found that they relied on their intuitive abilities more with borderline students. How the informants described their intuition and validated it with confirming evidence was similar to descriptions in the literature. However, unlike the literature, intuition as a form of higher intellectual ability and as a respectable element of decision-making was not addressed or implied by the informants.

A Sense of Trusting

Data collection and analysis for the theme concerning a sense of trusting transpired differently. Contrary to the other themes, the greater part of the data were elicited during the second interviews. Thus, this theme will be presented according to data collection during the two sets of interviews.

During the initial interviews, three informants discussed two comparable criteria used to assist them in making their difficult decisions to pass or fail a borderline student. Two informants envisioned the student as a care-giver for self or family members. Another teacher
thought about the student as a future co-worker. The following three quotations illustrate the presence of this theme in the initial interviews.

R: During your experience with borderline students, how did you go about making the final decision whether to pass or fail the student?
I: Whether I'd like them to look after me personally ... I have had students that I won't want them to look after my dead cat ... basically the bottom line is whether I want them at their level of expectations in the program ... looking after me, or one of my family members. Would I want them to be there?

R: How do you deal with this self-doubt?
I: ... thinking about whether you'd want the student taking care of you ... when you're feeling doubtful ... that's when you kind of go, no I wouldn't feel safe with this person, I wouldn't want this person taking care of me or my family ... it's not that s/he's a rookie / there's just something missing, I wouldn't feel safe.

I: To pass or fail, it is a real simple way I have of doing it. ... I always thought at this rate of their progression in another eight months would they be at a level that I would want to work with them as a grad? I
always imagined working with them on a night shift and they would be at one end of the hall and I would be at the other end, if I felt comfortable with this person working at the other end of the hall ... if I would feel safe with them. That was my simple criteria for judging whether or not / because the objectives you can sometimes / you can meet them with this only one behavior. My gut feeling is whether I would want to work with them, feel safe with them if they were a new graduate.

Indirectly, this last quotation illustrated the interrelationships between a sense of trusting, the ambiguous nature of clinical evaluation, and one's gut feeling or intuition. The informant alluded to how, because the objectives were ambiguous, she judged her perceptions of the student's performance based on her intuition -- "gut feeling" and whether or not she could trust the student as a future co-worker -- "feel safe."

Although only three of the eight informants spoke about this notion of trusting, many of the others suggested trustfulness. For example, "I just can't trust the student." In these instances, the informants did not expand on their perceptions or discuss how they evaluated this trust.

During the second interviews the researcher asked the informants whether or not this twofold sense of trusting fit
with their decision-making process. Given that all informants used at least one or both of these criteria, the theme was unanimously validated.

First, with respect to considering the student as a care-giver, the informants agreed to this criterion. Seven of the informants were definite in their responses. They replied with responses such as: "Definitely," "Yes very much so," and "I think that's a real good indicator as to whether or not they're competent to be nurses." The one other informant discussed how, until recently, neither herself nor a family member had ever been hospitalized. Therefore, the notion of having the student as a care-giver was unfamiliar. However, because this person's mother was ill recently, she asserted that this criterion seemed feasible.

Second, the informants' responses to the question about the borderline student as a future co-worker received mixed reviews. This criterion fit for those individuals who had recently nursed at the bedside. However, for those teachers who had limited hospital-based clinical experience considering the student as a co-worker was less valid. The following transcript excerpts typified the two different responses.

I: Yeah, as a co-worker, yeah ... would they be able to hold their weight, would I be carrying all the responsibility as opposed to them ... yeah I think
about that ...

I: No, I haven't because my hospital experience is limited and I think that makes a difference ...

According to the informants, a sense of trusting was a product of their intuition and their analysis of "hard data" or "documented evidence" of the student's performance. Marquis and Huston (1987) explained that people make decisions by evaluating their perceptions with analytical thinking, intuitive thinking, and/or with feelings. Therefore, in accordance with this explanation, the informants evaluated their perceptions of students' clinical performance by analyzing their "hard data", using intuition, and determining if they would "feel safe" with these students as co-workers and/or care-givers.

The ambiguity of evaluating borderline students was inherent in the discussions about a sense of trusting. To assist them in making their evaluative decisions with ambiguous data, the informants questioned whether or not they could trust the student as a future co-worker and/or care-giver.

