HOW DOES THE NATURE AND DURATION OF TEACHING EXPERIENCE OF A CLINICAL NURSING INSTRUCTOR AFFECT THE LEARNING OUTCOMES OF NURSING STUDENTS ENROLLED IN A NURSING PROGRAM?

by

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Abstract

The role of clinical teachers' experience in clinical teaching in nursing and its influence on student learning outcomes has not been widely explored within the nursing literature. Yet this topic is critical in order to provide optimal nursing education that yields safe and competent nurse practitioners. In this research, a qualitative ethnographic design was used to explore the perceptions of novice, experienced, and administrator clinical teachers. Data was collected by the use of focus groups for the novice and experienced groups and personal interviews for the administrator group. Each group consisted of four participants each. The participants were recruited from Schools of Nursing in Saskatchewan and British Columbia.

Analysis of the data revealed there are distinct differences between the two groups of clinical instructors. The participants suggested that the experienced instructor is more confident and competent in her/his role, which translates to specific, consistent, and positive successes and outcomes for the students. However, although novices were generally portrayed as anxious, lacking confidence and lacking teaching knowledge, the participants indicated that these instructors contribute positively to student education due to their enthusiasm, energy, recent clinical experience, and current knowledge. They proposed that although the experienced instructor is better equipped with more knowledge, skills and personal qualities, both instructors have attributes that do contribute to the education of nursing students.

These findings have implications for nursing education and research. This research has provided insights into how administrators can support both novice and experienced clinical instructors in their practice. Furthermore, this research has revealed how novice and experienced instructors can benefit from the unique contributions each has to make to the other.
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Chapter 1

Introduction

Clinical education in nursing is a diverse and complex topic that has lent itself well to research endeavours. The area of clinical teaching has been a core topic of nursing inquiry for over thirty years. Many issues and questions related to clinical teaching have been explored and investigated. In particular, nurse researchers have most often focused on classroom and clinical instructor behaviours that evaluate teacher effectiveness.

However, there are many issues regarding clinical instruction that remain unclear and under explored. For instance, topics such as novice and expert clinical teaching practice remain enigmatic. Yet these topics are critical to in-depth nursing education inquiry as well as advancing nursing knowledge. It is evident that further research is required by nurses to advance knowledge on such a crucial subject.

Problem Identification

There is a definite lack in the nursing literature regarding the duration of clinical teaching experience as it pertains to student learning outcomes. To date, research in nursing education has been primarily concerned with effective teaching behaviours, particularly in the classroom (Jacono & Jacono, 1985; Krichbaum, 1994; Wong & Wong, 1987). In general, most researchers have considered teaching effectiveness in classroom nursing education as something that an individual inevitably accrues with teaching experience, in particular the passage of time. However, the role change from staff nurse to clinical educator of student nurses can be a difficult and challenging transition. Novice instructors enter into nursing education with limited teaching experience to effectively teach nursing students (Karuhije, 1986). Although novice instructors may have developed a knowledge base regarding clinical instruction as a result of graduate education, this
knowledge remains at a theoretical level until they have sufficient teaching experience to integrate it into their teaching practice.

A lack of teaching experience may have repercussions for nursing students and their subsequent learning outcomes. A novice instructor is not able to rely on previous experience in teaching to guide student learning, as a more experienced colleague can. Novice instructors may lack the necessary tools to effectively transmit knowledge and foster learning in students. Furthermore, Benner (1984) asserts that clinical instructors need to be expert at ensuring that the novice student practices in the clinical environment in a safe and efficient way. An instructor with limited teaching experience may have greater difficulty accessing resources that ensure that student learning outcomes are met appropriately and effectively. Although it seems likely that the inexperience of novice teachers could affect students’ learning outcomes, it is not entirely clear if that is in fact the case. If indeed the teachers’ inexperience affects learning outcomes of nursing students, it is not known how the teacher’s experience affects students’ learning and what the specific nature of that impact might be.

Research Problem

The purpose of this study was to explore and uncover how the nature and the duration of teaching experience influences student learning outcomes in clinical nursing education.

Thus, the research question for this qualitative study was: How does the nature and duration of the teaching experience of a clinical instructor affect the learning outcomes of nursing students enrolled in a nursing education program?
Definition of Terms

Clinical teaching.

The primary purpose of clinical instruction is to prepare nursing students to:

integrate previously acquired basic science and nursing theory with performance oriented skills and competencies associated with 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 (Meleca, Schimpfhauser, Witteman, & Sachs, 1981, p. 33).

Clinical teaching is defined as the process of providing students with the opportunity to put theory into practice (McCabe, 1985). Furthermore, clinical teaching is instruction that occurs in settings and situations in which the student is giving direct care to real client or clients as part of a planned learning activity (O’Shea & Parsons, 1979; Wong & Wong, 1987). Thus, clinical teaching is the facilitation and instruction of nursing student learning. This learning typically occurs in a facility where students provide nursing care for patient populations, such as acute care, long term care, or community based settings.

Novice clinical instructor.

Benner (1984) maintains that a novice is any nurse entering a setting where she or he has no prior experience. A novice clinical instructor may be defined as an individual who has less than two years of experience teaching in clinical nursing practice (Davis, Dearman, Schwab, & Kitchens, 1992). For the purposes of this study, a novice clinical instructor is an individual who has zero to three years of teaching experience and who actively teaches nursing students in the clinical setting within an approved nursing program.
Expert clinical instructor.

The expert nurse has an enormous background of nursing experience (Benner, 1984). An expert nurse is an individual who is highly experienced, motivated to perform well, and has access to the usual resources (Benner, 1984). For the purposes of this study, an expert clinical instructor is an individual who has actively taught in the clinical setting in a nursing program for greater than 10 years and who has been identified as being an expert instructor by the administrator of that program.

Student learning outcomes.

Student learning outcomes are critical nursing behaviours that are identified by nurses, educators, administrators, and students as desirable and applicable to safe and competent nursing practice. Student learning outcomes are intended to guide the nursing student in his/her practice and to ensure success in nursing practice.

Student learning outcomes are typically individualized to individual nursing programs. However, typical behaviours can be identified to ensure competent nursing practice globally. Such student outcomes have been described as: clinical problem solving skills and knowledge, psychomotor skills, and student attitudes (Dunn & Hansford, 1997; Infante, Forbes, Holden, & Naylor, 1989).

Conceptual Framework

The conceptual framework that guides this thesis is based on Benner’s (1984) theory regarding novice to expert practice in clinical nursing. The basis of Benner’s (1984) theory is that nurses typically move through five stages of development as they gain experience in nursing practice. These stages have been identified as: novice, advanced beginner, competent, proficient, and expert (Benner, 1984).
Unique levels of development with regards to problem solving and knowledge characterize each stage. For instance, the problem solving capacities of an expert will be different than that of the novice due to the acquisition of advanced knowledge. Moreover, clinical knowledge and expertise is gained over time (Benner).

The thinking processes of the novice appear to be different from that of the expert. For example, the novice’s ability to mobilize appropriate resources and to grasp the importance of situations is different. Benner (1984) has demonstrated that the novice has a tendency to adhere closely to rules, which may interfere with successful performance. Novice and advanced beginners have a difficult time grasping situations because they may be too new and strange. Hence, a novice’s practice may not be as effective or refined when compared to an expert’s practice.

Conversely, the expert typically demonstrates an intuitive grasp of the situation and does not need to waste time with unproductive solutions. Experts tend to demonstrate an advanced level of risk taking and discretionary judgement. Experts are more efficient and productive in their problem solving abilities. This level of expertise takes time and motivation to develop (Benner, 1984).

Benner (1984) discusses the notion that when a nurse is in a new clinical area, she or he will progress through each of these stages. A nurse who moves to a new area in nursing will also be considered near the beginning of the continuum, most likely at the novice level. A combination of factors, such as motivation and time should enable the nurse to progress through the levels in anticipation of achieving expert status (Benner, 1984).

Benner’s (1984) framework is readily adaptable to all areas in nursing. One can transfer the novice to expert framework to any nursing role. For instance, a staff nurse who becomes a nursing instructor may now be considered a novice in clinical teaching, as this is a new area in nursing for this individual. The novice instructor probably will demonstrate different problem
solving abilities from the expert instructor. Furthermore, nursing instructors will then be at varying levels of development depending on the time, experience, and knowledge they have accrued.

Several researchers in nursing education have identified differences in novice and expert nurse educators. Fundamentally, interpretation of student learning differs between novice and veteran instructor (Wong & Wong, 1987). Novice instructors have demonstrated similar developmental characteristics to that of the novice nurse practitioner. Novice clinical instructors tend to be more anxious and insecure (MacNeil, 1997) and are governed by rules (Diekelmann, 1990). Novice instructors cannot rely on intuition and feelings about students due to teaching inexperience (Duke, 1996).

Conversely, veteran faculty have more experience with understanding what behaviours affect student learning because they can recognize past experiences (Wong & Wong, 1987). An experienced instructor can utilize knowledge and intuition in her/his teaching repertoire (Wong & Wong, 1987). Veteran faculty are typically associated with being more knowledge and effective with their approach to students.

Hence, one can apply Benner’s framework to nursing education. Novice and expert nurse educators exhibit different behavioural and developmental characteristics. Novice and expert clinical instructor will react and respond differently to similar student situations. It is also expected that, with experience, a novice instructor will advance along the continuum as outlined in Benner’s framework.

Benner has identified a number of questions that can be posed to nurses that enables them to reflect and discuss their experiences. These critical incident questions have been adapted to this thesis and have formed the bases of the interview questions in this study. An example of an
interview question was: Tell me how your experience with teaching students has affected your attitude towards your personal knowledge (Benner, 1984; Morgan, Krueger, & King, 1998)?

Assumptions of the Study

There are three underlying assumptions embedded in this thesis that must be explicated. The first assumption is that teaching practices and behaviours of clinical instructors have an effect on student learning. It is clear in the nursing literature that effective teaching behaviours have some influence on student learning outcomes (O’Shea & Parsons, 1979). However, the degree of correlation between teaching practices and student learning remains unclear.

The second assumption is embedded in Benner’s framework. Benner discusses the notion that theory that is learned in nursing education should allow the novice to practice safely and efficiently. It stands to reason to assume that that novice nurse instructors who are prepared in graduate clinical education should be able to apply theory to clinical teaching in a safe and efficient manner.

Benner neglects to address a key concern. Benner does not discuss if patient outcomes vary as a result of interactions with novice versus expert nurses. This has led me to ask: does the practice of novice practitioners elicit similar clinical outcomes as the practice of experts? It is assumed that this critical question will be addressed in this thesis.

Significance of the Study

This study has critical implications for all nurse educators and nursing education. With the looming nursing shortage, there will be an even greater demand for qualified and efficient graduates in nursing. Furthermore, the nursing shortage will also affect the need for an increased number of clinical instructors. Hence, issues related to the performance of nurse instructors will continue to be examined and in particular, those behaviours of novice nurse instructors.
This research is closely related to the current research regarding clinical instructor effectiveness. This thesis will further understanding of the significance of instructor experience in nursing education. The findings of this research should contribute further to the evolving concept of clinical instructor effectiveness and more importantly, to that of the novice and experienced educator’s role. As a result, I believe this thesis to be relevant to nursing education today and critical for nursing education tomorrow.

Overview of Thesis Content

This thesis consists of five chapters. Chapter one has provided an introduction to the thesis by identifying the problem, explicating the statement of purpose, providing definition of terms, and discussing the significance of the study along with underlying assumptions. Chapter two will be an extensive literature review of the subject. This will include literature that is deemed essential and relevant to the topic. Chapter three will be a discussion of the methods employed to conduct this research. This chapter will identify and defend the method utilized to conduct the research, provide a description of the sampling procedure, and discuss the data collection tools. Chapter four will be an analysis of the data and report the findings of the research. Chapter five will provide an interpretation and discussion of the research findings. This chapter will further provide a summary and conclusions of the findings and conclude with a discussion regarding implications for nursing teaching practice and research. Appendices will be included to ensure completeness of information.
Chapter 2

Review of the Literature

The intent of this chapter is to provide a relevant and contemporary review of literature that is pertinent to the phenomenon of clinical teaching experience. A search into the literature indicates that the thesis topic has neither been specifically addressed nor researched within the nursing field or other professions. However, concepts related to the topic have been examined, which will provide useful insight into the problem. For instance, nursing education research has tended to explore such issues as teacher characteristics, behaviours, and effectiveness from both student and instructor perspectives, which has provided valuable information regarding optimal teaching practice. To gain further clarity and understanding into the problem, the ensuing discussion and in-depth analysis will be largely extrapolated from relevant research. As the thesis topic is primarily a nursing problem, the majority of the research will be derived from the nursing literature. Research from medicine, psychology, and education will also be discussed to provide differing perspectives to the problem. Concepts related to Benner’s (1984) theory regarding levels of nursing practice provide an entry point and framework for the understanding of the thesis topic. The majority of the literature review will be derived from Benner’s concept of expertise, as it relates to clinical teaching. In particular, assumptions relating to novice and expert clinical instructor knowledge and practice will be identified, explored, and discussed.

Expertise Assumptions

The underlying theme of Benner’s (1984) theory of Novice to Expert is the notion of expertise. Benner’s framework introduces the idea that nurses engaged in nursing practice will typically gain clinical knowledge over the time spent working in a specific clinical area. Clinical and theoretical knowledge when combined with practical experience contribute to expert nursing
practice. The desired outcome is that expertise will develop as one continues to practice nursing in an unchanging clinical area. The ultimate goal is the attainment of expertise.

There are many underlying assumptions regarding expertise that can be extracted from Benner’s framework. Those assumptions that specifically address clinical instruction will be explored. Some of these assumptions have been discussed within diverse literature; others have yet to be identified. The assumptions that are applicable to clinical instructing are: transfer of expertise, expertise and knowledge relationship, expertise and experience, expert clinical teaching, and the development of expertise in clinical teaching.

Transfer of Expertise

The first assumption is that expertise can be identified in any nursing field. It can be logically assumed that expert nursing practice is not just unique to clinical nursing practice as initially identified by Benner (1984). Expert nursing practice should be demonstrated and implemented in all nursing areas. Although Benner discusses expertise in relation to clinical practice, nurse researchers have identified expert nursing practice in other areas, for example, nursing education (Diekelmann, 1990; Westerman, 1991; Wong & Wong, 1987). Expert practice is a global phenomenon.

A related belief about expertise is the issue of portability from one area of practice to another. Benner (1984) states that when a nurse moves areas, she/he is no longer considered an expert in that new area. The nurse is now viewed as a novice in this new area of nursing practice because the nurse has different knowledge and skills to learn and integrate. Although there has been little research into this assumption, it is my belief that most authors have treated this assumption as fact.

Some confusion regarding the transfer of expertise arises when one looks at some researchers who believe that a nurse can transfer expertise. In clinical education, this has been a
source of controversy. Some nurse educators believe that an expert clinician would naturally transfer to being an expert clinical instructor and that being an expert clinician will guarantee expertness in teaching clinical content (Stafford & Graves, 1978). Furthermore, it is felt that one must be an expert in a clinical area in order to teach clinically (Baillie, 1994; Choudhry, 1992; Myrick, 1991). Expertise is seen as a constant attribute.

However, other authors have disagreed with the notion of transferability and support Benner's theory. Researchers recognize that expertise in clinical practice is insufficient to guarantee expertise in clinical instruction (Davis et al., 1992; Karuhije, 1997; MacNeil, 1997; Meleca et al., 1981). Nursing journals are increasingly publishing articles regarding the phenomenon of novice clinical instruction. The phenomenon of novice clinical instruction is gaining impetus in research, which further supports the notion that expertise is not transferred. Although expertise in practice may be a critical factor in becoming an expert instructor, it is not immediately evident within the literature.

A related assumption has been that an expert classroom teacher will automatically transfer to being an expert clinical instructor (Karuhije, 1997). This assumption has been disputed within the research (Karuhije, 1997). It is becoming apparent that classroom teaching and clinical instruction are two vastly different entities. The impetus for this change in thought may be related to the explication of expert practice that was identified within Benner's (1984) framework and the recognition of varying levels and complexities of nursing practice.

A final related assumption relates to the context of transfer of expertise. When reviewing Benner's (1984) theory, it is apparent that expertise is discussed in isolation without regards to context or secondary influences. This suggests that instructor expertise is not affected by contextual influences such as the setting in which clinical instruction takes place, institutional policy, and student behaviour. One can make the assumption that an expert clinical instructor will
be effective no matter what clinical area she/he is teaching in. There is a paucity of support in the
literature regarding this assumption and therefore a need for more research is warranted.

It is apparent that the blind assumptions regarding the transfer of expertise in nursing from
one situation or setting to another are no longer plausible. Benner’s (1984) theory provides a
clear discussion that the transfer of expertise is not automatic or immediately viable. Current
research regarding clinical instruction supports Benner’s notion. Expertise does not appear to be a
constant phenomenon, that is, it is not readily transferable from situation to another. It is a
dynamic and complex attribute that is continually evolving depending on the situation. Perhaps
one can bring expert ability to a new situation or practice area but must adapt it to fit a new
context and develop this skill over time.

Expertise and Knowledge

Benner (1984) discusses the role that knowledge plays in the development of expertise in
nursing. Knowledge can be derived from both theoretical and practical knowledge. It is believed
that nurses require a blend of practical and theoretical knowledge to enable the development of
expertise (Benner, 1984). Theoretical and practical knowledge are both independent from and
interdependent with one another. It is assumed that a combination of both is essential to the
development of expertise.

Theoretical knowledge

In general, educational preparation can be seen as an essential component to the
development of knowledge. Specifically, adequate educational preparation can provide nurses
with the tools with which to problem solve effectively and critically reflect. Appropriate
educational preparation ensures the individual is provided with adequate background knowledge
in which to nurse safely, effectively, and appropriately (Benner, 1984). The nurse with limited
education may lack the necessary tools to learn from experience (Benner, 1984).
It is assumed that nurse educators also require the theory of clinical teaching before they can teach effectively. This theoretical knowledge is derived from educational preparation. It is the “knowing that” (Benner, 1984). The literature documents the importance of having properly prepared clinical instructors. The future, integrity, and credibility of nursing knowledge lie in the hands of those that educate the nurses (Karuhije, 1986; Myrick, 1991; Wong & Wong, 1987). Hence, the better prepared a nurse educator is the better educated nurses can be (Karuhije, 1997). It is essential that teachers be prepared who will function with ease and effectiveness (Karuhije, 1997). However, some authors purport that nurse educators and clinical instructors are generally unprepared for the teaching role (Meleca et al., 1981), the primary deficit being lack of educational preparation (Choudhry, 1992). Educational preparation is seen as integral to the development of appropriate teaching skills and knowledge.

