HOW DOES THE NATURE OF SETTING INFLUENCE CLINICAL TEACHING?
THE PERCEPTIONS OF PEDIATRIC AND MATERNITY CLINICAL TEACHERS.

by

KAREN ANN DAVIDSON

B.Sc.N., University of Alberta, 1982

A THESIS SUBMITTED IN PARTIAL FULFILLMENT OF
THE REQUIREMENTS FOR THE DEGREE OF
MASTER OF SCIENCE IN NURSING

IN

FACULTY OF GRADUATE STUDIES

THE SCHOOL OF NURSING

We accept this thesis as conforming
to the required standard

THE UNIVERSITY OF BRITISH COLUMBIA

August, 1997

© Karen Ann Davidson
In presenting this thesis in partial fulfilment of the requirements for an advanced degree at the University of British Columbia, I agree that the Library shall make it freely available for reference and study. I further agree that permission for extensive copying of this thesis for scholarly purposes may be granted by the head of my department or by his or her representatives. It is understood that copying or publication of this thesis for financial gain shall not be allowed without my written permission.

School of Nursing
The University of British Columbia
Vancouver, Canada

Date Aug 28, 1997
Abstract

The nature of setting (context) as an influence of clinical teaching in nursing education has not been explored. As nursing educators in North America move to educate nursing students in a variety of settings, including non-traditional settings, there is a need to explore how context in traditional settings (i.e., hospitals), influence how clinical teachers teach. An ethnographic design was used to explore the perceptions of six clinical teachers who clinically taught in the specialty areas of pediatrics and maternity. The six volunteer participants were selected from community colleges/universities in British Columbia which offer a Bachelors Degree in Nursing. Pratt's (1992) General Model of Teaching was used as the conceptual framework to guide the research design. The researcher in this study proposed a model of clinical teaching which considers the complexity of teaching in the context of the hospital setting.

Analysis of the data revealed components of context (i.e., geography, culture, ideology and history) and relationships with individuals/groups and entities (professional organizations, institutions or hospital agencies) which influenced clinical teaching in a variety of ways. Factors which influenced clinical teachers in general were the history of nursing education, the agency, relationships between staff nurses, clinical teachers and students, the nature of the specialty area (i.e., pediatrics...
and maternity), and the unit. Cultural groups within the context of clinical teaching that became evident were various members of the health care team, students, and patient and families. Specific factors which influenced pediatrics and maternity differently were the nature of the patient, the influence of family at the bedside, and the unit/units of clinical learning. These findings have implications for nursing education and nursing research. It is hoped that this study will help nursing educators consider the factors and aspects prior to the placement of teachers and students on a particular clinical unit.
# Table of Contents

Abstract ........................................................................................................... ii
Table of Contents ......................................................................................... iv
Acknowledgements ....................................................................................... ix

## Chapter One: Introduction ............................................................................. 1
  Background to the Problem ........................................................................ 1
  Research Question ...................................................................................... 2
  Definition of Terms .................................................................................... 3
    Clinical Teaching ..................................................................................... 3
    Context ................................................................................................. 3
    Teaching and Learning Environment ..................................................... 3
    Specialty Area ....................................................................................... 4
    Setting ................................................................................................. 4
  Conceptual Framework .............................................................................. 4
  Significance of the Study .......................................................................... 6
  Overview of the Thesis Content ............................................................... 7

## Chapter Two: Review of the Literature ......................................................... 9
  Clinical Learning Environment .................................................................. 9
  Classroom Teachers' Perspectives ............................................................. 11
  Clinical Teachers' Perspectives ................................................................. 13
  The Clinical Teacher and the Marginal Role ........................................... 14
  The Student ............................................................................................ 20
    The Student Stress Experience ............................................................... 20
    The Students' Perception of the Learning Experience ....................... 21
The Students' Work Experience ........................................ 22
Group Size, Level of Student & Length of Experience ........ 24
The Student-staff Relationship ........................................... 25
The Organizational Setting ................................................ 27
The Nursing Staff ............................................................. 30
  The Head Nurse ............................................................ 31
  Staff Nurses ............................................................... 31
The Patients ................................................................. 33
  The Patients' Acuity ....................................................... 34
  The Patients' Length of Hospitalization .......................... 35
Patient Characteristics .................................................... 35
The Specialty Area .......................................................... 37
The Setting ........................................................................ 40
  The Layout ................................................................... 41
Learning Opportunities ...................................................... 42
Resources ...................................................................... 43
Summary of the Literature Review ........................................ 43

Chapter Three: Research Method ........................................ 45
Research Design ............................................................... 45
Issues of Reliability, Validity and Generalizability ............ 48
Sample Selection, Recruitment, Inclusion Criteria and Size .................................................. 50
Data Collection ............................................................... 52
Data Analysis .................................................................. 54
Ethical Issues .................................................................. 55
Summary of Research Method .............................................. 56

Chapter Four: Research Findings ........................................ 57
The Nature of the Educational Program .............................. 57
    The Staff Nurses' Perception ..................................... 59
Relationships Between the Nursing Staff and
    Clinical Teacher ..................................................... 62
The Influence of the Educational Program on Students .... .... 65
    Location of the Student in the Program ...................... 65
    Holidays and Student Breaks ................................. 68
    Agency/Institutional Policies ................................. 69
    Prior Educational Experiences ................................. 72
The Agency and Staff as an Influence on Clinical Teaching 75
The Influence of Agency Changes ..................................... 75
The Influence of Agency Staff ......................................... 77
    Head Nurses ....................................................... 78
    Staff Nurses ..................................................... 78
    Doctors ............................................................. 81
    Unit Clerks ....................................................... 82
    Other Health Care Team Members ............................. 82
Patients and Family as an Influence on Clinical Teaching. 83
    Maternity Patients ............................................. 83
    Pediatric Patients ............................................. 86
    The Family ....................................................... 90
The Nature of the Specialty ........................................... 93
    The Nature of the Pediatric Area ............................ 93
Families .................................................. 133
Nature of the Specialty ................................. 133
Maternity .................................................. 133
Pediatrics .................................................. 135
Unit ......................................................... 136
Implications .............................................. 137
Future Directives for Nursing Education .......... 137
Future Directives for Nursing Research .......... 140
Limitations .............................................. 144
Conclusion ................................................ 144
References ............................................... 146
Appendices .............................................. 155
Appendix A: Pratt's General Model of Teaching... 156
Appendix B: Participant Information Letter ....... 158
Appendix C: Permission from Deans/Directors ... 161
Appendix D: Participant Consent .................... 163
Appendix E: A Model of Context in Clinical Teaching .. 166
Acknowledgements

I would like to acknowledge those individuals who provided me with assistance during this research project.

A very special thank-you to my thesis committee chairperson: Dr. Barbara Paterson who provided me with support, guidance and leadership; Dr. Daniel Pratt who provided invaluable higher education references and perspective; and to Marilyn Dewis who provided encouragement and valuable feedback.

I would like to extend my appreciation of thanks to my friends and colleagues who listened to me while taking on this major endeavour. Lastly, I would like to thank my family who endured a mother and wife who spent countless hours over the last year, at the computer desk.
Chapter One
Introduction

The health care system is in a state of disequilibrium. Health care restraint, the rising cost of care, the changing demographics of the population, and the trend toward care in the community has a direct affect on the "type" and "setting" of patient care in Canada. Similarly, within the hospital, the changing health care system influences the type and level of patient acuity and consequently has an impact on the personnel who work and learn within this setting. Therefore, the clinical teacher and the student nurses who venture into the hospital setting for clinical learning experiences are also affected. Likewise the interchange between teacher and student in the clinical area, referred to as "clinical teaching", is influenced by the health care system. This qualitative, ethnographic study seeks to determine how the nature of the clinical setting influences clinical teaching.

Background to the Problem

There is a paucity of research on clinical teaching (Oermann, 1993; Wong & Wong, 1987). Within the last decade, there has been an increase in the number of research articles on clinical teaching but most focus predominantly on teacher behaviours reflecting clinical teaching effectiveness (Oerman). There is little written as to how and why perspectives in clinical teaching change over time (Guskey, 1986; Hollingsworth; 1986; Hollingsworth, 1988; Shefelbine &
Hollingsworth, 1987). There is also little research on how the nature and characteristics of the setting influences clinical teaching. For example, it is unknown how the unique characteristics of specific specialty areas (e.g., medicine, pediatrics, psychiatry etc.) influence how clinical teachers teach and students learn. Furthermore, most of the available research as to how the nature of the setting influences clinical teaching was conducted in the 1980's, in the context of the nursing educational system in the United Kingdom. Therefore, generalizations with regards to the North American context cannot be made. The few studies which discuss the influence of context in North America involve the following limitations. They are: small sample size, sample group differences (e.g., staff nurses, returning students), and problems with tool/instrument reliability and validity. The dearth of research on the clinical teaching context has provoked the researcher to investigate the following question.

Research Question

The research question in this qualitative, ethnographic study is: How does the nature of the clinical setting influence clinical teaching?

The purpose of this study was to explore and articulate the differences and similarities of clinical teachers' experience in teaching in the clinical teaching contexts of maternity and pediatrics'.
**Definition of Terms**

**Clinical teaching.**

Clinical teaching is a process that is dynamic, interactive and occurs in any place where the teacher and learner interface. Meleca et al in 1978 described clinical teaching as;

preparing students to integrate previously acquired basic science information with performance-oriented skills and competencies associated with the diagnosis, treatment, and care of patients and to acquire the kinds of professional and personal skills, attitudes and behaviours thought essential for entering the health care system and embarking on continuing forms of education (Cited in White & Evans, 1991, p.2).

**Context.**

Context or "the nature of the setting", can refer to the cultural, historical, political, geographical, physical, social and organizational environment (Pratt & Associates, 1997). Context is a broad concept which includes many aspects which must be considered simultaneously. It includes the health care organization (e.g., the system, specialty areas, departments and units), the personnel who work and learn in the hospital and the people who receive care within the hospital.

**Teaching/learning environment.**

This environment refers to the context of teaching/learning in which the teachers/students find themselves. The teaching/learning environment can be influenced by many factors. Examples are: setting, the schedule, the circumstance (Pratt & Associates, 1997) and
personnel.

**Specialty area.**

A specialty area within the hospital setting provides a specific type of nursing and medical care to patients. Examples are medical, surgical, geriatric, critical care, maternity, pediatrics, and mental health. Generally, the majority of patients within a specific area of nursing/medicine would present with situational or developmental changes/concerns which are commonly cared for and treated within that area of specialty.

**Setting.**

A nursing/medical unit in the hospital where an organized system exists for the provision of patient care. Clinical teaching occurs on a variety nursing units. The clinical teaching setting is multipurpose in nature and is influenced by the learning outcomes, diversity of nursing competencies, variations in teachers and students and the uniqueness of the practice area (Reilly & Oermann, 1992).

**Conceptual Framework**

The conceptual framework that directed the research process in this study is Pratt's, General Model of Teaching (Appendix A) (Pratt & Associates, 1997). As Pratt notes, in much of the research and literature regarding adults and higher education, there is an underlying assumption that educators share similar perspectives and understandings about teaching. It is also assumed that effective teaching is
similar, regardless of differences in context, learners, content, and teachers. He goes on to postulate that "what is needed ...is a plurality of perspectives on teaching adults that recognizes diversity within teachers, learners [students], content, context, ideals and purposes" (p.4).

Pratt's "General Model of Teaching" identifies elements and relationships that may be important in teaching. The elements include: (a) teacher, (b) learner, (c) content, (d) context, and (e) ideals. The possible relationships between these elements include: the means to engage learners with the in content (line x), the relationship between teacher and learner (line y) and the establishment of a teachers' content credibility. These elements and relationships have similar relevance and significance to all learning experiences but educators show a greater/lesser commitment to some of the elements, as compared with others, when they verbalize about teaching (Pratt & Associates, 1997). For the purpose of the research the influence of context in clinical teaching is the focus.

Some teachers are highly committed to context. This is manifested by the need to locate learning in the "authentic contexts of practice and social relations" (Pratt & Associates, 1997, p.8). The context in Pratt's "Model for Teaching" refers to context as physical and social; in others words, where teaching/learning occurs. The examples of the First Nations People and trades people are given by Pratt as
individuals or groups who see context as the critical element for meaningful learning. There are a number of analogies of this experience to that of clinical teaching in nursing: (a) these groups or individuals work/learn along side someone with more experience, (b) learners watch, listen and then gradually participate in the social community of working and living, (c) the experience takes place in a community of people that are interdependent, and (d) classroom learning is often viewed as artificial and devoid of the realities of practice. This study does not limit the concept of context to the physical and social environments but include the cultural, organizational, political and geographical environments as well.

Pratt has identified a number of questions that can be posed to teachers to determine their actions, intentions and beliefs in regard to context. These questions have been adapted by Paterson, Pratt, Macentee & Page (1996) and formed the bases of the interview questions in this study. An example of a question was: How does setting affect the way you teach and learners learn? (Paterson et al).

**Significance of the Study**

This study has practical significance for clinical nursing teachers and student nurses involved in the clinical teaching relationship. Knowing the characteristics of the setting and how they influence the clinical teaching experience of nursing students, assists educators to plan learning experiences and to teach in more effective ways.
Nurses and other staff members who interact with teachers and students on the clinical learning unit are indirectly influenced by this knowledge. Therefore, nurses who find themselves in the situation of clinical teaching may emulate the methods and strategies which they have seen the clinical teacher demonstrate.

The findings of this study will contribute to nursing education's body of knowledge. Specifically, this study will add to the general clinical teaching research in regard to how the nature of the setting influences clinical teaching. This study may be regarded as a precursor to future studies, those which explore the context of community and how the nature of this setting influences the teaching of student nurses.

**Overview of Thesis Content**

This thesis consists of five chapters. Chapter One has provided significant background to the research question. It includes the definitions of common terms and the conceptual framework, which provides structure and meaning to the research question. Lastly, the significance of the study is described as providing rationale for the research study. Chapter Two consists of a literature review. It includes the analysis of the conceptual and research literature which the researcher has regarded as important and meaningful. Chapter Three includes the methodology section. Information regarding the design, the sample, the setting, the generation and analysis of data, the strategies employed to ensure rigor and
ethical considerations are discussed. Chapter Four presents the findings of the study. Chapter Five includes a discussion of the research findings as they relate to the literature review, and conceptual framework as well as new understandings. Research implications for nursing education and recommendations regarding future research in clinical teaching are made. This chapter closes with a summary and conclusion.
Chapter Two

Review of the Literature

In this chapter, the context of clinical teaching is discussed in relation to a variety of factors which have been identified in the nursing, teacher and higher education literature. This discussion focuses particularly on how these factors influence the context of teaching and learning in the clinical area. The context of maternity and pediatrics' as a clinical learning environment has not been specifically addressed in the literature. Therefore much of literature reviewed in this chapter has been extrapolated from literature that addresses context within general clinical settings. The discussion begins with a general overview of the clinical teaching environment, teachers' perspectives and then the factors that affect context. This is be followed by a review of research regarding the influence of setting in clinical learning experiences in nursing with some reference to this in other disciplines.

Clinical Learning Environment

The clinical learning environment in nursing can be described as the context within the health care system where teachers and students interact and make decisions regarding the well-being of the patient (Reilly & Oermann, 1992). Traditionally, clinical learning has been situated within the hospital setting but as health care policy, government restraint regarding funding and the preferences of patients
and their families are appreciated, the setting of clinical teaching has become diverse. Settings within the hospital can include specific or general units, clinics and outpatient departments. The setting possibilities within the community are just beginning to be explored. The range may include community health units, wellness centres, self-help groups and agencies, homeless shelters, campus nursing units, recreation/summer camps, and the penal system. There are many factors within each of these settings, which may affect teaching and learning from the perspective of the teacher.

Authors have made reference to the nature of the clinical setting and its influence on teaching/learning in the clinical area. However, little research has been conducted about how the nature of setting affects teaching and learning within that setting. The majority of the research described in this chapter has been extrapolated from relevant areas of research (e.g., teacher and higher education, registered and psychiatric nursing, staff development and organizational literature). In the literature, the following aspects have been identified as factors to consider with regards to context. It must be acknowledged that the significance, order of importance, interrelatedness, and all inclusiveness of these factors has not been established. These factors and others may be revealed as the proposed research progresses. Generally, the discussion as to how context influences clinical teaching begins by examining teachers' perspectives and the role of the
clinical teacher. Further to this, students are influenced by the nature of the clinical setting and consequently, their learning experiences affect the clinical teacher's role. Therefore the nature and characteristics of students as a contextual factor is described. As both student learning and clinical teaching are affected by the health care agency, the agency staff, and patients, research pertaining to these factors influencing clinical teaching are discussed. Finally, in the last section of this chapter, the specific research regarding setting is reported.

Before we can begin to appreciate how the clinical context affects teaching and learning, a discussion as to how context may influence teachers' perspectives within the classroom and clinical setting must be described.

**Classroom Teachers' Perspectives**

Perspectives on teaching can be viewed as "an interrelated set of beliefs and intentions which give meaning and justification for our actions" (Pratt & Associates, 1997, p.29). A perspective is the way one views the world of teaching and learning (Pratt & Associates). In other words, perspectives or beliefs about teaching and learning "...is believed to be significant in the interpretation of why teachers do what they do" (Briscoe, 1991, p.186). Research pertaining to teachers' perspectives, value orientations or conceptions of teaching has been approached it a variety of ways, within a diversity of disciplines. Much of the research
to date has occurred in the fields of teacher education and higher education. Little research has been conducted in nursing with regards to teachers' perspectives. Commonalities revealed in the research of higher education (Kember, in press; Pratt, 1992), teacher's education (Ennis, 1994), nursing (Paterson, 1994) and occupational therapy (Munroe, 1988) literature are: (a) teachers are influenced by a number of value perspectives, (b) there may be one priority or predominant orientation, and (c) there is little consensus as to whether perspectives (orientations, categories) are discrete, adjoining and or hierarchical (Kember).

Studies regarding teachers' perspectives have focussed mostly on classroom teaching, in particular how the experienced and inexperienced teacher know and develop classroom teaching knowledge (Calderhead, 1987; Clark & Peterson, 1986; Feinman-Nemser & Floden, 1986; Nespor, 1987; Shavelson & Stern, 1981). Researchers have acknowledged that all teachers can change their perspectives on teaching but little is known as to how this occurs (Guskey, 1986; Hollingsworth, 1986; Hollingsworth, 1988; Shefelbine & Hollingsworth, 1987). Kember (in press) in his literature review on conceptions of teaching acknowledges progression or development through categories or orientations. Further to this, progression is likely to be slow and arduous (Kember). The significant themes affecting the classroom teacher's perspective which emerge within the teaching and higher
education literature are: (a) the teacher as person; (b) the teacher's experience as a teacher and a learner; and (c) the context of teaching (Britzman, 1991; Crandall, 1993; Fenstermacher, 1986; Kember, in press; Pratt, 1992).

**Clinical Teachers' Perspective**

Research on classroom teaching can not be generalized to the clinical setting. Clinical settings are unique, complex and unpredictable. Patient care is often the priority in clinical teaching, not teaching and learning (Cranton & Kompf, 1989; Michael, 1976). Within complex clinical settings are the health care needs and learning needs of the patients and students respectively and the art of effectively interacting and communicating with various staff members, students and patients. These aspects make the clinical environment significantly different than that of the classroom setting.