I: Definitely and I have had other instructors say to me, if you are having trouble making the decision think about whether or not you would want this student
Summary. During the clinical evaluation process with a borderline student, the informants would ask themselves if they would "feel safe" with the learner as a future co-worker and/or care-giver. Because of the ambiguity of evaluating borderline students, using the criterion of trust may afford the informants' some clarity and direction in making evaluative decisions. Although a review of the literature did not refer to this theme, according to this study a sense of trusting was a valuable decision-making strategy.

Summary of the Informants' Accounts

Three overlapping concepts with inherent, interrelated themes emerged from the analysis of the informants' accounts. These concepts were ambiguity, student's self-awareness, and laborious decisions. Of these concepts, ambiguity was the most prevalent.

The informants viewed borderline performance and clinical evaluation as ambiguous in nature. Borderline students' enigmatic, inconsistent performance was difficult to evaluate within an ambiguous process. The process was described as ambiguous because of its subjective element, implicit criteria, and the unclear distinction concerning when to teach and when to evaluate. The ambiguity of clinical evaluation was magnified when applied to an ambiguous performance.
According to the informants, borderline students challenged their simultaneous responsibilities to students and to patients. These students were perceived as "walking" an ambiguous "fine line" between safe and unsafe. Further, ambiguity pertained to the clinical teachers' focus of responsibility. Informants teaching in the earlier semesters tended to be more student focused, whereas later semester teachers were more patient-and profession-oriented. Exactly when this focus of responsibility changed was deemed ambiguous.

The concept of student's self-awareness focused on borderline students' lack of insight into their clinical competency. Students' limited awareness precipitated their defensive responses which in turn evoked an emotional response from the informants. Thus, limited insight influenced the teacher-student relationship and complicated the process of evaluating these students. Although fostering a student's self-awareness was viewed as hard work, it was germane to eliminating defensiveness and reducing the possibility of an appeal if a failing grade was assigned.

The concept of laborious decisions pertained to the informants' emotional decision-making process. The laborious nature of this process was, in part, fuelled by ambiguity.

Uncertainty was one of many negative emotions generated from evaluating borderline students. Primarily, the
Informants dealt with their anxious uncertainty by seeking peer support and validation. Being separated from colleagues in the clinical setting evoked feelings of loneliness and a longing for peer support. Other engendered emotions related to the excessive time devoted to borderline students. In addition, deciding a borderline student's passing or failing clinical grade created dissonance. Wanting the student to be successful pushed the informants toward awarding a passing grade while perceiving the performance as unsatisfactory pulled them toward assigning a failing grade. The informants dealt with this emotional discomfort by rationalizing their decisions.

Intuition was an intrinsic component of the informants' decision-making process. The use of intuition encompassed a sense of the student's whole performance and a sense of trusting. Intuition, holism, and thinking about the student as a future co-worker and/or care-giver helped to diminish the ambiguity and arrest the informants' irresolution over the final grade. The informants did not view their use of intuition as a positive element of their decision-making process.

In summary, the experience of evaluating a borderline student was shrouded in ambiguity and involved working with a defensive learner who had limited self-awareness. The decision to pass or fail the student was laborious, uncertain and emotional. The foundation of the decision-making process was intuition which encompassed a sense of
the whole and a sense of trusting.

This chapter discussed the informants' accounts in the context of the relevant literature. Pertinent references reviewed in Chapter Two were reexamined and additional ones were discussed. Many of the themes were supported by the literature. In particular, the informants' perceptions that their experiences were difficult, hard work, emotive, and challenging were congruent with the literature. Although the literature was consistent with various thematic categories, there was no explicit reference to borderline performance as ambiguous, no reference to a change in responsibility focus from early to late semesters, and no mention of a sense of trusting as an evaluative criterion. Further, in contrast to the informants, the literature described intuition as a high-level thinking process and a respectable decision-making strategy.

The study's summary, conclusions, and implications for nursing education and research will be the focus of the following chapter.
CHAPTER FIVE
Summary, Conclusions, and Implications for Nursing

Summary

Borderline nursing students present clinical teachers with an evaluative dilemma because they exhibit an inconsistent marginal level of clinical performance. The challenge of working with borderline students is a reality of the clinical teacher role; however, research which investigated the experience of evaluating these students was not found. This study was undertaken to describe how teachers perceived their experiences with this phenomenon.

The researcher selected the phenomenological method. Because this qualitative method explores experiential meaning, it was an appropriate approach to study clinical teachers' perceptions of evaluating borderline nursing students. The researcher recruited eight diploma program-based clinical teachers who had evaluated these students. The teachers taught in medical-surgical settings, their years of teaching ranged from one to 18, and their reported experiences with borderline students varied from three to 100.

