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Expertise in clinical nursing educators: An exploratory study

Nancy Ann Kramer
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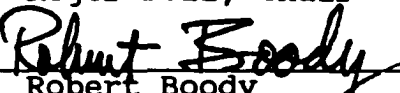
EXPERTISE IN CLINICAL
NURSING EDUCATORS:
AN EXPLORATORY STUDY

A Dissertation
Submitted in Partial Fulfillment
of the Requirements for the Degree
of Doctor of Education


Approved:



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July 1996

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DEDICATION

I wish to dedicate this work to my mother and father, who passed away unexpectedly on November 18, 1995, before I could share the completion of this project with him. Without their years of encouragement and support I could not have attained my goals. They never hesitated to let me know how much they loved me and were proud of my accomplishments.

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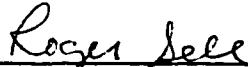
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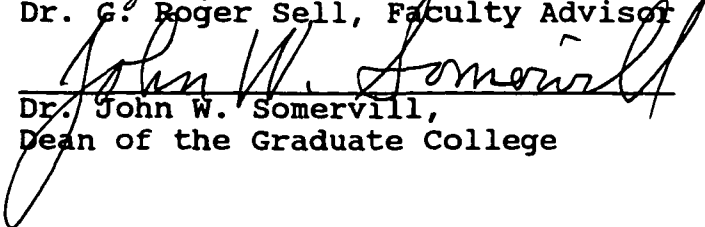
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Approved:



Dr. G. Roger Sell, Faculty Advisor



Dr. John W. Somerville,
Dean of the Graduate College

Nancy Ann Kramer
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July 1996

ABSTRACT

A primary goal of professional education is to prepare practitioners who can provide quality care essential to the well-being of individuals and society. An essential component of professional education is a practiced-based experience. The purpose of this study was to identify and describe the qualities of clinical nursing educators who were recognized by peers as being expert clinical practitioners. This study was exploratory and non-experimental. A qualitative approach was used. Through observations and interviews, beginning descriptions and explication of dimensions of expertise of clinical nursing educators were achieved.

The population for this study was selected from nursing faculty of 10 private baccalaureate nursing programs in one Midwestern state. Only full-time faculty involved in clinical nursing education as part of their faculty role were chosen. A sample of six teachers was chosen from three of the nursing programs that responded to the survey. All of the participants had a minimum of five years teaching experience.

Data were gathered through semi-structured interviews and observations. The participants were observed in a variety of settings including community agencies, client homes, hospitals, and laboratories. The settings reflected a diversity of acuteness, and urgency.

The constant comparative method was used in analysis and interpretation of the data. Whereas many unique factors influenced the personal attitudes and histories of the participants, four commonalities emerged. From a thematic analysis of these data four major attributes were identified as representative of expert clinical nursing education: commitment, integration, intuition, and reflection.

All of the participants sustained their commitment to teaching by on-going, personal and professional growth, facilitated by change and challenge. Knowledge components were integrated in relation to the resources and demands of the settings observed and maintained by knowledge development and experience. The expert practice of these clinical educators was characterized by intuitive links between ability to read situations and ways of responding. Reflective thinking nourished their sense of mission and belief in the educational process.

This study provided rich descriptions of the beliefs and practices of six experts in clinical nursing education. These descriptions can provide a structure for viewing clinical nursing education through participant reflection and performance in practice. The study demonstrated that commonalities can be identified among clinical nursing educators across diverse specialized settings.

CHAPTER I

STATEMENT OF PURPOSE

A primary goal of professional education is to prepare practitioners who can provide quality service and care essential to the well-being of individuals and society. One distinctive feature of professional education, whether in the health professions, education, or other fields, is a practice-based experience for the development and/or demonstration of competencies in a field setting.

It is generally accepted in nursing, medicine, and education that experiential learning is an essential part of professional development (Infante, 1975; Irby, 1983; Rugg & Norris, 1975). In contrast to conventional classroom instruction aimed at the mastery of content knowledge, practice-based or clinical experiences provide professional candidates with the opportunity, under supervision, to apply content knowledge and perform tasks in situations with those being served, that is, clients, patients, or students. While supervised practice in one or more clinical settings can be provided throughout a professional education program, it most frequently occurs during the final stages of professional preparation and serves as a kind of "capstone" experience. Supervised practice in a clinical setting, therefore, is a critical

aspect of professional education aimed at the preparation of competent practitioners.

In light of the current era of accountability and financial constraint, education is vulnerable to budget cuts. Costs of clinical experience are a major part of the overall cost of professional education, in particular, nursing. The Pew Health Professions Commission (1993) stated their belief that any effort to reform health care must address the education of health care professionals. The skills, attitudes, and values of health care professionals have an impact on health care. The kind of care these individuals provide, how they provide it, what they value, how they interact with others, how they define quality, and how efficiently they work determines to a great extent the availability, quality, and cost of health care.

If the quality of the clinical experience of professional candidates is influenced by the expertise of supervising clinical teachers, one would want to be able to answer this question: Which knowledge, skills, attitudes, and beliefs are represented in expert clinical teachers? However, the clinical experience component in professional education has not been systematically and fully explored with regard to the expertise required of clinical teachers. This study was undertaken to address this concern within the field of nursing education.

Need for the Study

The nursing profession has been studied primarily from the sociological perspective, focusing on role relationships, socialization, and acculturation. There has been little focus on the knowledge, skills, attitudes, and beliefs of practice or experiences related to nursing expertise. Qualitative case studies have attempted to define the expert nurse in clinical practice (Benner, 1984; Benner, Tanner, & Chesla, 1996). Few have addressed the expertise of clinical nursing educators (Bevis & Watson, 1989).

Another major concern is the lack of educational preparation of nursing educators before being placed in the clinical teaching setting. Most lack formal instruction in teaching and new faculty members often receive minimal guidance as compared to student teachers with a major in education. Without formal training in teaching, nursing educators often determine how to teach (or not teach) based on examples of teachers in their own nursing education experience (Fitzpatrick, 1991; Meleca, Schimpfhauser, Witteman, & Sachs, 1981, 1983; Princeton, 1992).

To ensure that nursing students and graduates are prepared to provide safe, effective client care, it is important to understand what constitutes expert clinical teaching. An explication of the knowledge, skills,

attitudes, and beliefs associated with expertise in clinical teaching in nursing could (a) enable faculty and administrators to enhance the quality of clinical nursing education, (b) contribute to the clinical competence of nursing graduates, (c) elevate the recognition of nursing as a profession, and (d) aid the development and extension of nursing theory.

Rich descriptive characteristics of clinical educators also could provide a vehicle for faculty development and improvement through faculty evaluation. Identification of these characteristics could assist in faculty recruitment and selection activities, assigning educators to clinical teaching specialties, and assigning new faculty to mentor with "expert" clinical role models.

Statement of the Problem

Clinical learning confronts educators with challenges absent from the conventional classroom setting. These include but are not limited to: little control of environmental conditions; need for the student to combine cognitive, psychomotor, and affective skills to respond to client needs; client safety; and the need for the faculty to monitor not only student needs but client needs (Windsor, 1987).

Supervision and direction of individualized learning often have been neglected by investigators of student evaluation of teaching despite their suggested importance

(Irby, 1978a, 1986b; Meleca et al., 1981, 1983; Rugg & Norris, 1975). In a review of the research on client-related supervision, Dagget, Cassie, and Collins (1979) conclude that most studies focus on the authors' ideas or beliefs about what constitutes effective instruction. Little empirical research has been offered to support such beliefs. Moreover, few studies have attempted to describe faculty roles or purposes in the clinical teaching setting.

Teaching in the clinical setting is an essential component of nursing education. In contrast to teaching in traditional elementary, secondary, or postsecondary settings, little attention has been directed toward describing expert clinical teachers (Irby, 1978b; Menges, 1979). Numerous quantitative studies have investigated characteristics of effective clinical teaching in nursing through the perceptions of faculty and students (Bergman & Gaitskill, 1990; Brown, 1981; Mogan & Knox, 1987; Nehring, 1990). A major difficulty is that the characteristics identified in these studies tend to be so broad as to be of limited use in attempting to improve clinical teaching in nursing education (De Tornyay, 1982; Pugh, 1986; Zimmerman & Waltman, 1986).

The literature has emphasized the uniqueness, importance, and challenges of clinical nursing instruction. Unfortunately, a missing foundation is a

rich and meaningful description of the characteristics identified as critical qualities of an expert clinical nursing educator (Streubert & Jenks, 1992). This missing foundation is the focus for the problem under study.

Purpose of the Study

The purpose of this study is to identify and describe the qualities of clinical nursing educators who are identified by peers as being expert clinical practitioners.

Research Questions

1. Which knowledge, skills, and attitudes of clinical nursing educators are reported by or observed for faculty identified as expert clinical practitioners?
2. Which, if any, similar knowledge, skills, and attitudes do expert clinical educators share?
3. Which beliefs, backgrounds, and educational experiences describe clinical nursing educators who are perceived and identified as expert clinical practitioners?

Limitations

1. The study was limited to full-time nursing educators who teach in the clinical setting as a component of their faculty assignment. Therefore, the subjects did not include adjunct or part-time faculty, or faculty whose only responsibility is clinical teaching.

2. The study was limited to clinical nursing educators from private baccalaureate nursing programs. It did not include public baccalaureate nursing programs, RN (registered nurse) completion baccalaureate programs, or the home institution of the investigator.

3. The study was limited to baccalaureate nursing programs in one Midwestern state, Iowa.

4. Participation was voluntary.

5. Results were not generalized. As the title suggests, the study was designed to be exploratory.

Definition of Terms

Baccalaureate faculty member--a registered nurse, who has a minimum of a master's degree in nursing, teaching in a four-year baccalaureate nursing program.

Clinical--based on actual observation and treatment of disease or conditions of life instead of an artificial situation (Infante, 1975).

Clinical instructor/faculty member--a teacher of nursing students in the practice setting.

Clinical setting--an institution, home, or community agency where a nursing student comes in contact with a client or group of clients for the purpose of acquiring intellectual and psychomotor skills (Infante, 1975).

Full-time nursing faculty member--a nursing educator whose FTE (full-time equivalent) is greater than 75 percent or 30 hours per week.

Laboratory--any place, situation, or set of conditions that is conducive to experimentation, investigation, and observation (Infante, 1975). This may include but not be limited to a hospital, a client's home, a community health agency, or a laboratory setting.

CHAPTER II

REVIEW OF LITERATURE

Chapter two provides a literature review of substantive and methodological issues regarding effective and expert clinical teaching, especially relevant for nursing education. The chapter will conclude with a review of issues surrounding the methodology of the study.

Clinical Teaching

Clinical experience in medical, nursing, and education programs for professional practice provides the means for students to develop knowledge, cognitive and technological skills, and a value system for care of clients. Through their clinical experiences, students learn methods of assessing for clients' needs, problem solving skills, and ways to become socialized within the profession. Regardless of the setting for clinical practice the teacher plays a decisive role in developing meaningful experiences for students to achieve these outcomes (Oermann, 1996).

The majority of research on clinical teaching has focused on characteristics and qualities of the teacher. In a review of research on clinical teaching in nursing from 1965 to 1995, Oermann identified 134 studies, 94 of which were reviewed based on the criteria of representing empirical studies. Her research was divided into four

major classifications of empirical studies: (a) teacher behaviors in the clinical setting ($n = 27$); (b) clinical teaching methods including patient assignment, written assignments, clinical conference, observation, media used, and preceptorships ($n = 46$); (c) student perceptions of clinical ($n = 10$); and (d) the clinical experience in general ($n = 11$). Oermann found that study designs were predominantly descriptive, involving surveys of students, and quasi-experimental. Few studies used qualitative methods. In general, investigators surveyed students in one setting only. Questionnaires, rating scales, written tests, case studies, tape recordings, and observational techniques were used for data collection.