Research on perspectives has been conducted in the domains of social work, medicine and in physio and occupational therapy (Macdonald & Bass, 1983; Michael, 1976; Munroe, 1988; Scully, 1974; Williams, 1981). These researchers have identified a variety of perspectives which are similar to the goal orientations described by Ames and Ames in 1984 regarding the perspectives of classroom teachers. Paterson in 1991 described perspectives within clinical teaching of six Canadian clinical nurse educators regarding their theoretical, knowledge and value claims of clinical
teaching. This study identified mediating and contextual variables which influenced the perspectives of six teachers, including the nature of the clinical setting in which the teacher teaches. This research suggests that perspectives of teachers evolve with experience in teaching. To date, few researchers have considered the influence of context on teachers perspectives within the classroom setting. Kember's (in press) recent literature review on conceptions of teaching revealed three researchers who acknowledged context within their research. Sheppard and Gilbert (1991) and Martin and Ramsden (1992) considered context from the students' perspective. Pratt's research in 1992 explicitly considered the influence of context on the conceptions of teaching. Therefore Pratt's conceptual framework was chosen to guide and direct the research process.

In summary, within the discipline of nursing, there is a dearth of knowledge regarding the influences of clinical teaching practice. Classroom teaching has demonstrated that perspectives change as the teacher achieves more experience in teaching and that these changes are influenced by a variety of personal and contextual variables. To date, there is little research investigating how clinical teachers' perspectives of teaching change with experience.

**The Clinical Teacher and the Marginal Role**

The clinical teacher, teaching within the context of the hospital setting, perceives and enacts his/her role in
relation to the perceptions of self and others (Lee, 1996; Packer, 1994; Paterson, 1991). According to Lee the role of the clinical teacher is in dispute and influences how clinical teachers teach and students learn. This dispute exists because of: (a) the lack of research in this role, (b) the low priority it is given, (c) the lack of preparation for it, and (d) the lack of educational input into the clinical area. Lee contends that:

there is only a limited amount of literature dealing directly with the clinical role of nurse teachers. Furthermore, the number of comment articles far exceeds the researched work and the issue is usually addressed as a more wide-ranging discussion of nurse teachers or nurse education (p.1127).

The role of the clinical teacher in nursing is considered of low priority in comparison to the role of the classroom teacher, the administrator and the researcher (Smyth, 1988; Wong & Wong, 1987). Studies conducted by Crawshaw (1978) and Gallego et al (1980) reveal that either three hours or as little as no time was allocated towards clinical activities or preparation by clinical teachers. In contrast, Crawshaw's study cites an average of 12 hours per week as spent on classroom teaching preparation (Cited in Lee, 1996).

There is a lack of preparation for the role of the clinical teacher (Lee, 1996; Windsor, 1987). Many undergraduate and graduate nursing programs have not and are not adequately preparing the clinical teacher for this role (Fothergill-Bourbonnais & Higuchi, 1995). Paterson (1991) contends that clinical teachers learn to teach by trial and
error. Further, the clinical teacher's teaching is influenced by: (a) the way he or she was personally taught and (b) his or her previous experiences with student groups (Paterson).

The fourth point made by Lee (1996) supports the "guest in the house" or marginal role theory which will be alluded to in this section. A guest has little power, control and influence over the environment in which one is a guest; therefore, the clinical teacher, as a guest in the clinical agency, lacks educational input into the clinical teaching area. This phenomenon is best understood from a historical perspective.

Historically, the clinical teacher within the hospital system, was the "ward sister". This role fostered student learning through the provision of service (Reilly & Oermann, 1992). In Canada during the 1970's, the education of the student nurse became the responsibility of the college or university system. This system was segregated and separated from the hospital system except for guided practice where an clinical teacher or preceptor was present. At that time, the role of the clinical teacher became a temporary one, sometimes labelled as the "guest in the house" (Glass, 1971; Packer, 1994; Paterson, 1991). The role of the clinical teacher was seen by clinicians as one that lacked credibility because clinical teachers were perceived as being isolated from the realities of practice (Packer; Royle & Crooks, 1986). The "guest in the house" role within the hospital unit was
associated with several problems for the clinical teacher; e.g., the difficulty of knowing the staff, routines, policies, procedures and the unit's politics. This situation existed even when teachers were consistently placed on the same unit (Packer). Paterson (1997) described the "guest in house" role as one which the clinical teacher is viewed by the staff nurses as a nuisance. As a consequence, the clinical teacher teaches defensively and becomes preoccupied with the avoidance of student errors. The outcome of the "guest in the house" situation is one of territoriality in which the students are viewed as belonging to the teacher and, conversely, the patients and hospital setting are perceived as the property of the hospital unit (Oermann, 1993; Paterson, 1991). The clinical teachers in Paterson's (1991) research attempted to minimize the negative outcomes of the "guest in the house" role by compromising, courting and negotiating behaviours with the hospital staff.

One reason why the "guest in the house" status is often assigned by staff nurses to clinical teachers is that the teacher belongs to a different culture than that of the nursing staff. This culture is one which bridges the cultures of education and service. The culture of education belongs to those at the college/university setting while the culture of practice belongs primarily to those who work in practice. The clinical teacher can be viewed as one who attempts to belong to both cultures without legitimate membership to the practice
arena. Each culture has goals, values and a socialization process which is unique to the group and those who belong. The criteria for acceptance of the clinical teacher into the practice culture is ambiguous. Paterson (1997) and Smyth (1988) support the notion that membership of the teacher in the practice arena depends largely upon the quality of the relationship the clinical teacher has with the head nurse and other key members on the unit. The clinical teacher who is excluded from the practice culture, that which belongs to the staff nurses, experiences a sense of alienation and attempts to search out fellow clinical instructors either in the hospital setting or the university/college for support and a sense of belonging.

In contrast, other authors contend that when the clinical teacher is familiar with the hospital staff and clinical unit, the student's learning experience is maximized. This occurs through the development of effective working relationships between the teacher and the unit staff (Fothergill-Bourbonnais & Higushi, 1995). If the clinical teacher is respected and perceived as a credible, competent clinician by the staff, this in turn creates a positive learning environment, one that is conducive to student learning and mutual acceptance (Campbell, Larrivee, Field, Day & Reutter, 1994; Royle & Crooks, 1986).

The unit staff's past and present experience with clinical nursing teachers can influence their acceptance
and/or rejection of nursing teachers and their students (Paterson, 1991; Shailer, 1990). Shailer describes a situation in the United Kingdom whereby the teacher withdrew her student group early from the clinical experience because the learning setting did not meet the proposed standards. This situation created contemptuous relations between the clinical teachers, the clinical practitioners and the general managers of the organization because the nursing staff perceived that they were being slighted by this decision (Shailer).

Various authors have addressed the issue of power and its influence on the marginal role of the teacher. Stew (1996) views the teacher's role as powerless, one that lacks control in the clinical setting. Other authors contend that the teacher lacks control over the factors and the learning experience which affect student learning (Packer, 1994; Wong & Wong, 1987). Furthermore, Smyth (1988) argues that the teacher in the clinical setting has no structural authority or power to manage resources.

The marginal role of the clinical teacher has its underpinnings in the history of nursing in Canada. Literature supports this role as being one which is temporary, marginal, culturally different and one that lacks power and authority. The clinical teacher attempts to reduce the marginality by varying his or her behaviour with the members of the unit. Within this discussion, the influence of the student on the
learning environment has not been addressed. The next section addresses this very important influence.

**The Student**

The nature and characteristics of the nursing student have a great influence on the teaching and learning environment within the clinical setting. The literature delineates the following as student factors that influence clinical teaching as: (a) the stress experience, (b) the student's perception of the learning experience, (c) the student's work experience, (d) group size, level of student and length of student experience, and (e) the student-staff relationship.

**The stress experience.**

Student anxiety in the clinical area is an often reported phenomenon by researchers (Oermann, 1993; Smith, 1987; Fothergill-Bourbonnais & Higuchi, 1995; Kleehammer, Hart & Keck, 1990; Pagana, 1988). Students' anxiety in the clinical area influences how clinical teachers teach in the following ways. Clinical teachers frequently adjust the amount and type of supervision in relation to the students' anxiety level (Sutherland, 1995; Paterson, 1991). Furthermore, teachers who are attempting to lessen a student's anxiety feel compelled to observe that student indirectly and at a distance (Paterson). Researchers have demonstrated that close clinical supervision has a tendency to increase the students' anxiety as well as
inhibit the occurrence of learning (Kleehammer et al).

Packer (1994) notes that students' are anxious about asking questions of their clinical teachers therefore they frequently approach their peers for the information. The clinical teacher needs to devise strategies to assess student knowledge and understanding in non-threatening ways. Other situations and factors which produce high levels of anxiety in student nurses and consequently influence clinical teaching are: (a) the initial clinical experience on a unit, (b) the fear of making mistakes, (c) clinical procedures, (d) hospital equipment, (e) the level of student and (f) the perception of non-supportive faculty (Kleehammer et al, 1990).

The students' perception of the learning experience.

The students' perception of the learning experience affects clinical teaching. Researchers have described students' attitudes and perceptions when caring for geriatric, terminally ill, homeless and disabled patients (Anderson & Martaus, 1987; Eakes, 1986; Hartley, Bentz & Ellis, 1995; Lindgren & Oermann, 1993). Authors in the area of psychiatric nursing can identify a process which all psychiatric students undergo in their first psychiatric experience. They identify the stages of adaptation to this experience as shock, intellectualization, rescue fantasy, anger, immobilization and eventual mirroring of burn-out (Bissell, Feather & Ryan, 1984). Effective clinical teaching in this clinical setting would include: (a) active intervention, (b) the provision of a
supportive environment (c) the provision of good interpersonal relations, and (d) effective communication (Bissell et al).

Clinical teachers need to become aware of what types of behaviour and which strategies have an positive influence on the students self-esteem and self-confidence. The students' perception of their clinical experience can influence their self-concept and self-confidence. Studies conducted by a variety of researchers provide evidence that faculty often contribute to the students' lowering of self-esteem and self-confidence (Flagler, Loper-Powers & Spitzer, 1988; Pagana, 1988; Windsor, 1987). "Findings in all three studies demonstrated the students' desire for more positive feedback from faculty and presented evidence that students' negative experiences with faculty had adverse effects on their self-confidence" (Mosingo, Thomas & Brooks, 1995, p.116). Understanding students' perception of their clinical experience assists clinical teachers in their teaching and students in their learning.

The work experience of the student.

Prior work experience that is of a health care nature influences students' attitudes, self-esteem and has an influence on clinical teaching (Baillie, 1993; Lindgren & Oermann, 1993; Paterson, 1991). Mozingo et al (1995) found a significant positive correlation between student employment in a health care setting during the academic year and perceived levels of competency. Clinical teachers of students who have
worked in health care settings feel challenged to offer these students learning experiences that build on this past experience. As well if students work during the academic year, they may be tired and stressed in the clinical area. This may affect their ability to learn and the clinical teacher's ability to teach them.

Paterson discovered in her ethnographic study (1991) of clinical teachers that students' personal and professional experience influence how the teachers interact with them. Two examples of how teachers' may perceive students with previous health care experience is described in the following statements: Teacher X: "...so many of these students with aide or orderly experience think they know everything and don't want to learn new ways of doing things" (Paterson, p.189).

Teacher Y: "She can be counted on to let someone know if something untoward happens. However, I worry about six months from now when she's required to make independent decisions" (p.189). This last remark was made regarding a nursing student who had previous knowledge and experience as a licensed practical nurse (L.P.N.). In short, clinical teachers formulate perceptions about their students regarding the students previous education and experience. Consequently, their perceptions influences how they teach clinically.

Baillie's (1993) research found that prior experience in the same setting (community placements) could help or inhibit
learning. The study results were influenced by the individual student concerned, as well as the type of previous experience which the student has already gained in this setting (Baillie).

**Group size, level of student & length of experience.**

Clinical student groups have been addressed by various authors in relation to the student's familiarity within a group and in regards to the number within the student clinical group. Research has demonstrated that student groups that are familiar and connected experience less tension and anxiety (Campbell et al, 1994). Furthermore, Paterson's research (1991) identified characteristics of groups which influence how teachers teach (e.g., familiar, strong, weak, healthy and motivated groups).

Leonard (1994) examined factors which were perceived to facilitate and impede the learning of staff nurses in the workplace. The factor "small group size" was perceived as facilitating learning (Leonard). Two limitations of this study are the absence of a "small group" definition, as well as the ability to generalize this finding to student nurses and their clinical teaching.

The level of the student can influence clinical teaching. Paterson (1991) found that, as student progressed through an educational program, clinical teachers became less directing and mothering. Few studies have examined the influence of the level of the student on the role of the clinical teacher.
Battersby and Hemming (1991) found that the length of time student's spent in the clinical setting was not significant in regards to the quality of graduate nurse performance (cited in Packer, 1994). It was observed that the quality of the experience was important, not the quantity. Other research on the structure of clinical practicum failed to demonstrate any significance between the length and pattern of clinical practice and its influence on nursing knowledge, test scores (e.g., achievement tests, state boards and scores on simulations) and self-confidence (Oermann, 1993).

**The student-staff relationship.**

The student-staff relationship is directly influenced by the beliefs which various members hold concerning the role of the student. The clinical teacher and the student envision the primary role of the student as learner, while the staff nurse may perceive the student role as one of service (Infante, 1985). This dichotomy confuses the student, influences the clinical teacher as previously discussed in the "marginal role" and consequently affects clinical teaching (Wilson, 1994).

In the situation described in the preceding paragraph, the student experiences two roles. At the college or university, the student is considered a learner. Within the domain of the hospital, the student is considered a worker (Wilson, 1994). These roles are viewed by the students as
conflicting and competing (Wilson). In clinical practice, the student as well has difficulty differentiating between the role of the student and worker (Campbell et al, 1994). Furthermore, the student who is viewed as a worker is expected to give care comparable to the care which is given by a registered nurse (R.N.) (Packer, 1994; Wood, 1987).

Students within the clinical setting desire to contribute and to feel like a team member (Windsor, 1987). Paterson (1991) contends that nursing students are unable to experience the team concept because they are considered by the nursing staff as guests. This experience is not dissimilar to the "guest in the house" experience which the clinical teacher experiences. This marginal role restricts the interactions that occur between the students and staff (Dewe, 1989; Paterson). Other relevant issues affecting the students' perception as a team member are: (a) the perceived lack of support and intolerance of the students and (b) the undervaluation of the students' nursing program (Campbell et al, 1994; Paterson). This adds to their anxiety in clinical learning and to the teacher's tendency to protect the students from negative interactions with staff.

Examples of positive relationships among the students and staff are revealed in the literature as well. Baillie's (1993) phenomenological study regarding student learning in community placements and Chalykoff's (1993) pilot project regarding the elements of a successful clinical experience
with "returning R.N. students" (R.N. students returning for their degree in nursing) found supportive staff who viewed learning as a shared process. Students in these two studies expressed "feeling like part of the team". Limitations revealed in these two studies are (a) the small sample size (e.g., n=8, n=15) (b) the inability to generalize to other settings and (c) the inability to generalize to all types of nursing students (Baillie; Chalykoff).

The students' experience within the clinical setting is influenced by the perception of their role as viewed by others. This view affects the student-staff relationship and influences how clinical teachers teach in this setting.

In summary, this section of the literature review addresses some aspects as to how the nature and characteristics of the student influences how clinical teachers teach. There remains a paucity of research is this area.

**The Organizational Setting**

This section of the literature review addresses how the nature and characteristics of the organization influence clinical teaching. The organizational setting may be within the confines of a hospital, a non-profit society, a homeless shelter or a wellness centre but for the purpose of this literature review, the organizational setting is be limited to the hospital setting.

Many authors have written about change within
organizational settings regarding the influence on staff nurses and patients but there remains a paucity of research on how the nature and characteristics of the organization affect clinical teaching (Oermann, 1993).

Health care agencies are currently under a tremendous strain. This strain is directly related to the dwindling resources (e.g. money), the demands made by the growing aged population as well as the rising cost of health care providers, supplies and technology (Reilly & Oermann, 1992). These factors have an influence on the agency and on all those who provide or receive service within its walls. A consequence of the dwindling resources and the high cost of service has forced organizations to evaluate their operating costs in relation to the provision of service (Kowalski et al, 1996). Many organizations have had to downsize as a result of government restraint and its resultant reduced budget. Downsizing (e.g., the reduction of patient beds with a complimentary reduction in staff) within hospital settings has forced a change within work groups (Suderman, 1995). This change causes the laying-off or the relocation of staff members to and from units which in turn has a direct effect on the morale, professional functioning, climate and the patterns of communication between individuals and groups (Ireson & Powers, 1987; Piscopo, 1994; Suderman). Piscopo found a significant positive correlation between the organizational climate, communication, and reported role strain in clinical
teachers. Furthermore, clinical teachers who had a positive perception of the organizational climate felt more comfortable about overseeing the student experience. Consequently, they were better able to fulfill their obligation as the teacher of students.

Reduction of hospital costs may occur through reorganizing management personnel or through operating units with a reduction of resources (e.g., staff and supplies). Staff shortages and the removal of first line managers has a direct effect on the nurses, students, instructors and patients (Leonard, 1994). Nurses who experience staff shortages experience increased levels of stress and tension (Dewe, 1989). Patients as well are compromised by receiving a change in the quality and level of care (Kowalski et al, 1990). The clinical teacher and students are directly influenced by the patient-staff ratio, the attitudes of the staff and the quality of care which is provided for the patients (Fothergill-Bourbonnais & Higuchi, 1995). These factors often reveal the widening of the "theory practice gap" and possible repercussions of negative role modelling on the part of the R.N. (Jarvis, 1992). The clinical teacher and student attempt to make sense of this situation.

The first-line manager, previously know as the ward sister, the head nurse or the team leader, may now be non-existent or have a strictly administrative role as the unit manager. The hierarchical pattern and the lines of
communication which once occurred between the clinical teacher and head nurse have been altered (Dunn & Burnett, 1995). If the teacher needs to communicate student clinical issues or problems to the organization, the clinical teachers may have difficulty identifying the appropriate person to discuss this matter. Frequently, discussion which should have occurred between the head nurse and teacher regarding clinical teaching is either left unsaid or is posted as an unimportant memo.

Organizations and various staff members can have a positive influence on learning environments. Fretwell (1980) found that the ward sister had the greatest influence in creating and promoting a learning environment in the hospital setting. Further, Leonard (1994), in her study of staff nurses, determined the factors which facilitate such as: (a) "support for education by nursing administration", (b) "availability of education", (c) "the inviting atmosphere of the staff development department", (d) "the expert instructor", and (e) "support of education by first-line managers" (Leonard, p.81).

The Nursing Staff

The nature and characteristics of the nursing staff can influence how teachers teach and students learn in the clinical setting. The quality of the learning experience which the students receive should not only be regarded as the responsibility of the clinical nursing teacher but that of the staff nurses as well (Slimmer, Wendt & Martinkus, 1990). In
this section, the nursing staff and their influence on
clinical teaching in nursing is examined.

**The head nurse.**

Previously in the literature review, the head nurse or
ward sister was alluded to as having an influence on clinical
teaching in nursing (Fretwell, 1980; Leonard, 1994). Head
nurses have a direct influence on their staff members and can
encourage or discourage the staffs' role with student nurses
(Paterson, 1991; Shailer, 1990; Smith, 1987). Furthermore,
Paterson in her research on clinical teachers, "...perceived
the head nurse's commitment to nursing education and his/her
behaviour toward the teacher and students as greatly
influencing the clinical teaching experience" (p.169).