Data were collected through the use of two unstructured audio-taped interviews with each informant. The initial interviews were guided by trigger questions which were formulated with direction from the concepts of the study's conceptual framework. These concepts were role, perception, and decision-making and were selected based on their
relevance to the clinical evaluation process and the review of the literature.

Consistent with the phenomenological approach, data collection and analysis were done concurrently. The interviews were transcribed and analyzed according to Giorgi's (1975a,b) approach to data analysis. The themes and concepts which emerged from the data were validated and clarified with each informant. This validation process ensured that the researcher's interpretations of the accounts remained faithful to the informants' experiences.

During the process of data analysis, three overlapping concepts with inherent, interrelated themes naturally unfolded. The concepts were ambiguity, student's self-awareness, and laborious decisions.

Ambiguity was a central concept which pertained to the nature of borderline performance, the clinical evaluation process, and the clinical teachers' dual responsibility to students and to patients. The ambiguity contributed to the difficult dilemma of evaluating borderline students. In particular, the ambiguous nature of clinical evaluation was brought to the forefront when working with students who demonstrated ambiguous performance.

The informants described borderline students as individuals who lacked awareness of their strengths and weaknesses. The teachers perceived fostering this awareness as hard work and time-consuming, yet requisite to students improving, accepting their clinical status, or withdrawing
if failures were imminent. Students with insight were deemed less likely to appeal their clinical failures. In addition, the accepting attitude of insightful students facilitated positive teacher-student relationships.

Five themes surfaced concerning the concept of laborious decisions. Two of these themes pertained to the uncertainty and emotional challenge of making evaluative decisions. The remaining three themes, a sense of the whole performance, a sense of knowing or intuition, and a sense of trusting, related to the process of making these decisions. The concept of ambiguity underscored why evaluating borderline students was laborious in nature.

The ambiguity of evaluating borderline students contributed to the informants' anxious uncertainty which was intensified for the three novice teachers. Primarily, seeking support and validation from their peers was the strategy used to dissipate this uncertainty.

Further, evaluating borderline students generated numerous other emotions and created dissonance which was reduced through various forms of rationalization. Having to devote extra time to the special needs of borderline students in the clinical group and being separated from colleagues in the clinical setting also contributed to the informants' emotional challenge of working with these students.

In order to evaluate an ambiguous performance within an ambiguous process, the informants would grasp a sense of the
student's whole performance, use intuition, and decide if they could trust the student as a future co-worker and/or care-giver. A sense of the whole performance and a sense of trusting were both intuitive in nature.

Chapter Four presented and summarized these concepts and themes in detail, discussed their interrelationships, and analyzed them with reference to the relevant literature. While some of the thematic categories paralleled those in the literature, others offered a new perspective. The findings supported the researcher's initial conceptualization of the research problem. The conceptual framework's concepts of role, perception, and decision-making were inherent in the descriptions of the informants' accounts.

Conclusions

The conclusions drawn from this study are as follows:

1. The experience of evaluating borderline nursing students is shrouded in ambiguity. Ambiguity characterizes borderline performance which amplifies the ambiguity inherent in clinical evaluation and in the nurse educator's dual responsibility to students and to patients.

2. Borderline students tend to have limited awareness of their performance problems. Fostering students' awareness, though time-consuming, is an essential element of clinical teachers' work with these students.

3. Dissonance and a variety of emotions, of which uncertainty is the most predominant, are associated with the
decision-making about borderline performance. Dissonance is reduced by using various forms of rationalization and peer support is essential for dissipating the uncertainty inherent in this decision-making process. Evaluating borderline students in clinical settings away from colleagues precipitates feelings of loneliness and intensifies the need for peer support.

4. Clinical teachers use strategies which are based on intuition during the laborious process of deciding a borderline student's final grade. These strategies include a sense of knowing, a sense of the student's whole performance, and a sense of whether or not the student could be trusted as a future co-worker and/or care-giver. The informants minimized the value of using intuition by underscoring the importance of having documented evidence.

**Implications for Nursing Education**

The findings suggest a number of implications for nursing education. The first five are for nurse educators and the remaining implications are for educational preparation for clinical teaching.

1. Clinical teachers may find the results informative and the description of the informants' accounts may provide a basis to validate their own emotional, laborious experiences of evaluating borderline nursing students.