What Constitutes Clinical Teaching?

Teaching that occurs in the clinical setting is an essential component of medical education for all health professions. Clinical teaching has been described as "that which occurs in an individual or small group setting, generally at the bedside but also in ward rounds and in small seminars" (Stritter, Hain, & Grimes 1975, p. 879). The supervisory function of the clinical nursing instructor has been defined as a process by which an expert practitioner guides and directs the performance of a student (Pohl, 1968).

In nursing, clinical teaching has not been systematically addressed or adequately described

(Windsor, 1987). In a descriptive study, Windsor interviewed nine students enrolled in their final semester of nursing. In an attempt to describe what comprised clinical teaching, students were asked to identify concepts important to their clinical learning. Concepts identified by the students included: skill development; time management; professional socialization; preparation; supervision; variety of assignments; personal problems; interpersonal relations; patient care; and need for approval.

Windsor maintained that the value of the study was in its implications for nursing education and claimed that few nurses who teach are prepared for this activity. She claims that: "A better understanding of what constitutes quality clinical education would be valuable in providing better educational experiences" (p 154). Windsor concluded that the question of what constitutes clinical education needs to continue to be investigated.

Effective Clinical Teaching

In contrast to teaching in elementary, secondary, or postsecondary settings, little attention has been directed toward characteristics of effective clinical teachers (Irby, 1978a; Menges, 1979). According to Stritter et al. (1975), studies previously reported described some type of "expert" observation of clinical instructors or perceptions of what has worked well for

individual clinical instructors. Other studies have asked students their perceptions of what effective clinical teaching is. For example, Stritter et al. (1975) surveyed 319 third-year and fourth-year medical students and found that the most significant factor identified by students was their desire to be active participants in the learning process. A major difficulty is that the characteristics identified in studies such as these tend to be so general as to be of limited use in attempting to further understand and improve clinical teaching.

Characteristics of effective clinical teaching also can be found in research that compares classroom and clinical instruction. Researchers have used a variety of scales to measure effective teaching in these comparative studies. According to Irby (1978b), the scales for classroom teaching, which are common to clinical teaching, tend to reflect instructor presentation, enthusiasm, knowledge, and relations with students. Irby suggested that factors unique to clinical instruction involve clinical supervision, clinical competence, and modeling of professional standards and values.

Irby, Ramsey, Gillmore, and Schaad (1991) used observations of attending physicians and interviews of medical students and residents to investigate the characteristics of effective clinical teachers in

ambulatory care medicine. Results indicated the most important characteristics of the ambulatory care teachers were that they actively involved the learners, promoted learner autonomy, demonstrated patient care skills, and role modeled clinical competence.

In a qualitative study using interviews, Crandall (1993) explored the use of "Schön's Model of Reflective Practice" in medical education to answer the question: "How do good teachers transmit to learners the knowing-in-action that is imbedded in experience" (p. 85)? Several themes were identified that revealed common characteristics of excellent clinical teachers: confident in their clinical competence and comfortable with their roles as mentor and teacher; supportive of learners and problem solving; used questioning as a major method for assessing learner understanding; open to opinions and diversity, criticism and feedback; and willing to offer praise.

In a study done by Windsor (1987), 19 senior nursing students in a large midwest public university were interviewed regarding clinical instructor characteristics which improved their learning experiences. Data were collected by interviewing the students twice. The students expressed the need for: (a) competent and experienced clinical instructors who are willing to share their knowledge; (b) positive and negative feedback, done

in private at frequent intervals; (c) instructors with high expectations, who assigned students difficult tasks and forced students to problem solve; (d) instructors who demonstrated professional behaviors of confidence, thoroughness, neatness, respect, and supportiveness; (e) instructors who possessed the personality traits of honesty, humor, warmth, respect and enthusiasm.

Educator Roles in Clinical Teaching

Irby (1986a) identified three main roles of clinical educators in medical education. These included "role modeling, clinical supervision, and instructional leadership and scholarship" (p. 38). Similar clinical teaching roles were identified in research by Grassi-Russo and Morris (1981), Morgan (1991), Stritter, Baker, and Shahady (1988) and Ullian, Bland, and Simpson (1994).

Role modeling, a potentially powerful teaching technique suited to clinical teaching, was defined by Irby (1986a) as a purposeful activity that demonstrates the knowledge, skills, attitudes, and ethical behaviors that students should acquire. Clinical supervision included providing structure for working and learning, promoting problem solving and critical appraisal skills, observing and offering feedback on student performance, and offering professional support and encouragement.

Irby described instructional leadership and scholarship activities as occurring outside of the immediate context of clinical teaching. Three components of instructional leadership were identified: curriculum development, evaluation and improvement of teaching, and educational research. Curriculum development promotes excellence in clinical education with attention to the organization of the experience, specification of learning objectives, identification of educational resources, and clearly defined evaluation procedures. Evaluation of clinical teaching is necessary because of the limited number of students who observe a clinical instructor on a given rotation. Evaluation is important for self improvement, academic promotions, and merit pay increases. Educational research is critical for the creation of new knowledge. This task can be applied to teaching and learning in the clinical setting by the investigation of issues concerning clinical instruction.

What residents consider important components of the clinical teacher role in medicine was the focus of a quantitative study by Ullian et al. (1994). Through content analysis of comments written on faculty evaluation forms by 268 residents, themes were identified, coded, and clustered into four role categories. The four role categories identified were physician, supervisor, teacher, and person. The

characteristics most frequently mentioned in these categories included: (a) physician role--knowledgeable, clinical competence, and role model; (b) supervisor role--provides resident with opportunities to learn and take responsibility, and involves resident in decision making; (c) teacher role--general teaching ability, interest in teaching, and commitment to teaching; (d) person role--supportive, easy to work with, and fun to work with. The researchers concluded that the results of the study could be used to improve the evaluation and performance of clinical teachers.

Mogan and Knox (1987) compared characteristics of the best and worst clinical teachers as perceived by students and faculty. Building on their previous research (Knox & Mogan, 1985), a 48-item teacher effectiveness checklist on individual teacher characteristics was distributed to 173 baccalaureate students and 28 clinical teaching faculty. Both students and faculty agreed that being a good role model was the most important characteristic of effective clinical teaching. This finding was confirmed by Nehring (1990) in a replication of the Mogan and Knox (1987) study.

Rauen (1974) in a study of role characteristics of clinical nurse educators found that demonstrating how to function in a real nursing situation was considered an important teacher skill. In Rauen's study, 84 freshman

and senior diploma-nursing students were questioned as to how they expected the clinical faculty to serve as a role model. Rauen identified the clinical educator as performing three roles: nurse, teacher, and person. Students ranked the nurse role characteristics as being significantly more important for the clinical instructor than the roles of teacher or person.

In a replication of Rauen's study, Stuebbe (1980) examined how students view the role of the clinical instructor and compared this with the teacher's own view of the role. Results revealed that, over all, students rated nurse characteristics as most important and faculty rated teacher characteristics as most important.

Pugh (1988) compared clinical teaching behaviors identified important by both teachers and students. Using a questionnaire with 20 teacher behaviors, faculty and students were asked to rank the importance of these behaviors for students learning. The most important characteristics identified by faculty were showing interest in students, giving feedback on assignments, encouraging self-evaluation, and giving positive reinforcement and praise in the clinical setting. Students reported that effective teachers demonstrate nursing care in a real situation, give feedback on assignments, and facilitate students' meeting learning goals. While the students ranked the teacher's ability

to demonstrate nursing care as most important, this was not rated as high by faculty participants.

In a case study design, Kinney (1985) sought to describe the faculty role in clinical education. In an analysis of clinical teacher interviews and observations, Kinney concluded that faculty were not effective in articulating theory with practice in the clinical setting. Students were frequently asked to complete independent learning activities for applying theory to practice, and student peers, instead of faculty, offered assistance in the application of theory to practice. The purpose of a study by Wiseman (1994) was to describe role modeling behaviors of the clinical faculty. Wiseman developed a questionnaire on 28 role model behaviors, based on Bandura's Social Learning Theory as a framework. Data were collected from 208 baccalaureate nursing students in three nursing programs.

Clinical Teacher Knowledge

The educator's theoretical and clinical knowledge used in practice has been labeled nursing competence by some researchers (Knox & Mogan, 1985; Mogan & Knox, 1987; Nehring, 1990). Findings of their research indicate that nursing competence is an important characteristic of clinical teaching effectiveness.

Effective clinical teaching requires competence in clinical practice. In a replication of a study by Mogan

and Knox (1987), Nehring (1990) found that the best teachers demonstrated expert clinical skills and judgment. The importance of maintaining clinical competence has also been reported in studies by Bergman and Gaitskill (1990), Brown (1981), Irby, (1994), Kiker (1973), Pugh (1988), Rauen (1974), and Ullian et al. (1994).

Several studies have identified clinical professional competence of the clinical instructor as a nurse as being more important than personal characteristics. Kiker (1973) compared views of effective teacher characteristics held by junior nursing students, junior education students, and graduate nursing students. She found that all three groups believed professional competence was more important than personal characteristics.

Numerous studies describe an effective clinical teacher as knowledgeable and willing to share that knowledge and expertise with students in the clinical setting (Armington, Reinikka, & Creighton, 1972; Bergman & Gaitskill, 1990; Brown, 1981; Irby, 1994; Mogan & Knox, 1987; Nehring, 1990; Ullian et al., 1994; Windsor, 1987). This knowledge includes an understanding of theories and principles used in practice and the ability to help the students in applying them (Bergman & Gaitskill, 1990; Brown, 1981; Pugh, 1988).

In a qualitative study, Irby (1994) investigated the knowledge components needed by clinical teachers in medicine. Using data from interviews and observations of six distinguished clinical teachers, Irby identified six domains of knowledge essential to teaching excellence: (a) medicine, (b) patients, (c) the context of practice, (d) educational knowledge of learners, (e) general principles of teaching, and (f) case-study based teaching. Irby concluded that ". . . these domains of knowledge allow attending physicians to engage in clinical instructional reasoning and to target their teaching to the specific needs of their learners" (p. 333).

In a descriptive study, Brown (1981) compared faculty ($n = 42$) and senior nursing students' ($n = 82$) perceptions of clinical teaching effectiveness. Using a questionnaire format, participants were asked to rate the importance of 20 characteristics of clinical teachers. Though differences existed between students and faculty in their descriptions of effective clinical teachers, both groups emphasized the importance of the teacher being well-informed and able to communicate that knowledge to students. A related behavior was the ability to assist students in applying theory to practice.

Bergman and Gaitskill (1990), using a descriptive design, extended Brown's study. Utilizing Brown's questionnaire, 134 baccalaureate nursing students and 23 nursing faculty in a midwest university were surveyed. Both students and faculty identified the need for the teacher to be articulate and knowledgeable. Other characteristics suggested by both students and faculty included: respecting the students, being objective and fair in evaluation, and the ability to provide useful feedback.

Clinical Teaching Practices and Skill

Research findings suggest that there are specific teaching skills needed by faculty in the clinical teaching setting. Skill in clinical teaching involve the ability of the teacher to diagnose learning needs, plan instruction which reflects students needs and the goals of the clinical experience, demonstrate procedures and skills, supervise students, and evaluate learning. The ability to plan assignments that help transfer theory to practice was rated as an important characteristic of teaching effectiveness by faculty in Pugh's study (1988). Characteristics of the best clinical teachers identified from research findings suggest the importance of demonstrating appropriate clinical skills and supervising students (Armington et al., 1972; Barham, 1965; Bergman &

Gaitskill, 1990; Mogan & Knox, 1987; Nehring, 1990; Pugh, 1988; Windsor, 1987).