Historically, controversy surrounds the exact educational requirements for becoming a clinical instructor. Nurse researchers have yet to agree on what degree and amount of education and clinical preparation are required for teaching in the clinical setting. Indeed, the premise has been that knowing the subject matter was all that was needed to be an excellent teacher (Infante, 1986). However, in the case of practice professions such as nursing, this belief appears to be insufficient.

It is commonly believed that to be an effective clinical instructor, one needs additional educational preparation (Choudhry, 1992; Hassenplug, 1965; Karuhije, 1997). The ideal venue for this preparation is within a graduate setting where the program offers specific courses in teaching (Duke, 1996; Hassenplug, 1965; Herrmann, 1997). What is needed is instruction in theoretical concepts for teaching, and guiding the nurse educator (Infante, 1986). Academic preparation provides the instructor with the necessary skills and knowledge with which to teach nursing
At the minimum, the clinical instructor should possess a Master's degree in nursing (Myrick & Barrett, 1994).

Indeed this notion is not limited to nursing. In other academic areas, such as education, it has been shown that teaching assistants (TAs) with training in pedagogical methods are rated as more effective than TAs without this training (Shannon, Twale, & Moore, 1998). The underlying assumption is then, the more education one has, the more tools one is able to utilize for effective teaching. It can be further assumed that effective teaching can develop into expert teaching practice.

The rationale for advanced and integrated educational preparation is the fact that clinical teacher must utilize diverse and creative activities. Clinical teaching employs diverse methodology in instruction due to unplanned activities that arise with individual client situations (Wong & Wong, 1987). As well, nurse educators occupy multiple roles in that they must teach technical competencies and model attitudes and values consistent with good nursing practice (Kopala, 1994). Furthermore because of the nature of unpredictability within the clinical setting, clinical teaching requires well developed nursing and teaching judgment (Redman, 1965). A solid knowledge base should enable appropriate and effective clinical instruction.

**Practical knowledge.**

Practical knowledge is context based. In nursing, this is knowledge that is derived from and dependent on the clinical situation and practice area. It is the “knowing how” (Benner, 1984). Benner (1984) states that nurses attain requisite practical nursing knowledge over the course of time. The nurse is often unaware of her/his growth in practical knowledge and finds it difficult to explain how it occurred.

In clinical teaching, practical knowledge is the application of instruction skills and theoretical knowledge. Practical knowledge of clinical teaching is learned and acquired over time.
spent in the clinical area with students. It is possible to master this knowledge, given the right circumstances and skills. Clinical teaching practice is a learned behaviour and can only be achieved through experience with teaching students in clinical situations. It is not something that can be taught but must be experienced (Herrmann, 1997). The length of time required for practical knowledge to develop remains unexplored.

It is critical to note that some nurse researchers feel that neither academic preparation nor nursing knowledge alone is sufficient in providing appropriate knowledge necessary for teaching (Myrick & Barrett, 1994). It is universally felt that aspiring clinical instructors need to be both educationally and clinically prepared in order to develop effective teaching behaviours (Wong & Wong, 1987). To be able to function effectively as an instructor, one needs to combine the knowledge of nursing with the skills in teaching (Oermann & Jamison, 1989). Both attributes are felt to be essential to teaching appropriately and effectively in the clinical setting. It is further assumed that an individual with advanced education and knowledge in nursing will become an expert instructor.

Expertise and Experience

A third underlying assumption pertains to the relationship that experience shares with expertise. It is assumed that experience contributes to expertise but the nature of this relationship is unclear. The literature indicates that in order for expertise to develop, one must have experience in a particular area (Benner, 1984; Jasper, 1994). However, Benner (1984) maintains that not all nurses who practice nursing in one area become expert. Although it is clear that expertise and experience have a relationship, there appears to be some confusion as to the exact contribution experience has to expertise. To further confuse the issue, the terms expertise and experience are often used interchangeably (Barnes, Duld, & Green, 1994), thus implying that they are one and the same.
Benner (1984) defines experience as the development of knowledge through clinical practice. Experience does not occur simply because time has passed. Experience results when knowledge and skills are tested and challenged (Benner) and the nurse has made a transition to further development. Experience is not something that can be taught but is facilitated by the sharing of knowledge and participating in clinical practice (Downey, 1993).

It has been assumed that all nurses become expert over time. However, this appears to be an unexplored and unsubstantiated myth. Benner (1984) acknowledges that despite the acquisition of knowledge as a result of experience, not all nurses become expert. This notion of unpredictability of expertise acquisition is an area that requires further exploration.

The role of experience in clinical teaching appears to be crucial. The nursing literature is in complete agreement that only the most qualified and effective instructors should teach in the clinical area to ensure quality instruction with the outcome of competent nurses (Barnes et al., 1994; Fong & McCauley, 1993; Karuhije, 1986; Myrick, 1991; Myrick & Barrett, 1994). It has further been assumed that the most qualified and effective instructors are those with the most teaching experience (Davis et al., 1992). It is becoming increasingly apparent that experience is thought to be correlated with effectiveness (Wong & Wong, 1987).

The rationale for wanting to ensure that the most qualified teach clinically is that experienced instructors have an increased capacity to recognize certain behaviours in students and will have the ability to respond most appropriately. Veteran faculty are perceived as more experienced with recognizing what behaviours affect student learning because they can rely on past experiences (Wong & Wong, 1987). The experienced instructor is believed to hold a more comprehensive view (Westerman, 1991), enabling her/him to see multiple variables simultaneously.
Education literature supports the notion that the most experienced instructors have more appropriate tools that should make them better able to teach students. Fogerty, Wang, and Creek, (1983) found that experienced teachers utilized prior knowledge during instruction and adapted complex categories of instructional actions more frequently than novices. Further, teachers with more teaching experience receive more favourable student evaluations (Herbert, 1995) and are rated as being more effective by students (Shannon et al., 1998).

It has been shown that experience is related to knowledge. A further assumption is that experience is correlated with effectiveness. As a result, a further assumption can be derived, that experience enables clinical instructors to become more knowledgeable and trustworthy in their judgments. Over time in the clinical area with students, clinical instructors gather valuable information regarding teaching that promotes learning and growth. This added knowledge and skill should translate into the experience necessary for optimal and perhaps expert teaching.

Expert Clinical Teaching

Some research has been conducted in general nursing that explores the attributes of expertise. For instance, expert clinical practice is thought to be based on experience, building and refining knowledge from practice, theoretical education and preparation, and personal attributes of the nurse (Benner, 1984; Jasper, 1994). It can be assumed that the evaluation of expertise in clinical teaching can be accomplished using the same specific criteria as those for clinical practice. The connection would be that the attributes of an expert would be similar despite differing areas of practice. Expert clinical instructors are often identified as those with numerous years of teaching experience, who are knowledgeable, and who possess positive and favourable personal attributes.

There is a paucity of literature that describes the specific attributes of expert clinical instruction. It appears that the method of preference that has been used to determine expert
teaching practice is an assessment of effective behaviours of clinical instructors. It can be assumed that evaluation of effective behaviours will identify competent clinical instructors that will ultimately ensure appropriate student learning outcomes. Hence, one may be able to determine expert clinical instruction by examining effective teaching behaviours. An assessment of student learning outcomes may also provide evidence of effective clinical instruction.

Furthermore, evaluations of clinical instructors should provide further insight into competent practice.

**Instructor effectiveness.**

In the past, most of the research regarding teacher effectiveness has been interpreted from classroom teaching. Classroom teaching behaviour has been assumed to be the same for clinical instruction situations. It is only recently that researchers have delved into clinical teacher effectiveness and corresponding behaviours. This area of research is becoming more prominent as researchers realize the impact this behaviour has on student learning.

Effective clinical teaching is rapidly becoming a core topic for research because of the implications for nursing. Effective teaching is critical in the clinical setting (Fong & McCauley, 1993) due to the impact on the future of nursing. If the quality of clinical education is to be maintained, clinical teachers must be as effective as possible (Kotzabassaki, Panou, Dimou, Karabagli, Koutsopoulou & Ikonomou, 1997). It is therefore essential to identify and explicate effective clinical teaching behaviours. However, although there is an abundance of literature regarding teacher effectiveness, it is difficult to find consensus amongst researchers as to what behaviours constitute effectiveness. A multitude of behaviours have been identified as critical for effective teaching, yet there has been a lack of agreement regarding specific behaviours that will ensure teacher effectiveness (Li, 1997).
The lack of agreement about behaviours may be due to the abstract and often complicated nature of clinical teaching. Effective clinical teaching is multifaceted and complex (Bergman & Gaitskill, 1990; Zimmerman & Waltman, 1986). Effective clinical teaching behaviours cannot be explained by considering only one or two teaching behaviours. Effective teaching is made up of a number of characteristics (Zimmerman & Waltman, 1986). This complex nature is further compounded by the fact that teacher effectiveness is dynamic. An instructor may be effective teaching in one year with a certain level of students but not in another (Knox & Mogan, 1985). Teacher performance and teaching effectiveness will vary among individuals (Irby & Rakestraw, 1981; Kirschling, Fields, Imle, Mowery, Tanner, Perrin, & Stewart, 1995).

Wong & Wong (1987) contend that to effectively teach students, clinical instructors have to explain, generalize, and relate subject matter of the discipline. Instructors must have knowledge, expertise, and an ability to assess important learner characteristics and diagnose learning problems (Wong & Wong, 1987). Generally, effective clinical teaching is defined as the instructor's ability to assist students to achieve their highest level of independent thinking and clinical competency (Kirschling et al., 1995). Effective clinical instruction requires a blend of knowledge of subject matter, interpersonal style, and flexibility in the use of a variety of teaching methods (Kirschling et al., 1995).

Effective behaviours have been divided into general categories. Depending on the researcher, these categories consist of three to seven essential components. Fong and McCauley (1993) state that there are five essential characteristics of effective teaching: teaching ability, nursing competence, ability to evaluate, interpersonal relationships and personality. Knox and Mogan (1985) also maintain that there are five categories of teacher behaviour: evaluation, interpersonal relationship, nursing competence, personality and teaching ability. Karuhije (1997) contends that there are three basic behavioural components: instructional, evaluative, and
interpersonal. Kirschling et al. (1995) identify four critical domains: personal style of teacher, teaching methods, knowledge and expertise and professional practice. These are just a few examples of general clinical teaching behaviours believed to be effective. Effective behaviours can also be divided into specific attributes. Examples of specific behaviours are: professional competence, self-confidence, good interpersonal skills, a sense of one’s own strengths and weaknesses, willingness to discuss what one knows, what one believes, and how one practices (Krichbaum, 1994).

It appears that effectiveness is indeed one of the critical components in describing expert clinical instruction. Although there is a discrepancy as to exactly what behaviours constitute effective clinical teaching, it remains that there are several core behaviours that can be identified. These behaviours are: knowledge, competent practice, and personal attributes. At present, the only quantitative assessment of expert clinical instruction is the identification and assessment of effective teaching behaviours.

**Student learning outcomes.**

Outcomes associated with student learning may provide some insight into expert practice. It is critical that students receive the best possible instruction to enhance optimal learning (Li, 1994). The clinical instructor is seen as the link between the student nurse and the environment in which learning takes place (Meleca et al., 1981). It can be assumed that clinical instructors influence student learning in some manner. There are several factors that are believed to influence student learning.

A competent clinical instructor is required to facilitate student learning (Campbell, Larrivee, Field, Day, & Reutter, 1994). It is believed that the experienced instructor is better able to recognize and interpret which behaviours affect student learning (Wong & Wong, 1987). Instructors need to know which behaviours make differences in achievement of learning for
students (Brown, 1981). It is felt that an instructor with a strong clinical background can optimize
student learning (Fothergill- Bourbonais & Higuchi, 1995).

It has been identified that unprepared teachers inhibit student learning (Wolff, 1998). Furthermore, teachers who are not competent themselves cannot assist students toward competency (Barnes et al., 1994). An incompetent and under prepared instructor could have deleterious effects on student learning. The outcome would be students who are less likely to succeed in clinical practice.

Instructor perspectives also have an impact on student learning. It has been discovered that the perspective of the instructor will result in differing teacher behaviours, which in turn influence specific learning by students (Paterson, 1994). Personal views and beliefs of the instructor are exhibited in behaviour and teaching style. The student then observes this behaviour and is in some manner affected by it. For example, novice teachers focused on that which is directly observable and measurable such as psychomotor skills. The students who also focused on skills subsequently modeled this behaviour. It should be noted that one of the novice teachers in Paterson’s study functioned at a higher level than the others who had less than one year of experience. That is, she did not place her focus entirely on skill development but rather focused on how she could promote achievement of student learning goals. This instructor had other teaching experiences in nursing, which she translated to clinical teaching. It remains inconclusive whether any one particular perspective is more effective in facilitating student learning (Paterson, 1994).

Based on these views, it can be assumed that clinical teaching influences specific student learning outcomes. It may also be assumed that a student would be more apt to be successful if the clinical instructor were an expert in teaching. However, both expert and novice instruction can have an impact on student learning. What remains unclear is whether novice teaching practice is associated with under preparation and with poor student outcomes.
Evaluators.

Historically, instructor evaluations have been based on peer and student assessment. It can be assumed that peers are the most appropriate assessors of instructor performance due to their integrated awareness with nursing skills and knowledge. Frequently, schools of nursing are utilizing students for instructor evaluation. Students can be seen as insightful and valuable assessors of instructor performance. It is believed that students, because they are recipients of instruction, are in the best position to assess instructor behaviours (Zimmerman & Waltman, 1986).

It has been found that students and faculty tend to differ in their evaluations of clinical instructors (Knox & Mogan, 1985; O'Shea & Parsons, 1979). Students may or may not vary from instructor peers as to the identification of what behaviours are critical for effective teaching. For instance, Reeve's (1994) study determined that students often value interpersonal skills and role modelling behaviour rather than professional competence. However, in Li's (1997) study, it was found that students and instructor peers often value similar behaviours with both groups identifying the same most important behaviours. The reason for this variance in student and peer evaluations may be due to the distribution of the sample. For example, students in the first year of a program may have different opinions from students in the fourth year of the same program.

A third source that is under utilized for instructor evaluation is that of administrators. Administrators share the responsibility for instructor competence (Fitzpatrick & Heller, 1980; Wood, 1986). Administrators must ensure that instructors employed in their program are competent because instructor competence lends credibility to a program. Therefore, administrators should partake in the evaluation of instructors to ensure that quality of instruction is maintained.
Ultimately, the evaluation and assessment of instructor competence and performance should be based on a variety of sources. A variety of sources encourage diverse opinions and varying perspectives that would provide for a holistic view of the clinical instructors' abilities. Administrators, students, peers, and most importantly, self-reflection feedback should all be utilized to ensure a comprehensive assessment of instructor competence. A combination of these sources should provide a complete and diverse picture of clinical instruction.

Development of Expertise

The development of expertise is believed to be a linear and attainable process. However, becoming a competent clinical instructor is not an additive process; it requires a change in knowledge, skills, behaviour, and values (Infante, 1986). It is believed that clinical instructors progress through several phases before expertise is attained (Herrmann, 1997; Wolff, 1998). It can further be assumed that this development of expertise occurs in a sequential trajectory.

It is also assumed that the teaching skills of instructors in a beginning phase of development will be different than those that are near the optimal or expert phase. The literature indicates that novice instructors teach quite differently from expert instructors (Choudhry, 1997; Wong & Wong, 1987). The literature often concludes that the teaching practice of novice instructors is fraught with complexities and difficulties. To gain a more comprehensive understanding of expert practice it is essential to look at the assumptions associated with stages of expertise, primarily factors associated with novice practice such as competence, confidence, and problem solving.

Stages of expertise

Benner (1984) introduces the idea that there are five levels of competency in nursing practice. These stages are identified as: novice, advanced beginner, competent, proficient, and expert. Each stage is uniquely different from the others and is characterized by specific
behaviours. The skills and knowledge of the nurse will vary depending upon which stage the individual is currently engaged in.

It can be assumed that nurses engaged in other types of practice also move through various developmental levels in pursuit of achieving expertise. This holds true for clinical instructors. It is believed that clinical instructors function at various developmental levels (Westerman, 1991) as they gain experience. Research in clinical teaching is increasingly gathering data regarding novice and expert clinical teaching. However, research regarding any levels in between the two is surprisingly lean.

In 1998, Wolff conducted an exploratory grounded research study addressing the development of competency in a novice clinical instructor. Wolff’s research determined that there are three stages of developing teaching competence. The first stage was identified as learning about clinical teaching. In this first stage, neophytes were identified as being focused on personal learning needs and self-image as an instructor. This stage is similar to Paterson’s (1994) “ability evaluative” phase also identified in novice instructors. The second phase of developing competence as an instructor is building one’s teaching style (Wolff, 1998). This is a process of trial and error in determining which teaching-learning strategies are most effective. The final phase is integrating complexities. During this stage, instructors direct their energies toward students and their learning. Wolff maintains that in order for an instructor to achieve this third level of competence, she/he must have achieved some degree of competence and self-confidence.

Novice teaching practice.

Benner (1984) purports that a novice is someone who has no nursing experience or knowledge in a particular clinical area. Benner’s work identified several behaviours unique to novice practice. For instance, the novice is typically rule-governed and inflexible. Benner
concluded that neophytes must follow the rules because they have no experience from which to draw ideas for conclusions.

Similar behaviour patterns can also be found in novice clinical instructors. Novice clinical instructors have been critiqued for their adherence to rules and lack of flexibility when dealing with student issues (Diekelmann, 1990). Novice instructors are lacking in the practical experience that is felt necessary to teach in the clinical setting. For instance, a neophyte instructor cannot rely on experience or past knowledge when faced with new and unique situations involving students. It is felt that novice clinical instructors are inexperienced in teaching and as such cannot rely on intuition and feelings about students (Duke, 1996; Wong & Wong, 1987).