**Staff nurses.**

The stability, composition, staffing level and the
workload of the staff on the nursing unit has an influence on
clinical teaching (Paterson, 1991; Smith, 1987). Stable staff
members who are aware of the students' level, skills and
knowledge can positively affect the nature of clinical
teaching (Shailer, 1990). Conversely, Paterson found that
senior discontented staff had an intolerance of nursing
students, consequently influencing the clinical learning
experience.

The practices and the composition of the staff e.g.,
R.N.s, L.P.N.s, float/casual nurses, can influence the nature
of clinical teaching. Teams with a high number of "float" or
"casual" nurses may increase the demands on staff nurses to answer questions and to teach; consequently, less patience is exhibited by the regular nursing staff towards the nursing students who are in the clinical area at the same time (Paterson, 1991). Stew (1996) found that different professional groups (e.g., midwives, L.P.N.s, psychiatric nurses) had loyalties to their speciality field; these loyalties affected their response to clinical teachers who had different clinical backgrounds. The two preceding findings may have implications for clinical teaching but further research is needed to explore the influence of various professional groups and staff members on the clinical teaching of student nurses.

Staffing levels and workloads affect the nature of the clinical area as a learning environment (Smith, 1987). Smith found that, as the physical workload of staff nurses increased, there was a perceived lowering of the quality of the clinical area as a learning environment. Moreover, other researchers found that staffing levels and workloads influence the nurse's sense of job satisfaction and role strain (Hallberg & Norberg, 1993; Leonard, 1994). This, in turn, affects the interpersonal relationships, the attitudes and the environment in which people work and learn (Dunn & Burnett, 1995; Fretwell, 1980; Shailer, 1990). The approachability and accessibility of the staff to students is an important element when creating a positive clinical learning environment.
(Fothergill-Bourbonnais & Higuchi, 1995; Smith). Studies which examine the relationship between mentors and students stress the importance of quality relationships in effective learning situations (Baillie, 1993; Campbell et al, 1994; Fretwell; Smith).

In summary, this section of the literature review addresses the nature and characteristics of nursing staff and their influence on how teachers teach and students learn in the clinical area. There is a paucity of literature and research regarding the influence of staff nurses on the clinical teaching of nursing students. Limitations in this body of research include lack of generalizability due to the uniqueness of the setting and location (e.g., United Kingdom which has a very different nursing education system than does Canada), focus on staff development rather than basic nursing education, small sample sizes, and the use of tools/instruments with no known reliability or validity.

Patients

Clinical teaching and the practice of nursing occurs with a diversity of patients in a variety of settings. This section of the literature review addresses how the nature and characteristics of patients in the hospital setting influence clinical teaching. Research is limited regarding how the nature of the patient influences clinical teaching but for the purpose of this literature review, the few studies found are be discussed.
The changing demographics in society, health care restraints, and the emphasis on community care have a direct effect on the types of patients cared for in the hospital setting. Common themes in this regard that are presented in the literature include patient acuity, length of hospitalization, types of patients, and types of illnesses.

The patients' acuity.

Many authors have written about the change in the level of patient acuity (the degree or severity of illness) in the hospital setting (Hartley et al, 1995). The movement towards early discharge and the emphasis on care within the community has left the most severely ill patients in the hospital setting (Oermann, 1994). Nursing programs in North America currently use the hospital domain for the majority of its nursing practice experience; therefore, students are learning from the most acute patients (Reilly & Oermann, 1992). This can be problematic to the learning of entry level nursing students because they lack the knowledge and skill to care for such complex patients (Corder, 1991; Hartley et al). These students are particularly prone to anxiety when faced with the demands of high acuity care (Corder). Augspurger and Rieg (1994) contend that the acuity of most pediatric units in the hospital is incongruent with the needs of novice learners in the area. In other words, the nature and acuity of the patients prevents the students' from focussing on course content and objectives. On the contrary, Wilson (1994) found
that acutely ill pediatric patients gave students a sense of urgency and necessity about their learning that was not present in the classroom setting. This consequently affected clinical teaching.

**The patients' length of hospitalization.**

The literature pertaining to how the length of the hospitalization may influence clinical teaching is limited. Smith (1987) suggests that "a positive atmosphere" on a unit is associated with the stability of the nursing staff and the quick turnover in patients on the unit. This positive atmosphere may increase the morale of the staff and students (Smith). Furthermore, Lewin and Leach (1982) found that the student nurses' performance did not deteriorate on wards with high patient turnover rates. In contrast, students' performance on low turnover clinical units deteriorated. No postulation was made by the researchers as to why this occurred.

**Patient characteristics.**

The nature of the patient can affect student learning and, hence, clinical teaching. Several authors report that gender, age and diagnosis influence clinical teaching because of their effect on nursing students.

Parks (1980) suggests that the gender of the patient may affect the students' ability to learn and care for the patient. These students experienced higher anxiety levels in regards to learning with an all male patient population (cited
Caring for the acute medical-surgical patient was perceived by students as a more meaningful learning experience than the care of elderly dependent patients (Smith, 1987). Factors which may have influenced the students' perception regarding the value of this learning experience were the physical workload and staffing levels on the unit.

Situations, where patients required emergency care, presented with a variety of diseases or required the student to perform a range of psychomotor and technical skills were regarded as positive learning experiences by students (Dewe, 1989; Fretwell, 1980). Clinical teachers may plan their student-patient assignment knowing which situations the students regard as positive learning experiences.

Krichbaum (1994) found that when students cared for critical care patients, the students learned best by first observing and then by doing. This situation has implications for clinical teaching. The clinical teacher teaching in this setting may first encourage observation and then participation.

Sudden unexpected changes regarding the patients' status or stressful clinical situations can have a negative affect on clinical teaching (Dewe, 1989; Smith, 1987). Dewe and Smith found that these situations increased levels of tension in all staff, including students. Consequently, students may experience decreased learning when they experience unexpected
or stressful patient situations (Smith).

Research demonstrates that the type of patient may affect the teachers ability to clinically teach. Hartley et al (1995) found that teachers, who conduct clinical teaching in the geriatric setting, may lack educational preparation in gerontological nursing and may not value the type of nursing given to the patients in this area. These finding have implications as to how teachers clinically teach and students learn in the geriatric setting. It is not known how unpredictable and unfamiliar patient situations influence how clinical teachers teach (Hartley et al).

In summary, patients in the hospital setting can be acute, highly complex, and unpredictable. This patient situation, one where the staff, the instructor and the students lack control over the factors which affect learning greatly influences the nature of clinical teaching (Wong & Wong, 1987). However, because patients and their significant others are beginning to demand active involvement in decisions about the patient's care, it would seem likely that the patient and his/her significant others may at times refuse care by students or request alterations in the usual methods of clinical learning. This is not discussed in the nursing literature.

The Specialty Area

Areas within the hospital are generally organized in relation to the type and quality of medical care which the
patient is to receive. For the purpose of this paper, specialty area is defined as any area within the hospital which provides a specific type of nursing and medical care to patients. Specialty areas include medical, surgical, geriatric, critical care, maternity, pediatrics and mental health clinical units. This section specifically addresses how the nature and characteristics of the specialty area influence clinical teaching.

Research findings suggest that specialty areas provide different learning experiences for nursing students (Fretwell, 1980; Lewin & Leach, 1982; Smith, 1987) Authors contend that clinical units with a common designation (i.e., specialty areas) do not necessarily have similar characteristics (Lewin & Leach). The study by Roper in 1976 revealed unit labels as pediatrics and geriatrics as misleading because a wide variety of learning experiences were available on these units no matter what the unit designation (Cited in Lewin & Leach). This author proposes leaving students on varied units for a longer rotation because of the diversity of experience. He speculates that this would decrease the students' stress experience as they enter the new "native culture" of a specific unit (Smith).

Parke (1980) found that "female students experienced higher levels of anxiety and depression and lower levels of work satisfaction on medical wards compared with surgical wards" (Cited in Smith, 1987, p.414). Another finding in this
study which may affect clinical teaching was that anxiety and satisfaction levels were higher on all male units when compared with all female units (Smith). No postulation was made by the researcher as to why this occurred.

Jarvis (1992) contends that speciality areas of nursing are different but there are areas of overlap. This premise has implications for clinical teacher. The astute teacher should assist students to build on their clinical experience instead of having the students' view the specialities areas as unique and isolated.

Clinical teachers need to be knowledgeable and competent in the speciality area in which they teach. Clinical teachers who assume that they can teach in all areas within a hospital can negatively affect the students' learning experience as well as the relationship between the university/college and the hospital unit (Wood, 1987).

An Australian study analysed stress variables for nurses across four hospital specialty areas (Cross & Fallon, 1985). The 45 variables were categorized under the following headings: (a) management of the ward, (b) interpersonal relationships, (c) patient care, (d) knowledge and skills, (e) work environment, (f) life events, and (g) administrative rewards. The researchers found that nurses (e.g., critical care, surgical, medical & maternity) differed in perceived occurrence of stressors in their specialty area. It is unknown whether nursing students and their teachers maintain
similar perceptions.

There is a paucity of research regarding how the specialty areas within nursing influence clinical teaching. The literature reviewed in this section to date is generally limited to registered nurses or to the experience in United Kingdom; therefore generalizability of these findings are limited.

The Setting

This last section of the literature review addresses how the nature and characteristics of the setting influence clinical teaching. The literature describes the following factors as having an influence on the clinical teaching of nursing students: (a) the layout, (b) learning opportunities, and (c) resources. Some authors (Cross & Fallon, 1985; Fothergill-Bourbonnais, 1995; Fretwell, 1980) consider the patient as "setting", but for the purpose of this part of the literature review, this section will address (a) through (c) only.

There is a paucity of research and clinical learning environment tools/instruments regarding the influence and measurement of setting on clinical teaching (Dunn & Burnett, 1995). Most of the tools/instruments to date were designed for use with the student nurse population and reflect the hospital-based nursing education system in Britain (Dunn & Burnett). Hence, there is little research on settings in Canada from the perspective of the clinical teacher.
The layout.

Authors have discussed the influence of layout on clinical teaching. Problems with the layout include long hallways that make the supervision of nursing students difficult and physically demanding (Paterson, 1991; Weitzel, 1996). Similarly, renovations on the unit have an influence on clinical teaching by restricting the nature and type of experience available for the student nurses (Farrell & Coombes, 1994; Paterson). The availability, appearance and location of student conference rooms affect clinical teaching if access to this room is limited or if their location means that the students and teacher are physically away from the "unit of learning" during conference time (Farrell & Coombes; Paterson). This may result in students not having learning opportunities which may arise if patient-related situations occur during that time on the unit.

The size of the unit has an influence on clinical teaching. The size influences the number of students who can clinically learn on the unit and the availability of the clinical teacher for the students (Krichbaum, 1994; Smyth, 1988). At times, a clinical teacher is required to supervise students on more than one unit to accommodate the numbers of students. The clinical teacher who clinically teaches on two or more units is less available for teaching and consultation with student and staff (Anderson, Nichol, Shrestha, & Singh, 1988; Smyth, 1988; Sutherland, 1995).
Windsor's (1987) study found that frequent and private feedback was appreciated by most students. The layout of the unit can influence the amount and type of feedback exchanged between the clinical teacher and student. Because private space on a unit is limited, clinical teachers and students have resorted to discussions about student progress (e.g., the critique of a skill/care) in the setting of the clean or dirty utility room, the linen closet and the hallway (Paterson, 1991; Shailler, 1990; Windsor). These less than private settings may influence what teachers and students discuss and how they attend to the conversation. Sutherland (1995) contends that teacher-student discussions should occur off the unit. This may be problematic by jeopardising teacher availability for other students. At times, the clinical teacher and student may desire to give/receive immediate feedback after the student's performance of a skill/care. This may be prevented if the teacher and student need to locate off the unit.

**Learning opportunities.**

Many authors have alluded to the nature and characteristics of the learning opportunities on clinical teaching. The learning opportunities which exist on the unit are unique to the clinical setting (Smith, 1987). Important qualities of the learning environment include course relevancy and significance, availability of patients and a range of adequate learning opportunities (Baillie, 1993; Lewin & Leach,
1982; Watson, 1979). Paterson (1991) found that as units underwent structural or procedural change, there may be less experience for the students (e.g., the patients' self-administration of medications reduced the students' opportunity to give medications). This in turn would lessen or vary the clinical teaching opportunities.

**Resources.**

Resources on the clinical unit may influence clinical teaching. Authors describe the importance of policy and procedure manuals, learning material and hospital philosophy as important resources for clinical teaching (Krichbaum, 1994; Shailler, 1990). Others describe the availability of operational and appropriate equipment as a genuine problem and a common source of frustration for both students and teachers (Anderson et al, 1988; Lewin & Leach, 1982; Paterson, 1991).

There is a paucity of research regarding how the nature and characteristics of setting influence clinical teaching. Research limitations include small sample size, the lack of reliable and valid tools/instruments and the inability to generalize across settings.

**Summary of the Literature Review**

Changes within our health care and educational systems have implications as to how and where clinical nursing teacher teaches. Students are requesting qualified and knowledgeable teachers who can teach in diverse and complex settings. The nature of the clinical setting in today's health care system
is complex, unpredictable and multifaceted. The competent clinical teacher needs to be able to identify and describe the nature and characteristics of the factors in the clinical teaching environment which influence clinical teaching. The teacher would then be able to use purposeful methods and strategies to enhance the learning environment for nursing students.

Research in clinical teaching in nursing has increased in the last decade. Most of the current research to date focuses predominantly on teacher behaviours reflecting clinical teaching effectiveness (Oermann, 1993). Few studies have examined the influence of the clinical setting on clinical teaching. The research regarding the learning environment and its influence on clinical teaching is limited by the use of clinical settings in other countries, specialized settings, small sample sizes, perceptions of staff nurses and students, and the use of tools/instruments without established reliability and validity.

Nursing education is dynamic. Clinical teachers and nursing students in the 1990's are entering clinical sites in the community, placements traditionally used for the advance practice of post-basic nursing education. Before we can begin to appreciate the complexity and the factors which may influence clinical teaching in a diversity of placements, researchers must discover how the nature and characteristics of the hospital setting influence clinical teaching.
Chapter Three
Research Method

This chapter addresses the study's research design, related issues of reliability, validity and generalizability, and ethical issues. Other components of this section include the sample/participant selection, including sample size and issues of recruitment. Lastly, this section identifies the strategies used to collect and analyse the data.

Research Design

The design selected for this research on clinical teaching was ethnography. Ethnography was considered an appropriate research design as it relates to the nature of the study (e.g., exploratory, descriptive, relation searching) and the research question (e.g., the study attempts to answer the question: "What is happening here?") (Germain, 1993). Ethnography has a series of interrelated orientating principles. According to Zaharlick and Green (1991), "ethnography is a culturally driven approach, ethnography involves a comparative perspective; ethnographic fieldwork involves an interactive-reactive approach; and ethnography is the basis of ethnology" (p. 205). It is these principles that distinguish this design from other forms of qualitative research designs in the social and behavioural sciences (Zaharlick & Green).

The tradition selected for this research on clinical teaching was based on Spradley's (1979) method of ethnography.
This method begins with the assumption that all cultures are valuable and that differences in human beings result from the culture to which human beings belong or have been exposed (Spradley). Ethnography in this tradition is the describing and comparing of one culture to another. Furthermore, it enables a member of one culture to study another culture in context by showing a range of cultural differences and how people with diverse perspectives interact (Spradley).

Specifically, ethnography was selected as the most appropriate study design because it: (a) involves interviewing members of the clinical teaching culture, (b) illuminates the cultural context of maternity and pediatrics', (c) assists the researcher to explore, describe and compare differences/similarities between the cultures of maternity and pediatrics', (d) does not end with understanding the human condition of a specific group (e.g., pediatric and maternity cultures) but rather concern itself with "understanding commonalties and variability in the human condition both within and across groups" (Zaharlick & Green, p.209) and (e) does not limit the findings to a description of a specific group (e.g., pediatric and maternity cultures).

The researcher based the research question, purpose and methodology on the assumption that the cultural contexts of maternity and pediatrics' present as two different cultures with defined roles, responsibilities, relationships and norms. This assumption enabled the researcher to select clinical
teachers who taught in the cultural context of maternity or pediatrics. Through the selection of two groups (e.g., maternity and pediatric clinical teachers) the researcher was enabled to explore the teachers' perception as to how the unique cultures of maternity and pediatrics affected the way they taught.

The ethnographer "aims to understand another way of life from the native point of view" (Spradley, p. 3). By becoming a student of the culture to be studied, the ethnographer receives and understands the insider's view. Ethnographic studies can contribute to the body of cultural knowledge by understanding complex societies, understanding human behaviour and by informing culture bound theories (Spradley).

Originally, ethnography was the method of choice by cultural anthropologists but in recent years, other disciplines have chosen this design to explore and describe the "what", "how" and "why" (Germain, 1993). The range of disciplines that have used ethnography includes nursing, anthropology, education, social psychology, sociology and political science (Germain). According to Rosenthal (1989, p. 115) ethnography: (a) has been largely ignored by nurse researchers, (b) "is well suited to professional education because it is sensitive to process...", and (c) is "the most adequate and efficient method for obtaining information in actively developing situations such as hospitals, where clinical teaching occurs...".
An important part of the ethnographic research process was that the researcher became part of the culture being studied. This was accomplished by the researcher being physically associated with the people in the setting during part of the fieldwork and/or by recognizing the members of the culture as co-participants in the research process (Germain, 1993). The researcher in this study, by virtue of her extensive experience as a clinical teacher, has an appreciation of the context of the clinical setting and the role of the clinical nursing teacher. This enabled the researcher to have an emic or insiders perspective of the clinical setting as context (Zaharlick and Green, 1991). The following section discusses the influence of validity, reliability and generalizability of the research.

**Issues of Reliability, Validity, and Generalizability**

Controversy exists as to what to label reliability, validity and generalizability in the qualitative paradigm. Some researchers have combined reliability and validity, naming it credibility (Glaser & Strauss, 1966). Credibility of the research study was enhanced by interviewing nursing teachers who clinically teach in different domains of nursing (e.g., pediatrics and maternity) and in a variety of institutions (Rosenthal, 1989). Interviews with each of the nursing teachers occurred on at least two occasions in order to cross-check the information. This process, described by Whyte (1982), involved cross-checking impressions and
confirming and refuting what was previously communicated (Cited in Rosenthal).

Validity is described by Leininger (1985, p.68) as "gaining knowledge and understanding of the true nature, essence, meaning, attributes, and characteristics of a particular phenomenon under study". Threats to validity include sample selection and observer bias, and accuracy in recording, analysing, and reporting data (Germain, 1993). In order to reduce these threats of validity, the researcher (a) sampled theoretically (e.g., initially select informants with regards to their ability to "illuminate the phenomenon being studied") (Sandelowski, 1986, p.31), (b) recorded interviews, (c) wrote field notes immediately after interviews, (d) journalled and memoed throughout the research process, and (e) collaborated coding and analysis of data with an expert in clinical teaching (e.g., a member of the thesis committee). The researcher kept a personal journal of reactions, biases and feeling. This process enhanced the researcher's reflexivity and was executed to identify "inner conflicts and biases and use them as an essential part of the data being collected" (Germain, p.254). Similarly, the process of memoing was implemented in order to record and reveal theoretical insights, ideas for theoretical sampling, and future questions (Germain).

Reliability is the "consistency of both sources of data, including participants and the researcher, and the methods of
data collection" (Germain, 1993, p.263). An ethnographic study cannot be replicated because people and settings change over time. However, a reliable ethnographic study can represent, what can be expected to occur through the use of a set of standard procedures (Germain).