Other studies emphasize the importance of the teacher's skill and practices in clinical evaluation. Findings confirm that positive and useful feedback on student progress is an important characteristic of effective clinical teaching (Bergman & Gaitskill, 1990; Nehring, 1990; O'Shea & Parsons, 1979; Pugh, 1988; Windsor, 1987).

O'Shea and Parsons (1979) collected data on clinical teacher effectiveness from 205 students and 24 faculty in a baccalaureate nursing program. Participants were asked to list three to five teacher behaviors that facilitated their learning in the clinical setting and a similar number of behaviors that inhibited their learning. The importance of providing positive feedback was identified by both students and faculty as facilitating learning, while insufficient and negative feedback impeded learning. Other instructional behaviors which facilitated learning included availability in the clinical setting and willingness to assist the student.

The importance of the teacher providing positive and frequent feedback to students in the clinical practice is evident in other research. Flagler, Loper-Powers, and Spitzer (1988) found that teacher behaviors which enhanced learning included: giving positive

reinforcement and specific feedback, encouraging questions, showing confidence in the student, and supporting the student.

Interpersonal Relationships with Students in the Clinical Setting

An important clinical teacher behavior is the ability to interact with students on a one-to-one basis and as a group (Jacobson (1966). Bergman and Gaitskill (1990) found that, among different characteristics of effective clinical teaching, interpersonal relationships with students were rated as most important. Included among these characteristics were conveying confidence in and respect for students, having realistic expectations of them, being honest, and encouraging students to ask questions. Nehring (1990) found that the best clinical teachers, as perceived by both faculty and students, were approachable, encouraged respect, and provided support and encouragement to students. Other studies have confirmed the importance of interpersonal relations with students in clinical teaching (Brown, 1981; McCabe, 1985; Mogan & Knox, 1987; Nelms, Jones, & Gray, 1993; Pugh, 1988).

In Beck's (1991) phenomenological study of student perceptions of faculty caring, 47 incidents of a caring student-faculty experience were analyzed; eight of which occurred in the clinical setting. The caring experience

between faculty and students illustrated three clusters of behaviors: attentive presence, sharing of selves, and effect of the experience in which the student feels consideration and worth.

Personal Characteristics of Clinical Teachers

Another important dimension of effective clinical teaching reported in the research literature relates to the personal attributes of the teacher. O'Shea and Parsons (1979) found that learning was promoted by friendly, supportive, and understanding behaviors of the teacher. Personal characteristics found related to effective clinical teaching in more recent studies include enthusiasm, a sense of humor, willingness to admit limitations and mistakes, patience, and flexibility in the clinical setting (Bergman & Gaitskill, 1990; Mogan & Knox, 1987; Nehring, 1990).

Teachers who are seen as more effective by their students are more likely to have positive self-regard and self-esteem, to be energetic and enthusiastic, and to have a positive view of others (Feldman, 1986). The enthusiasm of the teacher and the concern for the learner were identified by Krichbaum (1994) as correlating significantly with students' performance in clinical practice and cognitive outcomes.

The majority of studies on clinical teaching suggest that the personal characteristics of the teacher may

influence teaching effectiveness, though differences exist in how they are described. The characteristic identified consistently in the research is teacher enthusiasm. Krichbaum (1994) and Ullian et al. (1994) suggested that an enthusiastic faculty is important in students' evaluations of effective clinical teaching and may influence student performance and cognitive outcomes.

Attitudes, Values, and Beliefs about Clinical Teaching

The term attitude has various meanings. Criteria delineated by McGaghie et al. (1995) include:

- (a) evaluation constitutes a central aspect of attitude,
- (b) attitudes are represented in memory, and
- (c) affective, cognitive, and behavioral antecedents and consequences of attitudes can be distinguished.

Attitudes have also been defined as inclinations or dispositions to respond positively or negatively to a person, object, or situation (Shelly & Miller, 1991).

Attitudes are assumed to guide role judgments and behaviors.

Values are defined as beliefs or ideals to which an individual is committed and which guide behavior. Values are reflected in attitudes, personal qualities, and consistent patterns of behavior (Shelly & Miller, 1991) and may be held in common by members of a social group. Personal qualities are innate or learned attributes of an individual. Professional behaviors reflect the

individual's commitment to specific values. Behaviors can be defined as observable social acts performed by an individual (Hardy & Conway, 1988). According to Hardy and Conway, values generally refer to abstract but stable aspects of an individual's overall belief system, whereas attitudes are more specific and usually indicative of the values held.

Beliefs represent the intellectual acceptance of something as true (Chitty, 1993). Beliefs are opinions that may be, in reality, true or false. They are based on attitudes that have been acquired and verified by experiences.

A role is a set of shared expectations focused upon a particular position (Hardy & Conway, 1988). A role consists of several components which include: values, attitudes, and behaviors.

Attitudes toward practice are a reflection of the socialization process which occurs in education (Watson, 1986). Role socialization involves the internalization and shaping of specific values and attitudes and the acquisition of skills for the enactment of appropriate behaviors.

An area of concern to faculty is the degree to which their own values and attitudes influence their students. Nursing educators are significant persons in the students' environment and contribute to the professional

values that they develop (Ferguson & Calder, 1993). Because values are modeled and affirmed by significant persons, role modeling is a primary means of transmitting values into a profession. Waltz (1987) found that students' preferences for clinical area of nursing practice were associated with faculty preference for the clinical area of nursing practice. Williams, Bloch, and Blair (1978) confirmed findings of earlier studies (Gordon & Mensh, 1962; Kirchner, 1970) that students' values in nursing programs tended to become more like their faculty's as they progressed in their studies; Gliebe (1977) reported similar findings.

Pugh (1986) explored factors affecting the discrepancy between nursing faculty beliefs and teaching behaviors in the clinical setting. Pugh used a faculty and student questionnaire consisting of 20 teaching behaviors representing five clinical faculty roles: teacher, nurse, evaluation, application, and guidance. Faculty and their respective students completed questionnaires. Observations were used to verify student reports, to document and describe patterns of behaviors, and to study the contextual background of teacher behaviors.

The sample of nursing faculty reported that they believed in the importance of the behaviors, had positive attitudes toward them, and perceived their peers as

expecting them to use the behaviors. According to Pugh (1986), observed faculty behaviors did not follow stated faculty beliefs.

Reasons that Pugh (1986) suggested for lack of congruence between the faculty and student expectations included problems in measuring complex behaviors, students' understanding of behaviors which did not coincide with faculty understanding, and lack of opportunity for faculty to perform desired behaviors. Reasons for non-performance of desired faculty behaviors included: lack of understanding of role expectations, inability to perform as a result of lack of preparation, and absence of motivation.

The majority of faculty in the study identified themselves as nurses who teach nursing. Neither role identification nor role preparation alone had a significant effect on behavioral intentions, attitude toward specific behaviors, or perceived attitude of peers.

Goals of Clinical Experience

Considerable controversy exists within the nursing profession regarding the skills, knowledge, and level of performance needed by new graduates upon entering practice (Sylvia & Neuman, 1988). Clinical performance was defined by Schwirian (1978) as the usual functioning of a nurse in a clinical setting for the purpose of

meeting the health needs of clients through direct or indirect use of the nursing process. Differences in the needs of employment settings and the ability of new graduates to perform in different settings have created disharmony between nursing education and nursing administration (Berger, 1984; Moore & Boyd, 1985; Olson, Gresley, & Heater, 1984). In their review of published nursing literature, Sylvia and Neuman (1988) found that clinical performance ranks second in the numbers of studies suggesting considered importance; findings, however, have been inconsistent.

In a review of literature on outcomes of education, Sylvia and Neuman (1988) identified the need for research on measuring educational outcomes. Their review included cognitive, psychomotor, and affective outcomes as well as those related to educational experiences, critical thinking, analytical thinking, decision making, professional development, clinical competence, clinical performance, and job placement. Other indicators of academic achievement included grades and/or grade point average, scores on standard tests, and program completion rates.

The National Council Licensure Examination (NCLEX-RN) is often used as an outcome measure since successful completion of this exam is required by state Boards of Nursing in order to practice nursing. The NCLEX-RN, a

standardized criterion referenced exam, consists of multiple choice questions to test knowledge, comprehension, application, and analysis of concepts and theory in various patient situations (Sylvia & Neuman, 1988).

Most of the studies reviewed identified success on NCLEX-RN and factors or predictors associated with success. Predictors identified in the literature were cognitive measures, such as, course grades, ACT and SAT scores, or GPA. These measures do not provide data to demonstrate the importance of the relationship between effective teaching and teacher attitude toward clinical teaching and student competence.

Summary

The literature has described numerous studies identifying attributes necessary for effective clinical teaching. Results of these studies suggest behaviors of effective clinical teachers in nursing which are consistent with research in other health professions and higher education in general (Oermann, 1996). These studies were typified by an attempt to determine general categories of effective clinical instruction. Most often data were gathered from rating scales or critical incident instruments.

Research has evaluated clinical teaching characteristics from both the student and faculty

perspective. Common themes in much of the available literature on clinical teaching stress the attributes of knowledge, competence, teaching practices and instructional skill, having good interpersonal skills, and personal characteristics such as enthusiasm, flexibility, and a sense of humor. Limitations of the research include small sample sizes in some of the studies; the use of convenience samples of students and faculty, typically from one setting; need for further testing of instruments; lack of assessment of teaching effectiveness across clinical courses, practice areas, and types of clinical settings; lack of control of individual teacher characteristics which might influence teaching effectiveness; and characteristics of the students (Oermann, 1996).

There is sufficient research to conclude that two important dimensions of clinical teaching are the teacher's knowledge about the practice area and clinical teaching competence. While the research is inconsistent on the ranking of these characteristics, it is clear that effective clinical teaching requires knowledgeable and competent faculty who are able to engage students in acquiring and constructing their own knowledge.

A significant concept to glean from the literature on clinical teaching is that of role modeling. Students derive many of their perceptions of professional nursing

roles from their teachers. Other important roles suggested by the literature include:

(a) facilitator of learning through problem solving, (b) coaching through supervision, (c) evaluation, and (d) providing support and encouragement. Further study is needed to more clearly describe the role and instructional activities of the teacher in the clinical setting. Other role questions not addressed through empirical research deal with: preparation of faculty for clinical teaching; stresses experienced by clinical faculty; the use of part-time and adjunct faculty in clinical teaching; and, supervision and mentoring of new faculty.

Teaching is an interactional process dependent on the teacher's ability to develop effective relationships with the students. While important for teaching in any setting, effective interpersonal relationships are critical in the clinical teaching setting (Reilly & Oermann, 1992). Findings from the research verify the importance of cultivating a positive relationship with students in the clinical setting. Characteristics of effective interpersonal relationships with students include conveying respect for the students, being honest, and providing support and encouragement.

Competence of students and new nursing graduates is frequently evaluated by measures such as GPA, course

grades, or board exams. There is little consensus, however, as to what is considered clinical competence, or how it is measured and graded. This inconsistency can contribute to a perceived lack of agreement among educators as to the importance of experiential learning. It would seem that the portion of nursing education that involves the greatest expense, the most time, the highest faculty-student ratio, and the highest risk or potential for error should reflect more consistency or agreement on what constitutes competent practice. This lack of agreement can further be suggested to reflect on the degree of clinical competence exhibited by nursing graduates entering the practice sector and the quality of health care provided to clients and society.