There are many problems that a novice clinical instructor may face as a result of inexperience. Novice clinical instructors may face problems with juggling relationships with students (Duke, 1996) and establishing appropriate boundaries. All stages of the teaching process may constitute problems for the novice instructor. During the planning phase, novices may plan lessons that are too narrow or incorrect, which typically leads to learning problems for students (Westerman, 1991). Novice teachers may also utilize a narrower repertoire of instructional activities than more experienced teachers (Fogarty et al., 1983). Finally, the novice is generally unfamiliar with evaluation, dealing with boundary issues, and generally displaying a lack of awareness about scope of clinical teaching (Wolff, 1998). In general, novice instructors lack holistic cognitive & monitoring skills that experts possess (Wong & Wong, 1987).

The behaviour of novice instructors can be self-limiting. Often times the neophyte instructor is self-absorbed, worrying more what her/his students think of her/him as an effective teacher and a competent practitioner (Paterson, 1994; Wolff, 1998; Wong & Wong, 1987). The novice teacher tends to focus on maintaining credibility and personal learning needs (Wolff,
The neophyte becomes focused on her/his own needs and often does not identify or attend to essential student needs.

This lack of experience and focus on self needs is felt to have a deleterious impact on students. If novice instructors are so concerned with their own personal learning needs, they may neglect their true purpose, that being student learning needs. Novice instructors often fail to adapt teaching in response to student cues (Westerman, 1991). Furthermore, a narrower scope leads to difficulty in tailoring plans to accommodate student needs (Westerman, 1991). Many researchers agree that clinical practice is the most critical element in nursing education and as such, only the most experienced of instructors should teach in the clinical area (Karuhije, 1986). However, novice faculty are often placed in the clinical area, despite being under prepared for the teaching role (Davis et al., 1992; Wong & Wong, 1987).

Confidence.

It is felt that many novices tend to have a lower self-confidence than do experts (Duke, 1996; Wolff, 1998). This is perhaps related to the fact that confidence and knowledge are closely tied. If a nurse perceives her/his knowledge to be lacking then she/he may not be confident in her/his ability to perform expertly or even acceptably. This lower self-confidence may have implications for acquiring expertise.

It is common for novice instructors to experience feelings of anxiety and insecurity about the teaching role (MacNeil, 1997; Paterson, 1994). Inexperienced faculty tend to have lower self-esteem, which affects confidence in decision making and observations (Duke, 1996). This diminished self-confidence may inhibit the ability to effectively teach (Duke, 1996). Novice classroom instructors tend to be insecure and self-conscious of knowing theory and being able to teach it (Diekelmann, 1990; Duke, 1996). Finally, novices have been known to demonstrate a
lack of confidence in how to use resources and information and in trusting judgment (Westerman, 1991; Wolff, 1998).

Conversely, those individuals who have attained graduate educational background or who have had experience with teaching in other settings tend to have a higher degree of confidence. Nurses with an increased preparation for teaching have displayed increased confidence (Duke, 1996; Herrmann, 1997). In clinical teaching, Wolff's (1998) study determined that self-confident teachers had well-developed teaching styles. Typically those instructors with a well-developed teaching style combined with years of experience are more confident (Ferguson, 1996). Self-confidence seems to correlate strongly to attitude and ability.

**Competence.**

Competence also has a relationship with clinical instruction. For instance, there appears to be a correlation between competence and self-confidence. Wolff's (1997) study identified a positive relationship between self-confidence and competence. The study identified that the more confident an instructor became, the more competent she/he also became. This developing competence could be an attribute of expert teaching practice.

Some nursing authors assert that it is essential for a clinical instructor to be clinically competent and that this competence should be maintained throughout the course of teaching (Baillie, 1994; Barnes et al., 1994; Davis et al., 1992). A relationship has been identified between competence as a clinician and competence as an instructor (Wolff, 1998). It is also believed that there is a relationship between competency of an instructor and the quality of instruction (Choudhry, 1992). However others maintain that clinical competence is not essential; that knowing how to teach is much more critical (Davis et al., 1992; Infante, 1986). Furthermore, competence in one's area of specialization does not automatically ensure ability to teach.
effectively (Meleca et al., 1981). The controversy of these opinions indicates that an instructor may need to be competent both with teaching and in practice.

**Problem solving.**

The problem solving capabilities of an expert are felt to be different from that of a novice (Benner, 1984). This difference in abilities is attributed to differing levels of knowledge acquisition and abstractness of knowledge patterns. The discrepancy may stem from the belief that the levels of cognitive reasoning of an individual change with expertise (Tabak, Bar-Tal, & Cohen, 1996). As an individual gains knowledge, her/his ability to think in depth is enhanced. Benner (1984) would describe this as the differences between “knowing how” and “knowing that”. The increase in abstract reasoning may promote advanced problem solving skills.

An expert may be better equipped to problem solve because she/he knows how to perform a skill based on past experiences and knowledge (Tabak et al., 1996). Expertise enables the clinician to understand situations as a whole (Benner, 1984). Expert nurses apply this information to new situations (Benner, 1984). Appropriate and advanced problem solving abilities is a result of gaining experience.

In clinical teaching, an expert instructor has the knowledge to recognize issues related to learning needs and is also able to find more appropriate conclusions to these issues. Expert instructors have more refined problem-solving capabilities (Westerman, 1991). Experienced instructors are better able to sift through complex data and identify common themes, which enables them to achieve an appropriate and desired outcome. These advanced problem solving skills would be beneficial to student learning.

Research on problem solving by the novice instructor has been limited to classroom behaviours. Due to their narrow scope, novice classroom nursing instructors are unable to adapt to changes in situations (Westeman, 1991). A neophyte’s lack of experience may limit them in
their ability to respond to ambiguous and complex situations. Currently, there is a lack of research regarding novice clinical instructor problem solving behaviours.

Discussion

Five general assumptions have been identified and explored comprehensively within the constraints of the nursing literature. Predictably, there remain some unanswered questions and differing opinions regarding most of these assumptions. Many questions have arisen during the exploration of these assumptions, perhaps due to the limited research on the majority of topics. All of these questions continue to surround the concept of expertise. It is becoming clear that expertise in clinical instruction is a complex, dynamic, and multifaceted concept that remains under explored. There appear to be many variables that help to shape and define this term which adds to its’ intricacy. A discussion surrounding some of these questions is warranted to provide further interpretation and clarity.

Who Becomes Expert?

The literature indicates that all nurses have the potential to become experts in their field of practice. However, it appears that not all nurses are destined to achieve this goal. Even if the conditions are the same, that is education and work related experience; the outcome cannot be guaranteed to be identical. Why do some of us become experts and others do not? What is the basis for this difference?

There may be a multitude of reasons for this conundrum. Human behaviour remains unpredictable and inexplicable. Perhaps one answer lies within the personal characteristics and behaviours of the individual. Psychological research regarding motivation, confidence, personality, and intelligence can provide insight into complex human behaviour and may in part, provide answers regarding expertise acquisition.
Motivation theory for instance, provides one basis for understanding human behaviour. Some psychologists theorize that motivation is related to three factors: the need for achievement, the perceived value of the goal, and an individual’s expectation for succeeding at a particular task (Carlson, 1997). If I were to put this in context of expertise in clinical instruction, a nurse who is motivated to achieve is one who has a need to learn and grow, who values nursing, knowledge and expertise, and who has a strong desire and will to succeed at this goal. All three of these factors may be vital for the acquisition of expertise. While this does not entirely explain human motivation or nursing behaviour, it does provide a basis for understanding.

I can also argue that there is a strong correlation between personality characteristics of the nurse and expertise acquisition. When I reviewed the concept of self-confidence, I discovered that those instructors with higher degrees of self-esteem are more confident in their decision making skills and judgments, which then translates to more effective teaching ability. Within the literature, I have also seen a correlation between self-concept and effectiveness. I can then make the connection that those with a greater self-esteem are more apt to become expert because they believe in their abilities as an instructor.

When I look at the definition of expert in depth, I can also detect some clues that may indicate why acquisition of expertise is difficult to attain. Many believe that an expert is one who not only possesses appropriate knowledge but also has the ability to apply it (Fogerty et al., 1983; Westerman, 1991). Some instructors may have the remarkable ability for memorization and recall and are highly intelligent, but then have difficulty with communicating this knowledge comprehensibly to students. This difficulty may limit them in their ability to become expert, as communication of knowledge is an essential attribute of expertise in clinical instruction.

Finally, perhaps some clinical instructors did not have adequate preparation and support during the most influential and formative years of their practice. It is conceivable that some
instructors did not receive adequate graduate education in preparation for the instructor role. Furthermore, perhaps some instructors did not receive adequate support, advice, and nurturing from more experienced and knowledgeable peers, which would have provided the novice with the necessary tools to hone expert practice. Any one of these deficits may result in the inability to develop expert practice.

Due to the lack of research on this subject and the complexity of the term, I can only surmise why some instructors never become expert. I feel though, that a number of factors are required for developing expertise. If just one attribute is missed, it then may be more difficult to attain expertise. Further exploration and investigation is required regarding this subject to assist with the development and understanding of the concept of expertise.

Knowledge versus Practice

Another area for discussion and clarity is the difference between expert nursing practice and expert teaching practice. Some questions regarding these two areas are evoked. For instance, what are the qualifications of a clinical instructor? Specifically, should she/ he be expert in nursing? Furthermore, should she/ he possess a specialty in a clinical area? Or should an instructor simply be an expert in teaching?

There are few answers or research within the nursing literature that addresses these questions. Karuhije (1986) maintains that a clinical instructor should be competent both in nursing and in teaching. However, does competence imply expertise? Is not expertise further along the continuum of knowledge and skill? Is competence the minimum requirement for the clinical instructor? What if there is an expert nurse who is now a novice instructor? How will she/ he achieve competency without experience? Due to the limited experience on this subject, these questions are difficult to answer.
It is felt that clinical instructors should have expertise relevant to the clinical learning environment as a requisite for teaching (Fothergill-Bourbonnais & Higuchi, 1995). Furthermore, it is felt that instructors should teach in their specialty area (Wood, 1986). From personal experience, frequently clinical instructors, especially relief and new faculty, are shuffled to the greatest area of need, which is often not their area of competence or experience. Often these instructors possess little or no experience in that clinical area. Based on the literature, I can question both appropriateness and effectiveness of these decisions.

It is further felt that competence in one's area of specialty will not ensure the ability to teach effectively (Choudhry, 1992; Meleca et al., 198). Even though one is an expert nurse, this knowledge and ability does not necessarily translate to immediately being an expert instructor. There appears to be more to effective and expert teaching than simply being an expert nurse. The other part of the equation is teaching knowledge, ability, and experience.

I can begin to see that the other part of the equation is becoming significant. Instructors who are required to move into new clinical areas must rely on their teaching knowledge and ability in order to teach students effectively and appropriately. Hence, instructors with diverse and extensive experience and knowledge with clinical instruction may be better able to adapt to new clinical situations. Clearly, instructors who have experience both with clinical teaching and nursing practice may be more effective because they possess varied knowledge and tools with which to rely on when teaching students. Furthermore, these instructors may be more apt to achieve expertise due to their diverse knowledge and global experience. A combination of both theoretical and practical knowledge is essential when teaching in the clinical area.

It is clear that experience is critical to expertise acquisition. Obviously, a novice instructor must be provided with clinical teaching experience in order to become competent and achieve expertise. It appears that ideally, the most appropriate novice instructors would be those who are
expert in a clinical specialty and who also have obtained graduate education. It also appears that
while these novice instructors may experience difficulties along the way, they may be better
equipped to developing expertise than those instructors who are missing either of these elements.

Classroom Versus Clinical Expertise

A third question that warrants discussion is regarding the differences in expertise between
classroom and clinical instructors. It has been demonstrated that the expertise of the nurse
educator in the classroom is substantially different from that of the clinical instructor (Karuhije,
1997). The question is, how is it different? Moreover, what is the nature of this difference?

Classroom and clinical teaching are two distinct arenas (Karuhije, 1997) and therefore, the
expectations and knowledge of these instructors may also be different. The roles of the instructor
in each element will depend on varying conditions, needs, and environments. Based on these
factors, it can be expected that there will be differences in teaching tools and knowledge amongst
the two instructors.

The difference in knowledge and styles may be attributed to variances in priorities,
organization, operation, and structure. It stands to reason that the teaching expectations, styles,
and tools will vary in accordance to these learning environments. For instance, there is a vast
difference between the types of learning in the classroom to that of the clinical area. Typically the
learning in the clinical environment is unpredictable and complex. Learning is based on complex
human interactions, conditions, and responses. The teaching of an instructor in the clinical setting
will vary in accordance with the learning needs of the student and the learning experiences
available. For instance, a clinical instructor must be aware of and utilize a multitude of teaching
tools in order to enhance student learning in complex and rapidly changing situations. A clinical
instructor must utilize both diverse teaching strategies and practical knowledge and skills. The
clinical instructor must adapt teaching skills to unpredictable events. Often, the clinical instructor
has little control over the environment, the clients and hence, student learning.

Conversely, learning in the classroom environment is relatively predictable and somewhat more stable. The instructor in the classroom has more control over the environment and student responses. The instructor in this situation is generally concerned with students and learning. A classroom instructor, while still utilizing diverse teaching tools, is not faced with unpredictable or constantly changing situations. Typically in the classroom, the instructor relies on teaching strategies that facilitate the understanding of theory as it relates to skills rather than the actual application of nursing skills and knowledge.

It cannot be expected that expertise in classroom instruction will naturally translate to expertise as a clinical instructor or vice versa. The difference in learning environments and teaching tools is vast and complex. Although both of these environments require a combination of knowledge and experience, this blend is fundamentally different and requires time to develop. However, instructors with experience in either area may adapt to changes in teaching venues more readily than a novice.

Curriculum Shifts and Expertise

Another question regarding expertise is the relationship with educational paradigms. Perspectives regarding education of nursing students are fundamentally changing. Increasingly, the acceptable method of nursing education is a collaborative-caring curriculum in which there is a shared responsibility for teaching and learning. This shift in nursing education has precipitated a shift in the perception of the clinical educator role. In a caring curriculum, educators are no longer viewed as the sole expert in their field but as a co and expert learner (Bevis & Watson, 1989).

Learning is now considered a shared responsibility (Bevis & Watson, 1989; Kirschling et al., 1995). Both students and educators are expected to collaborate jointly in the learning process. Students are viewed as active and valuable participants in education. Students are increasingly
becoming collaborative partners in their learning. This shift encourages students to critically question all aspects of nursing as well as their learning environment. As a result, students are increasingly demanding knowledgeable and challenging instructors who can teach competently and effectively.

This shift towards joint responsibility creates an increased emphasis on student-teacher relationships (Kirschling et al., 1995), which has caused a change in the expectation of instructor knowledge. This shift in paradigms places instructor knowledge and hence, instructor expertise in a precarious position. Instructors are not entirely viewed as expert teachers but as expert learners in the education process (Bevis & Watson, 1989). What this means is that instructors are expected to utilize strategies and tools that enable students to critically reflect (Bevis & Watson, 1989).

What happens to the notion of expertise in this paradigm shift? I believe that the term expert is still valued, but in an entirely different context. There appears to be a shift away from instructors possessing specific nursing knowledge and towards diverse teaching strategies that encourage critical thinkers and intelligent practitioners. I also argue that this change in thinking has placed an even greater emphasis on expert practice and knowledge. Instructors now must be even more prepared and knowledgeable. The instructor is faced with even more diversity and complexities than ever before. Knowledge and student expectations have grown enormously so that instructor must be prepared for any situation. Instructors must utilize diverse teaching strategies to encourage student learning and growth. The term expert in the context of clinical instruction is becoming more complex and multifaceted.

Stages of Students

The final question is regarding instructor ability and the varying levels of students. When looking at expertise, I must ask, are there differences in student needs that warrant certain types
of instructors? Secondly, what type of instructor is most appropriate for what level of student? Finally, is the instruction different for different levels of student?

It has been discovered that not all instructors are effective teaching in each year of a program (Knox & Mogan, 1985). An instructor may be more effective teaching in one year than in another. However, typically instructors are shuffled from year to year without regard to appropriateness for student learning and needs. Furthermore, students in the first year of a nursing program may differ in expectations and needs than students in the second, third or fourth year of the same program. Based on the previous data and critical insight, it is rapidly becoming apparent that not all instructors will be appropriate for each of the developmental levels of students.

Moreover, it appears that perceptions of students as to teacher characteristics and competencies are also different from year to year (Bergman & Gaitskill, 1990). A student in the first year of a program may have different expectations and requirements of a clinical instructor. A first year student’s needs in the clinical area are substantial. These students require maximum teacher interaction, assistance, and knowledge. Conversely, a student in the fourth year of the program is working toward acquiring independence and thus may require the instructor more for problem solving with less direct interaction.

The differences in student needs should correlate to appropriate attributes in teacher characteristics. Certain instructors may be more appropriate and effective with specific student situations. Yet this critical issue remains under explored and undervalued. Administrators need to address the issue of instructor appropriateness if they are at all concerned with student learning and the quality of instruction.

Summary of the Literature Review

It appears that most of the questions uncovered in the review and discussion of the assumptions about expertise in clinical teaching remain obscure. Many of these topics require
comprehensive research to discover meanings and uncover relationships. The lack of research on aspects of clinical teaching has left many questions open to individual interpretation. There are many variables that shape expert clinical instruction. Yet the fact remains that novice and expert clinical instruction is under explored in the literature. Furthermore, the importance of expert clinical instruction is apparent.

In this chapter, I have explored multiple concepts related to the experience of the clinical instructor. One can see that a common theme is unfolding; that the most qualified, prepared, effective, experienced, and competent instructors should teach in the clinical setting. However, it is apparent that this is often not the case. Inexperienced instructors are often placed in the clinical setting. It is felt that most novice instructors are neither prepared academically nor psychologically for teaching in the clinical setting.

Students are increasingly requesting qualified and effective instruction in all aspects of nursing. Students are encouraged to share their views on how they are taught. It is the duty of administrators and educators to ensure quality instruction both clinically and theoretically. It is critical that nursing continue to strive towards excellence in teaching.