Sandelowski (1986) describes generalizability in the qualitative paradigm as "an illusion since every research situation is ultimately about a particular researcher in interaction with a particular subject in a particular context" (p.31). An individual's experience belongs to a specific group's experience and therefore represents just one experience or impression of the groups many experiences or impressions. This one experience may be representative or typical therefore some degree of generalizability can be made to others who are similar or typical (Germain, 1993).

**Sample Selection, Recruitment, Inclusion Criteria and Size**

Convenience, nominated and purposive methods of sampling was used to select the study participants. Convenience sampling selected those participants who are available and willing to participate in the study (Morse, 1986). In contrast, nominated sampling occurred when a convenience sample participant refers an interested and knowledgeable prospective participant to the researcher. Finally, purposive sampling was implemented in order to ensure the best cultural informants possible. These methods of sampling helped to ensure the selection of informants who could supply rich data
and accurately portray the context of the culture with regards to the research question (Germain, 1993).

Recruitment of study participants occurred by placing information letters (Appendix B) in the mail boxes of maternity and pediatric clinical nursing teachers at two educational institutions. Prior to the placement of letters, permission from the deans/directors (Appendix C) at each of the educational institutions was requested. The researcher setup an appointment with the deans/directors and requested permission to approach clinical teachers for the study. Furthermore, the information letter and the consent form was explained and made available to the deans/directors.

The selection of the participants was made by the researcher in consultation with the thesis chairperson. Participants who met the following inclusion criteria were considered and requested to participate in the study. The criteria included clinical teachers who: (a) taught at a Lower Mainland degree granting college/university in British Columbia, (b) taught part-time or full-time, (c) taught full-time or part-time diploma or degree student nurses, and (d) were currently teaching or had taught pediatrics or maternity nursing in the hospital setting within the last year. Clinical teachers who did not meet the inclusion criteria were excluded from participating in the study.

The recruitment letter, placed in the mailboxes of pediatric and maternity teachers, outlined the nature of the
study, criteria for selection of the participants, time commitment and ethical considerations. The participants who volunteered were given detailed study information and further screened in relation to the study criteria. This process culminated in the selection of six clinical nursing teachers (e.g., equal amount teaching pediatrics and maternity nursing) who had taught degree/diploma students within the last calendar year.

The research participants presented with a range of clinical nursing education experience between 4-30 years. The majority of participants, five of the six, had between 17-30 years of experience. All the participants had experience in their clinical teaching setting exclusively as a clinical teacher, except for one participant who had worked on the same clinical unit as a staff nurse. The participants had teaching experience in a variety of programs. The range included; teaching only in a university program to teaching in an assortment of programs (e.g., hospital/diploma/degree program) during their teaching careers.

Data Collection

Interviewing members of a culture is considered an essential component of ethnography (Germain, 1993). This was done in order to grasp the participants' point of view and to clarify discrepancies in perceptions among and between the participants and the researcher (Germain).

The interviews occurred at mutually agreed upon times and
locations, either the home or the work place of the participants. The interviews were informal and semi-structured and were intentionally created to ensure the sharing of unanticipated data and the perusal of promising cultural knowledge (Germain, 1993). Trigger questions had been formulated from the General Model of Teaching (Pratt and Associates, 1997). These were used to elicit information from the participants. They are listed as follows:

1. How does your relationship with the university/college affect the way in which you teach?
2. How does your relationship with the agency affect the way in which you teach?
3. How does your relationship with the agency staff affect the way you teach?
4. How does the context of nursing in which you teach affect the way you teach?
5. How does setting affect the way you teach and learners learn? (Questions #1, #2, & #5 Paterson et al, 1996)

Throughout the interviewing process, the researcher sought further meaning and the clarification of cultural meaning through the use of open-ended statements such as: Can you tell me more about ...? Are you saying...? A tape recorder was used throughout the interview to ensure an accurate and detailed account of what was verbally communicated. The audio tape was transcribed shortly after the interview. The transcript was formatted to allow the researcher to document
non-verbal communication in a large margin intentionally left on the right hand side of the transcribed material.

The intent of the second interviews was to clarify previously obtained data and ensure the saturation and repetition of consistent themes (Germain, 1993). When the researcher no longer experienced the revelation of new information, the active phase of fieldwork was completed (Germain).

The data collection stage culminated by distributing the findings of the research study to all participants. The participants were given opportunities to provide written or verbal comments and feedback to the researcher. Written and verbal feedback can be used to explore and or confirm data in qualitative and quantitative research studies. Specifically, the purpose of feedback was to share the perspective/meaning of the data that had been collected. If the perspective/meaning differed from that of the groups, the ethnographer may need to collect further data and or reexamine existing data in order to uncover different, incomplete or inaccurate data (Zaharlick & Green, 1991).

Data Analysis

"Ethnographic analysis is the search for the parts of a culture and their relationships as conceptualized by informants (Spradley, 1979). This process of analysis began after the initial interview and the collection of preliminary data. This researcher analysed the data using the analytic
inductive method. By using Spradley's analytic inductive method, the researcher analysed the field notes for cultural symbols and then searched for relationships among these symbols. Once relationships had been formulated, hypothesis were made and then verified and confirmed with the cultural informants. When new or different cultural data was revealed by the informants, the researcher proceeded to collect more data, formulate new hypothesis and then again, seek out the cultural informants for verification and confirmation. This process of data analysis ended when no new cultural meaning was revealed.

**Ethical Issues**

Ethical issues were addressed throughout the research process. The researcher in this ethnographic study complied with ethical standards by implementing the following steps:

1) A proposal and consent form was developed for this research study and sent to the British Columbia Behavioural Sciences Screening Committee for Research and Other Studies Involving Human Subjects (see Appendix D).

2) Informed written consent was obtained from the participant prior to the onset of data collection. This included verbal and written information as to how the data was to be collected, handled and disseminated. (See Appendix D for consent form.)

3) The negotiation/renegotiation of consent was discussed prior to interviews and throughout the
fieldwork period. This process was recommended because of the emergent design of qualitative research (Ramos, 1989).

4) Privacy, anonymity and confidentiality of the participants was protected throughout the research process (e.g., data collection, recording, discussion of results and publication).

5) Objective recording and reporting of study findings occurred throughout the research process.

6) Written study results were offered to all participants at the conclusion of the study.

Summary of the Research Method

The researcher in this methodology chapter has provided rationale for the selected study design of ethnography. Issues pertaining to reliability, validity, generalizability and ethical considerations have been discussed as they pertain to qualitative research designs. The selection of study participants occurred by: (a) requesting permission of the deans/directors at two Lower Mainland colleges/universities, (b) providing information letters to pediatric and maternity teachers, and finally by (c) selecting participants who met the study's inclusion criteria. This process culminated in the selection of six clinical teacher (e.g., three maternity and three pediatric clinical teachers) who have been teaching or have taught diploma/degree nursing student, in the hospital setting, within the last year.
Chapter Four

Research Findings

The research study entailed an investigation of the participants' perception of the influence of context on their role as clinical teacher. This chapter includes a description of the four themes that emerged from the data as significant contextual factors that influence clinical teaching; i.e., the nature of the educational program, the students, the agency staff and the clinical setting. Context, as described by the participants includes broad factors (e.g., those that affect clinical teaching generally) and specific factors (e.g., those that are unique to the specialties of pediatric and maternity nursing).

The Nature of the Educational Program

Five of the participants had experience clinical teaching (i.e., 17 to 30 years) in a variety of programs. Some of the participants indicated that the nature of the educational program influences clinical teaching because the philosophy of the degree or diploma program determines the foci of clinical teaching and learning. For example, diploma educational programs were perceived to focus on the contribution of students to patient care rather than learning. Consequently, clinical teachers who had taught in diploma programs described how they focused on the students being able to handle a full
nursing workload, rather than on their ability to make decisions and problem solve. Two participants stated that although they were certain that the nature of the program influenced clinical teaching, it was difficult to distinguish the extent of this influence from other factors such as changes within the profession or their personal philosophy of clinical teaching. “I don’t know what the balance was. Whether it was the program or my own experience and education.”

The participants described a major difference between diploma and degree educational programs as the emphasis on “training” and “rote learning” rather than on “education”. Teaching strategies used in diploma programs concentrated on training the students by repetition and drill and the observation of clinical role models in order to be able to assume a full nursing workload. In this model of education, the acquisition of psychomotor and organizational skills were valued more than knowledge and decision making. “I thought they didn’t have the theory base, the assessment ability, making sense of the data. The workload for the students was too heavy.”

Degree programs, however, have emphasized the teacher’s role as fostering the integration of theory with practice, concentrating on the student’s ability to function as a
professional. "The drive here is to educate people so they have the [clinical] theory to apply in any context and with any age group." In this model of nursing education, the clinical teacher is mandated with the responsibility to socialize the student to the profession; i.e., to help the student learn to think like a nurse. Consequently, the student in such programs is closely supervised by the clinical teacher and has little interaction with the staff. Teaching strategies commonly used in such a program are those that promote critical thinking and problem-solving skills.

The participants revealed a substantial difference between the degree and diploma programs is that students in university- and college-based programs receive less clinical experience and more classroom theory content. Less clinical experience meant that the degree-program students were not as comfortable or confident in the clinical setting as those taught in diploma programs. This difference required that the clinical teacher increase the amount of supervision of and teaching about clinical skills.

Within the old [hospital-based] program, they had a lot more clinical practice in the first and second year and when they hit maternity, they didn’t need as much supervision [as degree students] with their clinical skills.

**Staff Nurses’ Perception**

The preceding section outlines the philosophy of
educational programs as an influence on the educational goals of the program and, therefore, how students are taught in the clinical context. According to the participants, the shift from an emphasis on work to a focus on learning in the clinical area characterized the move from diploma to degree programs. This shift has also affected the way staff nurses have responded to teachers and students in the clinical setting.

According to the participants, the educational level of staff nurses and their familiarity with the students' educational program influenced the staff nurses' perception and expectations of the students. For example, some nurses expect degree students to be as skilled and experienced as diploma students. This expectation is a common source of conflict between degree program teachers and nursing staff. Furthermore, this source of conflict influenced the nature of the relationship between the staff, and clinical teacher and students.

[Nurses] see the [university/college] students as not having as much clinical hands-on experience and initially, they kept comparing. "Well, they are not like the [hospital] students." For a year and a half, I had to keep reminding them and then when they got to where the [university/college] students were at, then we stopped hearing these comparisons with the old [hospital] program.

Nurses can't always understand why the students can't do everything right now, because it's [skills/tasks] here and that's what you did years ago. Not at the
[Students] haven't learnt this and they can't do that, everything is leveled [structured]. Nurses do not always understand this.

The participants described strategies they used to decrease the frustration level and conflict that they experienced regarding the staff nurses' perceptions of the students. For example, some participants explained course objectives and the students' level and ability to the staff nurses before the orientation of a new group of students to the hospital.

One participant identified entry-level credentials for nursing as another area of conflict between teachers and staff nurses. In 1986, the Canadian Nurses Association advocated that by the year 2000, entry level into nursing should be the B.Sc.N. (Bachelor of Science in Nursing) (Bajnok, 1992). According to the participants, the majority of nurses currently working within the hospital setting hold a certificate of nursing from a hospital-based or community college-based program. "Some of these nurses perceive the B.Sc.N. entry-level requirement as unnecessary. Others view the influx of B.Sc.N.-educated nurses into the hospital setting as a threat." Not surprisingly, these perceptions influence the relationship between the staff nurses, and the students and teacher from a degree program.

At [hospital unit], there isn't one person who has their baccalaureate. There are a few persons who are working on their B.Sc.N. There seems to be this negative feeling about the year 2000 and why should everyone have their
baccalaureate and that sort of thing. I think that's part of the negativity towards the students.... The perception is that they do not see the B.Sc.N. as necessary.

**Relationships Between the Nursing Staff and Clinical Teacher**

As stated, the change in nursing education programs and the perceptions of the staff nurses towards students has influenced how they receive clinical teachers and nursing students in the hospital setting. Formerly, teachers and students belonged to the “school of nursing” within hospitals. The move by the schools of nursing from the hospital into the community college and university setting resulted in a different reception and decreased acceptance:

At [hospital program] you were a part of the hospital, a part of the program, you were accepted automatically, whereas when you work for the [college/university] and you go into the clinical setting, you feel like a guest.

The participants (and their students) are situated mainly in the college/university, except for clinical teaching (and learning), and frequently felt like guests in the clinical setting.

Five of the six participants described clinical teaching in the hospital setting as “getting to know [the staff]”, “establishing a rapport” or “feeling like a guest”. The teachers’ degree of comfort in the clinical area was influenced by the length of time spent in a particular setting, the teachers’ relationship with the staff and the
degree of clinical competence (capabilities as a nurse) the clinical teachers demonstrated in their clinical role. One participant provided the following analogy:

It's their [the staff's] house. It's their territory, the college/university is not part of the hospital....It's like having a neighbour, when you first go into their house, and you have to build that relationship. It's not like a family...you are a guest and you can't say what you want or rearrange this or I don't like that or why do you do this. You [teacher] have to let things be, let things settle, and evaluate things and know when to approach someone [staff] and when you [teacher] can say something.

In contrast, another participant made no reference to the concept of "guest in the house", but she stated that she had clinically taught in her current placement for many years. When asked how long it was before she became comfortable with the staff, she stated, "It was so gradual. I have always been comfortable in the clinical area." Two participants claimed that three seven-week rotations or one to two 13-week rotations may be required in order to feel comfortable and a part of the unit. Some participants recalled that even with stable placements on clinical units, they would still experience the "guest feeling", particularly when teaching in units with "unfamiliar staff nurses". Another participant had worked in a unit in two different capacities, initially as a staff nurse and then as a clinical teacher. Nonetheless, she too felt like a guest as a clinical teacher. As a clinical teacher in this unit, she had to be clear about her role and
boundaries, and sensitive about how to present concerns and issues to the staff nurses. This clinical teacher was very familiar to the staff nurses, but her changed role influenced how she worked and communicated with the staff nurses. Furthermore, her relationship with the staff nurses influenced how she clinically taught:

I am a lot more comfortable [when clinically teaching] and I think this is translated to the students....Some students feel I am not as anxious [as other teachers]. I know which R.N.’s I can leave the students with, the ones who can help me with the students and which R.N.’s I need to work with the students more.

The participants claimed that the relationships developed between the teacher and the individual staff nurses influenced clinical teaching. For example, they noted how the teacher’s comfort level influenced clinical teaching and student anxiety and how the staff assisted the clinical teacher. “Now that we [teacher and staff nurses] have established a rapport, I find that they [staff nurses] are very helpful looking for learning experiences for the students.”

Once you [teacher] are in an area for a time, you can almost do anything that you want to do and that’s all right with them [nurses]. You work things out....They don’t expect you to be perfect. You can make mistakes and they are not so hard on you and you are not so hard on them. It becomes a working relationship.

According to the participants, the degree of comfort a clinical teacher experienced when working with the nursing staff on a particular unit influenced clinical teaching by
decreasing the teacher's anxiety (which could be conveyed to the students), increasing the teacher's desire to try out new learning situations, increasing the staff's tolerance of student/teacher mistakes, and facilitating clinical teaching strategies. Staff nurses helped clinical teachers with whom they felt comfortable by assisting the teacher to select appropriate patients and assisting students through engaging in positive working-learning relationships.

The Influence of the Educational Program on Students

As demonstrated previously, the participants believed that change within educational programs has influenced the staff nurses' perception of and their relationship with clinical teachers and students. According to the participants, specific aspects of the educational program influenced students and, consequently, had a direct impact on how teachers teach. These specific aspects were the "location of the student in the program" (e.g. prior experience and knowledge developed within the program), time lapsed between clinical experiences, college/university and hospital policies, and the student's prior educational experiences.

Location of the Student in the Program

The participants found that the location of the student in the program influenced the student's level of "functioning"
(e.g., ability and independence). Consequently, this factor had a direct impact on how the clinical teachers taught.

Students entering pediatrics who had recent experience in maternity nursing were described as more "skilled with newborn assessment", "comfortable with patient teaching", and capable of "working with families" than students who had recent clinical experience in psychiatric or medical-surgical nursing. Similarly, students entering pediatrics with recent clinical experience in medical-surgical nursing were described as generally more comfortable with psychomotor skills than students from maternity or psychiatric nursing.

One participant described a teaching situation in which a student began a pediatric clinical experience with limited patient teaching and breastfeeding knowledge and ability. The participant helped prepare the student for this new clinical situation by teaching the necessary theory before entering the patient's room and then by role-modeling nursing behaviour at the bedside.

This situation would not preclude me [teacher] from assigning [the student] to this patient. I would help the student prepare for the necessary theory before going in and then go in [with the student] and do the necessary role modeling in terms of assessing how the breastfeeding is going and reinforcing information.

According to the participants, they adapted the students' clinical learning assignment, given the location of the student in the program and the student's needs and abilities.
For example, one participant offered challenges to a student group coming from maternity nursing by providing clinical experiences of an increased patient assignment; i.e., number of patients or complexity of cases that was more than in previous clinical rotations.

Participants revealed that students’ progression through the semester influenced student learning and clinical teaching. One teacher indicated that it took students two to three shifts before they felt somewhat comfortable in the new unit of learning. Another found that as students progressed through their clinical experience, their confidence and ability to teach families increased. These points influenced how the clinical teachers taught.

During the first few weeks...the students tend to be very tasky. They focus on tasks. My teaching is mainly on tasks, getting them comfortable with the task, the schedule. After that my teaching focus changes because they are comfortable and I am familiar with their level of expertise. Then I can help them see the big picture, the family, the community members and the health professionals...I get them more involved, going on rounds and working with families....As they progress throughout the term, they become more confident, comfortable and more secure....My style changes as they move.

The significant factors pertaining to location of the student in the program were the student’s previous experience, knowledge base and ability to learn throughout the semester. These factors, related to the location of the student in the program, influenced clinical teaching. Clinical teaching
strategies used by the participants include teaching theory before the experience, role-modeling at the bedside and helping the student move from tasks to the ability to see the "bigger picture".

**Holidays and Student Breaks**

The location of the student in the program clearly influenced clinical teaching. As well, the participants considered the amount of time between semesters, holidays and breaks from the clinical setting (e.g. illness, enrichment experiences) as influencing student performance and clinical teaching.

Sometimes they have spring break, or they are off for other reasons....This influences how I teach with regards to the student assignment....They come back just as lost as their first day. It affects their ability, reduces learning, limits skills and ability to integrate a lot of things.

I had a student off for two weeks. She had not been able to demonstrate early skills. I spent much time with this person and hardly saw the other students....One ends up spending a disproportionate amount of time with one student.

According to the participants, group differences related to planned student breaks and the location of the student within the program influenced the focus of clinical teaching. A participant who clinically taught student groups after the long summer break (group 1) found that teaching was different with these students than with students who commenced clinical learning of the same course after the shorter winter break.
(group 2). The difference according to the participant was related to the length of the student breaks.

[For group 1]...the teaching is different, style is different. Students generally need to relearn, it takes me [teacher] longer to establish their level of ability, skills. Students take longer to feel comfortable with the unit, staff and to organize.

"I would spend more time with the students, with communication and how to care for a small baby". It would "take past midterm to get an understanding as to where the students [group 1] were at. Usually after this time, they start having two patients. [Students in group 2 were] quicker to pick up (tasks and skills) and were quicker to increase the patient assignment."

According to the participants, student breaks, holidays and complementary experiences such as planned community experiences, influenced the students’ ability, the clinical learning experience and clinical teaching. These situations affected students individually and collectively. For example, the participants found that the amount of clinical teaching time required by one student influenced the amount and quality of time that the clinical teacher could spend with the other students.