Expertise in Clinical Teaching

What constitutes expertise? Only in the last 30 years or so has experimental research in cognitive psychology and related disciplines begun to discover what is required to be expert in some domain (Posner, 1988). According to the literature, experts exhibit certain attributes: among these are problem solving, experience, and reflective thinking. The literature is lacking a portrayal of expertise in teaching, more specifically, clinical teaching in nursing (Benner, 1984).

General Attributes of Expertise

An expert can be viewed as exhibiting certain attributes. Since the early 1970s researchers in cognitive psychology have investigated what is required to define an expert in some domain. One example of experimental research into expert performance attempts to explain the ability of people to memorize (Posner, 1988). However, Chase and Simon (1973) found that what appeared to be exceptional memory could be obtained by any normal person with repeated practice and the application of a mental coding method. In a related study, Chi (1976) found that changes in memory span resulted from learning how to code and recognize information instead of what was often thought to be an increase in storing capacity.

Persons considered as experts in their domain may have additional or unique motivation for long-term training (Posner, 1988). In considering motivation as a factor in expertise, it must be understood that this component may be a quality of not only innate ability but interest in the domain. Different kinds and amounts of motivation may not be unique to expertise but rather a set of qualities for describing individual differences.

Other than memory capacity and motivation, it appears that an essential talent possessed by experts, regardless of profession, is the ability to solve problems more accurately than other people (Johnson,

1988). Cognitive science has documented differences in the problem solving processes of experts and novices. Chi, Feltovich, and Glaser (1981) suggest that, though the nature of the problem solution depends on the task, experts have a better and more complete representation of the task domain based on experience and specialized knowledge. This representation allows experts to recognize, code, and decode new information more quickly and completely than novices.

The beneficial effects of specialized knowledge are constrained by the problem domain and by the goals we have in a particular domain. For example, nursing educators' specialized knowledge in nursing curriculum allows them to predict graduate success on national board exams. However, we would not expect this specialized knowledge to aid them in predicting how many of the graduates will marry and have children. It seems reasonable to hypothesize a relationship is established among three variables: specialized knowledge, problem domain, and specific goals in thinking and problem solving tasks.

When considering problem solving abilities, it is also important to distinguish between routine and nonroutine problems. According to Bransford and Stein (1993):

A routine problem is one that is familiar to an individual because it is similar to a problem that

he or she has solved before. In contrast, a nonroutine problem is novel and requires new thinking. (p. 6)

By this definition it is much easier to solve problems that are routine than ones that are not. Bransford and Stein stress that a given problem may be relatively routine for one person and nonroutine for another. The point is that even people considered as experts in a particular domain often have to deal with nonroutine problems.

The ability to solve problems is not only related to the amount and organization of the knowledge, but also to domain-specific experience (Bransford & Stein, 1993). Bransford and Stein stress the powerful effect that domain-specific knowledge and experience can have on problem solving, as well as the limitations of such knowledge for solving problems in other domains.

One way of describing the development of expertise is when a person tests and refines propositions, hypotheses, and principle-based expectations in actual practice situations, such as nursing (Benner, 1984; Irby, 1992). Similarly, experience can be described as resulting from preconceived notions and expectations that are challenged or refined by an actual situation. So described, experience and expertise are closely related; experience can be considered as a requisite for expertise (Benner, 1984). Both Chase and Simon (1973) and Chi et

al., (1981) underscore the importance of specific, continued experience in the development of expertise.

An examination of and description of domain-specific knowledge gained from experience can be explored from the perspective of clinical knowledge development (Benner, 1984; Benner et al., 1996). Clinical knowledge is embedded in expert practice and can be discovered or uncovered by interpretive studies undertaken in the respondent's natural setting. Benner further suggests that the expertise embedded in the practice of clinically skilled nurses can be transmitted to novices through observation of, and practice with, expert nurses.

"Development means dealing with experience in increasingly sophisticated and complex ways and being able to integrate this complexity into stable structures" (Freedman, 1979, p. 96). As a development process, expertise occurs over time and suggests a growth in knowledge and/or skill through experience.

Shulman (1987) defines reflection as reviewing, reenacting, analyzing one's performance, and establishing an explanation based on evidence. Kitchener and King (1990), in their research on reflective judgment, suggest that reflective judgment is the outcome of growth in domain-specific knowledge. They define a reflective thinker as ". . . someone who is aware that a problematic situation exists and is able to bring critical judgment

to bear on the problem" (p. 160). Kitchener and King found that reflective judgment ability consistently increased with age and education. The reflective judgment model regards statements by individuals ". . . as implicit clues to the person's meaning perspective" (p. 162). The research of Kitchener and King suggests that developmental stages of reflective judgment are identifiable, age related, consistent across different tasks, and change in a predictable fashion over time.

Expertise in Teaching

The literature lacks a richly developed portrayal of expertise in teaching (Shulman, 1987) and a well defined standard of expertise (Sternberg & Horvath, 1995). Sternberg and Horvath have proposed the development of a prototype view of expert teaching. A prototype represents the central tendency of all persons in the category. In utilizing a prototype framework for expertise, teachers can be viewed by their similarities rather than by a set of a priori features considered essential and adequate.

Sternberg and Horvath (1995) suggested several features to be considered in the prototypical view of teaching expertise. Three basic ways in which experts differ from novices were identified: knowledge--experts use domain-specific knowledge more effectively in problem solving than do novices; efficiency in problem

solving--experts accomplish more in less time than do novices; insights--experts are more likely to arrive at unique and suitable solutions to problems than are novices.

When viewing persons within this framework ". . . two equally valid members of a category may resemble each other much less than they individually resemble the prototype" (Sternberg & Horvath, 1995, p. 10). By viewing expertise as a prototype, experts can be distinguished from non-experts in a way that acknowledges diversity in the population without a set of rigidly required features. A prototype framework promotes a better understanding of the general attributes of expert teachers and a basis for interpreting social behaviors of expert teachers.

Taking a more prescriptive approach to understanding the development of expertise in teaching, Shulman (1987) proposed seven categories to be contained in the knowledge base for teaching: (a) content knowledge; (b) general pedagogical knowledge, including principles and strategies of classroom management; (c) curriculum knowledge; (d) pedagogical content knowledge; (e) knowledge of learners and their characteristics; (f) knowledge of educational contexts; and (g) knowledge of educational outcomes, purposes, and values. How do teachers develop such teaching knowledge? Shulman (1987)

described four sources of the teaching knowledge: scholarship in content disciplines, materials and settings of the institutionalized educational process, research on social phenomena that affect teaching and learning, and wisdom gained from practice.

Expertise in Clinical Nursing Educators

Nursing as a profession has been studied primarily from a sociological perspective (Benner, 1984), focusing on role relationships, socialization, and acculturation in nursing. In comparison, much less attention has focused on the knowledge, skills, attitudes, and beliefs of nursing practice, or the experiences related to nursing expertise and its development.

The effect of nursing practice on the role of the clinical teacher was examined by Kramer, Polifroni, and Organek (1986). The sample included 134 senior baccalaureate students and 14 clinical nursing faculty. Students taught by practicing faculty scored higher in three areas: integrating theory into practice, possessing a realistic perception of the work environment, and cooperating and participating in nursing research. In addition, these students demonstrated a higher degree of autonomy and positive self concept than students taught by faculty not in practice.

Although qualitative case studies have been published that have attempted to define the expert nurse

in clinical practice, none have addressed the expertise of a clinical nursing educator (Benner, 1984; Benner et al., 1996; Bevis & Watson, 1989). Nursing instructors must be proficient not only in teaching, but also in nursing (Karuhije, 1986). A skillful practitioner is not necessarily a good teacher, nor is a good teacher necessarily a good practitioner.

Little work is reported in the literature that provides a description of the knowledge, skills, attitudes, and beliefs essential for expert clinical nursing educators. For example, although the vital role of nursing faculty has been recognized, the characteristics of expert clinical nursing faculty have not been identified or described from the faculty perspective (Streubert & Jenks, 1992). Numerous studies have investigated students' perceptions of the characteristics of competent clinical teaching (Brown, 1981; Irby, 1978b; Kiker, 1973; Knox & Mogan, 1985; Stritter et al., 1973).

Methodological Issues

Several issues can be identified when considering the application of qualitative methods of study. Some researchers hold the belief that quantitative methods are the only valid, reliable, and acceptable research methods for scientific studies (Leininger, 1992). They hold the belief that qualitative methods are soft, unreliable,

nonscientific, and could never lead to a scientific study. Qualitative methods are valuable not only in generating theories and conceptual frameworks but in studying extant theories and conceptual models and in generating thick descriptions of and rich insights about unknown or vaguely known phenomena (Leininger, 1992). The use of qualitative findings can provide new insights and improve conditions through action research.

Another issue when considering use of qualitative methods is the potential for the researcher's biases and experience to affect the results. Researchers must know their biases, remain open to learning, and sensitive to people and different contexts. Related to the use of the self as instrument is an exploitation of our own subjectivity (Glesne & Peshkin, 1992). Eisner (1991) explained: ". . . the way in which we see and respond to a situation, and how we interpret what we see, will bear our own signature" (p. 34). This unique signature does not have to be viewed as a liability but a way of providing insight into a situation. Goetz and LeCompte (1984) suggested that biases held by the researcher towards the participants of an investigation as well as the researcher's own experience be included in the conceptual framework.

A third major issue is the failure of qualitative researchers to use qualitative criteria to evaluate

qualitative data. The literature does not justify the use of reliability and validity to evaluate qualitative research (Leininger, 1992). The goals of qualitative research are not to measure something but rather to understand fully the meaning of phenomena in context and to provide thick accounts of phenomena under study. Moreover, the purposes of qualitative research are not directed toward producing generalizations of findings from large samples to populations using statistical verifications (Leininger, 1992; Lincoln & Guba, 1985). Instead, the researcher systematically and with detailed narrative examines certain phenomena that characterize particular individuals or groups.

More stress needs to be placed on the use of qualitative research findings to understand and to improve human conditions. Qualitative studies can be used to gain new insights about human conditions related to specific cultures, groups, lifestyles, and population issues (Leininger, 1992). The findings from qualitative research can provide new ways of looking at human environments, life contexts, beliefs, and values.

Qualitative research has the natural setting as the direct source of data (Bogdan & Biklen, 1992). Researchers spend considerable time in the setting under investigation. Data may be collected through observation and interview.

Interviews are a common strategy for data collection in qualitative research. Glesne and Peshkin (1992) emphasized employing several approaches to capture how respondents think, feel, and account for a concept or belief. Approaches suggested include:

- (a) structured--specific questions that need to be asked,
- (b) open--willingness to follow unexpected leads that arise in the course of the interview, and
- (c) depth-probing--pursuit of all points of interest with various expressions that mean "tell me more" and "explain."

Not all of the essential knowledge embedded in expertise can be captured through systematic discussion and suggestion. Furthermore, theories espoused may not correspond to theories in action and the person may be unaware of the inconsistency (Argyris, Putnam, & Smith, 1985). Generally, a person is aware of espoused theory, since it is the theory he or she claims to follow. Theories in action often form the patterns by which people act. Therefore, participant observation is another primary data collection technique used by qualitative researchers (LeCompte & Preissle, 1993). Data are acquired through detailed observation and descriptions of people, places, objects, events, activities, and conversations. The intentions, expectations, meanings, and outcomes of action or expert

practice can be described and aspects of clinical knowledge can be captured by reflection and interpretive descriptions of actual practice (Argyris et al., 1985; Benner, 1984).