2. Faculty members need to develop and implement strategies which ensure that colleagues receive support when faced with the challenge of evaluating borderline nursing
students. In particular, faculty members need to structure ways to provide this support to teachers who work in clinical settings separated from colleagues.

3. Clinical teachers, from different levels in the program, need to share their concerns, approaches, and interpretations of evaluative criteria and data. The changing dynamics of evaluating students in the earlier versus late semesters needs to be discussed amongst faculty members.

4. In order to facilitate students' acceptance of their clinical standing and reduce the likelihood of appeals, clinical teachers should have the understanding and capabilities of fostering learners' awareness of their clinical competency.

5. Clinical teachers must acknowledge the inescapable, underlying subjectivity and, hence, ambiguity of clinical evaluation. Teachers need to accept that, in the end, they "must call it as they see it" (Meisenhelder, 1982, p. 348). Using intuition, a sense of the whole performance, and a sense of trusting should be considered as appropriate decision-making strategies to resolve the dilemma of evaluating borderline nursing students.

6. Future nurse educators need to be introduced to the challenges of evaluating borderline students. Educational preparation should realistically, yet sensitively, elucidate the laborious and emotive dimensions of this experience.

7. Courses focused on clinical teaching need to give
significant attention to the ambiguity inherent in the evaluation process with borderline students. Emphasis on developing an understanding of and skills in evaluative decision-making that includes the use of intuition would be appropriate course content.

8. Course content focused on working with borderline nursing students needs to encompass: ways to structure peer support into the clinical evaluation process, strategies to foster students' awareness of their clinical competency, and the impact that these learners have on clinical teachers' dual responsibility to students and to patients.

These last three implications apply equally for continuing education programs, workshops, or faculty development focused on teaching and evaluation for experienced clinical teachers.

Implications for Nursing Research

This study's findings suggest the following areas of research which would enhance understanding of the complexities of clinical evaluation.

1. According to the informants, failing students, in contrast to borderline students, were less challenging. Their clinical performance was viewed as more "clear-cut" and the evaluation process perceived as more simplified. However, clinical teachers' perceptions of their experiences with clinical failure or with failing students have not been studied. Research of this nature may enhance understanding of the differences between evaluating borderline and failing
students. It may also determine if the crux of the difficulty rests in the ambiguous performance of the borderline student or the act of rendering a failing grade.

2. This study explored the experiential meaning of evaluating borderline students from the perspective of diploma program-based clinical teachers. Repeating this study with baccalaureate faculty members would enrich the understanding of this phenomenon and contrast the nature of their experiences.

3. The findings indicate that new teachers faced heightened uncertainty and tended to reduce their dissonance with self-blame or blaming their peers. Further, although the literature associated the use of intuition with a solid knowledge base and experience (Benner, 1984; Benner & Tanner, 1987; Bruner, 1965; Polanyi, 1962), this study's three inexperienced teachers confirmed its use. A study specific to new clinical teachers' perspectives would enhance understanding of this phenomenon.

4. Studies exploring the strategies used by clinical teachers to cope with the uncertainty and dissonance specific to the clinical evaluation process would add to the limited research concerning the emotive dimensions of this process.

5. Although all of the informants used intuition as an intrinsic component of their decision-making, a review of the literature did not reveal any research on clinical teachers' use of intuition. Research of this nature may
promote respectful understanding amongst clinical teachers for its intrinsic role in evaluative decision-making.

6. Future research which explores nurse educators' dual responsibility to students and to patients may substantiate or expand the findings concerning the change in responsibility focus.

In summary, the phenomenological approach has been useful in elucidating the clinical teachers' experiences of evaluating borderline nursing students. The research findings illuminate teachers' emotional, laborious dilemma of evaluating these students. Given the limited research from clinical teachers' perspectives, further studies which enhance understanding of this phenomenon or explore other aspects of their multitude of responsibilities is warranted.
REFERENCES


349-360.


Polanyi, M. (1962). *Personal knowledge towards a post-


Data Collection: Trigger Questions

1. Based on your own experiences, what was it like for you to evaluate borderline clinical nursing students?

2. During your experiences evaluating borderline nursing students, how did you go about making the decision whether to pass or fail them?

3. During your experiences evaluating borderline nursing students, what was your relationship like with these students?

4. During your experiences evaluating borderline nursing students, what was your relationship like with your colleagues?
Appendix B

Explanatory Letter for Agency Consent

School of Nursing
The University of British Columbia
Vancouver, B.C.