Clinical instruction is multi-faceted and complex. To date, much of the research in nursing education has centered on behavioural aspects of clinical instructors, such as teacher effectiveness. Research into novice and expert clinical instruction is limited or lacking. Many questions remain unanswered. However, the main question remains: Is it possible to be an effective clinical instructor if one has little or no experience teaching but has theoretical education and nursing knowledge and skill?
Chapter 3

Research Methods

The intent of this chapter is to identify specific issues in relation to the study's research methods. Issues of concern regarding research methods in a thesis research project are those related to the research design and methodology. Thus, the areas that will be primarily covered are an identification and discussion of the design of choice as well as issues regarding sample selection and recruitment. A key area that will also be included in the discussion is the issue of scientific rigor, particularly the areas of reliability, validity, and generalizability. Data collection and analysis procedures are also identified and discussed. Finally, this section will address issues regarding ethical considerations and study limitations.

Research Design

Ethnography was the research design selected for this study regarding the effects of clinical teaching experience on student learning. Generally, ethnography was considered the most appropriate research design due to the experiential, descriptive, and relational essence of the study and to the question that was addressed: "What was happening within this particular group of nursing instructors?" (Germain, 1993; Roper & Shapira, 2000). Ethnographic research aims to explore and describe the "what", "how", and "why" of research problems (Germain). Ethnography is a unique mode of research because of its focus on holistic human perspectives (Roper & Shapira, 2000) from a culturally driven perspective. The primary goal of ethnography is to understand and describe the perspectives of a particular cultural group (Germain; Spradley, 1979). Thus, ethnography aims to provide knowledge, meaning, and insight regarding a specific group of individuals (Germain; Spradley). Ethnography also seeks to answer questions related to aspects of cultural perspectives and behaviours (Germain). The aim of ethnographic research is to uncover hidden meanings and
further explicate obvious knowledge embedded within the culture (Germain). Ethnography also seeks to answer descriptive questions with the ultimate goal of yielding theory development (Germain) and of providing explanations for complex actions (Rosenthal, 1989). Ethnography uncovers feelings, ideas, and meanings regarding subjects that affect that particular culture. Ethnography encourages an understanding of people by learning from them (Roper & Shapira, 2000).

Culture is defined as the customary beliefs, social forms, and material traits of a religious, racial or social group (Webster's, 1995). Within ethnographic research, culture may be viewed as the way of life and customs of a particular group of people (Germain, 1983; Spradley, 1979). Culture research seeks to explain human behaviour (Spradley). Cultures generally have a set of standards that they aspire to, whether these are achieved or not (Burns & Grove, 1993). It is critical to uncover and understand these standards to gain further insight into a cultural group. Any group that is brought together for any period of time is viewed as a culture (Germain). A cultural group may share a common interest or engage in a specific purpose.

The tradition selected for this thesis topic was based on Spradley's (1979) method of ethnography, which assumes that knowledge of all cultures is valuable. The salient concept of this method is the idea that important differences naturally occur within each cultural group and that determining these differences in cultures contributes towards meaningful knowledge of human behaviour. Ethnography in this tradition is the discovery and describing of cultural events, which ultimately uncovers meanings of group behaviour. The key to interpreting cultures is understanding the language and the symbolism of the group and translating this into clear and understandable ideas.

Ethnography was an appropriate method to study clinical instructors because these nurses are representative of a distinct culture. Clinical instructors share a common purpose, engage in
practice in clinical settings, interface with students, and thus may encounter similar problems and concerns. Clinical instructors often share a kinship as a result of homogenous work environments and perspectives on issues. In particular, novice clinical instructors may also share unique worldviews of teaching with similar characteristics, behaviours, and emotions. An ethnographic study of novice clinical instructors was meant to identify the realities of practice concerns within this community. Furthermore, an ethnographic study of this culture was hypothesized to provide knowledge and insight regarding current practices and knowledge with the ultimate goal of striving towards improving practice, preparation, and knowledge of clinical instructors.

Specifically, ethnography was the most appropriate study design for this thesis because it:
(a) involved group discussions among the various cultural groups of clinical instructors, specifically novice and expert groups (b) uncovered and identified the cultural meaning of clinical teaching, (c) assisted the researcher to explore and describe the cultures of clinical instructors, (d) provided a holistic perspective regarding cultural insiders that can explicate aspects of culture (Germain, 1993; Roper & Shapira, 2000), (e) compared and contrasted the perspectives of two groups within a culture, and (f) provided valuable insight into human behaviour (Spradley, 1979), (g) was conducted by a researcher with an insider perspective into the culture.

The researcher based the research question, purpose, and methodology on the assumption that the culture of clinical instruction was unique and could be divided into several cultural groups such as novice and expert practice groups. Furthermore, each group may experience varying and unique perspectives on student learning. This assumption enabled the researcher to select clinical instructors who taught within the culture of a clinical environment and who possessed varying amounts of clinical teaching experience. Through the selection of these two groups the researcher was expected to explore the perceptions of instructors regarding how students are affected by teaching methods of these two diverse cultural groups.
A critical component of the ethnographic research process is that the researcher attempts to become a part of the culture that is being studied (Roper & Shapira, 2000; Spradley, 1979). This affiliation should enable the researcher to integrate into the culture, which will ideally provide valuable access to information and perspectives. The researcher, was and still is employed as a clinical nursing instructor within a college setting, readily achieved this component. This integration enabled the researcher to possess an "emic" or "insiders view" of the culture being studied (Germain, 1993; Roper & Shapira) which was expected to enhance data collection.

Sampling

The most appropriate cultural informants are those who are immersed within the culture and have knowledge and experiences to share (Germain, 1993; Spradley, 1979). A cultural informant should be able to recount specific and honest anecdotes from experiences (Germain). In ethnographic research, the best participants are those who have some ability to share experiences, which ultimately aids the researcher in gathering the most relevant data (Germain; Spradley). The most appropriate cultural informants are those that are ingrained and participating in the culture and who have adequate time to contribute towards the data gathering process (Spradley). Participants should have had some interest in the research topic to encourage both a diverse and meaningful sharing of experiences.

Sample selection for this research study was based on purposive and convenience sampling techniques. Purposive sampling ensures inclusion of those individuals who will provide the best opportunity and experiences for meaningful data collection (Germain, 1983; Morse, 1986) and who meet the needs of the research project (Morgan et al., 1998). Convenience sampling should ensure inclusion of those participants who are available and willing to participate in the study (Morse). Both of these methods of sampling helped to select the most appropriate and interested cultural participants.
The sample in this study was derived from the nursing clinical instructor culture. Inclusion criteria consisted of: (a) novice clinical instructors with less than three years of clinical teaching experience, (b) experienced clinical instructors with greater than ten years of clinical teaching experience, (c) administrators of nursing programs, and (d) individuals who were employed with the Nursing Education Program of Saskatchewan (NEPS) and working in Saskatoon, Saskatchewan or individuals who were employed in the Psychiatric Nursing Program at Douglas College in New Westminster, British Columbia. All three groups were believed to bring varying perspectives and insights regarding the research problem. It was not possible within the confines of this study to research all the levels of knowledge and expertise as outlined in Benner's framework. A sampling on either end of the continuum was felt to be sufficient to provide an exploratory insight into the problem. Administrators were sampled due to their knowledge of and association with hiring requirements for competent instructors.

Recruitment of participants was carried out by a variety of methods. Initially, contact was be made with administrators of nursing programs. The researcher provided information regarding the study, obtained permission to approach clinical instructors for the study, and gauged administrator’s interest in participating in the study. The administrators also were able to indicate which clinical instructors most likely fit with the sample criteria. Information letters were then placed in the mailboxes of instructors who were felt to meet the inclusion criteria (Appendix A). Two weeks prior to data collection, appropriate participants were contacted by telephone or email to determine interest and appropriateness for inclusion into the study. One day prior to data collection groups, participants were again notified for reminders (Morgan et al., 1998). These steps were meant to ensure appropriateness and commitment of participants.

The recruitment letter was placed in the mailboxes of novice and experienced clinical instructors as well as administrators' mailboxes. The letters included information regarding the
purpose of the study, criteria for selection of participants, time commitment, and ethical information. Participants who volunteered or were contacted were then provided with additional information regarding the study and were further screened for appropriateness regarding inclusion criteria.

The number of participants was directly relational to the data collection methodology. Data was collected using both focus groups and individual interviews. The use of focus groups for clinical instructors as a data collection method restricts the sample size between four to ten participants per group (Morgan et al., 1998). Furthermore, the typical number of groups is three to five, depending on the amount of diversity being explored (Morgan et al.). Specific types of participants are placed in different groups to ensure compatibility and homogeneity in data collection (Morgan et al.). Individual interviews were used for data collection from the administrator group.

For the purpose of this study, there were four groups of participants for the clinical instructors. Novice instructors were divided into two groups of four instructors each, as were the experienced instructors. Each group met for two focus group sessions, the first lasting approximately 60 minutes and the second lasting 30 minutes. Participants were made aware that more than one focus group meeting would be required due to the need to clarify data. Administrators were interviewed on an individual basis. Individual interviews were necessary due to the logistics of procuring administrators at a set time.

Reliability, Validity and Generalizability

The issues of reliability, validity, and generalizability in qualitative research are a source of controversy and critique. Many researchers feel that these terms do not apply within the qualitative framework and as such, have reclassified certain categories to achieve fittingness and rigor within qualitative research (Sandelowski, 1986). For instance, reliability in qualitative
research has been reclassified as auditability (Sandelowski). Essentially both of these concepts are meant to describe the consistency of the testing procedures and its subsequent findings (Sandelowski). Consistency means that another individual could follow the decision path of the researcher and that an outside researcher could arrive at comparable conclusions, as did the researcher who conducted the study (Sandelowski).

It is believed that one cannot replicate ethnographic research due to issues with time and transferability (Germain, 1993). Specifically, an ethnographic study cannot be replicated because people and settings change over time due to experiences. However, aspects of reliability can and should be maintained. One way in which a researcher can ensure reliability is by asking the same questions to different participants over the course of time (Germain). A second strategy is to re-interview the participants to seek explanations for discrepancies within the analysis and to achieve saturation (Germain; Morgan et al., 1998; Roper & Shapira, 2000).

Reliability or auditability was met in this study by attempting to achieve several factors. First, multiple participants with varying perspectives and experiences were included in the study. Second, participants were expected to be involved in a second group process to clarify data, obtain missed data, and achieve saturation. Third, participants with similar experiences were placed in the same groups to ensure homogeneity. Fourth, data were reviewed by a research supervisor to ensure that coding and themes were captured appropriately.

Validity is another concept that has been reclassified into a term defined as credibility (Sandelowski, 1986). These concepts are viewed as essential components of an ethnographic research study, whichever term is used. Validity tests how accurately the researcher measures the reality of the participants and how accurately this reality is described in the study (Germain, 1993; Sandelowski). Validity is obtained through verification of data with multiple participants (Germain) to obtain diverse and multiple realities within that culture. Furthermore, the researcher
must trust the experiences of the participants and accurately record and reflect this information (Germain). Credibility ideally describes a factual and truthful interpretation of the participant’s experiences, so that the participants can determine the written experience as their own (Sandelowski).

Threats to validity and credibility include sample selection bias, observer bias, and accuracy in recording and reporting findings (Germain, 1993; Sandelowski, 1986). Validity and credibility was ensured in this study by several methods: (a) data was obtained from a variety of participants with similar and contrasting experiences, (b) data was recorded both with field notes and electronically and was transcribed verbatim to ensure accuracy in statements, (c) the researcher journaled throughout the process to decrease bias and be cognizant of reactions and feelings (d) the researcher collaborated on coding and analysis of data with an expert in clinical teaching and focus groups (chair on thesis committee), and (e) feedback was obtained from the participants to ensure accuracy of findings and to ensure analysis truly reflected the participant’s experiences.

Generalizability in qualitative methods can be reclassified into the term fittingness (Sandelowski, 1986). Generalizability or fittingness refers to an unbiased selection of participants and further that the findings of the study can be transferred to other groups and contexts (Sandelowski). It is difficult to generalize in an ethnographic, qualitative study due to smaller and more selective sample sizes and the diversity of participant’s experiences and knowledge. However, in ethnography the researcher is often interested in making comparisons of results to other similar studies (Germain, 1993). These findings then may help support or refute existing theories regarding similar cultures (Germain). As well, fittingness refers to the meaningfulness of data analysis in relation to the participant’s experiences (Sandelowski). Generalizability was obtained in this study by: (1) ensuring that participants met the selection criteria requirements and
could contribute towards deeper meanings and insights regarding issues of the study (b) ensuring that findings were reviewed with participants for appropriateness and meaningfulness to experiences.

**Data Collection**

Data were collected by the qualitative technique of focus groups and individual interviews. Data collection by the use of focus groups is a technique that capitalizes on the interaction within a group setting to elicit rich experiential data (Ashbury, 1995; Morgan et al., 1998). Focus groups are a valid qualitative interviewing technique that relies on group interaction to stimulate thinking and thus provide the researcher with detailed and wholistic perspectives (Ashbury; Morgan et al.). Focus groups enable the researcher to gain a deeper understanding of beliefs and perspectives about a subject (Morgan et al.).

Interviewing is an essential technique in ethnographic research because it enables the researcher to collect diverse points of view (Germain, 1993; Spradley, 1979). The use of focus groups in ethnographic research is particularly useful because interviewing in a group environment provides the researcher with a creative perspective on data collection. The researcher gains insights into the needs and perspectives of a particular group, which offers diversity in data collection (Morgan et al., 1998). Group behaviour can elicit both common and differing points of view, which encourage exploration and detailed data. Participants who have common experiences are key to the research in focus groups (Ashbury, 1995; Morgan et al.). Focus groups are especially useful when the research problem is regarding complex behavioural motivations (Morgan et al.).

Individual interviews were utilized for the administrator population. In-depth interviews assisted the researcher to grasp the participant’s point of view (Germain, 1993) on an individual basis. Although, the administrator participants were asked the same questions, as were the focus
groups, the administrators were also invited to share any unsolicited and additional information regarding the thesis topic. This unsolicited information was meant to provide richness and insight into cultural knowledge regarding the data collection.

Focus group sessions occurred either at Saskatchewan Institute of Applied Sciences and Technology (SIAST) in Saskatoon or Douglas College in New Westminster. The sessions occurred during the work week, typically scheduled at the end of the participant’s workday so they did not have to travel or be inconvenienced for the sessions. The room utilized was a conference room in the School of Nursing and was set up in a circle arrangement with a table in the middle and chairs surrounding the table to enable the taking of notes by participants as needed. Electronic tape recording and field notes were utilized for the purpose of collecting data. Data from these modes were then transcribed verbatim after each session and analyzed simultaneously. The first focus group sessions for each group lasted on average 60 minutes and the follow up sessions lasted 30 minutes.

Individual interviews occurred at the administrator’s work place, typically in that person’s office, either in Saskatoon or Vancouver. The use of the individual’s office was for convenience so that the administrator was not inconvenienced by travel. The individual interview lasted approximately 60 minutes. A follow up interview was scheduled if needed, to clarify and review the data. This follow up interview lasted approximately 30 minutes.

Each focus group and individual participant was asked a series of questions. As this was an exploratory study, questions were loosely formed in order to elicit varying thoughts, perspectives and unanticipated findings. Exploratory research encourages the participants to reveal perspectives and to discover new insights and ideas (Morgan et al., 1998). Questions in focus groups are asked in a conversational manner to encourage comfort and socialization (Morgan et al., 1998). The questions were flexible and loosely formed to ensure unanticipated and
spontaneous responses (Germain, 1993; Morgan et al.). Questions in a personal interview are asked in a more open manner to encourage dialogue and unanticipated thoughts (Germain, 1993).

According to Morgan et al. (1998) there are five categories of questions relevant to focus groups. All focus groups and individual participants should encompass all the types of questions: opening, introductory, transition, key, and ending. Each type of questioning has a purpose although all do not elicit data for analysis. For instance, opening questions are meant to put the participants at ease and are based on facts. Introductory questions introduce the general topic and foster some discussion, which is not necessarily needed for analysis. Transition questions move toward the key questions and are more in depth. Key questions drive the study and are essential for analysis. Ending questions are meant to effect closure and reflection in both the participants and researcher (Morgan et al.).

The amount of time each question requires varies on the type of question. For instance, opening questions should take only five minutes to answer, while key questions are anticipated to take approximately 15 minutes to answer (Morgan et al., 1998). Morgan et al. (1998) suggest avoiding using “why” questions as these types of questions may not elicit reliable answers. The use of open ended questions is more appropriate because these typically elicit rich responses (Germain, 1993; Morgan et al., 1998). (Appendix B).

It is an essential quality of a focus group moderator and interviewer to be able to listen actively and to possess effective communication skills (Morgan et al., 1998; Spradley, 1979). These qualities were utilized in order to help ensure that responses to questions were addressed appropriately and timely and that responses were understood clearly. Probing questions were also used to help elicit information when the participant was being unclear or when converse attitudes were encouraged that helped look at the issue from a different perspective (Germain, 1993; Morgan et al.). Examples of probes that were used are: (a)"Who else has some thoughts about
The intent of the second round of focus groups and individual interviews was to clarify data from the first round of questioning, to elicit perspectives on the discovery of data, and to clarify analysis. Saturation was then obtained which is an essential component of qualitative research (Morgan et al., 1998). During this phase, participants were provided with written and oral comments of the data that had been analyzed to that point. Participants were encouraged to provide feedback on this data. The purpose of eliciting feedback is to ensure that perspective that is analyzed is similar to the participant’s experiences (Germain, 1993). If the perspective is different then revisions will need to occur to properly reflect the participants’ realities.

Data Analysis

The goal of ethnographic analysis is to search for relationships that emerge within the culture being studied and as perceived by the participants (Spradley, 1979). Ethnographic data analysis begins immediately following interviews with participants (Spradley). Accordingly, each interview (both individual and group) was analyzed separately when the transcription of the interview was available and then the analysis of all interview transcripts were compared to each other and as a whole. The analysis of the focus group interviews occurred according to the guidelines detailed by Morgan et al. (1998). In such focus group data analysis, it is critical to analyze according to the responses of the group culture and not individual comments (Ashbury, 1995).