Much of the research on clinical teaching in nursing uses quantitative methodology involving surveys of students and faculty (Oermann, 1996). Mogan and Warbinek (1994), however, reported on the development and testing of an instrument to observe and record teaching behaviors of clinical faculty. The researchers' instrument consists of 44 items on effective and ineffective teacher behaviors grouped in nine categories. The researchers observed 12 volunteer clinical teachers across five hospitals in Canada for two consecutive hours recording their observations of the teacher. Following the observations the behaviors were categorized. The researchers concluded that the observational instrument appeared to capture an aspect of clinical teaching not measured through surveys.

Qualitative analysis involves an inductive approach (Polit & Hungler, 1993). Thus, qualitative analysis begins with a search for themes or patterns. The constant comparative method may be used in analysis and interpretation of data (Glaser & Strauss, 1967). This strategy combines inductive category coding with

simultaneous comparison of all incidents observed and coded (LeCompte & Preissle, 1993).

Summary

Several testable assumptions have been drawn from the literature. These assumptions provide an initial framework for the study and a basis for generating questions. It will be assumed that experts in clinical nursing education: (a) excel mainly in their own domain; (b) have the ability to solve problems more accurately and efficiently than novices; (c) possess strong self-monitoring ability; (d) are highly motivated; (e) perceive broad meaningful patterns in their domain of knowledge; (f) develop expertise through problem solving experience in the domain; (g) develop knowledge through experience; and (h) through growth in domain-specific knowledge become reflective thinkers. Finally, the participant's understanding about domain-specific knowledge, skills, and attitudes can be explored from a semi-structured interview, in which open-ended questions stimulate reflection and elaboration regarding professional goals, personal and educational background, and views on teaching and learning. Furthermore, expertise among clinical nursing educators can be understood meaningfully within the framework of a prototype view of expert teaching.

CHAPTER III

METHODOLOGY

This study was exploratory and non-experimental. A qualitative approach was used in this study. Through observations and serial interviews over time, some beginning descriptions and explication of dimensions of expertise of the clinical nursing educators were achieved.

Merriam (1988) described a case study as an "examination of a specific phenomenon such as a program, an event, a person, a process, an institution, or a social group" (pp. 9-10) which is well-suited to situations in which phenomenon is closely linked with the context. Due to the complexity of the social context within the clinical teaching setting and the lack of research available about the attributes of expert clinical nursing educators, the use of a case study approach was employed.

Experience and Bias of the Researcher

Goetz and LeCompte (1984) suggested that biases held by the researcher towards the participants of an investigation as well as the researcher's own experience be included in the conceptual framework. The researcher has had 28 years of experience in nursing, 13 of which have been in nursing education. The researcher has been involved in both classroom and clinical teaching for all

of those 13 years, having worked in or taught in five of the specialty areas common to participants of this study.

Instrument Design

Surveys were sent to all nursing faculty of private baccalaureate nursing programs in one Midwestern state. Nursing faculty were instructed to select from their program not more than three full-time clinical nursing faculty whom they perceived as exhibiting characteristics of expert clinical practice. Nursing faculty were also asked to list two or three characteristics which they believe distinguish selected faculty as expert clinical nursing educators.

A supplementary demographic data record was used to obtain data from the final selected sample of six participants. The data record requested information relative to teacher age, gender, educational preparation, years of experience in nursing, years of experience teaching nursing, specialty area taught, number of years at current position, type of basic nursing education, and highest degree held.

Interviews are a common strategy for data collection in qualitative research. Glesne and Peshkin (1992) emphasized employing several approaches to capture how respondents think, feel, and account for a concept or belief. Approaches suggested include:

(a) structured--specific questions that need to be asked,
(b) open--willingness to follow unexpected leads that
arise in the course of the interview, and
(c) depth-probing--pursuit of all points of interest with
various expressions that mean "tell me more" and
"explain."

A semi-structured interview guide was used as a
primary strategy for the data collection. It included a
list of topics, questions, and probes employed by the
interviewer to guide discussion with the participants
(Roberts & Burke, 1989). This approach to interviewing
is less structured than using an open-ended questionnaire
or schedule. The guide addressed personal and
educational philosophy, professional goals, role
orientation, and problem solving orientation (Burger,
1988; Freedman, 1979). Illustrative questions included
but were not limited to the following:

Why did you become a nursing educator?

What characteristics do you think might cause others
to identify you as an expert?

How do you define clinical teaching?

Describe the ideal clinical teaching situation?

What kinds of professional tasks do you prefer?

What are characteristics of colleagues that you
admire?

What do you value about clinical teaching?

Participant observation is another primary data collection technique used by qualitative researchers (LeCompte & Preissle, 1993). Data are acquired through detailed observation and descriptions of people, places, objects, events, activities, and conversations. Observations were documented using fieldnotes. After completion of each observation people, places, objects, events, activities, and conversations were described in depth. In addition, as part of the fieldnotes, ideas, strategies, reflections, hunches, and notation of emergent patterns were documented. The fieldnotes included a written account of what was heard, seen, experienced, and thought of in the course of collecting and reflecting on the data (Bogdan & Biklen, 1992).

Population and Sample

The population for this study was selected from nursing faculty of 10 private baccalaureate nursing programs in one Midwestern state. Only full-time faculty involved in clinical nursing education as part of their faculty role were chosen. Full-time faculty included all faculty whose FTE or full time equivalence was greater than 75 % or 30 hours per week. Adjunct, part time, or percent faculty whose only responsibility was clinical teaching were not considered. Subjects were selected based on responses obtained from the initial surveys. Initial surveys were sent to all nursing educators at the

10 private baccalaureate nursing programs in the state. Six of the 10 programs returned completed surveys. A sample of six teachers was chosen from three of the nursing programs that responded to the survey. The sample was selected through modified reputational-case selection, a process by which teachers are nominated by colleagues on the basis of their professional expertise and positive personal characteristics (Goetz & LeCompte, 1984). Recommendations were to be made based on perceived and identified attributes of expert clinical nursing practitioners. All nominees have a minimum of five years teaching experience.

The sample, drawn from the faculty of 10 private baccalaureate nursing programs in one Midwestern state, consisted of six full-time faculty involved in clinical nursing education as part of their faculty role.

The participants were from three of the 10 baccalaureate nursing programs, two from each of the three. A total of approximately 40 nursing education faculty are employed in these three programs. All of the participants were Caucasian females, and have taught a minimum of five years. The number of years of experience in nursing ranged from 17 to 42 with a mean of 28. The number of years in nursing education ranged from five to 37 with a mean of 18. The number of years at the current

position ranged from five to 18 with a mean of 12. The age range of the participants was 39 to 62 with a mean of 51.

Two of the participants have a doctorate in education, one participant has all of her course work completed toward a doctorate in education, and one participant has taken 12 hours toward a doctorate in family therapy. Five of the participants have their master's degree in nursing and two have a master's in education.

Procedure

Phase I

Surveys were sent to 10 private baccalaureate nursing programs in the state. The survey was distributed to all nursing faculty involved in clinical teaching as a part of their responsibility. The purpose of the initial survey was to identify clinical nursing educators who were perceived as exhibiting characteristics of expert clinical practice. Nursing faculty were instructed to select from their program not more than three full-time clinical nursing faculty whom they perceive as exhibiting characteristics of expert clinical practice. Respondents were also asked to list two or three characteristics which they believed distinguish selected faculty as expert clinical nursing educators. Respondents were

instructed that they may not name themselves on this list.

Phase II

Prior to initiation of the interview phase of the study the researcher piloted the semi-structured interview format with a researcher who is an authority in the use of the interview as a data collection device. Following the practice interview and critique, changes in format and methodology were made. The interview and observation designs were also piloted using two clinical nursing educators at the researcher's home institution. Data from the pilot study were coded. Coded data were audited by a researcher who is an authority in qualitative analysis, for the purpose of establishing confidence in the procedure used.

From the names submitted on the initial surveys, a list was compiled. Selection of the final six was determined by the degree to which potential participants exhibit characteristics of expertise as identified by the nominator that correspond to the literature, the number of years of teaching experience, and the number of years of clinical nursing practice. Respondents identified on the final list were contacted by phone and the nature of the research explained. Criteria for inclusion included the respondent's willingness to participate and

availability. Based on the above criteria, six clinical nursing educators were selected to participate.

Prior to the interviews and observations, access was gained through administrative channels. The participants were asked to sign an informed consent. The consent described the purpose of the study. The participants were asked to give written permission to allow tape-recording the session, so that their responses could be recorded accurately. The participants were told that the tapes would be transcribed, erased, and the notes used for categorizing their responses. They were told that at no time would their responses be identified with their name, the name of their college, colleagues, or students. Confidentiality was maintained.

Serial interviews over time were used to gather data. The interviews were conducted in the participants' natural work setting. The interviews took from 1 ½ to 2 ½ hours with a mean of 2 hours. Participants were also asked to complete the supplementary demographic data record following the interview. The participants received a transcribed copy of their interviews prior to the observation phase of the data collection.

Unstructured conversations were also held with five of the six participants on several occasions. The conversations took place in the participants' work settings and averaged 30 minutes. Two of the

participants were also contacted by phone. Each of those conversations took approximately one hour. The purpose of the unstructured conversations was to clarify participants' responses and to elicit examples and more detailed explanations regarding verbal responses or observations.

Prior to each observation contact was made with the participant and a date and time determined. All six of the participants were willing to continue the study by participation in the observation phase. Immediately prior to the individual observation phase the transcribed interview was reviewed by the researcher. The observation guide, which highlighted key characteristics, was also reviewed. During the actual observation, the guide served only to highlight or help focus on certain behaviors. The guide was not used as a check list. Observations were documented as fieldnotes, taking care to jot down key words, phrases, and quotes.

Observations were made of the clinical nursing educator in a clinical setting, which included, but was not limited to, interactions with students, clients, and nursing staff. The observations took place during a regularly scheduled clinical teaching time. The observation periods took from 3 to 5 ½ hours with a mean of 3 ½ hours.

The format of the clinical schedules provided occasional breaks in activities. This afforded the researcher opportunities to ask additional questions and clarifications of the participants. The researcher found it valuable to make notations of the questions as the thoughts occurred. This strategy was effective as the questions or concerns remained current and readily retrievable. At the conclusion of the observation, the researcher thanked the participants for their time and assistance.

After completion of each observation people, places, objects, events, activities, and conversations were described in depth. In addition, as part of the fieldnotes, ideas, strategies, reflections, hunches, and notation of emergent patterns were documented. The fieldnotes included a written account of what was heard, seen, experienced, and thought of in the course of collecting and reflecting on the data.

The descriptive nature of the research required on-going analysis during data collection as well as a final analysis. Data analysis was combined with data collection as the transcripts of the tape-recorded interviews and fieldnotes were coded and interpreted. During the analysis of data the researcher searched for emergent themes and patterns. Additional interviews were

conducted with the same participants as categories emerged.

Data Analysis

The constant comparative method (Glaser & Strauss, 1967) was used in analysis and interpretation of the data. This strategy combines inductive category coding with a simultaneous comparison of all incidents observed and coded (LeCompte & Preissle, 1993). This means that as data are recorded and classified, they are also compared across categories. During this process the researcher looks for key issues, recurrent events, or activities in the data that become the categories of focus. The discovery of relationships begins with the analysis of initial observations and is continuously refined throughout the data collection and analysis process. As events are constantly compared with previous events, new dimensions and relationships may be discovered.

Data for qualitative analysis in this study took the form of fieldnotes from participant observations and interviews, transcriptions, and audiotapes of interviews. Fieldnotes were the written account of what the researcher heard, saw, experienced, and thought in the course of collecting and reflecting on the data in this study (Bogdan & Biklen, 1992). After each observation and interview, the researcher wrote out descriptions of

the participants, the conversations, circumstances surrounding the interview, as well as ideas, strategies, reflections, and "hunches" about themes and patterns that emerge. Transcripts were the typed interviews and observations reproduced from the audiotapes and fieldnotes.