Dear Director:

My name is Mary Boyer. I am presently doing graduate studies in nursing at the University of British Columbia. For my master's thesis, I am interested in studying clinical teachers' perceptions of their experiences evaluating borderline nursing students. My interest in this topic stems from my own experiences as a clinical teacher in Alberta. I anticipate that the benefit of this study will be an enhanced understanding of the challenge that clinical teachers face in the evaluation of borderline students.

I would like to request the volunteer participation of members of your nursing faculty. I hope to interview clinical teachers who have evaluated at least one borderline clinical nursing student, are willing to share their experiences, and have completed at least a baccalaureate degree in nursing. For the purpose of this study a borderline student is defined as student who received an unsatisfactory appraisal or failing grade prior to the final clinical evaluation.

Due to proximity I am accessing various college nursing programs in the Vancouver area. The use of more than one nursing program will facilitate insight into a wider range of experiences and will ensure finding enough clinical teachers who can speak to the experience.

The teachers' participation in this study would involve 2 or 3 unstructured audio-taped interviews that would last approximately 1 hour, would be scheduled 2 to 4 weeks apart at a time convenient for them, and would be in a setting of their choice. The initial interview would involve the teachers answering a few questions regarding their academic and nursing backgrounds. At the completion of the study an abstract of the study will be available to your faculty members.

The names of the college and teachers, the audio-tapes, and the reporting of the written findings will be kept confidential and anonymous. The teachers will be asked not to name or reveal any identifying information about the
borderline clinical nursing students.

For purposes of the University's ethical review committee, a written consent from the college is required for my study to be approved. Please find an enclosed agency consent form and a brief overview of the proposed study. In person, I would appreciate an opportunity to further elaborate on my study, answer any questions, and if approval is granted obtain your written agency consent. In addition, I would appreciate an opportunity to present the study to your faculty members. Please contact me to arrange an appointment at your earliest convenience. My home phone number is 737-2908. Thank you for your attention to my request.

Sincerely,

Mary Boyer, RN, BScN
Appendix C

School of Nursing
The University of British Columbia
Vancouver, B. C.

Agency Consent Form

I, the undersigned give permission to Mary Boyer to approach the clinical teachers in order that she may conduct her study entitled "A Phenomenological Study of Clinical Teachers' Experiences with Borderline Nursing Students" with the clinical teachers employed at this college nursing program.

Director's Signature __________________________

College Name ________________________________

Researcher's Signature _________________________

Date ________________________________
Appendix D
School of Nursing
The University of British Columbia
Vancouver, B. C.

Agency Handout: A Phenomenological Study of Clinical Teachers' Experiences with Borderline Nursing Students

Overview of the Proposed Study

The study is designed to explore the difficult, emotional dilemma that clinical teachers face in fulfilling their professional and legal obligations in the clinical evaluation of borderline nursing students (Brozenec, Marshall, Thomas, & Walsh, 1987; Carpenito, 1983; Majorowicz, 1986; Meisenhelder, 1982; Welborn & Thompson, 1982; Wood, 1971). Given that the clinical performance of a borderline student is inconsistent, the teacher's decision to pass or fail a student is a stressful challenge (Brozenec et al.; Welborn & Thompson; Wood). Although nursing articles depict the clinical evaluation of borderline students as stressful and challenging, the meaning of this experience from the teacher's perspective has not been explored. Therefore, it is clear that more knowledge is needed to understand how teachers perceive this experience which is inherent in their professional role. The purpose of this study is to present a description of how clinical teachers perceive their experiences of evaluating borderline nursing students. The study will be significant in the advancement of knowledge in the clinical evaluation process
with borderline students.

This study uses a phenomenological approach, a form of qualitative research which searches for the meaning of an experience from an individual's subjective perspective. The data will be collected through the use of two or three audio-taped, one hour, unstructured interviews (open-ended questions) with clinical teachers who are willing and able to speak about their experiences. Through a process of analysis the study will conclude with a description of how clinical teachers perceive their experiences of evaluating borderline students.

References


Appendix E

Letter to the Informants

School of Nursing
The University of British Columbia
Vancouver, B.C.

Dear Clinical Teacher:

My name is Mary Boyer. I am presently doing graduate studies in nursing at the University of British Columbia. For my master's thesis, I am interested in studying clinical teachers' perceptions of their experiences evaluating borderline clinical students. My interest in this topic stems from my own experiences as a clinical teacher.