**Agency/Institution Policies**

The participants commented on the college/university and hospital policies, the amount and type of clinical experience,
and teacher-student ratio as influences on the clinical teaching of nursing students. The program's curriculum influenced the "selection of the student learning experience" (type and length), the students' "expected level of functioning" (degree of independence, what they can do) and the student/teacher ratio.

An example of how the educational institution's policies influenced the clinical teaching of nursing students was provided by the maternity teachers. Maternity nursing is considered a specialty area of nursing; therefore nurses, who wish to practice in this area of nursing after graduation frequently need advanced education (e.g., a certificate in obstetrics). Because college/university curricula emphasize the "normal" maternity patient as appropriate for student learning, the clinical teaching assignment reflects this desired student experience (e.g., students in the postpartum unit learn to care for mothers and babies who have mild to moderate needs). Similarly, students undertake part of their clinical learning in labour and delivery. The school and hospital policies clearly state the nature of the student experience in this area: the experience is one of observation, with the provision of basic care by the student.

Consequently, the participants planned the student clinical learning experience around the curriculum, course objectives
and agency/institution policy.

According to the participants, the type of clinical learning unit and the available times on the unit for student learning was influenced by the agency (e.g., the hospital) and the college/university. One participant discussed how the availability of clinical time on the unit influenced clinical teaching:

The students sometimes say that they wished they had the opportunity to come back the next day. Specifically, if they have had an unorganized day....They feel they [students] could do better the second day. An eight hour and a four hour day would be preferable. The demands on the hospitals by schools restrict our [university/college] access to two days per week....This is out of the control of the instructor.

The single twelve-hours day of learning on this particular unit limited the students' ability to repeat the learning experience, reorganize their plan of care and feel confident about their learning experience. The one-day clinical learning experience also influenced the clinical participants' expectations of their students' ability and progress. Generally, the participants expected a higher level of ability when students had an opportunity to repeat skills and learning experiences of the previous day.

Agency guidelines and policies also influenced clinical teaching. Participants confirmed the need to know agency policy in order to inform the students, and to operate within these guidelines/policies when clinical teaching on the unit.
One participant discussed "hospital guidelines" that were being developed for student learning in that agency. Because the participant in this situation realized the potential influence of these policies on teaching and learning, she became informed and involved.

Teacher/student ratio and group size influenced clinical teaching. "What that [group size] means is that I have to focus on students that I think need attention, or need time observing, while the others are almost neglected."

Participants indicated that if clinical supervision was necessary and the clinical teacher was unavailable because he/she was busy with other students, students were requested to seek out the registered nurse (R.N.) caring for their patients for assistance or supervision.

**Prior Educational Experiences**

Participants stated that clinical teaching is influenced by the students' prior educational experiences. According to the participants, students often have a variety of educational backgrounds, including previous degrees, certificates (L.P.N., Registered Psychiatric Nurse [R.P.N.], paramedic), and high-school graduation.

Participants commented that students have varied levels of learning backgrounds and styles. The participants' aim was to "challenge them, challenge their thinking, help them to
problem solve and through that process, help them to think critically". They found that students with previous degrees or those who "fast-track" through the program (with electives taken before nursing courses) may need "challenging". Clinical teachers challenged these students by increasing the amount or the complexity of their patient learning experience.

Two of the three participants who teach students with prior nursing certificates (e.g., L.P.N. and R.P.N.) commented on other factors that may affect how such students influence clinical teaching. According to these participants, the students' prior educational preparation needed to be considered in terms of when they graduated and the nature of their work experience.

Sometimes [L.P.N.'s] are really quite functional and sometimes their theory isn't there. So I try to get them to focus on what they are doing and then I try to pull the nursing theory through. R.P.N.'s are excellent with their communication. [Communication is] always an asset no matter what area they are in. In medicine and surgery, the R.P.N.'s aren't doing people. They are talking people. I find they sometimes fall back on their organization and skill ability.

This participant would assist R.P.N. students to focus on theory, skills and organization by questioning them on these aspects. The participant stated that her teaching approach was the same for all students, but the specific focus was different depending on the student's educational background.

Other participants found that students who have previous
hospital experience interact and approach patient care differently. They clinically taught this group of students by challenging them in different ways and assisting them to progress through the clinical objectives more quickly. Furthermore, the participants found that these students had an understanding of the role of the R.N. and knew what they were attempting to achieve. This understanding enhanced their motivation and assisted their progression through the clinical experience.

One participant who teaches students with prior health care certificates attempted to integrate these students with those who had started in the nursing program one year earlier. This participant encouraged student-to-student assistance/interaction during clinical training for both groups of students. "[It] helps to have different types of students because...each of the students can add to the whole." "They [students] can learn from each other."

Thus, the participants found that the nature of the educational program influenced students. Significant factors in this regard include the location of the student in the program, student breaks/holidays, the agency/institution policies and the students' prior education. These factors influenced how clinical teachers teach, resulting in teachers altering their approach to student groups or individuals,
varying the amount and type of clinical supervision, altering the students' assignment through challenging or delaying experiences and varying the staff nurses' involvement with the student.

The Agency and Staff as an Influence on Clinical Teaching

Change within nursing education has affected the relationships between the staff nurses and the clinical teachers. It therefore has an influence on how teachers teach and students learn in the clinical area. According to the participants, the changing agency environment of the hospital also has an influence on the working and learning environment and on the relationships between the staff (nurses, doctors, unit clerks and other team members) and clinical teachers and students.

The Influence of Agency Changes

The participants described the agency as "one of change" and "political", with a strong influence on the working and learning environment. For example, the recent changes in union collective agreements have altered the "qualities" or "characteristics" of the nursing staff on the units and, therefore, the teaching/learning environment for the teachers and students:

[There] are a high percentage of part-time workers in the last number of years, displaced workers because of closed units, [and] some of these people do not come with a lot of history concerning policy and procedures for that
hospital.... People used to be called for casual positions because of their ward dedication. Now they are being called in relation to their most senior casual hours.... Someone called last week [into pediatrics] was very experienced with coronary care experience.

Recently, [the staff] voted on the addition of six adult short-term stay beds to be incorporated within the pediatric unit. This has placed additional pressure on them [staff] related to what their skills and abilities are. As some move away from caring for pediatric patients, this affects their refinement of skills.

Part-time, displaced and casual staff who may be unfamiliar with unit policies, procedures and/or the specialized nursing care required on a particular unit influenced how the participants clinically taught. Participants found that they role-modeled with and supervised their nursing students differently depending on the staffing stability of the unit; participants altered the amount and type of responsibility they assumed for the delivery of patient care according to their perception of this stability. For example, participants assumed most/all of the responsibility/supervision for the students when they clinically taught on units with a disproportionate (i.e., compared with regular/full-time staff) number of casual, part-time or unfamiliar staff.

Similarly, a maternity participant discussed the influence of "cross training" and how this practice and other aspects of change influenced the staff and the teaching and learning environment for students. Cross-training involves training nurses to work in all areas of maternity: antepartum,
labour and delivery and postpartum. This participant found that the nurses were "in turmoil", "anxious" and "less tolerant" of students and teachers. Change, uncertainty, workload and stress of influenced how the nurses performed and consequently how participants taught. It resulted in the participant role-modeling more frequently for the students and discussing change and stress and its influence on nurses with students.

Other agency changes, of a less critical nature were described as policy, procedure and charting changes. According to the participants, these changes were communicated to the students in verbal or written form during hospital/unit orientation or throughout the semester. It affected teaching by influencing the staff/teacher/student relationships. The participants found that the staff were generally more tolerant of student questions.

**The Influence of Agency Staff**

Change and the political nature of the agency influenced the staff, clinical teacher and students and, therefore, the act of clinical teaching. According to the participants, the agency staff includes head-nurses/unit managers, staff nurses, doctors, unit clerks, and other health care team members. The participants considered these individuals/groups as important and significant influences on clinical teaching.
Head nurses.

Participants discussed the absence of the head nurse role in many clinical areas as influencing clinical teaching. One teacher commented, "There is not a consistent person in charge anymore....Rather than adjust to the leadership on a daily basis, I find it easier to be more responsible for the overall care that the students provide to patients." Another teacher found that there was "less hierarchy" and "fewer lines of communication". She stated, "Clinical teaching was a lot easier" now because she could go directly to the R.N. when she encountered a problem.

Those participants who had worked previously with a head nurse/unit manager stated that head nurses influenced the working/learning environment and the relationships on the unit:

A lot of the tone is set by the head nurse/charge nurse/nursing unit manager....If it is good, it makes it much easier for me as a faculty member....If the head nurse is trusting of her staff, supportive, staff feel more positive about their work environment

According to the participants, such a positive, supportive learning environment contributed to the students' feelings of worthiness and to a positive working relationship between the staff, clinical teacher and students.

Staff nurses.

The participants stressed the importance of effective
working relationships with the staff nurses: "It is important to know the people and get them to understand the level [of the students], and what they can expect the students to do and how I [teacher] will work with them." The participants promoted effective working relationships between the students and the staff nurses by assisting the R.N.'s to feel comfortable teaching and working with the students, by encouraging the students to go to the staff for assistance, and by clearly defining the teacher-student working relationship. ("Within the areas that I work in, I always emphasize the role of the co-assigned R.N.").

According to the participants, knowing the staff nurses was very important for effective clinical teaching. The participants would vary their involvement with the students in relation to how effective the nurses were in working with the students. A participant with both maternity and medical-surgical teaching experience compared maternity nurses with medical-surgical nurses. She found that maternity nurses were more tolerant of students asking questions: "The focus (in maternity) is on teaching, so as the nurses teach patients, they just take the students along and just include them." This participant stated that clinical teaching was facilitated when the staff nurses were involved in the teaching of students: "If you are on your own, you have to prioritize and
you cannot assist all students with everything." Another participant went on to say:

I sometimes look at which R.N.'s are on [the unit]....That affects my teaching because if I need to attend to all of my students all the time, I have to be a lot more organized, on my toes....Students working with the nurse sometimes see the whole picture more easily. Because at times I am in a situation where I am working with skills/tasks.

Participants mentioned staff "who did not like students" or "who were poor role models". All participants were asked if their selection of the student assignment was influenced by the nature of the staff nurses on the unit. One participant stated that her assignment was not influenced by the staff; this participant had a limited number of pediatric patients from whom to select and assumed most of the responsibility for the patients she assigned to her students. Two participants stated that they would select certain patients depending on which staff nurses were assigned to those patients. One stated she would avoid assigning students to patients of nurses who had proven to be problematic with students in the past.

There are some staff members I might avoid because I feel they are not good role models....Last week we had a incident. The nurse took over. She didn't leave the patient for the student to do.

The remaining three participants stated that their selection of patients was not dependent on the staff assignment. However,
...if I know that an R.N. has a certain preference, I do let my students know. (E.g. clean tidy unit).... Certain priorities are different. You just need to recognize it and let the student know.

Another added:

In fact, I select my assignment first...and then I will look at the R.N.’s assigned to the patients. I hate to say this, at times I have a sigh of relief when I look at who’s on....[Staff] can help me double check a lot of things that sometimes I may not have time to help oversee, because I am with another student.

One participant explained how she coped with staff nurses who did not like to work with students:

Depending on how long I’ve known [them], I’ll frequently talk with [the nurses] about their behaviour. Confront them with it because sometimes it’s just them [nurses] and that’s the way they are and the student needs to understand that and they are not going to change. I’ll help the student work with that person rather than taking it personally.

According to the participants, the nature of the staff nurses influenced clinical teaching. The participants fostered positive relationships between the staff, and teacher and students by encouraging teaching opportunities between the staff and students, carefully selecting the patient assignment, and using unit orientation manuals to decrease the number of unnecessary questions asked of the nurse.

Doctors.

The participants discussed doctors as an influence on clinical teaching. Generally, the participants noted awkwardness, hesitancy and uneasiness when students came in
contact or communicated with doctors: “Students are sensitive. A doctor’s behavior can affect the students’ confidence.” The participants then sought out strategies to help the students appropriately interact with the doctors. They encouraged students to ask questions of the doctors and to offer information about patients, either in person or by telephone. One participant provided opportunities for her students in which they could observe and assist the resident doctor with the admission of a pediatric patient in order to assist students to develop a comfort level with the doctor.

**Unit clerks.**

Half of the participants voluntarily commented on unit clerks as influencing clinical teaching. “Some unit clerks can be a bit unpredictable” and their area “is sacrosanct”. “You do not want to get in [the way of] the working area of the unit clerk.” The participants warned students on orientation day and discussed strategies to work effectively with the clerk.

The students don’t mind and they can respect it. It’s much easier to tell them upfront instead of them being reprimanded for doing something. Because that affects them more than telling them upfront.

**Other health care team members.**

The participants commented on health care team members and how they influenced the clinical teaching of nursing students. All the pediatric participants stated that in the
pediatric setting, there was "true collaboration of the team members", including the teacher and students.

Our area [pediatrics] demands closer working with multi-disciplinary health care team workers. A lot of work is coordinated with whatever else is happening. (E.g. coordinating your [student] work and working together)....Your [student] assessment is strongly intertwined especially if social workers are involved in your [the student's] case. Ensure that [the students and teacher] have an open dialogue with them.... Students are...encouraged to be an integral part of the team, [more so] than they are in any other areas [of nursing].

The participants discussed, encouraged and role-modeled interactions with various health care team members. The intent of these teaching strategies was to assist the students to feel like and become part of the health care team.

Patients and Family as an Influence on Clinical Teaching

Another significant influence on clinical teaching is patients and their families. The nature of the patients' influence is different in each of the specialty areas of maternity and pediatric nursing. This section, therefore, specifically addresses how the nature of the patient and family in the two specialty areas influences clinical teaching.

Maternity Patients

The maternity patient was described as "different", "well", "normal and happy" and "healthy". The focus of patient care was "mainly being with the patient" and on "teaching and learning".
According to the participants, the complexity of the patient’s case influenced clinical teaching. The participants would initially focus on the normal, healthy maternity patient (i.e., normal vaginal delivery of a health baby) and progress towards the more complex patient (a difficult birth or a baby in a specialized care unit). “If these were beginning students, ... I would not give them a fresh post-op caesarean-section mom. I want [the student] to know the normal [clinical experience] first.” “As they get more experience, we deal more with the complex situations.” Some complex patient situations assigned by the participants were “breastfeeding difficulties”, “extensive perineal injuries” and “Caesarean sections”. “If the mother’s baby is in custody [e.g., with the department of social work], I do not usually assign a student to these moms [and babes].”

Similarly, the nature of the baby’s health influenced clinical teaching. Initially, the participants assigned newborns who required basic care, but as the semester progressed, the participants would assign newborns with health challenges. The participants’ aim was to give students a variety of patients of increasing complexity throughout the semester.

Some participants described “taking the opportunities as they present [themselves]” and “not going in with a set
agenda" for the students. An example was a patient who had breastfeeding problems. The participant would take the student to the patient's bedside and role-model breastfeeding methods.

The participants discussed the length of the patients' hospital stay as an influence of clinical teaching. "Normal postpartum" mothers are generally discharged from the hospital the day following the birth of the baby. This short stay had an impact on how and when the participants selected their students' patient assignment. It was common for the participants to choose their student assignment the morning of the clinical experience.

According to the participants, the students were provided opportunities to observe and give patient care to the labouring patient. The nature of the labouring patient influenced clinical teaching as an observational, enriching experience where the clinical teacher was minimally present. As a result, the participants helped to prepare the students for this learning event by using various learning activities and emphasizing the role of the student as a self-directed learner:

In labour and delivery, I buddy them with an R.N. and what I do is run between the two areas and sometimes I get there for a delivery. I find the majority of the R.N.'s take the students under their wing.

The nature of the patient in the specialty area of
maternity had a direct influence on clinical teaching. Participants teaching in this area emphasized the "normal process" of childbearing, "being with the patient" and "teaching" the new mother. Strategies used by maternity clinical teachers were role-modeling, assigning normal to complex patients, and exposing the student to a variety of experiences unique to this area of nursing.

**Pediatric Patients**

The pediatric participants also found that the nature of the patient influenced clinical teaching. They identified specific patient factors as age, type of illness, level of acuity and patient response.

According to the participants, the patient's age (i.e., newborn to 16 years of age) and "the effects of hospitalization" (e.g., regression) influenced how the participants and students communicate with, provide care for and teach patients. The participants described using "a variety of verbal and non-verbal techniques to communicate with children" and extensive use of role-modeling when teaching nursing students in pediatric settings. Furthermore, the participants attempted to balance experiences with different age groups of patients among the students in order to provide similar experiences to all students.

Pediatric patients have a variety of illness, described
by the participants as communicable, seasonal and at times "unit specific" (e.g., orthopedics, neurology). According to the participants, the nature of a communicable disease influenced clinical teaching.

When [students and teachers] have respiratory kids, we have to mask and gown....It reduces my quick access to the students....It creates a bit of a barrier, so you [teacher] are not quite as free to walk into a room as quickly as you might [e.g., to check an intravenous and its settings].

The participants found that the seasonal nature of disease influenced the availability of pediatric patients for student experience. However, two of the participants provided alternative learning experiences in pediatric day surgery or in an adult diagnostic area if the pediatric patients available were inadequate for student learning.

The participants discussed the complexity and acuity of pediatric patients for suitable student learning. The participants identified patients who present with "non-accidental trauma" (NAT) as complex and unsuitable for student experience. In this situation, patient suitability was determined by the potential for court involvement. The participants found that the students' patient assignment, as well as the staff's morale and their receptivity toward the clinical teacher and students, was influenced by the presence of such a complex patient in the unit.

The only stressful time is when [the staff] have many NAT
patients. Staff become less hopeful, less cheery, less tolerant with students, express themselves differently. At these times, I try to limit interaction between the students and the staff [because they are less tolerant of students].

One participant described spending a lot of time with the students, supporting them emotionally, and discussing appropriate care for these patients and families because of the perception that these experiences would be traumatic to students.

Likewise, the acuity of the pediatric patient influenced clinical teaching. According to the participants, patient acuity influenced their student assignment, teaching strategies and their daily organization plan.

If the client needs a lot of care, students will end up with one patient, so they can give them their full attention. Otherwise [students] will have two. If they have one client, I try and review the chart, look at the finer detail when it’s quiet with the student. I try to do this with each of the students during the semester.

With a three-day average hospital stay, kids really change rapidly. The change that the patient has experienced in the last 24 hours helps me [teacher] determine which [student] to work with first.

There are certain circumstances, [where] I [teacher] would assume the care for a child. Perhaps if [the circumstances] were beyond the theoretical level of the student....However, if I feel I am limited in resources that I can provide, that will be more the determining factor in selecting the kinds of patients.

I would say it’s the acuity of the patients that determines my teaching and organizational approach. I tend to spend more time with students who have more acute patients, more demand than other students....The students...
with easier patients tend to be left to after 9 AM. I sometimes see them in the hall and ask them how their patients are and themselves.

Participants commented on the unpredictable nature of the pediatric patient during nursing procedures and how this influenced clinical teaching.

Regardless of [students’] expertise in skill delivery, the variable is the child again. Most often the child may react in some unexpected fashion. And so even if [students] are skilled, this creates anxiety in them [students].

Because the child’s unpredictable response influenced clinical teaching, the participant would generally accompany the student during the performance of skills.

All pediatric participants commented on ensuring the “patient’s safety and protection” and on being a patient’s “advocate”.

One [teacher] is very much an advocate for the children as well. The safety and protection of the children is really critical. I have to assess with more intensity the student’s abilities, their ability to think critically and their self-directness, [student] willingness to seek help from peers or other multi-disciplinary health care team members.