The main task in organizing qualitative data is developing a method for indexing. Indexing involves the development of codes that can be assigned to segments of the data. Once the coding scheme is developed, the data can be reviewed for content and coded according to the theme that is being addressed (Polit & Hungler, 1993).

Qualitative analysis involves an inductive approach (Polit & Hungler, 1993). Thus, qualitative analysis begins with a search for themes or patterns. The search for themes involves not only a search for shared themes across subjects but also a search for natural variations in the data. In addition to a search for themes the researcher identified patterns in the data. Were there certain conditions that preceded the observed theme? Were there certain contexts in which the themes appeared?

Validation of the understandings that the thematic examination has provided was accomplished by viewing the data from multiple perspectives. Multiple perspectives provided a form of investigator triangulation. The methods that were utilized to provide triangulation

included audiotaping the interviews, use of fieldnotes, clarifying tentative findings with the participants, and sharing copies of the transcription and analysis with the participants.

The descriptive data that were obtained from transcribed interviews and observations formed the foundation for the descriptive presentation of the research findings. The demographic data gathered from the supplementary demographic data record provided personal data. Procedures were followed for content analysis in determining coding categories, sorting data, interpretation of data, explanation of data, and developing a final written product presenting the researcher's focus.

Establishing Trustworthiness

In order to determine that the data and findings of qualitative research studies are credible and applicable to other contexts and respondents, Lincoln and Guba (1985) suggested the standard of trustworthiness. They proposed the following four criteria for establishing trustworthiness: credibility, transferability, dependability, and confirmability (Lincoln & Guba, 1985).

Credibility

Credibility refers to the accuracy of the data interpretation and findings. Lincoln and Guba (1985) discussed the need for the process of the inquiry to be

implemented in a way that the findings are accurate and that the credibility of the findings are enhanced, "by having them approved by the constructors of the multiple realities being studied" (Lincoln & Guba, 1985, p. 296). This study utilized two mechanisms identified by Lincoln and Guba to establish credibility: peer debriefing and respondent debriefing.

Peer debriefing was used to assist the researcher in becoming aware of personal perspectives, obtain feedback about data collection techniques, and to discuss hypotheses that emerged from the data. A college of nursing dean with a doctoral degree in nursing served as the peer debriefer. She had experience in qualitative methods and taught research. The research design, data analysis process, and findings of the study were reviewed by her. Revisions were made based on her insights.

Respondent debriefings are discussions with the key respondents to solicit feedback regarding the credibility of the findings, analysis, interpretations, and conclusions of the study (Lincoln & Guba, 1985). Throughout, and at the conclusion of each interview, the researcher summarized what was heard and asked the participants for clarification of misconceptions. The participants reviewed the transcripts after each interview and clarified misconceptions.

Transferability

Transferability refers to the extent to which the findings of the study can be transferred to a different context. Lincoln and Guba (1985) noted that it was the responsibility of the researcher to provide a thick description of the data and setting so that others who were interested in making a transfer of the findings could make a decision based on the similarities of the context. In the results of the study findings the researcher provided a description of the setting and key participants. The data were described in themes and each theme was discussed using the participants' words where appropriate.

Dependability and Confirmability

A audit trail helps to establish the dependability (the appropriateness of the decisions made) and the confirmability (that the findings are supported by data) criteria. An audit trail included: (a) raw data, such as audio tapes and interview notes; (b) data reduction and analysis products, such as documentation of coding and categorization; (c) data reconstruction and synthesis products, such as category descriptions, findings, and the final report; (d) materials relating to intentions and dispositions, such as fieldnotes and notes of meetings with the peer debriefer.

Rights of Human Subjects

This study was approved by researcher's dissertation committee and the University of Northern Iowa Human Subjects in Research Committee. The initial letter to prospective respondents discussed the purpose of the study and the credentials of the researcher. Each participant signed a research consent form. All transcripts and field notes were kept in a secured cabinet.

CHAPTER IV

A DESCRIPTION AND ANALYSIS OF INDIVIDUAL CASES

The purpose of this study was to identify and to describe the qualities of clinical nursing educators who are perceived and identified as being expert clinical practitioners by their peers. In this chapter, data are presented which were derived from observations and interviews conducted during the course of the study. Data are presented and analyzed for each case in this chapter.

The study consisted of data derived from six cases. The participants will be referred to by pseudonyms. Data are presented regarding Carole, Rebecca, Jessica, Laurie, Andrea, and Patricia. Pseudonyms will also be used for any reference in which the name of a student or patient is used.

Within the context of the research questions and the interview framework, five categories were identified. After presenting background information on the clinical educator in each case, data are presented in each of the five major categories. To explore the expertise of clinical nursing educators, data obtained during semi-structured in-depth interviews and observations were analyzed in relation to the five categories, which include:

1. Educational Philosophy
2. Value Perception
3. Role Orientation
4. Problem Solving Strategy
5. Goals

Carole

Carole was a 48 year old white female. A veteran nurse of 30 years, Carole has been teaching nursing for 11 years, all of which have been at her current position. Carole's educational preparation included completion of the programs for licensed practical nurse, associate degree in nursing, baccalaureate degree in nursing, and master's degree in nursing. Her highest degree held was the master's degree in nursing with a focus on administration. Carole acknowledged that she did not have formal courses in teaching. Most of her preparation for teaching came through faculty development courses and observing experienced faculty. Carole's teaching responsibilities included senior medical-surgical nursing, senior leadership/management, and a sophomore foundations in nursing course. Carole was both a theory and clinical instructor for these courses.

Carole stated that she was attracted to nursing education through her experiences as a new practitioner. She explained that as a new practitioner she wanted to become more proficient and more of an expert in her

field. Because of this she was drawn to education. She explained that in the clinical setting you are involved in teaching with the clients and staff. She believed that nursing education was a natural follow-up.

Carole stated that she had no formal preparation for teaching, other than doing in-service education, teaching CPR, and teaching coronary care classes to the staff. She explained that because her education was in administration there were no education classes. She stated that her only preparation has been through faculty development courses.

Carole was dressed neatly and professionally both during the interview and observation phase of the data gathering. Carole demonstrated a relaxed, open, and friendly manner to the researcher. During the interview Carole leaned slightly forward, was attentive, maintained good eye contact, and smiled frequently. Carole spoke with enthusiasm during the interview as demonstrated by voice inflection and use of gesturing. The researcher noted the same behaviors during student interactions. The students appeared comfortable approaching Carole to discuss their assignments and ask for assistance.

Educational Philosophy

Representation of educational philosophy was reflected in descriptive comments about clinical nursing educator roles, definitions of clinical teaching, the

ideal clinical teaching situation, what it means to be an expert clinical nursing educator, and the knowledge and skills needed to be an expert. Educational philosophy was further represented by observation of actual clinical nursing roles and demonstration of clinical nursing skills and theory based knowledge.

Carole described her role as guiding the students and helping them make connections. She saw her role as helping the students link theory to their practice. She stated, "I helped them work through what they were seeing with their assessment . . ." building on a nursing foundation and "bringing it all together." She further elaborated:

I don't do the skill, I have them do it and then work them through as they need. It is different for each student. Some students are much more comfortable, some are much more frightened. It also depends on the level of the student. I have the beginning student the very first time on the floor and I have the Seniors nearing graduation.

Carole defined clinical teaching as putting theory into practice. She stated that critical thinking goes along with this. She further defined clinical teaching as:

Fostering critical thinking in applying what is learned. It is fun because students will say to me in clinical evaluations, you know you can read it and read it and read it, and you can practice in lab, but when you have a real patient it's so different and I think that is the fun part of it, that is, helping it come alive for the students.

For Carole the ideal clinical teaching situation would involve having more time and a smaller number of students on the clinical unit. She stated that she would like more time to prepare and more post-conference time to do more teaching. She contended:

What is hard is when I have seven or eight students in a clinical area and I try to help all of them make connections and sometimes I don't feel like I do a very good job because I have too many. The ideal would be smaller numbers and really working more with the individual student.

Though Carole declared that she did not see herself as an expert clinical educator, she identified an expert clinical educator as one who helps make the connections for the students. Carole went on to say that an expert needs the theory to back up practice and must be a critical thinker in order to take in all that is known and help the students pull it together. She described an expert as needing not only a theory basis but clinical experience. She stated that an expert clinical educator needed to be competent as a practitioner. This competence can be attained by continued practice in the clinical setting outside of the teaching responsibilities. She stated:

Someone can be a lot brighter than I am and have a much better theoretical background. You have to have that, but you also have to be able to practice and make the connections.

In viewing herself as an expert Carole explained:

I guess I am very patient and the students think that I help make connections. I am clinically

competent. The students know that I practice and that I worked and that other people identify me as competent.

In response to the question about knowledge and skills needed, Carole identified the importance of a solid science foundation and at least a basic liberal arts background. An expert clinical educator "must be able to do all the basic skills that the new practitioners need to come out with." The expert needs to be able to interpret and apply the principles behind the practices of the profession. For example she stated:

I don't know that an educator has to be proficient at starting IV's and that kind of thing, but certainly knowing the techniques and how to teach are important.

Overall, Carole modeled what she identified as characteristics of an expert clinical nursing educator. She displayed facilitation by clarification, linking theory to practice and guiding students to make connections. This was demonstrated as she visited the rooms of assigned patients. Carole asked the students leading questions about the patient's condition, a treatment, or a medication and then gave the student a chance to respond. If they did not respond correctly she gave them a clue and quietly waited for the student to sort out the information. Correct answers were followed by "good" or "yes." Incorrect answers received the guidance of "have you thought about this" or "how does that work or come into play in this situation" or "what

other information do you need." Questions about patient diagnosis or issues that required confidentiality were not asked in front of patients or visitors.

Carole role modeled as she demonstrated skills. Empathetic communication skills were noted as she greeted not only patients, but staff and physicians, in a courteous and respectful manner.

Carole coached as she helped students work through new experiences. One example involved helping Anna change intravenous tubing and adjust the infusion rate. First she talked Anna through the procedure. Then she watched as Anna proceeded. Though Anna was slow and inexperienced Carole did not attempt to take over. When Anna completed the task Carole double checked and gave her a "good work." As Anna was doing the procedure, Carole gave the patient reassurance and asked Anna to explain the procedure in response to the patient's questions. During the procedure Carole was in a physical position to watch closely. She occasionally gave a word of instruction. Throughout the procedure positive feedback was given to Anna.

At the completion of the procedure Carole continued to work with Anna on establishing the infusion rate. She asked Anna to apply the information available to a standard formula. Anna was a little confused about the terminology and where to place the data into the formula.

Carole gave her several clues allowing her to find needed information and successfully solve the problem.

A similar situation was experienced by the student Beth. Carole began by questioning Beth about what was known and what she needed to find out. The student was hesitant but slowly followed through. Carole discussed this type of situation with the researcher afterwards. According to Carole, student inability to apply factual information into a standard formula was a concern to faculty. This was echoed by four participants in this study. Carole stated that students learn the concepts and principles early in their education. She stated that with the use of infusion pumps and unit dose medications, much of the preparation was completed by the pharmacist before the materials arrived on the nursing unit. As a result, nurses did not need to calculate dosages. She said other faculty did not reinforce this learning and she feels frustrated. She believed that it was the faculty's obligation to reinforce this and other learned skills throughout the curriculum.