Data for both individual and focus group interviews were analyzed using an analytic induction method, which included sorting through data, identifying relationships and patterns and cultural symbols, and then verifying these findings with participants (Huberman & Miles, 1994; Spradley). The tape was spot checked immediately to ensure proper recording operation. Field
notes were reviewed to ensure that meanings were clearly understood and that meanings corresponed with the taped conversations (Morgan et al., 1998; Spradley, 1979). Each session was then transcribed and coded. The transcript was formatted to allow the researcher to copy verbatim notes in the left margin, along with observations of nonverbal communication and coding in the right margin. Coding occurred by breaking down each sentence and highlighting and identifying the salient and pervasive ideas (Strauss & Corbin, 1990). These ideas were then compared and clustered according to similar categories and statements and common meanings (Germain, 1993; Strauss & Corbin). The delineation of these meanings and their relationships ultimately lead to the identification of cultural themes. The themes were derived from identification of patterns amongst the categories and were meant to capture the essence of the participant’s experience (DeSantis & Ugarriza, 2000). At this point, a hypothesis regarding data and its relationships was formulated. When no new data had been revealed or identified from the participants the process of data collection was complete. At this point, saturation occurred and conclusions were reached.

**Ethical Issues**

Research that involves human subjects needs to be ethically reviewed to ensure that there is no risk to the participants (Morgan et al., 1998). Areas of particular ethical concern are issues of privacy and confidentiality of participants (Morgan et al.; Spradley, 1979). Ethical issues were addressed throughout each phase of the research process. The researcher complied with ethical standards by implementing the following steps:

1. A proposal and consent form was developed specifically for this research study and sent to the British Columbia Behavioural Sciences Screening Committee for Research and Other Studies Involving Human Subjects.
2. The proposal and consent form was also sent to institutions where research participants were obtained from: University of Saskatchewan, SIAST, and Douglas College.

3. Permission to conduct the study was obtained from department heads and administrators within NEPS and Douglas College.

4. Informed consent was obtained from each of the participants prior to and throughout the research process. This included verbal and written consent regarding collection, handling, and distribution of data (see Appendix C).

5. Privacy, anonymity, and confidentiality of the participants was ensured and protected throughout the research process.

6. Participants were informed of and understood the research objective.

7. Objective recording and reporting of study results was maintained throughout the process.

8. Written study results were made available to each participant if desired at the conclusion of the study.

Limitations

There were several apparent limitations associated with performing this study. One notable limitation was that student responses were not utilized to expand on the culture of clinical instruction. The lack of student input was due to the fact that time and purpose of the study limited their responses. A second limitation was that all of the participants were volunteers. The use of volunteers as participants was a limiting factor because only those interested in the subject were more likely to participate in the study. For instance, a novice instructor may have valuable insights to offer but may be too intimidated to participate in the project. A third limitation was that the researcher was already a part of the clinical instruction culture and therefore, was interviewing colleagues and friends. There was a concern that peers would not be as honest with responses due to the risk and consequences involved with responding honestly. A fourth limitation
was the inability to use focus groups for administrator responses. Although the responses of the administrators were analyzed as group, the inability to use focus groups detracts from the object of obtaining diverse group responses. A fifth limitation was that the researcher moved to a new province at midpoint through the data collection process due to personal reasons. This move caused an unfortunate interruption in data collection and analysis, which may have some impact on continuity of data.

**Summary of Research Method**

This chapter has addressed issues related to research method. The rationale for the research approach of ethnography was introduced and clarified. Issues regarding validity, generalizability, and reliability were discussed according to recent anecdotal qualitative beliefs. The selection of study participants through convenience and purposive sampling was described. The study location was determined by where the researcher was living at the time. Data collection procedures with the use of focus groups and individual interviews were outlined and data analysis processes were described. Ethical considerations and limitations of the study were identified and addressed.
Chapter 4

Research Findings

The intent of this chapter is to discuss the findings that arose from the data. The research study entailed an investigation regarding how the nature and duration of clinical instructors' experience affected student learning outcomes in the clinical setting. The two significant themes that arose from this investigation are (1) attributes of the experienced clinical instructor and (2) outcomes associated with clinical instructor experience. I will present the sample demographic information about the participants. Next the themes of the attributes of an experienced instructor will be presented and discussed. Finally, the theme of student learning outcomes that are associated with instructor experience will be discussed.

Sample Information

The participants were divided into three groups of novice or experienced clinical instructors, and administrators. Each group consisted of four participants with the majority of participants female. The clinical instructor group participants taught either in a psychiatric nursing college diploma program or a combined psychiatric/RN degree program, either at the college or university level. The administrators were heads of departments or deans of degree programs, either at the college or university level. The novice group participants' level of education ranged from a bachelor's degree of arts (psychology) or nursing to a master's degree in nursing or business administration. The experienced group participants all possessed a master's degree in nursing or education. The novice group participants had several months to three years of experience with clinical teaching, while the experienced group had fifteen to twenty-five years of clinical teaching experience. The ages of all participants ranged between 33 and 56, with nursing practice experience ranging between seven to 27 years.
Attributes of the Experienced Instructor

Participants in the study discussed their experiences, feelings, and observations regarding the practice and knowledge of both novice and experienced clinical nursing instructors. The data from these findings uncovered substantial and specific differences between these two groups of instructors. Due to the nature of the question, the theme of attributes of the experienced clinical instructor was subsequently uncovered. These qualities comprise both positive and challenging attributes that outline and describe the knowledge, skills, feelings, and behaviour of these instructors. The data regarding this theme then diverged into five sub-categories that comprehensively describe the attributes of the experienced instructor. These five sub-categories are identified as: letting go, navigating the waters, expanding core skills, believing in self, and managing challenges. Each of these sub-categories will be presented individually and discussed in detail. Supporting data in each of these sub-categories will be compared and contrasted to novice versus experienced instructor observations.

Letting Go

The sub-category of “Letting Go” encompasses a range of responses identified from the participants with the common thread being the notion of letting go. As a clinical instructor becomes more knowledgeable and gains more experience, she/he tends to let go of issues related to herself and the student. This letting go process occurs over an undetermined time period, as one becomes an experienced instructor. The letting go process describes both a physical and psychological withdrawal of the clinical instructor over such ideas and actions as, control over the student and the experience and control over personal preparation, responsibility related to the student and his/her learning, expectations of the student and of self, and subsequent feelings of guilt associated with this withdrawal. The ability to let go of these areas appears to be in response to the changing ideology of the novice instructor and the comprehensive understanding that
comes with experience. For instance, novice instructors recognize that they tend to over prepare for clinical instruction. Furthermore, they recognize that experienced instructors tend to shift the responsibility of learning onto the student but the novices cannot yet fathom doing this themselves. The experienced instructors in the research stated they cannot pinpoint when this shift first occurred, indicating that it is a gradual shift.

Control.

The notion of letting go of control arose from discussions from both the experienced and administrator groups and was alluded to in discussions from the novice groups. The term “let go” arose frequently in the experienced and administrator conversations. Control was described as both a physical and psychological authority over the students with specific regards to the students’ knowledge and provision of care to clients. Control was also described in the context of the clinical instructors’ personal knowledge and preparation for teaching in the clinical setting. The experienced instructor has come to relax regarding the degree of control over the students in certain instances as well as the amount and degree of her/his preparation for teaching.

Letting go of control over the students was discussed by the two experienced focus group participants as primarily not being either physically or psychologically present for the students during certain instances in the course of the clinical day. For instance, all of the experienced instructors discussed not having to be constantly with the students during skill application with clients or not having the need to quiz students at length regarding their knowledge and preparation for clinical experiences. As one participant in the experienced focus group stated, “I have needed far less control over the students. I don’t feel that I have to hover and watch as much as I used to.” The same focus group participants went on to further elaborate regarding letting go of control over the students. “I used to think I had to do all the skills with the students... It may be part of a control thing, I don’t really have to control all of their experiences”.
When discussing changes in teaching strategies over the years, one of the experienced instructor groups talked about not giving up quizzing the student regarding knowledge, but changing the way they went about it, thus changing the face and degree of control.

But as far as medications that’s something that I’ve changed in the sense of not doing the drill but doing the drill in a different way. And by saying I need to know that you know what medicines you are giving, what the interactions might be, you tell me when it’s a good time to talk about that.

The experienced instructor still recognizes that she/he has a responsibility to gauge the student’s knowledge but has shifted of when and how to go about determining this understanding. The experienced instructor is more willing to understand certain knowledge of the student’s, on the student’s terms. Thus, the experienced instructor has given students control over when their knowledge is to be tested. The experienced instructor does not have the need to control all aspects of student learning.

A consequence of letting go of control of the students is that the experienced instructor is more relaxed during her/his interactions with students and with how to determine knowledge and safety. All of the experienced instructors talked about how their behaviour and demeanor has relaxed over time, which may be both a consequence and has enabled the letting go process over the students.

You’re not quizzing but you sure do know if they have that background, if they have the knowledge to know what to pick out and how to interact and do a procedure with them and stuff, so I’ve relaxed a little bit from that.

Experienced instructors also talked about letting go of the need to prepare at length for the clinical experience. These instructors do not need to prepare vast amounts of information regarding both the clinical area and clinical teaching. Furthermore, the experienced clinical instructor does not have the need to prepare for any and all situations that can arise in the clinical setting. The experienced instructor has realized that she can neither predict nor control all
situations that occur in the clinical setting, and therefore, realized that is unnecessary and impractical to prepare at length.

I think as a beginning instructor I had the need to, and I believed I could, control the experience. I believed I could kind of predict all the things that were going to happen... I tried to prepared for every eventuality and I tried to sort of map things out very clearly because I thought okay if I plan to do it this way then I have a plan.

Novice instructors alluded to this need to be prepared for the clinical experience and for events that can occur in the clinical day. These instructors recognize that at times, the amount and time spent on preparation is problematic, "I mean I was over prepping. Where I was, every waking moment, involved with work". The novice instructor recognizes early that she is overzealous in her approach but has yet to relinquish that control over being prepared for all clinical events.

Responsibility.

The experienced groups talked about letting go of responsibility issues related to the student. The experienced instructor tends to place the majority of the onus of preparation and hence, learning, on the students. "I don’t have to spend all the time preparing, all these details about the patients that the students care for. Well, that is their responsibility. They take responsibility for that patient." This shift in responsibility is meant to encourage the student to become more empowered in life long learning and to understand the amount of responsibility involved in caring for clients safely and appropriately. Furthermore, this shift in responsibility has enabled the clinical instructor to let go of expectations related to her own preparation for clinical. This letting go of personal expectations also encourages the student to take on more responsibility regarding their preparation. The shift in responsibility has an intimate relationship with the letting go process. As the experienced instructor begins to let go of control over the clinical experience and her own preparation, she/he starts to encourage and shift responsibility of learning on the student.
Both of the novice groups are cognizant of the experienced instructors shifting of responsibility towards the student. Though the novice is aware of this shift, she/he cannot imagine doing the same. As a novice group participant stated, “I can think more about my responsibility and they put it back to the student’s responsibility”. Novice instructors feel they have a very strong sense of responsibility with regards to personal preparation and ensuring thorough student preparation.

I think we put in way more time in a lot of respects, part of that is our learning curve but part of that again, our overdeveloped sense of responsibility in the sense that we are trying to do and overdo.

Novice instructors do not see that owning the responsibility or over preparing is necessarily a draw back or a negative attribute because they feel the need to have ownership for the student’s learning. The novice instructor often feels that the expectations regarding the students’ ability to provide care safely as more of a shared responsibility between instructor and student, “... but the bottom line is it is a shared responsibility and I really try to focus on that.” The novice instructor is unable at this time to let go of the ownership of responsibility regarding clinical preparation and experiences.

Expectations.

Experienced instructors also discussed that their expectations of the students and of themselves had changed over time. For instance, the experienced instructor has changed her/his expectations regarding the amount and depth of preparation the students are required to complete for clinical assignments,

I expected them to come, demonstrating to me that they had done chart research and that they had an idea of what the priorities were for the patient but their ability to actually plan the care for the patients as students was much better after they finished the experience than it was before and so I didn’t-- I changed my expectations in terms of preparation and in terms of they way they presented it.
The experienced clinical instructor still requires that the students be prepared to administer safe and knowledgeable care to clients but does not have the expectation that the research be detailed or that the student's knowledge and understanding be thorough or comprehensive. The expectations regarding student preparation are still present but the degree of understanding requested of the student regarding procedures and theory has shifted and is more relaxed in nature. The experienced instructor then works with the student to problem solve clinical situations and thus to expand on the student's knowledge base.

The experienced and administrator groups felt that novice instructors tend to get caught up in expectations of the agency, of the department, and of themselves. For instance, it is felt that novice instructors tend to be more rigid in their expectations of student preparation. As one administrator participant remarked,

Plus, the novice gets caught up with your expectations as faculty member is that if I don't have everybody hand in this all in at, on this date, it will be a reflection on me- I must be a poor clinical instructor or I must not be setting a guideline and stuff.

Some of the novice instructors admit to having high expectations of the student, "I think I am tougher on my students because maybe I have higher expectations than some...". Novice instructors are acutely aware of the repercussions for themselves with regards to students delivering safe client care and as a result tend to expect detailed preparation from their students. One way a novice instructor can determine if a student is safe to deliver care is to quiz the student regarding knowledge related to client care. The novice instructor may then be more focused on the content the student can demonstrate rather than the process of learning.

The novice instructor quickly recognizes the need to prove her/himself and her/his knowledge, which results in having high and often unattainable expectations of her/himself. As one novice instructor remarked, "It is hard, especially when you are a new instructor because you just want to make sure that you shine through the whole thing...". The novice instructor has a
need to prove that she does have appropriate knowledge and is adequately prepared to teach students. Consequently, novice instructors strive to meet the expectations that they set for themselves and are often more anxious to meet these goals.

**Guilt.**

Feelings of guilt can be a consequence of letting go of control, responsibility, and expectations of the student and of themselves. One group of experienced instructors discussed that they had also let go of the guilt associated with letting go of control and responsibility. “So that’s my thing, is that I let go of the guilt that I had when I didn’t quiz”. They stated that the experienced instructor recognizes that there are many strategies and methods for determining student learning, knowledge, and safety and therefore, has come to develop her own methods for testing and gauging this learning. They proposed that the comprehensive knowledge and abilities the experienced instructor possesses has enabled her/him to be more proficient and thus, may contribute to the teacher being more relaxed.

Participants concurred that the novice instructor generally recognizes that she/he has feelings of guilt associated with being a novice clinical instructor. They stated that the novice instructor acutely feels there are several areas in which she/he is lacking as an instructor, such as teaching strategies and problem solving, and feels that this may have repercussions for her/his students. “I felt really guilty after my first semester here because I think I did the students a disservice… I didn’t have a clue- I was on the fly”.

**Navigating the Waters.**

The second attribute that participants characterized the experienced instructor encompasses elements regarding a comprehensive and diverse knowledge base. This knowledge base is not confined to clinical teaching or nursing knowledge but encompasses a broad spectrum of information. They reported that the experienced instructor has maneuvered through many
situations, which has enabled her/him to determine and utilize diverse resources related to clinical teaching. Furthermore, she/he has observed many responses from students and clients to clinical instruction. Hence, the experienced instructor has a comprehensive knowledge base regarding many of the nuances of clinical instruction. The participants viewed navigating through the waters as an instructor as encompassing a broad spectrum of knowledge such as; knowing the system, which includes teaching knowledge, knowing the students, and knowing the resources.

**Knowing the system.**

According to all participants, experienced instructors possess a comprehensive teaching portfolio. They stated that experience has taught clinical instructors a wealth of information in terms of documentation and evaluation of the student, understanding the curriculum, teaching strategies, and even preparation for teaching assignments. It was unanimous among all of the groups that evaluation of the student is one of the greatest challenges for the novice instructor and that the experienced instructor is better equipped to prepare and administer this arduous task. For instance, the experienced instructor has learned how to document student behaviours that allows for a more germane evaluation of performance. The experienced instructor is adept at both evaluating student behaviours and learning and at providing feedback to the student in comprehensive yet understandable manner. “I find documentation much easier than I did in the early time period [of teaching]. Like just be able to say things in a fairly positive way as opposed to, you know make things constructive rather than make it negative.” Participants concurred that experienced instructors appear to better equipped in both deciphering information about the student and in disseminating critical feedback to students.

According to the participants, the novice instructor typically struggles with feedback and student evaluation. “…daunting task for the new instructor is evaluation of students and getting good formative evaluation in a timely way and in a way that is nonjudgmental and candid.” All of
the novice instructors in the research recognized that evaluation is a challenge to them and
express their frustration and difficulty with the task.

How do I evaluate is huge, just to actually put your finger on what you felt the problem
was and then to be able to identify soon enough that you can help the student along rather
than just at the end coming up with this is what I think.

And I find it easy just to tell a student they are doing fine but I am lost for words when
they want you to tell them what can I improve on. I really struggle with trying to find
things to tell them to work on because then I need to be able to measure that.

Evaluation of student behaviours and the ability to convey this information in an appropriate
manner to the student is of particular challenge to the novice instructor.

Participants identified another area of great challenge for the novice as comprehending the
curriculum and how it “fits” with the clinical rotation in which the instructor is teaching. They
stated that the experienced instructor has a history of the curriculum and the changes that have
occurred over time. Furthermore, the experienced instructor understands where the clinical
rotation fits in with the curriculum and thus has a broader understanding of student learning
needs. However, all participants perceived that the novice often has a difficult time “fitting the
pieces together” and thus finds it challenging to implement the curriculum appropriately.

I never took the program, right so I didn’t even know what really belonged to what
semester and how it was all put together. I mean I tried, I kind of went through the thing
but you really don’t have a sense of what, what it is and you really do get thrown to the
wolves so to speak.

Administrators are aware that understanding the bigger picture is of particular challenge to the
novice. “I think another thing that challenges new people as clinical teachers is implementing the
curriculum that we’re wanting implemented…”

Another area in which participants concurred that experienced instructors have a broader
knowledge base than novices is with regards to the general preparation for teaching in the clinical
setting. Accordingly, they believed that experienced instructors have established a foundation for
both preparation for clinical experiences and strategies to help students with their learning.” In
addition to what has been said you learn different strategies in the sense of clinical teaching
strategies and as a novice person I think I was pretty narrow in my approach to teaching.” They
viewed the experienced instructor as having experienced a wealth of student responses to various
teaching strategies and subsequently has learned to modify her/his skills over time to these
responses.

The administrator group reported that the novice instructor might struggle with seemingly
simple tasks regarding clinical preparation, such as patient assignments and effectively organizing
the clinical day for students. “You know they might not have had any experience in students, like
some of the things, like how do you do a patient assignment for student?” There are many tasks
associated with clinical start-up that seem simple and second nature to the experienced instructor
that require insight and thought from the novice.