Another participant, who was equally concerned about the safety of the pediatric patient, helped to prepare her students clinically by providing them with ongoing practice opportunities, assisting them with theory application and helping them to anticipate problems that may arise during the clinical day.
The participants found that the nature of the pediatric patient influenced the amount and type of student supervision. [Teachers] do supervise more than in an adult area; [there are] more things to check because of the safety issue. Students need to know that you are [providing more supervision] for policy reasons and you have to work around that level of anxiety that the degree of supervision might cause. [Teachers] have to accommodate by encouraging as much independence as possible in other areas. Let them do as much of the problem-solving on what they need to do. Then, run through it verbally.

Participants found that they closely supervised in the nursery setting. They attributed this close supervision to the patients’ age and the issue of safety.

Thus, according to the pediatric participants, the nature of the patient’s age, illness, unpredictability and vulnerability influenced clinical teaching. Accordingly, the participants varied their teaching strategies (e.g., role-modeling), the amount and type of supervision, the students’ patient assignment, and their organizational approach with their students.

**The Family**

In the previous section, the nature of the patient was identified as influencing clinical teaching. Likewise, the participants found that the family influenced teaching but the perception of significance and extent of influence differed between the maternity and pediatric teachers. The maternity participants briefly discussed the presence of the extended
family. In contrast, all three pediatric participants extensively discussed the influence of the family on clinical teaching.

Due to the nature of the age, parents are involved from day one. Seldom have I seen parents involved in any other way unless they [child] have been apprehended.... [Parents] question a lot more, very often they learn how to do a lot of tasks as well, especially with the chronically ill child.

Furthermore, the participants contrasted family involvement in this area of nursing with other areas, where "we either push the family away or discount them". "I have worked in adult areas. I don’t see as much family involvement."

The participants described students as "hesitant" and "concerned" about what the family would think of them. One participant described a situation in which the student became angry with the clinical teacher for letting the parent stay at the bedside while the student performed a dressing change.

[Clinical teachers] tell the students right from the start that they will be working with the whole family....[Students] work with children with health problems within the context of the family, so teaching is dependent on the age and directed towards the family. The family is important and needs to make decisions and participate in the care. I think the student needs to arrive at a balance as to where their role is and the family’s. If [students] are new and they do not have a lot of confidence, they sometimes back away from their nursing obligations and let the family take over without thinking, "What is my role?"

Other strategies identified by the participants included assisting the student "to recognize how the parents care for
these children at home, [to] try to bring the home setting into the hospital", and "to instruct them to always ask the parents, 'How do you like this done?'"

The participants indicated that the family's preparedness for the child's discharge influenced clinical teaching:

So making sure that the family or care-givers leave with the comfort of recognizing change which is pertinent to whatever the health problem is. And make sure they have this in writing.

[T]here's] the parents' own fatigue factor....We try to assess the other responsibilities the parents have and how well the child will be when they go home. The child may need much care at home and if the parent is fatigued and sick themselves, the child may end up back in hospital because the family is no longer well enough to provide care.

Two participants found that their teaching styles changed in the presence of families: "I sometimes show through demonstration. I walk in and I speak with the parent first, depending on the age of the child. I think students learn through observation." In contrast, another participant felt that the extended family "did not really" influence her clinical teaching: "I do a lot of role modeling for the students regardless of who is there."

Thus, according to the participants, the nature of family influenced clinical teaching. Student nurses were initially hesitant and awkward when providing care to the patient in the presence of the family. Therefore, the participants used strategies to increase the students' comfort level and to
assist the students to work effectively with families throughout the hospitalization. Furthermore, the intensity and amount of family involvement in the pediatric area was greater in the specialty of pediatrics than in the specialty of maternity nursing.

The Nature of the Specialty Area

The nature of the specialty area and its influence on clinical teaching has been discussed in various sections in this chapter. Unique or different aspects of the specialty area identified by participants are summarized here.

The Nature of the Pediatric Area

Key differences between the pediatric and maternity areas included the issue of safety, the collaboration of team members and family involvement.

The participants generally described the pediatric area as complex. They elaborated on the need for increased levels of supervision of skills and the administration of medications to children. They found that they spent more time calculating and supervising medications in pediatrics than in any other area of nursing. Aspects of complexity that influenced the nature of clinical teaching with student nurses were the performance of new skills, assessments and the use of various levels of communication.

Some participants found that the students were exposed
more often to new admissions and patient discharges than in other areas of nursing. The example of a three-day average patient stay was mentioned by two of the pediatric participants. Another participant elaborated that the specific type of patient illness/wellness (e.g., orthopedic vs respiratory), not necessarily the area of specialty, influenced hospital duration. All the participants described health status changes in pediatric patients as more rapid when compared with other groups of patients.

Earlier in this chapter, the aspects of "health care team collaboration" and the "close working/teaching relationship between students, teachers, patients and families in the specialty area of pediatrics were revealed as a significant influence on clinical teaching. These aspects had a greater influence as to how the pediatrics participants teach nursing students when compared with how maternity participants teach.

The Nature of the Maternity Area

The participants in the specialty area of maternity described the learning experiences and the atmosphere as different and unique. The participants exposed students to a variety of learning experiences within the hospital and community setting (e.g., two days in the community setting, two days of observation/basic care in the labor and delivery [L&D] unit and the remainder of the experience on the
According to the participants, these alternative experiences (community and L&D) influenced clinical teaching by increasing the need for clinical supervision after students returned to the postpartum unit. Furthermore, the participants found that their availability for students was decreased by having students on two units (L&D and postpartum). The participants planned and organized their schedule to accommodate students in the two different areas.

According to the participants, the atmosphere on the maternity unit was considered happy, normal and relaxed, with an emphasis on teaching. The atmosphere influenced the staff's acceptance of student questions and the students' confidence level.

The Nature of the Unit as an Influence of Clinical Teaching

As shown, the area of specialty influenced clinical teaching. The participants stated that the unit size, location, layout and schedule were also significant factors. Furthermore, the participants discovered that these specific factors influenced the relationships between the unit staff and the students and teacher.

Unit Size and Location as an Influence

According to the participants, the size and the number of beds influenced the location of the learning experience and
the number of students that could be accommodated on a particular unit. The participants reported that they occasionally had to locate the nursing students on two units to provide adequate and varied learning experiences. For example, the maternity participants had student experiences on the postpartum and L&D units. Furthermore, one of these participants had students on two different postpartum units that were joined by a patient lounge. This participant described her role as “walking back and forth”, “prioritizing student supervision”, “making appointments” with the students and getting to know two groups of nurses. Similarly, the participants who had previously taught students on two medicine/surgery units, reported being “less available” for observation and assistance and “spending more time on one unit”. As a consequence of teaching on more than one unit, the participants found that they had to depend more on the R.N.’s to support and supervise the other students when they were occupied on the other teaching unit.

If you [teacher] are on different floors, it makes it harder sometimes. Whether it’s med-surg or maternity. You can’t get to the area as quickly. You can’t see as much. You spend the time running back and forth. You have to get yourself organized. It’s easier if you are on one floor or in one area to supervise.

The size of the pediatric units ranged from 10 to 25 beds. The units where the pediatric participants taught were either small (10 to 16 beds) or linked with another area of
nursing (e.g., four to five same-day-admit pediatric surgical beds on a medical pediatric unit and six adult diagnostic beds on a pediatric unit). At the time of the study interviews, the participants had not assigned these additional beds to their students. The participants stated they would consider using these additional beds for learning experiences in the event of fewer patients with decreased nursing needs.

The participants described the size of specific rooms/areas (medication, patient, common areas) as an influence on clinical teaching. They discussed the patient’s room in relation to size and the number and type of patients that could be accommodated. One participant who taught on a unit of predominantly private rooms found “two-bedded patients’ rooms [to be] an unsatisfactory situation”. This participant described the importance of privacy between the teacher, student and patients. This could easily be compromised in rooms accommodating two mother and baby pairs. This participant went on to say:

> When I am with one student, I am with her fully. Which is good. I am not distracted by the other things that are going on. This means there is privacy for everybody, for what’s going on between me and the student and for what’s going on between the student and the client.

Similarly, a pediatric participant described two-bed rooms as being non-conducive to teaching. These rooms were found to be small, cluttered with cots, play objects, belongings and
medical equipment. Furthermore, the participants found there was little privacy between the patients when talking with the parents or students. According to the participants, the pediatric setting was generally comprised of a nursery, single-, double- and four-bed rooms.

One maternity participant described an experience she had 20 years ago which clarified for her the nature of a maternity ward and later influenced her clinical teaching:

When I first started at [hospital name], I went onto the unit to orientate and I couldn’t believe it. It was a ward, a complete long room with all the beds in it. It was great to supervise. You could stand in one place and just watch.

The nature of the nursery and “ward” setting influenced clinical teaching by making the teacher visible and accessible to students. Participants found the students in the ward or nursery setting were more easily supervised because the teacher could supervise many events while standing in one place.

According to the participants, single rooms decreased teacher-student accessibility. They found that students had difficulty locating the clinical teacher in settings which were comprised of many single rooms. The participants implemented strategies to assist students to obtain the required assistance or supervision for skills and decision making. They encouraged the students to use the student
patient assignment sheet posted at the nurses station in order to locate the teacher and if this attempt proved unsuccessful, the student would seek the assistance and support of their co-assigned R.N.

The Layout and Appearance as an Influence

One pediatric participant described the layout and appearance of the unit as an influence of clinical teaching.

The ideal is when the nursing station is a semi-circle and the rooms are lined up, facing it. The rooms have glass doors and when you walk by one [you] can see the staff, student or even the patient....When I walk by, I look through the glass, I notice what the students are doing. I don’t think I do it consciously, I do not watch how they are doing a procedure but notice what they are doing now. You cannot help it, but at that moment you may notice something incorrect and you pick up on it. Sometimes a gut feeling comes through.

This clinical participant was teaching in a “horseshoe-shaped” unit with the rooms located on either side and in front of the station”. She found it “difficult for the students to find the instructor” and “time-demanding” on the part of the teacher having to walk around to try to find the students. At times, this participant “resorted to calling out the students’ names in order to find them”.

According to the participants, the overall size of the “common space” (space used by many staff members including medication, report and utility rooms and staff lounges) influenced clinical teaching.

Eight people are a lot of people to come onto the unit as
[staff nurses] are trying to finish off. I make sure that the students are available to start report on time, that we have all of our chairs in there and we have left space for the staff, where they normally sit....Even things where students put their books, we [teacher and students] need to have them so the staff do not feel cluttered. When you [teacher] add eight more people, there is a physical thing that you have to do in order to make the staff feel that they are not being pushed out of the way and that they can work in the same way.

Another participant reiterated that "having a lot of bodies in a small area" meant that "you are constantly running into each other". Consequently, this crowding had an adverse affect on other health team members by influencing their attitude and the relationship between and among the staff, students and teacher.

The participants acknowledged the importance of having a place where they could take students for patient discussions, student feedback and group-teaching situations. At times, clinical feedback and discussion occurred in utility rooms, the head nurse’s office, in the hallway or in empty patient rooms. According to the participants, the amount and type of exchange between the participants and students varied depending on the privacy offered by the location where they could provide feedback.

Very often I have to pull the student out of the room to discuss something or we end up in the supply or utility room....Sometimes I have to delay telling my student things because of the situation and the people around. E.g. "Let’s talk about this later. Catch me later." Sometimes points get missed because you don’t mention them there and then. [The planned discussion] sometimes
loses its impact. It just depends on the situation.

The Schedule as an Influence

The nature of timing of aspects of patient care on the unit influenced clinical teaching. One participant altered the length and onset of the clinical experience in order to provide intravenous medication experience to the students; therefore, the "usual time of medication administration" influenced the nature of the students' experience and clinical teaching. For example, this participant had students commence clinical at 0630 hours and end their experience at 1400 hours rather than the traditional 0700-1300 clinical day. This schedule increased their learning experience by one hour daily. According to the participants, the schedule on the unit and the influx of nine additional bodies influenced clinical teaching. The participants prepared the nursing students to assist the night staff, be considerate of space and property issues, become part of the team and foster positive relationships with the staff.

The nature of the schedule...it's a mad rush in the morning and in the afternoon between two and five it is dead....It is so quiet, [students] are sitting there reading charts, yawning. So I may send a student to post-op and another to post anesthetic recovery (PAR).

I make sure the students are quiet and [do] not interfere with the night staff. We use [the patient] charts in a certain area so they are still accessible to the night staff as they are finishing. The students are now feeling comfortable about answering [patient] call lights, and to answer the phone, to help direct day care
patients while the [night] staff are finishing off.

The unit/setting has an influence on how clinical teachers teach and students learn. Specific factors identified by the participants in the specialty areas of pediatrics and maternity were the location, size, layout and schedule. Furthermore, these factors indirectly influenced the relationships between the staff, students and the clinical teacher.

**Conclusion of the Findings**

In this chapter, three maternity and three pediatric participants discussed in detail how the nature of the clinical setting influence clinical teaching. They offered what amounts to a comparative perspective on a broad range of issues central to effective clinical teaching. Specifically, they examined the impact of the type of educational program (i.e., college/university vs. diploma), the relationships between the staff and clinical teachers, the students, the agency or hospital, the patients and their families, the area or specialty, and the unit or setting.

In the next chapter, the significance of these findings will be discussed and their implications for future research on clinical teaching will be examined.
Chapter Five

Discussion of Research Findings

This chapter will include a discussion of the significant findings revealed in chapter four. These findings will be compared and contrasted with the relevant literature review (see Chapter 2) and with Pratt's framework (see Chapter 1) to structure the discussion. Pratt's (1992) study entailed interviews of 253 teachers from five different countries who taught in a variety of contexts (e.g., industry/business, government, educational and health education institutions). Pratt's framework explicates some components or concepts of context in teaching. These components and others, as revealed in this research study, will be discussed extensively within this chapter. A schematic representation of the components found to influence context in clinical teaching will be presented and explicated. A summary of the research study, the implications for future directives for nursing education and research, and the limitations of the study will also be presented.

A Discussion of Context

There were both similarities and differences between Pratt's (1992) General Model of Teaching (Appendix A) and the findings of this research. Many of the differences appear to be related to the general focus of Pratt's model and the
clinical teaching-specific nature of this study. The following section will begin with a presentation of the similarities and differences between the two conceptions of context in teaching and will conclude with a description of an alternative model of context.

Pratt's (1992) model refers and limits context to "the physical and social environment where people learn" (p.8). This model, based on his research of teaching, reveals that "conceptions [e.g., of teaching] significantly influence our perceptions and interpretations of events, people and phenomena surrounding us" (p. 204) and "are anchored in cultural, social, history, and personal realms of meaning" (p. 203). In contrast, this study revealed context as much more that than only the physical and social contextual factors. Context as defined by the participants reveals other components of context such as history, geography, ideology, and culture. Furthermore, these components were not considered by the participants to be exclusive or separate and distinct from one another. For example, the social component of context in clinical teaching is difficult to separate from the concept of culture and culture and ideology are overlapping.

Context, according to Pratt's (1992) model is confined to the broad concepts of physical and social. The findings of
this study suggest that although geography and culture may be implicit in these concepts, they are too significant to be integrated in broader concepts. For example, to relate context only to the physical aspects of teaching may not alert teachers/readers to the importance of geography or to the location of the clinical unit in relation to the educational institution as essential considerations in the influence of context in clinical teaching.

The participants in this study described the component of ideology as an influence of context in clinical teaching. To some degree, ideology is inherent in Pratt's (1992) model as the concept of ideals. Ideals in Pratt's model are described as the purposes of adult education. Pratt states that "conceptions of teaching represent normative beliefs" or ideals and that these are "impregnated with values and assumptions which inform action and guide judgement and decisions regarding effectiveness [of teaching]" (p.217). In this study, ideology was found to be subtly different from the ideals component described by Pratt because it is not confined to its influence on clinical teachers. Ideology not only influences clinical teachers but other cultural groups (e.g., students, health care team, patients and families) and entities (e.g., professional organization, agency and institutions) who/which interface in the clinical setting.
In this study, the clinical teachers' thinking and valuing influenced their perceptions of context. This is in accordance with Pratt's (1992) assertion that:

our perceptions are determined by our values, that is, we can only know the world through the lens of our beliefs. Nor can we detach our experience from the purposes and values that bring us to that experience (p. 23).

This study revealed that the teachers' thinking and valuing of clinical teaching was influenced by the university/college/agency in which they taught (e.g., mission, focus or philosophy), the profession of nursing (e.g., practice standards, entry into practice), prior teaching experiences (e.g., years of teaching in a specialty), personal values related to clinical teaching (e.g., emphasis on critical thinking), and relationships among staff, teachers and students (e.g., guest in the house). Similarly, in Pratt's study (1992), he found that teachers' intentions were (at times) synonymous with the ideology of the employing agency, organization and/or government. Furthermore, he found that teachers' beliefs as influenced by history and ideals were comprised of social, cultural, political or moral imperatives.

Pratt's (1992) model identifies only the teacher and learner (student) as participants in the learning experience. Other individuals/groups are not explicated or "there was little concern about the broader social context within which learning occurred; emphasis was on the individual, not the
collective (p. 214)"). For example, Pratt suggests that the "apprenticeship conception of teaching" in which a clinician mentors a student in the practice of the profession is prevalent within the helping professions. In clinical teaching in nursing education, however, apprenticeship may be not easily be extrapolated to the experience of the clinical teacher who comes from an educational institution to the hospital agency for the event of clinical teaching. The historical separation of staff from the clinical teacher and his/her students with the resultant guest in the house phenomenon will preclude such a model of teaching. Paterson (1997) found that "students' interactions with staff are often restricted, largely because of the traditional structure of clinical education that marks students as the teacher's territory" (p. 203).

The clinical teachers in this study expressed in a variety of ways how elements (i.e., context, content, ideals and purposes) and relationships (i.e., between teacher, student and health care team, patient and family) influenced clinical teaching. They did not qualify the relationships or elements. Similarly, Pratt (1992) proposed that no element or relationship is more dominant than others in teaching. According to Pratt, "it is assumed that effective teaching is similar regardless of variations in context, learners, content
and teachers" (p.32).

**Description of Schematic Representation**

The diagram in Appendix E is a schematic representation of the participants' description of the influence of setting in clinical teaching in pediatrics and maternity areas. As such, it represents an alternative model to Pratt's (1992) General Model of Teaching. According to the participants, clinical teaching in maternity and pediatrics is relational, entailing interactions between teacher, student, agency staff, and patients and their families. These interactions are influenced by and influence the nature and expectations of the nursing profession, the clinical agency, and the educational program. This is illustrated in Appendix E through the use of reciprocal arrows, and open, overlapping and interacting circles. Furthermore, the ordering of larger to smaller concepts is illustrated through the placement of profession, clinical agency and educational program from left to right. For example, whether a clinical teacher chooses to directly supervise a student or not is influenced by the professional standards the student is expected to attain and the requirements of the clinical agency and the educational program as to how much supervision the student requires in specific situations. However, if students make many errors and are viewed by the agency staff as incompetent, the staff
may advocate more direct supervision of the student by the clinical teacher. This expectation will be communicated to the educational program and, in turn, communicated to the teacher (Paterson, 1997).

Clinical teaching occurs within a broader overlying context of the geography or physical properties, ideology, history and culture of the parties involved (i.e., the profession, clinical agency, educational program, student, teacher, agency staff, and patient/family). These contextual factors influence how the parties interact with and their expectations of one another. This is illustrated in Appendix E through the use of open lines between the broader overlying context and the parties involved.