A third example of facilitating student learning was demonstrated by the methods Carole used to assist a student in determining a patient's insulin dosage. The student had completed an Acucheck, a procedure to determine blood sugar level. This procedure was necessary to determine how much insulin to give. Carole

stood back as the student began to gather materials needed to prepare the insulin. The dosage involved mixing two types of insulin. Carole asked the student which one she needed to draw into the syringe first. The student did not answer. Carole asked the student what was the principle behind the method used for determining the correct order. The student gave several responses but did not answer the question. Several clues were given, though the student was unable to respond correctly. Finally, Carole gave a scenario and asked why and how this fit. Still the student did not arrive at the correct answer. Ultimately, Carole explained the principle to the student. Though this incident took about twenty minutes, Carole remained quiet and calm. Though the student should have had the essential knowledge to answer the question, Carole did not demonstrate frustration or irritation in her responses.

Carole employed evaluation as she repeatedly used questioning and constructive feedback with students. Nurturing seemed to be ingrained as shown in her listening, encouraging, and positive reinforcement. Carole demonstrated excellent communication skills not only with students, but also with patients. Students did not hesitate to ask her a question and did not appear fearful or threatened as she questioned or assisted them. Carole admitted that she does not have all the answers,

but believes that being an expert means that you are willing and know how to find the answers.

Her knowledge base was illustrated in the questions that she asked of the students. The students were questioned about the relation of theory to the clinical situation. Carole frequently pointed out principles of pathophysiology and pharmacology and asked the students how they applied to a specific situation. Carole exhibited principles of teaching and learning by allowing the students time to answer, repeating to reinforce learning, using more than one strategy to teach a concept, and by helping the student problem solve.

Value Perception

Perception of the value of clinical teaching was examined in relation to three areas. The participants were asked whether clinical teaching was valued by administration, colleagues, and students. An additional area of investigation questioned perceived recognition and rewards received for teaching in the clinical nursing setting.

Carole stated that she believed clinical education was valued by administration but not understood.

It is considered like a lab, like a chemistry lab and so chemistry lab goes from 3:00 to 6:00 and your nursing lab is scheduled from 3:00 to 9:00. Well they think you are there from 3:00 to 9:00 or six hours. You go at 1:30 and you don't get out until 10:00 or 10:30. Those extra hours are not seen as part of that clinical experience and they say, well there is prep time for chem labs and so on - totally

different. You are not dealing with a test tube, you are dealing with live human beings with all of the legal implications that go with liability. So I do not know if that is really, truly understood.

When asked if her colleagues valued clinical teaching Carole emphatically answered yes. She personally valued the opportunity to have contact with patients and to help the students make connections. She said "It's kind of a personal thing and it meets my own needs."

She believed that students valued clinical teaching. Carole stated that students continued to say they needed more clinical experience. Again she emphasized the example of the student who said "you can read it and read it and practice on each other, but until you get out there and have a real patient . . . it doesn't hit you."

As Carole reflected on the rewards of clinical teaching, she concluded that the fact that it was valued by colleagues and students was the reward. She explained that no special rewards or recognition were received for the role of clinical nursing educator.

Value was demonstrated by preparation of student assignments prior to scheduled clinical time. Value was also assumed by Carole's manner with patients and students. Carole assured that not only patient but student needs were accounted for before her own. Other examples of value were demonstrated by following protocol for procedures and limiting breaks to assigned times.

Role Orientation

Roles were examined from several aspects of the nursing profession outside of actual teaching. It is believed that these aspects have a direct relation on the qualities exhibited by a person considered to be an expert in his or her field. Role related questions included: Is nursing practiced outside the teaching setting? How is professional and intellectual stimulation received? What are preferred professional tasks? What are the traits of colleagues what are admired? What are the traits of colleagues avoided?

Carole stated that she practiced in her specialty area outside of her teaching responsibilities. She explained that she worked during school breaks, in the summer, and on weekends. She said that this helped her become more familiar with the type of patients that she assigned to her students. It also allowed nursing staff and physicians to become more familiar with her abilities. Because of this she believed that they trusted her decisions and were more comfortable working with her and the students.

Professional and intellectual stimulation was received most importantly from colleagues. She especially appreciated several colleagues who were willing to listen, to share, and to be supportive even when they did not agree with her. Other sources of

professional and intellectual stimulation were received from attendance at workshops and conferences.

In regards to professional tasks, Carole preferred the teaching portion of her job. She liked to teach by getting students involved and listening to where they were coming from. She admitted that she did not appreciate meetings. She exclaimed:

I think women in nursing, because nursing is mostly women, do a lot of nit-picky stuff at meetings that men would never tolerate. It is easy to withdraw from the conversation when it starts getting into nit-picky stuff. Let's just deal with what we need to and move on.

When Carole was asked what attributes she most admired in her colleagues she explained that a willingness to listen, to share, to be supportive, and to understand were most important. She said "I value them not only as professionals but friends." The attributes that she least admired included inflexibility, rigidity, and unwillingness to listen.

Problem Solving Strategy

According to the literature an essential talent possessed by experts is their ability to solve problem's more accurately than other people (Johnson, 1988). For the purpose of assessing problem solving skills, the participants were asked to describe how they deal with a difficult choice or a problem and whom they might go to for assistance.

Carole stated that when she had a difficult problem to solve or a choice to make she tried to look at the big picture. As she studied the whole picture, she considered what the ramifications would be for various options. She considered both the negative and positive aspects of her options. She identified that she had a favorite colleague, "kind of a mentor," whom she felt comfortable going to when she had a difficult decision to make.

During the observation portion of this case, Carole elaborated on a current clinical problem she had with one of her students. She stated that the problem was related to her concern in preparing seniors to shortly become autonomous graduates. Carole stated that students often complained about the size of their assignment and have difficulty prioritizing. Carole believed that the student experience needed to be as close to reality as possible.

She explained that she had a student who was having difficulty getting her work done. The student was over an hour late with medications and in checking her patients' vital signs. Carole believed in giving the student time to succeed, but was concerned about responsibilities related to patient safety.

Carole approached the problem by first talking to the student. During the discussion she helped the

student problem solve, that is, had her list what needed to be done for each patient, when it needed to be done, and what help she would need. She further asked the student if there were not ways to delegate or to share help with her colleagues. She suggested practical, real life advice and helped the student put the plan in writing in the form of a schedule for her experience.

Goals

Finally, Carole was asked several questions related to her professional goals. She was asked questions about where she saw herself in 10 years and what would lead her to make a change in her teaching role in the future.

Carole saw herself still in education. She said that she did not know how much she would practice outside teaching because "there are limitations with age." She admitted that she had been struggling with the issue of whether to pursue a doctoral degree. When asked what would lead her to make a change in her teaching role she identified that college or department policy changes limiting how she practiced could have an influence. She also identified that a philosophical difference with the faculty or department chair might lead her to change.

Rebecca

Rebecca was a 39 year old white female. Rebecca has been in nursing for 17 years. She has taught nursing for 10 years, all of which have been at her current position.

Rebecca's background included completion of the programs for a baccalaureate degree in nursing, a master's degree in nursing, and a doctorate in higher education. The doctorate in education was her highest degree held. Rebecca's teaching responsibilities included teaching an elective in transcultural nursing, nursing research, a foundations in nursing course, and community health nursing. Rebecca was both a clinical and theory instructor for community health nursing, which was a senior level nursing course.

Rebecca was attracted to nursing through her work in a health department. She found that in this position she often worked with students and enjoyed helping people learn. She explained that this was what prompted her to look into teaching.

As her master's degree was in administration, Rebecca did not receive formal class work in teaching. She explained, that when she decided to teach she talked to some educators whom she thought of as mentors and who she felt were good educators. They shared ideas about what she should read and how she should prepare for her teaching responsibilities. Rebecca explained that she did a lot of reading and had some idea about learning theory and learning style through her reading. These things were helpful to her as a novice.

Rebecca presented a relaxed and easygoing appearance. She was casual and unpretentious in her dress. Rebecca spoke enthusiastically of nursing and her experiences during the interview phase of the data collection. Interactions with the students during the observation phase also appeared to be relaxed and easygoing. Students did not appear to hesitate to discuss assignments or to ask for assistance.

Educational Philosophy

Representation of educational philosophy was reflected in descriptive comments about clinical nursing educator roles, definitions of clinical teaching, the ideal clinical teaching situation, what it means to be an expert clinical nursing educator, and the knowledge and skills needed to be an expert. Educational philosophy was further represented by observation of actual clinical nursing roles and demonstration of clinical nursing skills and theory based knowledge.

Rebecca described her role as facilitating learning. She stated that she tried to help students make connections by emphasizing what was talked about in class or read about in assigned readings.

I try to provide an opportunity for the students to learn the concepts that we have talked about in class. I also try to provide them with opportunities to have clients that they can learn from and that they can use their own experiences with.

According to Rebecca, the students "have had a lot of information and knowledge about relationships with clients" from their experiences with hospitalized patients. Even though they have had experience with relationships the context is different in community health nursing. She stated:

It is my job to help them understand the contexts of the relationship and taking care of someone in their home. A lot of the issues have to do with control and this is really the first time they have been in a relationship where they do not have a lot of control. The goals actually have to be mutual with clients and it isn't that way in an institutional setting.

She further identified that she spent a lot of time talking about values clarification, respect, and their responsibilities toward their clients.

As she talked about the significance of making connections Rebecca, stressed the importance of helping the students become critical thinkers and scholars. Rebecca assisted senior nursing students in these endeavors by encouraging them in writing, investigating problems and issues, and presenting research articles in the clinical setting. Through these avenues students can apply learning to real life situations.

Role modeling was also identified as an important clinical nursing educator role. Rebecca stated that she spent a lot of time role modeling with the students. She also role modeled with the clients so that the students "have an idea about how that works for me."

Rebecca saw herself as a resource for the students. She stated that even though the students come with a lot of their own knowledge about health, nursing, and relationships they may need assistance "clarifying or applying those sorts of things in a different setting."

Coaching was used as Rebecca guided students in their selection of clients. She explained:

I usually try to give them the opportunity to select clients that would be best for them or best for their experience. I usually try to give them the opportunity to select clients that they believe would be the most beneficial to them and sometimes I need to suggest do you want to select someone who will help you learn about what it is like to be poor or have a chronic illness or something like that. So I guide them a little.

Rebecca defined clinical teaching as helping the students "come to an understanding about what it is like to be a community health nurse." She defined the ideal clinical situation as one in which "both the student and I were prepared." An ideal clinical learning situation would provide multiple opportunities for learning and the clients would be receptive to the students. In an ideal situation "the clients would have some dynamic things going on that would be helpful to the student." Furthermore, clients would be willing to have the students help them.

When Rebecca was asked what it meant to be an expert clinical nursing educator she cited current nursing literature. Although she agreed with the importance of

practice and experience, she stated she was not entrenched in the strict criteria that identifies a specific number of years practice. Rebecca further expounded:

You can't be an expert in a year, I think it is right in that it does take a while, because expertise means that you have situations that occur and you learn from those and you gain new knowledge each time. Usually it does take a period of time, whether it is five years or not. I think there are people that have been teaching 25 years and whom I would not say are experts.

She explained that a person who became an expert was willing to learn from their experiences and to reflect on what worked and what didn't work. An expert was willing to receive feedback. Rebecca stressed that experience is also a major criterion. In addition, one needs to have a "feeling about scholarship or a commitment to scholarship." Rebecca further reiterated:

If you say that you are going to be an educator, then you have to accept the role of being a scholar. Knowledge is not static, and you have to be willing to say you don't know everything. You must realize that you are never going to know everything and you might as well be up front about that. There is no way that you can know everything, but part of your role is to become a scholar, to find out what those things are and what the issues might be.