Novice participants stated that the experienced instructor has encountered a variety of
situations in the clinical setting, whether it is student learning needs, personal preparation or
agency expectations. They agreed that the experienced instructor often just “knows” what to do
in any given situation but that the novice instructor has some difficulty with knowing what to do
in many situations due to inexperience.

There are a lot of things sometimes about the clinical area or about teaching now that are
not written down and we have all done it for so long that we forget to tell other people
what it is that are those policies or whatever, and so I think it must be very hard for a
clinical teacher coming in to know all of what is unwritten kinds of things that have
evolved over time.

The unwritten information and rules of the clinical setting take time to grasp. Participants agreed
that the novice tries to navigate her/his way “through all this information” and provide optimum
learning for the student, which is often a daunting task, “…just trying to navigate the waters and
facilitate a rich learning experience.” The novice instructor not only has to meet her/his own
learning needs but also recognizes the responsibility and pressure to ensure appropriate learning experiences for the student.

**Knowing the students.**

According to participants, experienced instructors have a more comprehensive grasp of student behaviours and are more aware of student learning needs in the clinical setting. First, the experienced instructor is cognizant of student learning needs regarding appropriate knowledge for client care. Second, experienced instructors discussed how their view and understanding of student learning and behaviour has changed over time. Experienced participants concurred that in retrospect, experienced instructors feel that they understand student behaviours better now than as a novice “... understanding just sort of what are the behaviours that are acceptable, they are far more clear to me.” Participants stated that over time, the experienced instructor has come to recognize appropriate student behaviours as well as patterns in behaviours. As a result, the experienced instructor has been able to adapt teaching strategies to individual student needs. Consequently, the experienced instructor tends to pick up on learning and behaviour problems quicker and can address these issues in an appropriate time frame.

Experienced participants perceived that the experienced instructor has “come to understand the student” in a more comprehensive manner, understanding and viewing student learning in connection with the entire curriculum and not just limited to the clinical course. The experienced instructor knows what level of knowledge the student is expected to have at any given time.

And if we have taught in a variety of different areas and a variety of different years we have an idea of what someone is talking about in terms of levelling, whereas a novice teacher may have more difficulty figuring out the level that is appropriate for a particular time period within a year as well as looking at the course.

Participants reported that the experienced instructor has had time to understand how clinical rotation fits in with the curriculum and thus can see the broader picture regarding learning needs
and expectations. Consequently, the experienced instructor understands how the student fits in to the clinical area and at what level of development and knowledge the student should be at. The experienced instructor knows what the student needs to learn in order to achieve success in the clinical rotation.

_Knowing the resources._

A third area of knowledge in which many of the participants perceived that experienced instructors are better equipped is in having a more comprehensive understanding of the agency in which clinical instruction takes place. According to participants, the experienced instructor clearly understands how the agency is managed and who the key people are. Consequently she/he is aware of which resources are beneficial for student learning and how to access those resources.

“Students get a better sense of the agency and how things are run. And many better opportunities that you wouldn’t have access to if you didn’t know the people and the system, you know.”

Furthermore, participants stated that the experienced instructor is often placed consistently in her/his area of clinical expertise, which ensures many benefits and successes for both the student and instructor. A consequence of remaining in the same clinical area is that the experienced instructor has had time to develop relationships with agency staff. This has enabled the instructor to access more varied resources on behalf of the students; “I think I know the system well enough too that we may know how to access things for students more easily within the system than maybe a novice teacher would.” In contrast, participants agreed that the novice instructor is often placed in clinical areas that are not congruent with her/his area of clinical expertise.

Sometimes you do get thrown into an area that isn’t maybe your area of expertise... You know, is that really fair that instructors should be thrown into areas where they don’t have the expertise and that is just going back to that whole philosophy that if you can teach in one area you can teach in another.
They suggested that the placement of novice staff in areas that are not congruent with their area of knowledge and expertise is indeed problematic. The novice instructor must negotiate her/his own learning of that clinical agency, as well as integrating knowledge regarding teaching, which may place the novice at an even greater disadvantage.

**Expanding Core Skills**

Participants identified a third attribute of the experienced instructor as encompassing elements related to her/his skills and abilities as a clinical instructor. All participants stated that the experienced instructor has built upon core skills essential for nursing practice and has further adapted and honed these skills in order to effectively teach students in the clinical area. The core skills that emerged from the data are; communication patterns, intuitive processes, and problem solving skills.

**Communication.**

A skill that all participants determined as being an essential requirement to teach in the clinical setting was the ability to maintain effective and positive communication with various groups of people. "... and certainly good communication skills in terms of being able to liaison with staff and working with different groups of people." They described communication as both the inter-related domains of interactional patterns and public relations (PR) with the staff of the agency and nursing unit in which the instructor is teaching.

The experienced instructors felt that they had improved in their communication skills during their teaching career. Moreover, they had also come to recognize how critical PR is for facilitating positive learning opportunities for students. Thus, they described the experienced instructor as investing effort in ensuring open and respectful communication with essential personnel.
I believe that ties into one thing that I learned as I taught for a few years is that a large part of my job is PR. Like I didn’t realize it at first, you know. I mean I was just there to teach the students and then realizing that in order for the students to learn and have a good experience in clinical I must do PR and so right now that probably is a major portion of what I do.

Experienced instructors viewed building positive relationships with the agency and nursing staff as essential to ensure comprehensive and positive learning experiences for students.

**Intuition**

It was recognized by both novice and experienced instructors that intuition is a quality that many experienced instructors possess. They stated that intuition in clinical teaching appears to be a quality that develops and emerges over time, as a result of recognizing patterns in student behaviour and augmenting one’s knowledge. The experienced instructors recognized that they have become more intuitive about student behaviour and any subsequent learning difficulties as they experienced situations in clinical teaching.

Going back to being intuitive about people a lit bit more, I find now I am a little more intuitive about students in terms of I seem to be able to pick up easier on students that are having difficulties than I used to when I first started teaching and it is almost like a sense you get and I am more comfortable now acting on that sense a lot quicker than I used to be.

They stated that the experienced instructor more aptly senses information about the student quickly, such as learning difficulties or personal problems, and thus can respond to these issues within an appropriate time frame.

The novice instructors in the research noted that experienced instructors were more intuitive about students and teaching issues. They attributed the development of intuition to having experienced many different situations with students over time.

The experienced ones just have that intuition that comes from “doing it” for so many, many years and just intuitively they know what’s right, what’s wrong, what’s good, what’s bad, what works, what doesn’t for the majority of them.
They stated that they were not as attuned to student learning difficulties and furthermore, were often at a loss of how to explore and correct the problem.

**Problem solving.**

All participants concurred that experienced instructors had stronger problem solving capabilities, that is, the ability to work through issues that arose regarding student behaviour and learning. Furthermore, they stated that experienced instructors were able to work through these issues in primarily an independent manner. The novice instructors in the sample identified this skill as an attribute of the experienced instructor and discussed how problem solving through student issues was a challenge for themselves.

**Believing in Self**

The fourth attribute of the experienced clinical instructor that was identified by the all of the participants was belief in one's abilities as an instructor. They stated that the experienced instructor has broadened her/his knowledge base and thus has grown more competent in teaching skills. Consequently, this has allowed the experienced instructor to become confident in her/his abilities as an instructor. They also reported that the experienced instructor has developed many abilities and has come to believe in and trust her/his skills as an instructor.

According to participants, the experienced instructor has honed a variety of skills related to teaching and has become aware of the importance of certain aspects of clinical teaching, such as PR, that she/he did not recognize as a novice. As a result, she/he nurtures and advances these skills. Furthermore, the experienced instructor has worked with a broad spectrum of students and thus has been able to recognize patterns and developed the ability to problem solve independently. As one experienced focus group participant remarked, “You can handle more on your own.”

Experienced participants agreed that as a result of increasing competence, the experienced instructor has become more confident in her/his skills as an instructor and trusts the decisions and
judgments she/he makes in relation to clinical teaching. Consequently, she/he tends not worry about what others think about her. As one experienced focus group participant shared, “I think with experience you can sort of say, ‘Well, this is my way!’ ” Experienced participants stated that this increased confidence enables the experienced instructor to be more assertive in sharing her/his knowledge and in teaching students. As a result, the experienced instructor perceives that students and agency staff listen to her/him intently and trust her/his judgment more. “I suppose the experience gives you the ability to speak with authority too…”

Conversely, the novice instructors in the study identified that they were lacking in confidence in their skills and knowledge as an instructor. All participants stated that lack of confidence in teaching knowledge and knowing the system is a major challenge for new instructors.

When I was a real novice I didn’t have confidence and I, how do you do that, you know, phoning people, trusting yourself and knowing that you do have knowledge and you can do what it is and finding your own way.

The novice instructors in the research agreed that even seemingly simple issues for the experienced instructor are a challenge to the novice. “My biggest challenge as a novice is just that overwhelming, all that other stuff. I mean I knew what I was doing but I think establishing faith in myself and trusting my knowledge and the confidence kind of thing.” They stated that the novice instructor has to build others’ and their own trust in her/his abilities and knowledge; this can be problematic because every new situation regarding clinical teaching is foreign to the novice.

Participants concurred that the novice instructor often feels that she/he must prove herself/himself to both students and peers. She/he must demonstrate that she/he is worthy to be an instructor and that she/he does have pertinent knowledge. Participants stated that the novice’s need to prove oneself is related to a lack of confidence in abilities. Furthermore, at times, the novice instructor feels that she/he is not adequately prepared to be teaching students and thus is
frequently worrying about her/his abilities. As one experienced focus group participant noted, the
novice instructor may suffer from “Impostor syndrome --- you know what’s going on and I’ll be
found out that I don’t know what I’m doing.”

Participants identified one outcome of the novice’s lack of confidence is that the novice
instructor is more anxious about her/his abilities as an instructor and may convey this anxiety to
students and agency staff.

I think at the beginning I was so anxious about my teaching that my own anxiety, I think,
made me a little more rigid with my students, now I understand myself as a teacher and
how I can work around some issues so I think I now try to lower the student’s anxieties as
well.

This anxiety may be translated into observable behaviours and mannerisms, such as being
controlling with assignments. The students may then subsequently notice and respond negatively,
such as becoming more anxious themselves.

Another outcome of decreased confidence identified by participants is a feeling of
insecurity that may instill in the novice instructor a desire to be liked by the students and faculty.

I’ve moved from that sort of insecure, “Oh I hope they like me’ as that sort of would
affirm to me that I’m a good instructor because they liked me, whereas now there’s a
different sense of what feels like a good instructor and it’s not the “like” things has so little
to do with it.

Experienced instructors concurred that one result of trying to please students is that the novice
instructor may experience difficulty in understanding and establishing roles and boundaries with
students.

They [novices] have a harder time establishing their role with the student. Boundary issues
are tough and that is probably again, tough for the novice instructors as well, to try and
figure out the difference between being a friend and being supportive, you know, and there
is a difference in terms of where you draw the line.

A difficulty in establishing boundaries with students may have some repercussions, such as making
the evaluation process less objective.
Managing Challenges

The research findings have demonstrated that the experienced instructor may incur many positive benefits from years of experience in teaching. However, all of the participants also identified challenges that experienced instructors face as a result of working intensely with students for many years. In particular, experienced instructors frequently encounter challenges such as declining enthusiasm, adapting to change, and remembering the novice role.

Declining enthusiasm

The greatest challenge that experienced instructors in the focus groups stated they encounter is maintaining enthusiasm for teaching the same courses yearly and conveying enthusiasm to the students.

I think sometimes maintaining your enthusiasm when you are describing something for number 525 times, you know, because when you have been teaching for an extended period of time particularly when you stay in the same clinical area, you go over the same material often, again and again, year after year after year after year, so there are changes around it but some of the basic stuff stays the same and so it is always trying to remember that although I have gone over it again and again and again, this is the first time that they are hearing it and they have a right for me to be enthusiastic about their learning and sometimes I have to remind myself to do that.

Both experienced and novice instructors alike recognized that aspects of teaching can be monotonous at times and the obvious outcome is boredom. Experienced instructors stated they often have to fight the impulse to be bored with teaching the same content and must “work conscientiously” at conveying enthusiasm for the students.

Get bored doing the same job all the time, even though your student group is changing all the time, if the course is still the same, if the expectations are still the same, sometimes you need to look at if everything else is staying the same what can I do that is different that challenges me and keeps me interested. So keeping your enthusiasm I think is a bit of challenge some days.

Conversely, all participants stated that the novice or new instructor is often very enthusiastic about teaching and frequently conveys this enthusiasm to the students. The novice often explores a variety of information and is very invested in teaching the material to students.
The novice is often very animated with teaching and guiding students with their learning. As one novice participant remarked,

And I thing the other thing that the experienced instructors, like all must be exhausted because they have tried all these different things and they just keep going from day to day whereas a new instructor you are always trying different things.

The novice participants also agreed that the novice might be more willing to take risks with teaching strategies and with conveying the material to the students.

Adapting to change.

Participants identified a second challenge facing experienced instructors as being psychologically prepared to adapt to changes both in the curriculum and in the practice setting, particularly in regard to technological advances. Experienced instructors in the focus groups indicated that although they “did not mind the idea of change”, putting new ideas into practice was becoming more problematic with time and at times, this was very stressful.

The thing that I have found, with the last decade, is that the change has just become so rapid and so complex and I am getting older and would like less. I like change but I wish it would slow down.

They proposed that change might be more difficult for the experienced instructor due to having invested more time and effort in a certain way of doing things.

Change is often harder because they have a high level of skill in what they are doing now and if you ask them to do something different it is, they have got more invested in what they have done before so change can often be an issue.

Novice participants proposed that being able to adapt to change is not as problematic for the novice instructor due to a lack of history with the curriculum or past teaching strategies.

Additionally, the novice instructor is typically up to date with changes in technology due to a recent experience with the practice settings.

Some of the experienced instructors in the research stated that they struggle with adapting to change in the clinical setting, such as new procedures and equipment. While some of the
experienced instructors interviewed are currently employed on a casual basis in practice settings and did not consider this to be a significant issue, the majority of the experienced instructors do not currently practice clinical nursing outside of teaching and voiced their frustration with an inability to maintain current with nursing practice.

I think the challenge for the experienced instructor is number one is to stay current. Current around research for evidence based practice, current in terms of the kinds of clinical situations they are going to be in, what is happening clinically, and it can be from, you know, there is a new thermometer on the unit, there is new equipment, and how do you kind of keep abreast of that when you are not in the clinical area on a regular basis, except with your students and of course the expectation is that you would then of course know all these things to be able to teach your students.

The novice instructors who were interviewed have either just stopped practicing in the clinical area or are still employed in practice settings. These instructors stated they feel quite confident in their skills as a nurse and with sustaining a current knowledge base. The novice instructors viewed the experienced instructors as being removed from the practice setting and thus not being as aware of changes in technology.

I thing sometimes too the novice, like kind what you are saying, is still quite connected with the actual clinical area, has just maybe recently been there and has worked in that area and not that an experienced instructor doesn’t know her stuff but they are just not that connected, I guess, and I mean they may well be connected but they are not up to date.

They also stated that their recent knowledge and experience with clinical practice affords them a certain amount of credibility and respect from the students and staff in the agencies.

**Remembering the novice role**

The final challenge that the experienced instructors discussed is in remembering the novice role of both the student and novice instructor. Experienced instructors stated they often have a difficult time remembering what it was like to be a student facing the practice setting for the first time.
The first thing that jumps out for me and, I forget what it's like to be a student in the new practice area for the first time and I'm noticing it more in the last couple of years in a sense that I am not tuning into that.

They further recognized that they have in some ways forgotten what it was like to be a novice instructor and although cognizant of this, were at times at a loss of how to help new instructors integrate into the program.

As a new instructor coming into education right now it would be difficult because those of us who have been around for a while have been around together for awhile and you sort of have this little group and you almost forget as an experienced instructor how to help new people back into the system because we haven't had new people for so long.

The novice instructors in the study stated that they feel that they are often left to problem solve for themselves and shared a sense of frustration with having to be so independent when they were not quite ready to be; “I think that guidance and leadership is missing because we don’t have a whole lot of direction; we’re basically given a package and said this is what you’re teaching and that’s it!” At times, they perceived that they were abandoned by more experienced peers and experienced a sense of frustration.

Student Outcomes Associated with Experience

Participants in the study discussed their perceptions and insights regarding how experience with clinical teaching impacts the students. They agreed that although novice instructors do empower learning in students, experience in teaching accounts for some advanced and consistent learning, skills, and successes for the student. The data revealed that there were several positive outcomes for student learning that the experienced instructor facilitated and nurtured. The outcomes that the students are more apt to possess as a result of being taught by an experienced instructor were identified by participants as increased confidence and decreased anxiety, greater independence, more holistic knowledge base, better problem solving skills, and increased safety.
Increased Confidence/Decreased Anxiety

The experienced instructor and administrator groups concurred that students were more confident in their skills and abilities as a result of being taught by experienced instructors. They believed that experienced instructors are more adept at nurturing increased confidence in the student on several levels. First, increased confidence in the student can be attributed to experienced instructors both being more relaxed and comfortable with themselves as instructors and more confident in their knowledge and skills. As a result of a comprehensive knowledge base and insight into teaching styles, experienced instructors are now able to shift the focus from their own learning needs and attend more intently to the needs of the student. The student benefits from a more relaxed and giving relationship and draws strength from the instructor’s confidence. Secondly, the experienced instructor has let go of many control issues in the clinical area. This letting go of control has also enabled the experienced instructor to empower the students in their learning. Consequently, the student has been shifted more responsibility for her/his learning which helps to increase her confidence in her abilities.

One of the things that I think is very significant outcome that we see is that development of confidence. Like over a time period you will see them come to a rotation being very anxious about the experience, very anxious about many of the things that are expected of them and by the time that they are ready to leave there is just an increased confidence level, you can see them relax more. They are far more free, I think, to make clinical decisions as they develop that confidence.

Participants stated that this increased confidence in the student inspires the student to trust herself/himself and her/his decisions; therefore, the student is more comfortable to make decisions regarding client care and is more confident and trusting that these decisions will be appropriate.

Furthermore, experienced instructor participants perceived that the experienced instructor is more aware when students are anxious and that a high level of anxiety can negatively impact learning. They stated that the experienced instructor often knows what situations students find
anxiety provoking and how to intervene appropriately to ensure that the situation is not too stressful.