The way I hope to learn more about teachers' experiences with the clinical evaluation of borderline students is to interview individuals who have evaluated at least one borderline clinical nursing student, are willing to share their experiences, and have completed at least a baccalaureate degree in nursing. For the purpose of this study a borderline student is a student who received an unsatisfactory appraisal or failing grade prior to the final clinical evaluation.

If you feel you are interested and agree to participate, the study will involve two or three audio-taped unstructured (open-ended questions) interviews, about two to four weeks apart, at a time convenient for you, and in a setting of your choice. The interviews will each last approximately one hour. The initial interview would involve you answering a few question regarding your academic and nursing backgrounds. Your name and any identifying information will not be included in the tape recordings and transcripts of the interviews, nor will they be revealed in any printing of the findings. The name of the college, the students, and any identifying information will not be revealed. The only individuals who might listen to the audio-tapes will be myself, and possibly my thesis advisors. I will erase the audio-tapes and destroy the transcripts of the interviews upon the completion of the study.

You are under no obligation to participate in this study. Whether or not you participate will have no effect upon your role as a clinical teacher. If you agree to participate and later change your mind you are free to withdraw your consent. You are free to ask and refuse to answer any questions. You have the right to ask that disclosed
information be erased from the tape and, therefore, be excluded from the findings.

I anticipate that the benefit of this study will be to help me learn more about teachers' experiences in evaluating borderline clinical students and that the study will enhance understanding in this area of nursing education. I do not anticipate any direct benefits to you for participating. There are no financial benefits in participating.

For your information, I have enclosed a brief overview of the proposed study and at the completion of the study an abstract of the thesis will be made available. If you are interested in participating in this study, or need more information, please contact me at 737-2908. In addition, for more information you may contact my Thesis Chairperson, Anne Wyness at 822-7485. Thank you for your cooperation.

Sincerely,

Mary Boyer, RN, BScN
Appendix F

Informant Data

The following questions will be posed during the first interview with each informant. This information will be used to describe the characteristic of the informants who participated in this study.

1. What is your educational background?
2. Please briefly highlight your experiences in nursing prior to your role as a clinical teacher.
3. How many years of experience do you have in clinical teaching?
4. What clinical area(s) do you teach in?
5. How many borderline students have you evaluated?
Appendix G

Informant Consent Form

Title of the Study: A Phenomenological Study of Clinical Teachers' Experiences with Borderline Nursing Students

Researcher: Mary Boyer, RN, BScN (737-2908)
Master of Science in Nursing Student
The University of British Columbia

Thesis Chairperson: Anne Wyness RN, BSN, MN (822-7485)
Associate Professor
School of Nursing
The University of British Columbia

I understand that:

1. The purpose of this study is to find out how teachers perceive their experiences evaluating borderline clinical nursing students.

2. The benefit of this study is to help the researcher learn more about the teachers' experiences of evaluating borderline students, and promote an understanding in this area of nursing education. I will not receive direct or financial benefit for participating.

3. This study will involve the following:

   a) Two or three audio-taped recorded interviews which will be scheduled at my convenience, at a setting of my choice. The interviews will be conducted two to four weeks apart and last approximately one hour. Therefore, my participation in this study will total between two to three hours.

   b) During the first interview, I will answer a few general questions on my academic and nursing background and disclose the number of borderline students I have evaluated.

   c) During the interviews, I will answer open-ended questions with respect to my experiences with the clinical evaluation of borderline students.

4. I am under no obligation to participate in the study. If I decide not to participate in the study, it will have no effect on my role as a clinical teacher.

5. The researcher will ensure confidentiality and my anonymity by:
a) My name and other identifying factors will not be included on the audio-tapes, the transcripts of the interviews, nor be revealed in the printing of this study.

b) I am not to name or reveal any identifying factors with respect to the borderline clinical nursing students or the college.

c) At the completion of the study the audio-tapes will be erased and the transcripts, and any notes taken during the interviews will be destroyed. The only people who might listen to the audio-tapes will be the researcher and possibly her thesis advisors.

6. I may:

   a) ask any questions and ensure that the questions are answered to my satisfaction
   b) withdraw from the study at any time
   c) refuse to answer any questions
   d) ask that specific disclosed data be erased from the audio-tape, and therefore not be included in the printing of the study.

7. A copy of the abstract of this study will be made available to me at the completion of the study.

8. That by signing this form, I have voluntarily given my consent to participate in this study and the signing acknowledges that I have received a copy of this consent form.

Date ________________________________
Informant's Signature ____________________
Researcher's Signature ____________________