A Discussion of Contextual Factors as Influences of Clinical Teaching

The participants in this study discussed a variety of contextual factors (e.g., history of nursing education, unit layout, beliefs about nursing education, cultural identity of patients and families) which influenced clinical teaching. The contextual factors described by the participants were found to be either unique, similar to those experienced by others teaching in the same specialty or common to the experience of all clinical teachers. These contextual factors will be discussed in relation to significant literature as it
relates to clinical teaching in general and then with regards to the specialty areas of pediatrics and maternity.

**Geography.**

Geography refers not only to the physical properties of an organization (e.g., the layout of the unit) but to its distance and location. For example, the location of the educational program as separate from the clinical agency results in the guest in the house phenomenon, causing the clinical teacher to spend considerable effort courting staff in order to facilitate a positive learning experience for students (Paterson, 1997). The clinical teachers in this study discussed this geographic influence but did not refer to some obvious aspects of being a guest in the house. For example, they did not discuss if they encounter difficulty finding a place on the unit to put students' purses and coats. The fact that these aspects were not discussed may relate to their lack of significance in the participants' consideration of the topic or to the researcher's interviewing abilities. Paterson (1991,1997) suggests that such issues are a universal consideration in relation to the context of clinical teaching; however, the participants who had many years of teaching experience did not consider matters of physical territory of significance. It is possible that they took this territorial inconvenience for granted and not worthy of discussing.
Similarly, Paterson (1997) mentions the physical territory of staff (e.g., the chairs) as significant in the negotiating of context in the clinical area; however, in this study, the participants only referred to the territory of the unit clerk.

Other examples where clinical teachers discussed the geographical/physical context include the layout and appearance of the unit and the location of students throughout the clinical area as an influence of clinical teaching. Although the participants did not refer to the size of their clinical group as physical/geographical context, they implied that the larger the group, the less they were able to see and supervise all students.

The duration of clinical experience (i.e., one versus two days) was discussed by only one participant as influencing the nature of clinical teaching. The other five participants did not appear to challenge or question the traditional clinical placement of two days per week in the hospital setting. Dunn, Stockhausen, Thornton and Barnard (1995) found that a two-week block of clinical experience increased student confidence and organization, and assisted staff, students and teacher to form a predictable relationship. Consequently, the staff nurses were more familiar with the students' objectives and capabilities, and were found to relinquish control of the patients to the students more readily.
Culture.

Culture refers to "the customary beliefs, social forms and material traits of a racial, religious, or social group" (Merriam-Webster Dictionary, 1994, p.191). In the original formulation of this study as articulated in Chapter One, the definition of context did not explicate or consider the cultural aspects within the specialty areas or within the practice of clinical teaching in general. Cultural groups which became evident as this research study evolved were clinical teachers in general, clinical teachers within specialty areas (i.e., maternity/pediatrics), students, hospital personnel, and patients and families.

A component of the cultural experience was the guest in the house experience. This finding is congruent with other research (Fothergill-Bourbonnais & Higuchi, 1995; Paterson, 1997; Piscopo, 1994). It was determined that being a guest is significantly related to "feeling comfortable in the clinical setting", being familiar with the unit and staff and feeling accepted by the staff, as well as the length of time spent on a particular unit and unit factors (e.g., staff stress/satisfaction and head nurse's philosophy). However, some participants revealed that regardless of consistent placements, they still felt like guests (Packer, 1994). Why they experienced this and others did not was not explored in
The participants differentiated between staff who were good role-models, working effectively with students, and those who were not. If staff were perceived by the clinical teacher to be poor role models for students, they compensated for this by increasing their (teacher) use of role-modeling and by avoiding the use of staff for the supervision of nursing students. This phenomenon is not widely discussed in the literature.

The majority of study participants worked/supervised/assisted their students closely. They described "getting their hands dirty" and "getting right in there" to assist the students. Royle and Crooks (1986) relate such behavior to more than a commitment to students' learning; it is often an attempt to establish clinical credibility on the unit of learning.

The participants discussed the influence of students in clinical teaching with regards to their location in the program, breaks/holidays, agency/educational policies, and prior educational experience. However, the clinical teachers did not discuss student stress or student group familiarity as influencing the nature of clinical teaching. According to Wong and Wong (1987), "students are frequently thrown into unplanned activities with the patients, medical and nursing
staff" and patient care situations demand full student involvement (i.e., "initiate, respond and react") (p. 507). This accentuates students' stress and affects their needs for teacher supervision and support. Campbell et al (1994) found that a positive relationship between teacher and staff increased student acceptance on the unit, and a safe environment decreased student anxiety and consequently increased the likelihood of learning to occur. Similarly, a close knit student group decreased tension and anxiety and facilitated student learning.

The participants did not discuss how student anxiety affected the amount of direct or indirect teacher supervision. Paterson (1997) and Sutherland (1995) suggest in their research that some students' anxiety and errors are enhanced when they are directly supervised and that clinical teachers make decisions about how they supervise these students so as to minimize the reactive effects of the teacher's presence. Perhaps the participants who had an average of 20 years of clinical teaching experience regarded student anxiety as expected/usual and not worthy of mentioning in the interview as influencing the nature of clinical teaching.

Ideology.

Ideology refers to the "body of ideas characteristic of a particular individual, group, or culture" (Merriam-Webster
Dictionary, 1994, p.366). When comparing the definition of culture to ideology, it is difficult to clearly distinguish or separate these contextual components. Ideology appears to be inherent in culture. The participants in this study made reference to shared as well as unshared ideals among the cultural groups of staff nurses, teachers, students, and patients and families.

According to the participants, ideology is diverse but inherent in nursing programs (e.g., mission, foci), agencies (e.g., philosophy) and in specialty areas and units (e.g., family centered care). These ideals are enacted by the various cultural groups (i.e., nurses, teachers, students and patients and families) in their actions, intentions and communications.

Participants in this study discussed the influence of their ideology on the agency and conversely, the influence of the agency's ideology on them. It is noteworthy, however, that they only vaguely discussed the influence of the educational program and the profession's ideology on the way they taught. They did not discuss their influence on the program's ideology and only alluded to having an influence on the profession's ideology. It is possible that this occurred because the participants were very seasoned teachers and took their influence on the program and the profession for granted.
Furthermore, the lack of or limited discussion may relate to their perception of lack of significance of these matters in the consideration of the topic.

The participants discussed the influence of ideological conflicts, particularly in regard to professional/unprofessional role-modeling and entry into practice, at some length. No studies were located that specifically studied the effects of ideological conflicts on clinical teaching; however, one group of researchers suggest that students experience ideological conflicts in a manner similar to their teachers. Reuter, Field, Campbell and Day (1997) studied baccalaureate nursing students and found that almost all their study participants had difficulty "coping with the implicit and explicit negative feedback received from staff nurses about the...B.Sc.N. program" (p. 152). These authors postulated that students who experience a difference in ideology with staff nurses, feel like an outsider and "may not derive full benefits of role modeling by expert practitioners" (p. 155).

The participants in this study discussed the ideology of the unit (e.g., family centered nursing) and the staff (e.g., nurses who were "poor role-models") and how these aspects influenced clinical teaching. They suggested that ideological conflicts occur most often when there is a difference between
what the teacher wishes students to value/believe and what the staff nurse verbalize or demonstrate to students. Reuter, Field, Campbell and Day (1997) discussed the influence of such a situation from the students' perspective. Students in their study were found to "learn both the informal and formal norms of the unit" (p. 153) when they changed learning settings, and that;

    they may attempt to "fit in" but do not "give in" to the norms and values of the nursing unit when these are discrepant with the norms and values conveyed by the faculty (p. 154).

The participants in this study did not discuss the influence of unit change on students or how they dealt explicitly with differences in ideology between teachers and staff nurses. They did however, avoid "certain nurses" and warn students regarding the staffs' particular preference (e.g., tidy unit). In contrast, the student participants in Reuter et al's (1997) study found that through discussion, the students were able to share and reaffirm their own ideals with fellow students and their clinical teacher.

**History.**

History refers to the aggregation of past events or course of human affairs (Merriam-Webster Dictionary, 1994). Historical events in this research study that were found to influence clinical teaching include the history of nursing education (e.g., training versus education), the history of
the agency (e.g., reorganization, fiscal restraint), the
history of the nursing profession (e.g., B.Sc.N. as entry to
practice), and the impact of past experiences between
teachers, students, staff, and patients and families (i.e.,
guest in the house).

The influence of history on clinical teaching was
demonstrated in the diverse ways that the participants worked
with and relied on the staff nurses, as well as how they
approached the clinical teaching of nursing students (e.g.,
styles, strategies and techniques that they used while working
with students). This diversity is congruent with Alexander's
finding that "there was no discernible pattern to the nurse

The participants in this study identified the historical
influence with regards to the supervision of nursing students
in the clinical area (i.e., by hospital based staff/teachers)
and how changes in nursing programs influenced the staffs'
expectations of students (e.g., diploma to a university
program). On many occasions, the result of this historical
influence was the guest in the house phenomenon whereby staff
were separate from the learning experiences of students.
Freiburger (1996) postulates that some nursing staff view
clinical teaching "as being solely the responsibility of the
clinical educator" (p. 11). Research suggests that what is
needed is a model/system of clinical teaching which facilitates student learning by promoting participation, collaboration, collegiality between clinical teachers and nursing staff (Freiburger, 1996; Baird et al; 1994; Melander & Roberts, 1994). This would clearly define the staff-nurses involvement with teachers and students.

One historical influence that the participants alluded to but did not discuss at length was their preparation, or lack of, regarding clinical teaching. According to Fowler (1996), Lee (1996) and Kirchbaum (1994), clinical teachers lack educational preparation with regards to clinical teaching. Furthermore, those who obtained formal courses about teaching found it did not prepare them to supervise students (Fowler).

A strong linkage of students, faculty and staff allows free interchange of ideas, increased interpersonal support, maximal utilization of nursing strengths, increased dialogue about decision making, and enhanced clinical judgements, all of which combine to produce both higher quality client [patient] care and increased participant satisfaction with the teaching/learning experience (Melander & Roberts, 1994, p. 424).

**Contextual Factors as Influences of Clinical Teaching in the Specialty Areas**

The preceding section concentrated on how the components of context and the various cultures influenced clinical teaching in general. This section will focus on the specific context of clinical teaching in the specialty areas of
pediatrics and maternity.

**Geography.**

The contextual factor of geography/physical influenced the specialty areas of maternity and pediatrics in different ways. The maternity participants discussed the location of students and teachers in a variety of settings (i.e., postpartum, labor and delivery, special care units and community) and its influence on clinical teaching (i.e., disruptive, much walking back and forth, the teacher being less available for students, having lower expectations of student performance/abilities). In contrast, the pediatric participants were primarily located in one setting. In the event of a decreased patient census and inadequate learning experiences, the clinical teachers in pediatrics would select patients/experiences in adjoining units (i.e., adult diagnostic unit and pediatric day care) but this was the exception, not the norm. Having students on two units meant establishing rapport and credibility with two groups of staff, being less available/accessible for the students, having more reliance on the staff for the supervision of students, and having less control over student performance and thus patient safety. Sutherland (1995) and Smyth (1987) were the only researchers located who have considered the influence of assigning teachers to multiple units. They suggest that this
practice results in the teacher's limited contact with students and staff.

The pediatric participants in this study made reference to small units, the use of adjoining units and the unique nature of clinical teaching in this specialty area. However, the participants did not discuss the increasing complexity of the patients, the decreasing number of patients on the pediatric unit or the trend toward community and home nursing (Kowalski et al, 1996) in pediatrics. The increasing trend to care for and treat mild to moderately ill children in the home/community setting and to admit acutely ill children to the hospital setting (Kowalski et al, 1996; Augspurger & Rieg, 1994) is well-documented in the literature. These situations have an impact on clinical teaching by increasing the teacher's involvement (i.e., care and supervision) with the student and by limiting the selection of suitable patients for student experience. Perhaps the participants had already experienced these changes in the patient population and had adjusted their teaching by selecting alternative learning experiences (i.e., adult diagnostic testing and pediatric day care) for the students. This was not explored.

The pediatric participants discussed the impact of having nine additional people (i.e., the students) on the unit for the nursing staff and the effect of this on their teaching.
The participants attempted to minimize the impact by altering the students'/teacher's schedule (e.g., begin clinical before the onset of day shift), having the students assist the night-staff (i.e., answering call lights and telephones) and attending to the staff's physical space needs (e.g., ensuring enough chairs for staff and students during report). In contrast, the maternity teachers did not discuss the impact of the additional people. This may have occurred because the maternity students were situated in a variety of settings (i.e., postpartum, labor and delivery, community and special care nursery) and the impact of their presence was minimized by situating the group in more than one setting at any one time.

**Culture.**

The concept of culture was discussed differently among maternity and pediatric teachers. The maternity participants described the maternity staff as a unique culture that experienced little staff turnover (i.e., stable staff) and unit change. However, the unique culture of pediatric nurses was perceived as one that was being erased (i.e., less stable) due to hospital, unit and personnel changes (i.e., casual staff sent to a unit on the basis of seniority; some nurses were scheduled to work on two different units). Prior research has demonstrated that organizational change
influences staff-nurses, staff development educators (Suderman, 1995; Ireson & Powers, 1987) and the communication between staff and clinical teachers (Piscopo, 1994). However, these studies did not address the influence of organizational change and staff stability on clinical teaching. The participants in this study revealed that the maternity staff assisted students and, indirectly the teachers, by taking them to the bedside for patient teaching situations. This practice was thought to be related to the stability of the staff and their longevity on the unit. In contrast, the pediatric participants who experienced unit change and a less stable staff (e.g., casual and nurses working on two units) supervised their students more closely and did not rely on the staff nurses for the clinical supervision of students.

The culture of patients and families was also viewed by the participants as unique to the specialty areas in which they taught. Cultural aspects discussed by the maternity participants were the types of patients, early discharge and the presence of husbands or significant others. Working with well mothers and babies was thought to influence clinical teaching by creating a positive environment in which the students could learn. Similarly, Cross and Fallon (1985) found that nurses caring for well mother and babies experienced less patient stressors when compared with other
nursing specialties.

The pediatric participants discussed the age and development of the pediatric patient, an average discharge of three days and the presence of family members throughout the hospitalization period as influencing clinical teaching. Kowalski et al (1996) postulate that families and patients in the pediatric setting share in the responsibility for information, decisions and management of care among families. This shared responsibility is translated to clinical teaching in that the pediatric teacher must include the family and patients as partners and consumers of the student's care.

The culture of clinical teachers in this study as defined by the participants was diverse. The clinical teachers who were situated at the community college taught a variety of clinical courses (i.e., maternity/pediatrics and medicine/surgery) and expressed their culture as largely college-based. Most of the clinical teachers located at the university setting, however, taught only in their area of specialty and defined their culture as mostly maternity or pediatrics-based. This is in keeping with Stew's (1996) finding that clinical teachers associated with professional groups (e.g., midwives, psychiatric nurses) expressed loyalty to their specialty area rather than to the concept of college membership. The clinical teachers in this study did not
explicitly express loyalty to either the college/university or to their specialty group. They did, however, discuss feeling like a guest or having a degree of comfort/confidence in the clinical setting according to their level of familiarity with the unit and unit staff.

The culture of the student with regards to stress and challenge in the clinical practice areas of maternity and pediatrics was vaguely discussed by the participants (i.e., stress in the presence of families). Oermann and Standfest (1997) found that students experienced moderate levels of stress, challenge and threat associated with their pediatric clinical experience. They postulate that "caring for children is a stressful experience and is likely to evoke a high degree of response and emotion form students" (p. 232). In contrast, nursing students in their study most frequently described emotions "such as stimulated, excited, and pleased" (p.231) in maternity courses (Oermann & Standfest). The students' perception of the specialty areas was not the focus of this study but because the participants recognized that the presence of stressors for students affects the nature of clinical teaching, it is interesting that the participants did not discuss student stressors specifically associated with either maternity or pediatrics. One reason for the lack of discussion regarding this topic might be that the teachers do
not view these stressors as specialty-specific (e.g., the presence of family is a consideration in all clinical settings).

**Ideology.**

Ideology was discussed in a variety of ways by maternity and pediatric teachers. According to the maternity teachers, the nursing staff on the postpartum unit valued nursing students and patient education. In contrast, the pediatric nurses were perceived to have little contact with the nursing students. The pediatric clinical teachers assumed most of the responsibility for student teaching/learning (i.e., role modeling, support and supervision). Perhaps the pediatric staff nurses hold a different philosophy (ideals) regarding clinical education of nursing students than maternity staff and clinical teachers. Another postulation may be that the participants altered how and when they clinically taught in relation to the staffs' involvement and ability to work with or supervise the students. For example, the maternity teachers had little contact with their students in labor and delivery. It is unclear whether the clinical teachers withdrew from clinical teaching in this area (i.e., labor and delivery) because of its highly specialized nature or because the demands of eight to nine students on three units (i.e., postpartum, labor and delivery and the special care nursery)
command that the teachers spend the majority of their time on the postpartum unit. This practice is in contrast with the pediatric participants' beliefs and values and the university/college/agency policies regarding student supervision and patient safety that dictate the need for close student supervision by the teacher in the pediatric area.

The participants described the ideals (e.g., the family's perspective of the child's needs, care and treatment at home) of families in the specialty area of pediatrics as an influence of clinical teaching. In contrast, the maternity participants did not overtly discuss this influence despite the regular presence of fathers and other significant others in maternity settings (Reeder, Martin & Koniak, 1992). This may have occurred because the maternity teachers did not perceive family presence as directly influencing student's stress and therefore clinical teaching. Pediatric teachers, however, made it clear that family members' concern for the safety and welfare of the ill child was a significant factor in determining the need for teacher guidance and support.

History.

The historical influence on the specialty areas of maternity and pediatrics was described by the participants in a variety of ways. The maternity participants discussed the staff (i.e., stable staff) and the organization of the
maternity area (i.e., organized separately, labor and delivery, postpartum and special care nursery areas) as influencing clinical teaching in maternity areas. These aspects influenced how the staff worked with students and how clinical teachers designed student learning experiences in maternity settings. Furthermore, the influence of organizational change (i.e., cross-training staff to work in all maternity areas) influenced clinical teaching by increasing the staff nurses' stress level and affecting how the clinical teacher and students were accepted/received on the unit.

The pediatric participants discussed how they prepared the students for the clinical experience (i.e., family involvement, close student supervision and the need for skill competency) because of the historical expectations of students and the learning experience. The teachers' preparation of the students for clinical experience was influenced by their past pediatric experiences with students, patients and families, as well as program and agency policies. This study demonstrated that significant historical events which transpire on a particular unit/specialty area (e.g., students in one group making several medication errors; a clinical teacher who is deemed incompetent as a clinician by the staff) influence how clinical teachers teach and staff nurses work with students in
the specialty areas.

**Summary of Contextual Factors**

The preceding sections in this chapter included a comparison between Pratt's General Model of Teaching and this study's model of clinical teaching. Next, a discussion of the study's significant findings in relation to the clinical teaching literature ensued. This discussion was structured in relation to the model of clinical teaching, specifically the contextual factors as revealed by this research study. The context of clinical teaching was described as diverse with many components of context (e.g., history, culture), and relationships (e.g., profession, agency, staff, patients and families) which had a direct influence on clinical teaching.