I can look at that quickly so that I don’t have to put them on the spot- my biggest thing is try and decrease their anxiety cause I find if I can decrease their anxiety they’ll perform better, they’ll give better care and they actually have the knowledge without even knowing it.

In contrast, all participants described the novice teacher as often anxious about her/his knowledge and abilities as an instructor and lacking in confidence. They stated that this anxiety and self-consciousness can often be transmitted to and “picked up” by students. The student in turn, may become more anxious.

I think at the beginning I was so anxious about my teaching that my own anxiety, I think, made me a little bit more rigid about my students, now I understand myself as a teacher and how I can work around some issues so I think I now try to lower the student’s anxieties as well.

Participants agreed that the novice instructor, who is “caught up” in her/his own anxiety, is unable to assist students to decrease their anxiety. Furthermore, they emphasized that the novice instructor may not be aware of which situations will be the most anxiety provoking for students and therefore, will not be able to intervene appropriately, resulting in an exacerbation of the student’s anxiety. The student who is more anxious and less confident may make inappropriate decisions that can affect patient care and safety. Furthermore, the student may associate anxiety with learning; this can have a negative impact on future clinical rotations.

Greater Independence

Participants identified another learning outcome associated with instructor experience is that students are often afforded a greater level of independence with implementing skills and care and for making clinical decisions. They stated that students of experienced instructors are encouraged to be independent with decisions and implementation of care earlier in their education.
As one experienced instructor remarked, “A higher level of independence is what I see. They start out sort of right beside you and then by the end they can sort of spread out more.”

Participants identified several ways in which the experienced instructor nurtures student independence. First, as previously discussed, experienced instructors shifted responsibility for learning onto the student. This encourages the student to take more control in her/his decisions in the provision of care. Second, experienced instructors tend to be more relaxed with students and more comfortable with students taking control of their learning experiences, and decision-making. The ability of the instructor to let go of control encourages independence in the student. Third, the experienced instructor encourages the student to be more self-reliant and to problem solve independently, which also fosters independence.

And to tie in that independence, it probably ties into what you were saying about at experienced instructors we tend to be a little more laid back. We don’t tend to feel as if we need to control or be right beside the students at all times. I think that then allows them, or necessitates that they become much more independent so that is what they gain, is that sense of independence.

Finally, the experienced instructor tends to trust students more. Participants reported that experienced instructors appear to be able to distance themselves from the student at appropriate times in their learning. They stated that the experienced instructor knows that in order for students to learn, they need to problem solve independently and do things for themselves. When the experienced instructor “pulls back” her/his support and presence, she/he is encouraging the student to trust her own judgment and knowledge. As a result of the instructor having a more relaxed and trusting nature, the student is afforded the ability to venture out solely and practice nursing care more on her/his own.

In contrast, participants described the novice instructor as more rigid in her/his approach to teaching and to assume primary control of the student’s learning. Participants concurred that these behaviours at times stifle students’ independence. For instance, a novice instructor who is
"rigid and controlling" tends not to encourage students to practice skills independently and tends not to trust students' decision making and problem solving. Experienced participants and administrators agreed that many novice instructors do not encourage students to be self-reliant or to venture too far from the instructor.

**More Holistic Knowledge Base**

Participants identified a third learning outcome as related to students' knowledge base. Participants agreed that the experienced instructor has a wide repertoire of skills and knowledge related to clinical teaching. They suggested that this "broader tool box" of knowledge and skills of the instructor translates to more diverse learning and a comprehensive knowledge base for the student.

... the advances that have been made and why they have been made so that when you are trying to explain to the students a certain way to do something, if you know the way it used to be done and why those changes were made, you can share those to give the student a broader understanding of, you know, sort of principles and rationales behind things.

Furthermore, they emphasized that the experienced instructor, who is consistently placed in a clinical area in her/his area of clinical expertise, can enhance student learning. They gave as an example instructors' comfort with the types of client populations and subsequent health challenges in the setting. Furthermore, experienced instructors have often established and nurtured positive relationships among agency staff and have learned to access diverse resources within the agency. This knowledge and increased access to a variety of resources encourages more appropriate learning opportunities for students and thus a comprehensive insight for students of many aspects of nursing.

Clinical things that I have noticed too as I increased my experience, I guess, is that I just know the system so much better that I know who are the appropriate resources in different areas and so you can sometimes make things happen or facilitate them happening, that I could never have done at the early time period because I didn’t know the people or the system in depth.
I think more so than certainly when I first taught that I needed to have that direct communication all the time with the student, that I am far more comfortable letting RN's on the ward look after a lot of those things.

Finally, experienced participants stated that the experienced instructor has come to recognize the importance of process oriented learning as opposed to content oriented learning. Over time, the instructor has learned to relinquish control of some traditional learning experiences, such as post-conferences, and to encourage students to participate in the learning process. Participants proposed that this transformation in the instructor then encourages the student to develop more critical thinking skills.

"... it is much more important to engage the students in the process of their own rather than have them academically look at is as okay, how do I nail all these things down that I need to know and I have done that, let's move on. Process is important, it what is happening to them."

They stated that this shift in thinking enables the student to be a more holistic and diverse critical thinker.

**Better Problem Solving Skills**

Participants identified a fourth learning outcome as more appropriate and advanced problem solving skills. Once again, they suggested that due to the experienced instructors' shifting responsibility for learning to students and encouraging a more process-oriented learning, the student is encouraged to work through issues regarding knowledge and care independently.

"Learning to hang back and let the students ask the critical questions or helping them formulate critical questions so they could make the next step." In addition, they stated that the experienced instructor is able to teach the skills of problem solving due her/his own abilities as an advanced problem solver; the student comes to understand the problem solving process after observing the experienced instructor problem solve situations that directly and indirectly impact students. For instance, the experienced instructor is often quicker to resolve conflicts with students and agency
staff. Students see how these conflicts have been resolved and can integrate this problem solving behaviour into their knowledge base.

**Increased Safety**

The fifth learning outcome associated with instructor experience is that of psychological and physical safety of and for the student. Participants concurred that the experienced instructor is more aware of the pitfalls and troubles for students when delivering client care, such as medication errors, as a result of recognition of patterns of student behaviours. The instructor, who is aware of the dangers, is more readily able to intercept troubles before they start:

I feel more comfortable now about my ability to keep students safe in the clinical areas than I certainly did as a novice and part of that is knowing the pitfalls but the other part of it is, being able to pickup on that pattern recognition where you know somebody isn’t really quite on top of something so I think that accountability and safety issues are easier now.

Participants also stated that the experienced instructor is more apt to “pick up on” student problems and to intervene in a timely manner due to their ability to recognize patterns of behaviour. They perceived that attending to the dangers that students face and being able to stop or at least minimize these allows the student increased safety. The implication is that students of the experienced instructor do not encounter many unsafe situations with regards to client care or acquisition of knowledge.

**Summary**

In this chapter, I have provided a discussion of the findings that emerged from the data. Data that emerged from focus group discussions about both experienced and novice attributes were compared and contrasted. I articulated the characteristic attributes of the experienced instructor. The data provided a comprehensive portrayal of experienced instructors as more confident and competent in their role as clinical teachers. However, although novices were generally portrayed as anxious, lacking confidence, and lacking knowledge, the data revealed that
their energy, recent clinical practice, and newness made significant contributions to students’ learning. The key attributes that emerged from the data that exemplified the experienced instructor were those of letting go, navigating the waters, advanced skills, belief in self, and fighting challenges. In the second section of the chapter, I reported the participants’ views of the student outcomes that resulted from instructor experience. These outcomes were increased confidence and decreased anxiety, increased independence, more holistic knowledge base, better problem solving skills, and increased safety. In the following chapter, I will address the implications of these findings and will provide suggestions for future research.
Chapter 5

Discussion of Findings

The intent of this final chapter is to provide a comprehensive discussion regarding the implications of the research findings that were revealed in chapter four. First, I will summarize the findings, as outlined in the previous chapter. Second, I will draw conclusions from these findings. Third, I will discuss the implications of the findings within the context of my original framework and connect it to current and relevant literature. Fourth, I will outline and discuss the implications of the findings within the context of nursing education and research. Limitations regarding the study will also be presented. Finally, I will provide recommendations for future inquiry as it relates to this research topic.

Summary of Findings

The purpose of this research study was to explore and uncover how the nature and duration of clinical teaching experience influences student learning outcomes in nursing education. The research methodology chosen to accomplish this goal was that of a qualitative ethnographic design, using Spradley's (1979) tradition of ethnography. Concepts related to and regarding novice and expert practice were derived from Benner's (1984) framework and from information in the nursing literature. This study has significance in nursing education due to the implications of instructor competence and knowledge, in particular with ensuring student safety and learning in the clinical area. This research is necessary due to the current dearth of research in nursing regarding novice and experienced teaching practice implications in clinical nursing education.

Participants for the study were obtained through purposive and convenience sampling techniques. Criteria for inclusion into the study were based on: (1) novice clinical instructors with less than three years of clinical teaching experience, (2) experienced clinical instructors with greater than ten years of experience, (3) administrators of nursing programs, (4) individuals who
were currently employed within an accredited nursing program, either in Saskatchewan or British Columbia and, (5) willing to participate in the study. Data for the study was obtained with the aid of focus groups and personal interviews. The participants were separated into three homogenous groups of novice instructors, experienced instructors, and administrators. The focus groups comprised of two groups of novice instructors and two groups of experienced instructors. Due to time and personal challenges, personal interviews were conducted with the administrator group. All of the separate groups consisted of four participants per each group. The participants were primarily female and the level of education ranged from a bachelor of arts (psychology) or nursing to a doctoral degree in nursing. Data from the groups and interviews was transcribed verbatim and analyzed using an analytic induction method (Spradley, 1979).

The findings from the study revealed two themes. The first theme that arose describes the attributes of the experienced clinical nursing instructor. Within this theme, several sub- categories were uncovered that further describe the attributes of the experienced instructor. These sub-categories include such behaviours and actions as: letting go, navigating the waters, expanding core skills, believing in self, and managing challenges. The sub- category of letting go identified how the experienced instructor is able to let go of issues and actions related to the student and self, such as control, responsibility, expectations, and guilt. The sub- category of navigating the waters outlined the comprehensive knowledge base of the experienced instructor, such as: knowing the system, students and resources. The third sub- category described the core skills that the experienced instructor has expanded on, such as communication, intuition, and problem solving. The fourth sub- category discussed how the experienced instructor has become more confident in her/his abilities and therefore, has come to establish a belief in the self. Finally, the fifth sub- category identified the challenges that the experienced instructor faces as a result of
teaching students intensely over many years. These challenges were identified as: declining enthusiasm, adapting to change, and remembering the novice role.

The second theme uncovered was pertaining to the outcomes of student learning associated with clinical instructor experience. It appeared that experience in clinical instruction does account for some advanced learning and more consistent successes for students. The positive outcomes that were identified were: increased confidence and decreased anxiety, greater independence, more holistic knowledge base, better problem solving skills, and increased safety. As a result of the instructor being more relaxed and letting go of control and responsibility, the student becomes more relaxed which decreases anxiety and increases her/his confidence. Furthermore, when the instructor lets go of control and responsibility the student is encouraged to become more independent. Students acquire a more holistic knowledge base because the experienced instructor has a broader knowledge base and increased access to resources, which enhances the learning experience. Students are able to integrate better problem solving skills due to the experienced instructor’s knowledge and comprehension of process oriented learning. Finally, students tend to be safer when working with experienced instructor due to the instructor’s ability to recognize patterns and to intervene in a timely manner when problems arise.

The findings revealed that there are differences between experienced and novice clinical instructors. The data suggests that the experienced instructor is more confident and competent in her/his role, which translates to specific, consistent, and positive successes and outcomes for the students. However, although novices were generally portrayed as anxious, lacking confidence and lacking teaching knowledge, the data also suggested that these instructors contribute positively to student education due to their enthusiasm, energy, and recent clinical experience and knowledge. Although the experienced instructor is better equipped with more knowledge, skills and personal qualities, both instructors have attributes that do contribute to the education of nursing students.
Discussion of Findings

The data from this study has revealed some significant findings that are both expected and unexpected. These findings will be compared and contrasted with Benner’s (1984) framework (chapter one and two) and the relevant literature review (chapter two).

Comparison to Benner’s Framework

There were more similarities than differences between Benner’s (1984) theory of novice to expert in clinical nursing practice and the findings in this research. First, Benner asserts that a nurse who moves to a new area of practice is again considered a novice. The findings from this study support this assertion. Both the novices and experienced clinical instructors in the study stated that they do consider themselves or had considered themselves as novices when they started clinical instruction. Furthermore, the qualities of the novice clinical instructor in this study correlate to many qualities of the novice nurse in clinical practice.

For instance, Benner (1984) had identified that the novice nurse practitioner is rule governed and tends to have greater difficulty mobilizing resources. These qualities were also apparent in discussions regarding novice practice in this study. Upon reflection, experienced clinical instructors discussed how their thinking and practice had changed from novice instructors. These instructors reflected that they had come to rely on their own way of doing things, thus no longer relying on a recipe for teaching. Furthermore, experienced practitioners felt they had access to multiple resources, which they did not have as novices. Not only were experienced instructors more aware of resources, but also more able to access appropriate resources in order to enhance student learning.

Second, Benner (1984) also describes the novice practitioner as being inflexible. However, the novice participants in this study described themselves as both flexible and risk takers, which is in contrast to Benner’s description of the novice. The novice instructors in this study discussed
how they implemented various teaching methods to determine what was appropriate for student learning and were not afraid to try something new to assist with learning. They also found themselves teaching in areas other than their area of expertise, which contributed to their flexibility. However, experienced instructors in this study felt that novices were rigid in their approach to student learning and with ensuring that expectations were met. What this discrepancy may suggest is that novice clinical instructors are flexible with nursing generally but not with teaching specifically. Furthermore, the discrepancy with Benner’s theory may be explained in part by the maturity of the clinical instructor, her/his ability to adapt to changing situations as a result of years of clinical practice, and her/his motivation to prove her/himself to peers and students.

Third, Benner (1984) describes the expert practitioner as being intuitive and having advanced problem-solving capabilities. The findings from this study suggested that experienced clinical instructors do have advanced problem-solving abilities and are more intuitive about students, which substantiates Benner’s work. The findings in this study also demonstrated that the experienced clinical instructor was significantly more advanced and capable in these areas than the novice clinical instructor.

Benner’s (1984) work does not identify if patient outcomes are affected as a result of novice versus expert practice. The findings in this study suggest that student learning outcomes are indeed affected as a result of experienced versus novice clinical instruction. Experienced clinical instructors in this study discussed advanced attributes that positively affected student learning outcomes and hence ensured consistent and successful experiences for students. Although novice clinical instructors do promote student learning, they are not as consistent facilitating student learning outcomes as their more experienced peers. The degree of difference between the two groups of instructors however remains unclear.
Comparison to the Literature

This study has addressed some of the assumptions and ideas explored within the nursing literature. Again, there are similarities and differences between the present study and the literature. The areas that will be addressed within this discussion are: clinical instructor effectiveness, advanced skills, education versus practice, novice practice, confidence, student learning outcomes, and administrator perspectives.

Clinical instructor effectiveness.

The attributes of the experienced clinical instructor that were explicated in this study correlate to the attributes and behaviours of the effective clinical instructor as identified by some nurse authors. For instance, specific behaviours of the effective clinical nursing teacher, as described by Krichbaum (1994), have similarities to the attributes of participants found within the present study. The data in the present study suggested that the experienced instructor has strong interpersonal skills and is confident in her/his abilities as an instructor, which are identical to two of the qualities found within Krichbaum's study. However, it is interesting to note that the novice clinical instructor also has similar attributes with Krichbaum's study findings, such as being aware of one's own strengths and weaknesses, and having a willingness to share her/his knowledge. What this comparison demonstrates is that although novice and experienced instructors have different attributes, there are qualities about each group that can promote effective clinical instruction.

Past studies regarding effective clinical instructors focused almost exclusively on the positive attributes of the instructor and ignored the challenges that more experienced instructors face. Several studies have addressed the qualities of ineffective instructors, such as a lack of support for students and poor role modelling behaviour (Nehring, 1990) and instructional rigidity (Wong, 1978). The results of these past studies have implications for the present study. Although
some caution may be warranted due to the time passed since Wong’s (1978) study, the essential components of nursing instruction have not fundamentally changed; it is still likely that Wong’s findings are relevant today. These ineffective qualities appear qualitatively different to the challenges that experienced instructors encountered in this study. Experienced instructor limitations, such as declining enthusiasm, are not necessarily associated with the ineffective instruction, according to the results found in these other studies.

Second, these past studies do not indicate if ineffective teachers are novice or experienced. Third, these past studies do not describe the specific nature of the impact ineffectiveness has on student learning. The findings in the present study suggest that novice clinical instructors are rigid in their approach to teaching students, which represents one aspect with Wong’s (1978) description of an ineffective instructor. The present study does suggest that a rigid approach to teaching produces more anxiety and less independence in the student, which fosters poor learning outcomes. However, at this point, novice instruction cannot be associated with ineffective teaching.

Advanced skills.

This study has proposed differences between novice and experienced clinical instructor’s knowledge and practice. For instance, this study has suggested that the experienced clinical nursing instructor is more appropriately prepared to enhance student learning and to provide more positive learning outcomes for students. This preparation is multifaceted, including knowledge, resources, competence, problem solving, and intuition. The results from this study validate Wong and Wong’s (1987) assertion that experienced instructors are better able to recognize behaviours that affect student learning. For example, experienced instructors in this study were able to recognize anxiety behaviours in students and consequently work with students to decrease this
anxiety. Due to this advanced pattern and behaviour recognition, the student is afforded a greater opportunity for a more successful learning experience.

The literature regarding novice and experienced clinical teachers discusses differences in the knowledge base of teachers in general. Fogarty et al. (1983) found that experienced teachers had a larger repertoire of instructional activities and were able to use prior knowledge to problem solve. A difference in the knowledge base of the two groups of participants in this study was also identified. The experienced group was found to be more knowledgeable about aspects of clinical teaching, such as knowing the system and student, as a result of years of teaching experience. However, it was also found that novice instructors are more knowledgeable about current nursing practice. This finding may be unique to nursing instruction in the clinical area, where current practice techniques evolve rapidly.