Pratt's (1992) General Model of Teaching reveals many important aspects which influence teaching in general. This study revealed context specific to clinical teaching and as more than physical, social and ideals. The individuals, groups and entities which interface with the clinical teachers and students in the hospital setting were found to have a significant impact on clinical teaching; therefore, a model which represents the contextual influences of clinical teaching must entail the components of context as identified in this study and the many individuals/groups who are stakeholders or major players in clinical teaching and
learning.

The discussion of contextual factors that influence clinical teaching presents evidence that any model of teaching that is designed for classroom settings will not be readily translatable to clinical teaching. Clinical teaching is often unpredictable and is influenced by the history, culture, geography and the ideology of the organization, profession, institution, agency and the relationships between all the people who work, learn and receive care in this setting. In contrast, in the classroom setting, the teaching/learning activities are generally structured, there is little/no element of risk to the safety and well-being of patients and the teacher has control over the major factors influencing student learning (Wong & Wong, 1987).

Summary of Research

The research was designed to explicate the how the context of maternity and pediatrics influences the nature of clinical teaching in these specialty areas. Six clinical teachers volunteered to be interviewed on two occasions to address this research topic.

It is apparent from the research findings and discussion that the nature of the unit/setting has an influence on clinical teaching. Specific setting factors discussed by the three maternity and three pediatric participants were the
educational program, agency staff, unit/setting, patients and family. The participants spoke openly and enthusiastically about their experiences teaching nursing students in the specialty areas of pediatrics and maternity. Some participants contrasted these experiences with their teaching in medical-surgical areas.

**Educational Program**

The participants described the philosophy, the structure of clinical learning and the nature of the student as influencing aspects of clinical teaching. The philosophy of the educational program (degree vs. diploma) was found to influence the foci of clinical teaching and learning. The participants varied their student "patient assignment", teaching strategies and expectations of students in relation to the mission and foci of the program.

The structure of clinical learning influenced how clinical teachers taught. Aspects revealed as significant were the time lapse between clinical experience, agency/institution policies, length of clinical experiences/rotations, and clinical group size. The participants discussed how the time between clinical experiences influenced the students' patient assignment, teachers' expectations and the amount and type of clinical supervision. Likewise, the length of student learning experience on the unit influenced
the teacher's expectation of student's performance.

Aspects of agency/institution policy revealed by the participants as an influence of clinical teaching were the placement of students in the hospital setting, the selection of learning experiences and the degree of student independence. The clinical group size as determined by the clinical agency and educational program was found to influence the availability of the clinical teacher for student supervision, as well as the degree of involvement that the unit staff had with students.

The participants described the nature of the student with regard to location in the program and prior educational experience as an influence on clinical teaching. The clinical teachers were found to vary their students' patient assignment, their expectations of students, and amount and type of supervision in accordance with the nature of the student.

**Agency and Staff**

The nature of the agency staff was discussed by the participants in relation to change within the agency, the variety and characteristics of staff members and the relationships between staff, clinical teachers and students. The participants discussed feeling like a guest in the clinical agencies where they taught. The degree of "feeling
like a guest" varied among the participants in relation to the length of time spent on the clinical learning unit, the stability of the nursing staff and the degree of clinical confidence that the teachers experienced. The participants' relationship with the nursing staff on the unit influenced the teacher-student anxiety level, the teacher's desire to try out new learning situations and the staff's willingness to assist the clinical teacher with student-learning. Other agency staff discussed by the participants as an influence of clinical teaching were doctors, health care team members and unit clerks.

Families

The specific contextual factors, patients and families in the specialty areas of maternity and pediatrics, influenced clinical teaching. Pediatric participants extensively discussed the influence of family on clinical teaching. They found the family-centered focus and the student's response to family members at the patients' bedsides influenced how teachers taught.

Nature of the Specialty

Maternity.

The nature of the specialty area of maternity influenced clinical teaching. Student learning experiences (e.g., postpartum, labor and delivery) influenced the availability
and accessibility of; and the teaching strategies used by, the clinical teacher. Similarly, the nature of the experience influenced the students' involvement with the patient. Students were found to experience observational learning experiences in complex patient situations and in specialized maternity areas (i.e., labor and delivery, special care nursery).

The uniqueness of the specialty and the complexity of the patient influenced the clinical teaching strategies used/demonstrated by the teacher. Specific patient factors (i.e., mother and baby) discussed by the participants were the well focus, being with the patient, and the emphasis on teaching and learning. Clinical teachers reported varying and increasing the complexity of the students' patient assignment (e.g., normal delivery patients to cesarian section patients) as the clinical teaching/learning experience enfolded. The average patients' hospital stay of 24 hours for a normal delivery and three days for a cesarian section influenced how and when the clinical teachers selected their patient assignment.

The staff on the maternity units were described as stable, experienced and generally accepting/supportive of students and teachers. Change and the issue of cross-training of staff in all maternity areas caused stress/disruption on the part of the staff and influenced staff/teacher/student
relationships (i.e., became less tolerant of students).

**Pediatrics.**

Specific contextual factors which influenced clinical teaching in the specialty area of pediatrics were the patient's developmental characteristics, complexity, the nature of the illness and the length of hospital stay. At times, the nature of the patient influenced the staffs' receptivity of the teacher and students.

The pediatric participants described unique safety concerns in the specialty of pediatrics. The teachers discussed safe-guarding the patients, more so in the specialty of pediatrics when compared with other areas of nursing, by thoroughly assessing their students prior to care/treatments/skills, increasing the extent of student supervision and being an advocate for the patient. Furthermore, the participants varied clinical teaching by providing a range of patients to the students and using a diversity of teaching strategies. Another significant aspect discussed by the pediatric participants was the disruption that the addition of nine extra bodies had on the unit. Teachers discussed strategies to decrease this impact.

The nature of the staff on the pediatric unit was described as casual, part-time, working on two units, and less tolerant of nursing students when compared with maternity
staff. Consequently, the clinical teachers reported working/supervising/assisting their students more closely because of the nature of the patient and the staff. In contrast, the participants discussed "true collaboration" with the health care team members. This collaboration influenced clinical teaching by creating positive learning situation for teachers and students.

The participants described the presence and involvement of family members as more extensive in the specialty of pediatrics, than in any other area of nursing. Family members influenced clinical teaching by affecting student confidence, teachers preparation of students prior to clinical experience, patient teaching and discharge planning.

Unit

The participants discussed the structure, layout, appearance and schedule as aspects of the unit which influenced clinical teaching. The structure of the unit affected the visibility, privacy and access between and among students and teachers. With regards to layout and appearance, space was discussed as the most significant influence of clinical teaching. Similarly, the students' and teachers schedule on the unit was also viewed as an influence of clinical teaching. Clinical teachers attempted to alter the impact of nine extra bodies on the unit by varying the times
of student learning and by discussing ways to decrease this disruption on the unit staff.

**Implications**

This study is a beginning investigation as to how the nature of setting in the specialty areas of maternity and pediatrics influences clinical teaching. Although preliminary, some general statements can be made that will affect nursing education and research.

**Future Directives for Nursing Education**

This study contributes knowledge to the field of nursing education. Nursing educators who teach nursing students in a variety of settings can begin to appreciate the uniqueness and complexity of hospital settings in general and within the specialty areas of maternity and pediatrics.

The nature of the agency was revealed as an influence of clinical teaching. Dialogue between clinical teachers and agency staff regarding how changes caused by health care reform influences availability of appropriate learning experiences and the staff's response to teachers and students, would assist educators to select and prepare for these learning experiences. Furthermore, an exploration of fit or congruence between the educational institutions's policies/philosophies and that of the clinical agencies' policies and practices before arrangements for clinical placements occur,
would assist educators to select/prepare for learning experiences.

The location of the teacher in relation to the clinical agency (i.e., guest in the house), influenced clinical teaching. The results of this research will help prepare teachers and students for negotiating the guest in the house status with staff nurses and health care team members. This study suggests the need for ongoing dialogue between clinical teachers and staff nurses with regards to effective work/supervision of students in clinical settings.

This study revealed that teachers who experience clinical comfort/confidence in the clinical setting perceive themselves to be less like a guest than those who do not have this level of comfort/confidence. This suggests that clinical teachers need to maintain a level of clinical practice expertise in order to appear credible in the clinical setting (as perceived by the staff) and to assist students at the patients bedside by role-modeling nursing behaviors. The exact nature of this expertise and how teachers can best attain this is a subject for future research.

The nature of the educational program influenced clinical teaching. This study suggests the need for further exploration of clinical configurations (e.g., length, duration and frequency of clinical practice) and group size on clinical
Patients, families, the specialty area, the specific unit factors (e.g., layout) were revealed as significant influences of clinical teaching. The study results will help inform and prepare teachers and students about these important factors that influence teaching and learning.

This study demonstrated that context directly affects the perceptions of clinical teachers and the nature of clinical teaching. It is no longer desirable or educationally sound to send eight to nine students and any clinical teacher to a nursing unit merely on the basis that they will be accommodated (i.e., no other students and teacher are currently placed on a particular unit). Wherever possible, clinical teachers should be allowed to return to clinical units where they are familiar with the unit, staff, policies and routine. This would decrease the impact of feeling like a guest and consequently improve student learning outcomes.

It is clear that nursing educators need to examine and dialogue about the variables, contextual components (i.e., geography, culture, history, ideology), factors (e.g., unit layout, history of nursing education) and relationships that significantly impact on how teachers teach and students learn in the clinical area. Such a discussion should include all stakeholders, including unit staff, students, and agency
administrative personnel.

**Future Directives for Nursing Research**

This study has implications for future directives for nursing research. This study examined context within the settings of pediatrics and maternity. Other studies which explore the influence of psychiatric, medicine-surgical, community and non-traditional settings on clinical teaching would be of significance to nursing education. Of importance are studies which investigate the settings of community and home. This would be congruent with the current trend to care/treat patients and families in these settings.

This study compared and contrasted context in two different specialties of nursing (i.e., maternity and pediatrics). A study which examines the influence of a variety of settings on clinical teaching within one specialty would be of interest. For example, an investigator could examine the differences between a hospital unit, a community and a home setting, all within the specialty of pediatrics.

This study revealed that teachers who clinically teach on more than one unit were less available/accessible for the supervision of nursing student. Specific studies which compare and contrast clinical teaching on one versus multiple units would be of value to clinical teacher. Currently, the increasing trend towards smaller units and the supervision of
students in higher semesters (e.g., students care for 5-6 patients), necessitates the need for clinical teachers to supervise students on more than one hospital units. Research which examines the impact of teaching on multiple units is lacking.

Furthermore, the participants and the literature review alluded to the value of longer clinical experiences (e.g., students would experience pediatrics and surgery on a pediatric-surgical unit) or block practicums (e.g., clinical practice for a two week period). Future studies need to compare and contrast the influence of clinical teaching in these diverse clinical arrangements with traditional clinical placements (i.e., two days per week). Similarly the literature, explored in the discussion chapter, reported the value of different models of clinical teaching (e.g., the clinical associate model). For example, the clinical teacher/supervisor in the clinical associate model is the staff nurse. Future studies which explores outcomes of teacher as the major source of teaching/supervision in comparison with staff nurses and fellow students need to be implemented. However, prior to this research, the perceptions and willingness of staff and administrators would have to be explored.

The clinical teachers in this study did not discuss their
influence on the profession of nursing. Similarly, they did not discuss their influence on the program. Research which explores these influences with regards to clinical teaching would be of value to this research study.

Likewise, the clinical teachers in this study presented with many years of teaching experience. The exact nature of their clinical teaching educational preparation was not explored. Studies which examine the influence of clinical teaching preparation would help prepare clinical nursing educators of the future. The participants had between four and thirty years of clinical teaching experience. Their familiarity with the field may have resulted in their articulating only those aspects of context that were significant/problematic. They may not have identified others that they regarded as routine or that they no longer questioned. Future research which explores the perceptions of inexperienced, sessional or contract teachers would be of interest.

The participants taught clinical courses that occurred in the middle of the nursing program. Future studies which compare and contrast these findings with findings which result from studies which occur at different intervals of the program would be of value.

In this study, the clinical teachers described using a
variety of teaching styles, strategies and techniques in an attempt to adapt to and incorporate the influence of context. Research which explores clinical teaching effectiveness in relation to context would assist clinical teacher and staff-nurses work/supervise nursing students more effectively and efficiently. One such contextual aspect is the presence of patients and families. Further research is dictated that will investigate how families and patients in maternity and pediatrics influence the nature of clinical teaching and how clinical teachers mediate this influence.

This study revealed some contrasting ideals between and among clinical teachers and staff nurses with regards to clinical nursing education (e.g., staff as role-models and teachers expectation as to how nurses work with students). Since this was not the focus of this research, it would be interesting to compare teachers' ideology with staff nurses ideology. The promotion of ideals by staff and clinical teachers may assist students to become indoctrinated into the role of the professional nurse more readily. Similarly, studies which explore the staff-nurses' perceptions with regards to their responsibility for nursing students (i.e., how they perceive their role and responsibility with students) would assist clinical teachers to prepare staff, student and other clinical teachers for the event of clinical teaching.
Limitations

The researcher recruited the study participants by requesting volunteers from two lower mainland colleges or universities. Three of the participants volunteered, while the remaining three were chosen by either "snowball effect" or purposeful sampling. Those that volunteered or were requested to participate agreed to be interviewed. Consequently, the volunteer nature of the participants limits the generalizability of the study to those that were interested and willing to participate. Those who refused to participate may have been disinterested in or had extremely negative opinions about the research topic.

Conclusion

This study examined the influence of a variety of factors (i.e., components of context, elements and relationships) on clinical teaching in the specialty areas of maternity and pediatrics. The study participants discussed many aspects, some superficially, others more in depth, that have not been written/acknowledged in the literature to date. The contexts of maternity and pediatrics was discussed in detail. Variations and similarities were acknowledged between and among these two areas of specialties. At times the participants compared these specialty placements with medical-surgical areas. They perceived that all units and
settings, regardless of specialty, where clinical teachers teach the practice of nursing are unique. This study provides a beginning understanding as to how context in the specialty areas of pediatrics and maternity influences clinical teaching. It is hoped that nursing educators consider the various factors and aspects which influence clinical teaching prior to the placement of students and clinical teacher on a particular unit.

Clinical teachers need to appreciate, comprehend and share knowledge of how the components of context and relationships influence how teachers teach and students learn in the clinical setting. It is timely that nursing educators fully understand the nature of the setting and how it influences clinical teaching. Furthermore, it is incumbent that nursing educators analyze factors and components which influence clinical teaching. Only then can students and teachers be placed in quality setting that are conducive to quality nursing education.
References


Appendices
Appendix A: Pratt's General Model of Teaching
A General Model of Teaching (Pratt, 1992)
Appendix B: Participant Information Letter
Dear Clinical Nursing Teacher:

I am a Registered Nurse and am presently enrolled in the Masters of Science in Nursing program at U.B.C. In order to fulfil my thesis requirement, I have chosen to study clinical nursing teachers and explore how the nature of the clinical setting influences the clinical teaching of undergraduate nursing students. My experience as a clinical nursing teacher, as well as the paucity of research regarding context or setting in clinical teaching has spurred my interest in this area.

I am particularly interested in speaking with nursing teachers who are either currently teaching or have taught in the clinical area of maternity or pediatric nursing within the last year. Your participation, if you decide to be one of the study participants, will involve two meetings approximately one to one and a half hours long. During the meetings, I will ask you questions or have you discuss your clinical teaching experiences within the context of the maternity or pediatric unit. The interviews will occur at a convenient place and time for you. The meetings will be tape recorded and the information transcribed. The individuals who will have access to the tapes and transcriptions will be myself, my thesis chairperson and a typist. The tapes and transcriptions will be stored in a safe place and within 7-10 years of conclusion of the study, they will be erased or destroyed. The transcribed material will have all names and identifying information excluded. During the course of the meeting or during any part of the study, you will be free to not answer any of the questions and decline from the study. After the completion of second meetings with all six participants, I will request that you meet with myself and the other two clinical teachers who teach in similar settings. This meeting may last up to one and one half hours and will confirm and clarify the common themes found in the interviews. The maximum number of hours required of each participant in this study will be four and one half hours. At the conclusion of the study I will be pleased to share written findings with you.

This study presents no known risks to the participants and will be supervised by my thesis chairperson from the onset until its conclusion. My chair person's name is Dr. Barbara Paterson and can be reached at xxx-xxxx. If you are interested in participating in this study and contributing to knowledge regarding the influence of setting on clinical teaching, please do not hesitate to call me at xxx-xxxx. I will be interested in answering your questions and if you are willing to participate we can arrange a convenient time and place to meet for our first meeting. During the first
meeting, I will present a written consent for you to sign prior to the onset of our interview and taping. Thank-you for your interest in this study. I look forward to your participation.

Sincerely,

Karen Davidson
Appendix C: Permission from Deans/Directors
Attention, Ethics Department at U.B.C:

I hereby grant the student investigator Karen Davidson permission to approach the clinical teaching nursing faculty at _____________ with a letter requesting voluntary participation in a research study. This permission is conditional on approval of the research study by the Ethical Review Committee at U.B.C. The study is titled: How does the nature of the clinical setting influence clinical teaching? The researcher requests participation of pediatric and maternity clinical teachers in the form of interviews.

I grant conditional permission and acknowledge receipt of the details of the study which are revealed in the information letter and participant consent form.

__________________________________________  ____________
Signature of Dean/Director                  Date

__________________________________________
Witness
Appendix D: Participant Consent
Consent to participate in the research study "How does the nature of the clinical setting influence clinical teaching?"

**Student Investigator:** Karen Davidson xxx-xxxx
**Faculty Advisor:** Dr. B. Paterson xxx-xxxx

You have been asked to participate in a nursing research study, conducted by Karen Davidson in fulfilment of the requirements for a Masters of Science in Nursing degree at U.B.C. The purpose of the research is to answer the question: How does the nature of the setting influence clinical teaching? If you decide to take part in this study, you will be interviewed about the nature of the clinical setting and how it influences your clinical teaching of undergraduate nursing students. The interview will last approximately one and a half hours. The interview will be audio-tape recorded by the investigator and then a typist will transcribe the interview into written data. A follow-up interview of approximately one hour, will be done to confirm, clarify and augment the information obtained in the initial interview. A third meeting may be requested, lasting approximately one hour, to confirm and clarify the information which you and other teachers teaching in similar areas of the clinical setting have acknowledged. The total amount of time requested of you is four and a half hours.

Should you decide to participate in this study, there are several potential benefits. You will be contributing knowledge about how the clinical setting influences the teaching of undergraduate nursing students. It is hoped that the emerging theory obtained from this research will assist in preparing clinical teachers to teach and to plan learning experiences in more effective ways.

There are no known risks to participating in this study and your participation is entirely voluntary. If at any time you decide not to continue in the study either in its entirety or in part, you are free to refuse without any disadvantage to you.

Any information resulting from this research will be kept strictly confidential and will be seen only by members of the thesis committee. The audio tapes and interview transcripts will have all the identifying information removed and your
name will not be used. Within 7-10 years of the conclusion of the study, all tapes will be erased, transcripts will be destroyed. Further to this, all identifying data will be removed from the data collection and analysis.

If you have any questions or concerns at any time or during this study you may contact the student investigator at xxx-xxxx. If you have any concerns about your treatment as a research subject you may contact the Director of Research Services at the University of British Columbia, Dr. Richard Spratley at xxx-xxxx.

I have read the above information and I have had an opportunity to ask questions regarding the research study. I fully understand what my participation entails. I freely consent to participate in the study and acknowledge receipt of a copy of this consent.

_________________________  ______________________  __________
Signature Participant      Witness                   Date
Appendix E: Model of Clinical Teaching
A Model of Context in Clinical Teaching