**Education versus practice.**

The nursing literature debates the theoretical and practical knowledge level required of the clinical instructor. For instance, an assumption is that a nurse who is an experienced clinician will be more apt to become a competent and effective instructor. Fothergill- Bourbonnais and Higuchi (1995) indicated that an instructor with a strong clinical background will optimize learning. The novice participants in this study all had greater than seven years of clinical practice experience yet all discussed how they were not sufficiently prepared to teach clinically. What this suggests is that it takes more than clinical competence to ensure optimal clinical instruction and student learning in the clinical area.

Additionally, the nursing literature suggests that the novice nursing instructor should be both educationally and clinically prepared to teach in the clinical setting (Wong & Wong, 1987). The findings from the present study are not entirely consistent with this suggestion. The majority of the participants in the study disagreed that a master’s degree in nursing or a related field, was
necessary to teach students in the clinical setting and felt that nursing practice experience was sufficient. At the same time, some of the novice participants discussed their feelings of inadequacy and underpreparedness for the teaching role. These feelings may have been reduced with advanced education in instructional techniques. Interestingly, it was those participants with advanced education, in particular, who advocated for the clinical instructor to have further education.

Wolff's (1999) study suggested that underprepared instructors inhibit student learning. In the present study the novice instructors did not suffer from a lack of preparation and in fact were over-preparing relative to their more experienced peers. These novice instructors demonstrated a high degree of commitment to their learning, to improving their practice, and to facilitating student learning. However, Wolff further suggested that those novice instructors with theoretical knowledge in teaching strategies were better able to develop a teaching style rather than deal with her/his own learning. What Wolff's findings may suggest for the present study is that a lack of theoretical education may be one form of under preparation and that the novice instructors in the present study compensated by over preparing in order to feel adequate when teaching students clinically.

Novice practice.

The attributes of the novice instructor were not explored within this study; however, several strengths and weaknesses of the novice were uncovered. The present study further concurs with previous studies regarding the qualities of the novice clinical instructor. The literature reveals that novice clinical instructors are unable to rely on intuition (Duke, 1996), experience boundary issues with students (Duke), and are inexperienced with evaluation of the student (Wolff, 1998). All of these findings were corroborated by both the novice and experienced participants in the present study. Diekelmann (1990) also suggested that novice clinical instructors
are inflexible which was partly negated in this study. Novice participants were flexible in their approach to nursing in general but rigid in their approach to teaching specifically.

Furthermore, some of the literature indicates that novice clinical instructors fail to adapt teaching strategies in response to student cues (Westerman, 1991). However, novice participants in this study discussed how they take risks with trying to resolve specific student needs and enlist assistance from experienced faculty. Scanlan’s (2001) study also found that novice clinical instructors were open to trying different strategies when working with students. Although novice instructors may be unable to adapt to the need immediately, it should be noted that they are aware of the need and the desire and motivation is there to help.

**Confidence.**

The issues of confidence and competence arose frequently in this study and the findings have strong similarities with the literature. Duke (1996) and Wolff (1998) both found that novice clinical instructors were lacking in confidence in their abilities to teach students. Werner, Bruggemeyer, and Kenner (1986) identified feelings of inadequacy and associated guilt in the novice instructor. The novice participants in the present study discussed their lack of confidence, feelings of inadequacy, and guilt, all associated with teaching students in the clinical area. The experienced instructors explained that their confidence increased as their knowledge base evolved and their ability to understand and evaluate students emerged.

Studies by Paterson (1994), Scanlan (2001) and Wolff (1998) suggested that the novice clinical instructor is more focused on personal learning needs and self-image rather than student needs. The present study supports the findings in those studies. Upon reflection, experienced participants discussed how they were focused on their own learning needs when starting instruction in the clinical area and most of the novice participants discussed the importance of personal image as it related to knowledge level and competence and how this image was
portrayed to students and peers. These feelings were related to a lack of confidence in their abilities as an instructor.

The present study further demonstrates that a lack of confidence in the instructor does affect student learning, in that students may be more anxious and less confident in their own nursing knowledge and abilities. Furthermore, the experienced instructors felt that their own increase in confidence led to an increase in confidence in students, which enhanced student learning.

**Student learning outcomes.**

The present study suggests that instructor experience does positively influence student learning in the clinical area. Experienced instructor participants and administrator participants felt that students were more likely to receive more consistent benefits, such as increased independence and a broader knowledge base, when being taught by an experienced instructor. Furthermore, Wood (1986) maintains that incidents will arise for students when the instructor is lacking in knowledge. Results of the present study suggest that students are safer when working with experienced instructors, due to the instructor's broad knowledge base and pattern recognition.

However, the participants in the present study also felt that the novice instructor also contributes positively to student learning, by being current with clinical experience and being enthusiastic. Participants did not feel that novice instructors actually detracted from student learning but rather did not entirely optimize learning. Students may benefit by both types of instructors, although their clinical experience may be more positive and less stressful when working with an experienced instructor.

**Administrator perspectives.**

Administrator perspectives and participation are essential to enhancing clinical teaching practice. However, the nursing literature regarding effective instructors implicitly indicates that
evaluations of instructors are completed on an individual or student basis. It appears that administrators are not often involved in the evaluation process of clinical instructors. Administrators in the present study were acutely aware of the issues facing both novice and experienced clinical instructors. These administrators also discussed strategies for assisting both groups to improve their teaching practices, such as a more formalized orientation process for novice instructors and supporting instructors who wish to pursue additional nursing practice or participate in educational opportunities.

Conclusions

The present study has addressed the research question and identified information that was lacking regarding novice and experienced practices of clinical nursing instructors and furthermore, how these practices affect student learning in the clinical area. Hence, the study’s findings lead to several conclusions regarding how the experience of the clinical nursing instructor affects learning outcomes for nursing students in the clinical area:

1. Novice and experienced clinical nursing instructors do approach teaching students in the clinical setting from a different perspective;

2. Experienced instructors tend to be more confident and knowledgeable with clinical teaching methods and understanding the student. Thus, experience with teaching/facilitating students in the clinical area does account for some more positive and consistent outcomes for students;

3. Experienced instructors have challenges, such as declining enthusiasm for teaching, that they should be cognizant of and manage in order to ensure continued positive experiences for the students and themselves;

4. Novice instructors tend to be more anxious and less confident about their abilities as a clinical nursing instructor, which may inhibit some aspects of student learning;
5. Although novice instructors tend to have flaws, their positive qualities, such as enthusiasm and current clinical knowledge, do account for some positive student learning;
6. Novice and experienced instructors can benefit from each other's unique knowledge base in order to enhance their teaching practice;
7. Administrator involvement is essential for supporting both groups of instructors to enhance their teaching practices.

Implications for Nursing Education

The present study contributes to the knowledge and practice of nursing education. Generally, this study provides meaningful insight regarding differences of novice and experienced clinical instruction in nursing. Specifically, clinical nursing instructors of various levels of experience and administrators can utilize these findings to enhance clinical instruction. For instance, Locasto and Kochanek (1989) noted that the neophyte instructor is enthusiastic and eager which was supported by the findings in the present study. Hence, novice instructors can realize they are not entirely ineffective in teaching students and do have qualities, such as enthusiasm, that are beneficial for student learning. These behaviours are strengths and should be recognized by the novice and supported and encouraged by peers and administrators.

The participants in this study discussed that challenges for the experienced instructor are remembering the novice role and maintaining currency. Consequently, experienced instructors would benefit from recognizing that working with the novice instructors would be of benefit to their knowledge and enthusiasm, while also benefiting the novices.

Finally, administrators of nursing programs can implement ways to support the challenges facing both novice and experienced instructors as well as encourage their unique differences. Nursing programs cannot function without a mix of novice and experienced clinical instructors. The challenge is how nursing administrators can build upon the strengths of the novice instructor
and support the novice in her/his learning a new role. The novice instructor is enthusiastic and motivated to increase her/his knowledge base. Administrators should not only encourage but also ensure working relationships between novice and experienced instructors. This relationship would be viewed as having mutual benefit. The novice would benefit from the knowledge and expertise of the experienced instructor. The experienced instructor would benefit from the enthusiasm and current clinical knowledge base of the novice. Wong and Wong (1987) discuss the benefits of pairing novice and veteran faculty but discuss only how this relationship benefits the novice. I propose that the pairing of novice and experienced clinical instructors would be a benefit to both members and seen as a partnership in advancing knowledge and best clinical teaching practices.

According to administrators in this study, the orientation for novice clinical instructors is typically inadequate. Novices in this study discussed their frustration with an inadequate orientation and minimal support for their new role, specifically trouble with determining clinical assignments and evaluations. The novice participants also felt that they were not always cognizant of what questions to ask until they had encountered a specific problem. Diekelmann (1990) maintains that the novice instructor requires guidance in order to ensure successful entry into the practice of teaching. It should be integral in nursing education that a more formalized process would be implemented to assist with novice learning. Furthermore, the novice would also benefit with regular, formalized meetings throughout the clinical year to ensure those questions/needs that arise through experience are addressed.

However, Fitzpatrick and Heller (1980) contend that it is unreasonable to expect the employer to provide orientation regarding basic competencies of the job. If this is the case, this statement supports the requirement that clinical instructors be educationally prepared to teach in the clinical setting. However, it can be argued that clinical teaching is a complex skill and process that requires on the job education and time to work through associated issues and challenges. It is
essential that administrators of nursing programs revisit the educational requirements for instructors, taking into consideration a wholistic perspective, such as clinical experience and ability to provide support for the neophyte.

Issues regarding experienced clinical instruction should be recognized and addressed by both instructors and administrators. The experienced clinical instructor has several challenges to overcome, such as declining enthusiasm. Administrators can assist with these challenges by ensuring that experienced clinical instructors have access to both the latest technology and educational opportunities to help them remain current and enthusiastic.

Finally, it has been suggested that consistency with clinical placements for instructors will lead to higher learning quality for students (Esper, 1995; Wolff, 1998). The novice participants in this study expressed their frustration with having to move clinical areas frequently. Administrators need to consider the instructor's area of clinical expertise and to ensure consistency with clinical placements when formulating the teaching assignment in order to ensure success not only for the instructor but also for the student.

Recommendations for Future Inquiry

The present research study is essential because it has clarified information regarding the differences in novice and experienced clinical instruction. Furthermore, this research is unprecedented, as it has suggested how instructor experience affects student learning in the clinical area.

Although this study has provided some insights regarding novice and expert practice in clinical instruction, it has opened up many new questions. Further research regarding this topic is required, specifically with student input. Students at various levels of nursing programs have learning needs based on their knowledge and skill level. Nursing students at different levels of learning may require different types of instructors. A cross section of student input is required to
gain further insight into novice and experienced clinical teaching practice, what students perceive as factors affecting their learning, and what type of instructor is more appropriate for what level of student.

Other questions come to mind. For example, even experienced instructors can feel like novices at certain times, such as when they change clinical areas or are learning new technology. What is the nature of this novice experience and what is the time frame for moving from novice frame of reference back to a place of comfort and experience?

Further research is required to examine the clinical and educational preparation of nursing instructors. The nursing literature advocates that the clinical instructor is prepared with a minimum of a master's degree in nursing or a related field. However, many participants in this study disagreed that a graduate degree was necessary to teach in the clinical setting. Many participants felt that clinical expertise was sufficient. However, it stands to reason that advanced education would be useful in supplying the novice with the necessary tools for teaching in the clinical area. Certainly, a study investigating groups of instructors grouped according to both education and clinical experience would be beneficial and assist in clarifying the question of appropriate educational preparation.

Another area for investigation relates to the attributes of the experienced instructor. The experienced instructors' ability to let go of control over issues pertaining to the student raises some questions. For instance, can the experienced instructor let go of too much control of the student and become too flexible? What effect does too much flexibility have on student learning in the clinical area?

Additionally, the nursing literature discusses the importance of confidence of the instructor. The present study suggests that increased confidence in the instructor promotes an increased confidence in the student and enhances positive learning. However, it is necessary to
question whether an experienced instructor can be over confident in her/his abilities and therefore lose sight of the student’s needs. What effect would over confidence have on student learning?

Limitations

There are several limitations associated with this study. First, instructor participants in the study were peers of the researcher. Although these participants appeared candid with their observations and remarks, I must question whether they were as forthcoming with responses as they could have been if complete anonymity was assured. Second, the ability to ensure reliability was compromised due to the researcher moving geographical areas and the challenge of verifying findings with distance participants. However, at the same time, the researcher’s move broadens the findings as the participants from different geographical areas provided similar responses. Third, due to the nature of the question and the methods for collecting data, these results cannot be generalized to a general population of nursing instructors. Fourth, student participation in the study would have added another dimension to the findings and unique perspectives into the problem.

Conclusion

This study investigated how experience with clinical instruction affected student learning outcomes in the clinical setting. The study participants discussed aspects related to their experiences with clinical instruction and what they perceived affected student learning in the clinical area. Some significant findings were revealed about the research question. Primarily, participants feel that there is a difference in teaching related to the degree of teaching experience and that experienced instructors do account for more positive successes for students.

This study has made a new contribution to nursing education. The findings in this study add to the literature regarding clinical nursing education and differences between novice and experienced practice. This research has been useful in explicating differences and providing
insights into how administrators can support both novice and experienced clinical instructors in their practice. Furthermore, this research has discussed how novice and experienced instructors can benefit from the unique knowledge of each other. A collaborative and respectful relationship between instructors can only enhance student learning, which should be the ultimate goal of nursing education.
References


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Appendices
Dear Clinical Instructor:

I am a registered nurse and am currently enrolled in the Master’s of Science in Nursing program at the University of British Columbia. In order to fulfill my thesis requirements, I have elected to conduct research regarding the clinical instructor culture. Specifically, my research is looking at how the nature and duration of teaching experience influences student learning outcomes in clinical nursing education. My experiences as a clinical instructor guided my initial interest in teaching research. As well, I discovered a lack of research regarding this topic, which further piqued my interest.

I am specifically interested in speaking with clinical instructors who are currently teaching in the clinical area and are either novice or experienced in clinical teaching. A novice clinical instructor would have less than three years clinical teaching experience and an experienced instructor would have greater than ten years clinical teaching experience. I plan to collect data via focus group interviews. These focus groups would be made up of approximately six participants per group. Your participation, should you decide to take part in my research, would be to attend two focus group meetings. The first meeting would be approximately 90 minutes long and the second would be 60 minutes long. During the meetings, I will ask you some questions in relation to clinical teaching experiences and invite you to share candid responses. The groups will occur at a convenient time and place for you. The meetings will be tape recorded and transcribed. The people who will have access to these tapes and transcripts will be my committee chairperson and myself. The tapes and transcripts will be stored in a safe place and will be destroyed in seven years following conclusion of the study. The transcribed material will have all names and identifying data removed from them. At the conclusion of the study, I will share written findings with you to ensure accuracy and satisfaction.

This study presents no known risks to the participants and will be supervised closely by my committee chairperson at all times. My chairperson’s name is Dr. Barbara Paterson and she can be reached at (xxx) xxx-xxxx. If you are interested in participating in this study and contributing knowledge regarding how experience affects student learning outcomes, please do not hesitate to call me at (xxx) xxx- xxxx/ (xxx) xxx- xxxx or email me at: thannesson@xxxxxxxxx. I will be delighted to answer any questions that you may have regarding the study. During the first focus group session, I will present to you a written consent for you to sign prior to the onset of data gathering. Thank you for your interest in this study. I look forward to hearing from you.

Sincerely,

Teresa Hannesson
Appendix B: Interview Questions
Interview Questions

1. Tell us your name, where and what type of setting you practice clinical instructing, and what you enjoy doing when you are not working (Opening).

2. What do you see as being the essential requirements that an instructor must possess to teach in the clinical setting (Introductory)?

3. We will now discuss questions that relate to the experiences of clinical instructors, paying close attention to novice and experience instructors. Tell me how you see these two categories of instructors as being similar or different (Transition).

4. What do you see as the challenges that face novice clinical instructors today (Key)?

5. What do you see as the challenges that face expert clinical instructors today (Key)?

6. Tell me how experience with teaching students has affected your attitude towards your personal knowledge (Key)?

7. Tell me about strategies that you tried but have discounted or modified in order to enhance student learning (Key).

8. Based on past experiences, knowledge or intuition, tell me what you see as essential practices that promote expert teaching practice (Key).

9. Is there anything you would like to add? Have I missed anything (Ending)?
Appendix C: Participant Consent
How the nature and duration of the teaching experience of a clinical instructor affects the learning outcomes of nursing students enrolled in a nursing education program

**Principal Investigator:** Barbara Paterson (faculty advisor), School of Nursing, UBC, (xxx) xxx-xxxx

**Co-Investigator:** Teresa E. Hannesson, School of Nursing, UBC, (xxx) xxx-xxxx/ (xxx) xxx-xxxx. This research is the work of a thesis project to fulfill the requirements of a Master’s of Science in Nursing.

**Purpose:**

The purpose of this study is to explore and uncover how the nature and the duration of teaching experience influences student learning outcomes in clinical nursing education.

**Study Procedures:**

If I decide to participate in this study, I will be asked to take part in two focus group interview sessions. The first of the focus group sessions will last approximately 90 minutes and the second will last approximately 60 minutes. The focus group sessions will take place either at University of Saskatchewan (U of S) or Saskatchewan Institute of Applied Sciences and Technology (SIAST), Kelsey campus or Douglas College in New Westminster. The total time requested of me will be approximately three hours. The interviews will be audio tape recorded by the investigator and who will transcribe the interview data into written notes.

**Confidentiality:**

Any information from this research study will be kept strictly confidential. All documents will be identified only by code number and kept in a locked filling cabinet. Participants will not be identified by name in any reports of the completed study.

**Remuneration/Compensation:**

There will be no monetary compensation for this study as this is a graduate thesis and is meant to fulfill the requirements of a graduate degree.
Contact:

If I have any questions or desire further information with respect to this study, I may contact either the student investigator at (xxx) xxx- xxxx/ (xxx) xxx- xxxx or faculty supervisor Barbara Paterson at (xxx) xxx- xxxx.

If I have any concerns about my treatment or rights as a research subject, I may contact the Director of Research Services at the University of British Columbia, Dr. Richard Spratley at (xxx) xxx- xxxx.

Consent:

I understand that my participation in this study is entirely voluntary and that I may refuse to participate or withdraw from the study at any time without jeopardy to my employment or status.

I have received a copy of this consent form for my own records.

I consent to participate in this study.

_________________________________________
Subject Signature Date

_________________________________________
Signature of Witness Date