Rebecca continued by describing other attributes she believed an expert should possess. According to Rebecca, an expert needed to be open and flexible. An expert must be willing to change and be non-judgmental toward students and where they are coming from. An expert should be self aware and willing to accept feedback.

Finally, Rebecca spoke about writing ability. She stressed that a good teacher needed to be a good writer. She further explained by saying that "in order to be a good writer you need to be able to synthesize a lot of knowledge." For Rebecca writing was the best way to synthesize.

When asked if there were any special knowledge or skills needed to be an expert, Rebecca again stressed the importance of being a scholar. She stated that "you have to have some fundamental knowledge about what it is to be a scholar and a nurse." Another important ability was that of critical thinking.

Rebecca identified the skill of being non-judgmental as being important. She stated that being open and learning from experiences are important skills. Rebecca explained that her knowledge about teaching might lead others to identify her as an expert. She stated that "she read a lot about teaching and has worked at teaching about ten years." She believed that she had learned from experience. She stated, "I am open to feedback and learning from my experiences." She further explained that she communicated easily with students.

Rebecca modeled the attributes identified as characteristics of an expert clinical educator. When a student asked Rebecca to explain an aspect of the assignment, she illuminated by giving an example.

Rebecca explained using the example of a young mother as the client. She stated that you would look at the total picture, including the children, the home environment, and available resources. You would consider which tools you could use to assess these aspects and arrive at strategies to provide care.

Rebecca facilitated learning by having the students share recent clinical experiences. The student Amy told about what had happened during her experience with a school nurse. She described a somewhat humorous incident about a child with a stomach ache. Rebecca made a teaching moment out of the situation by asking Amy why the school nurse handled the situation in the way described. She further asked the student to consider what might be the rationale for the decisions that were made by the school nurse.

Another student, Maggie, stated that she had been overwhelmed by her recent experience. Maggie identified that her frustrations began with difficulty getting past a parking attendant. Again Rebecca used this opportunity to encourage the student to consider what had happened and why. Rebecca listened attentively and offered constructive responses as to how to handle the situation in the future. She also nurtured the student by offering positive reinforcement for the way the student handled the situation.

Nurturing was also demonstrated by her concern for the student Katie who did not appear well. She asked Katie how she felt and touched her face. She asked her specifically if she had a cough or fever.

Several other students proceeded to explain various experiences. The whole atmosphere of the pre-conference was comfortable and easygoing. The students appeared to feel free to say whatever they wanted to the point of being a little disrespectful when speaking about clients, though a private environment was provided.

Rebecca conferenced with each student individually to evaluate their preparation for and understanding of the day's expectations. Rebecca asked each student to identify several areas of client need. She asked the students to explain what had previously been done for the client. The students were then expected to explain their plan for the day and rationale behind selection of interventions. The students were asked if it would be acceptable for Rebecca to bring the researcher with her into the client's home during the students' home visit. One student expressed some nervousness. Rebecca reassured her that she was doing well and had no reason to be concerned. This demonstrated a respect for each student as an individual.

The students were asked which goals they would be working on. For example, Julie stated that her client

had a problem with a knowledge deficit related to infant care. Julie proceeded to explain that her client was having difficulty understanding the feeding needs of a young infant. Julie continued to explain that the client needed winter clothing. Julie identified where resources could be found and how she would help her client get them. Rebecca coached her by reminding her to contact the Clothes Closet prior to leaving for her assignment.

Rebecca coached Julie to assess the baby and note the presence of Mongolian Spots on the infant's buttocks. Rebecca used this opportunity to determine Julie's understanding of the significance of Mongolian Spots, calling her attention to the fact that Mongolian Spots can be mistaken for bruises. In this way Rebecca guided Julie to make connections and clarify any misconceptions.

Sharon identified her frustration in caring for a family with blind children. She explained what she had done for the family already. Sharon stated that they needed blankets and that she was in the process of following up on resources. Rebecca reviewed the client record with Sharon and guided her in understanding the rationale behind "not just doing for the client but in empowering the client to care for himself or herself."

Rebecca continued to review client data and assessments with each student. Each student was asked to analyze the available data to determine client needs or

problems. Rebecca demonstrated critical thinking and problem solving by helping the students view data in a logical pattern and by providing cues to guide their thinking. This behavior could also be interpreted as modeling those two aspects of scholarly thinking for the students. Appropriate student responses were reinforced by nodding and by phrases such as, "good idea" or "yes, yes."

Erica shared a plan for her client. Rebecca asked specific questions about the client's medication and who helped him prepare his medications. Rebecca asked Erica to identify the teaching that would be necessary in relation to the medication. Rebecca guided Erica through her explanation by providing clues and by adding principles and knowledge where the student's responses were incomplete.

After the students were conferenced regarding their client needs and their plan for the day, the majority of the morning was spent visiting the clients and evaluating the students' performance in the clients' home. Attributes demonstrated by Rebecca in the home setting included facilitating, coaching, role modeling, evaluating, and nurturing.

She also demonstrated appropriate communication skills and demonstrated good teaching-learning principles

by modeling correct protocol and linking theory to practice through explanation and questioning.

After greeting Mr. Smith, Rebecca asked permission to wash her hands before observing the student proceed with the physical assessment. This would be an example of following protocol. As the student, Erica, continued to examine Mr. Smith and talk to him regarding what was happening in his life, Rebecca would lean forward, nod, and say "yes." Rebecca was seated at a slight angle next to the client and at his level. Rebecca modeled appropriate communication skills as Mr. Smith continued to talk about soreness in his heart. Rebecca would repeat words and phrases, that is, "soreness?" She would ask specific, concrete questions, such as, "what did you do to ease the soreness?" Mr. Smith continued by showing Rebecca and Erica a calendar where he kept track of things that happened to him. Rebecca offered positive reinforcement by saying "very good ideas." As he talked about how well he was doing, Rebecca encouraged him with, "Wow, that is great!"

As Erica continued with her assessment, Mr. Smith's medications were discussed. He showed them that he had his Nitroglycerine next to his chair. Rebecca probed as to whether he had taken the medication when he experienced the heart soreness. He claimed that he had not. Rebecca used this opportunity to assist the student

in explaining the proper use of the medication. Rebecca encouraged Erica to do the instruction and gave positive encouragement by nodding and saying "yes."

As Erica proceeded with the physical part of the assessment, Rebecca watched attentively as Mr. Smith's blood pressure and pulse were taken. Mr. Smith's blood pressure was higher than usual. Rebecca then asked the student to compare previous blood pressures with the current reading. Rebecca asked the client when he last took his blood pressure medication. Mr. Smith said that he had gotten busy and forgot to take it this morning. Rebecca asked the student what relationship this might have to the current blood pressure reading. With cues from Rebecca the student ascertained that this could have affected the current reading.

The physical assessment was followed with an Acucheck, which is a procedure for checking blood sugar levels in diabetics. As Erica prepared the equipment and commenced to carry out the procedure, Rebecca would nod, say "good," and occasionally coach the student, for example, suggesting the easiest way to position the equipment. At the completion of the procedure, Erica asked whether she should throw the lancet into the trash. Rebecca stated that this was acceptable. The researcher questions whether this was correct protocol for needle and blood precautions.

Similar attributes were observed with subsequent client visits. Rebecca frequently took advantage of teachable moments, not only with the students, but the clients. Most of the clients were from poor and diverse backgrounds. Rebecca provided suggestions for adapting materials and client teaching with consideration to the clients' educational and socioeconomic levels. An example was in the home of Lucy, a young women with a new infant and two other children under four. The infant had been suffering from diarrhea. It was discovered that the women had a broken refrigerator and was saving cans of pre-mixed liquid formula. Rebecca discussed the possibility of using a powdered mix, which can be prepared one serving at a time. She also suggested several options to refrigeration, such as, a neighbors refrigerator or placing formula outside, between windows, or in an unheated room, as the apartment did not have a functional furnace. All teaching was done with the emphasis on the client taking responsibility for the outcomes. As Rebecca continued to instruct the client, she emphasized the importance of washing hands and following written instructions for formula preparation. Rebecca praised Lucy for working to find an appropriate place for the infant to sleep and in her efforts to provide adequate infant nutrition.

Throughout the clinical experiences Rebecca was observed as playing not only a teaching role but a nurse role. She demonstrated a blending of the most important aspects of both roles. She continued to teach by asking probing questions, role modeling, reassuring, and providing clues and information, yet she practiced what she taught by demonstrating procedures, empathetic communication skills, and compassion toward not only the students but the clients.

At the completion of the home visits, Rebecca and the students met at the site of origination. Rebecca talked with each student about their morning visits. Information was processed and documented by the student. As the students proceeded to follow through on their assignments, Rebecca frequently responded with "tell me more about that." She probed for specific student responses using questions, such as, "what motor skills did the baby have" or "what did your senses tell you." Students were treated with positive regard as demonstrated by comments such as "good work" or "thanks." In several situations Rebecca did not have an immediate answer to student questions. She would proceed to help the student find the information in available resources or direct them where to look. The new information would be viewed by both Rebecca and the student and student's interpretation reinforced or clarified by Rebecca.

Value Perception

Perception of the value of clinical teaching was examined in relation to three areas. The participants were asked whether clinical teaching was valued by administration, colleagues, and students. An additional area of investigation questioned perceived recognition and rewards received for teaching in the clinical nursing setting.

Rebecca stated that she believed clinical education was valued by nursing administration. She stated that she believed nursing administration to be "committed to the philosophy that nursing is embedded in practice." She further stated that "if there was any issue, it would come from outside the nursing college."

Rebecca affirmed that teaching was valued by her colleagues and herself. Rebecca believes clinical teaching to be "real exciting." She stated:

I derive a lot of energy from teaching. I like it because it is always new things and you are always being challenged. There is always something new happening and I feel like I can have an impact on the way people think.

When asked whether she believed students value clinical experience, she stated that students see clinical as the most important part of their education.

I think they are good consumers of education. They want to get the most that they can from the clinical experiences that they have.

As Rebecca reflected on the rewards of clinical teaching, she concluded that the reward comes from students.

I feel more rewarded in clinical than I do in the classroom. I am able to see the direct correlation of the things that I have helped them deal with come to completion. In the classroom setting, you talk about the clinical, so I guess I get more rewards from the clinical.

She explained that no special recognition was received for the role of clinical nursing educator.

Value was demonstrated by preparation of student assignments prior to scheduled clinical time. Value was also assumed by Rebecca's manner with patients and students. Rebecca ascertained that not only patient but student needs were accounted for. Value was also demonstrated by following protocol for procedures and acknowledging the student as an individual with not only educational needs but personal needs, which affect learning.

Role Orientation

Roles were examined from several aspects of the nursing profession outside of actual teaching. It is believed that these aspects have a direct relation on the qualities exhibited by a person considered to be an expert in his or her field. Role related questions included: Is nursing practiced outside the teaching setting? How is professional and intellectual stimulation received? What are preferred professional

tasks? What are the traits of colleagues who are admired? What are the traits of colleagues avoided?

Rebecca stated that she did not currently practice outside of her teaching role though she had in the past. Rebecca emphasized "I think of education as my practice. That is really what I do."

When asked where she received most of her professional and intellectual stimulation, Rebecca identified two sources.

I get a lot of professional stimulation from talking to my colleagues. If I have a lot of colleagues who are good thinkers I talk to them about ideas, so they can help with issues. The other place that I get a lot of stimulation from is from reading. I like to read a lot of professional journals. I probably read six or seven a month. This is not much compared to some people, but for me it seems to be enough. It gives me a lot of good ideas that I can apply in the classroom or implement in the clinical setting.

The professional task most preferred by Rebecca was teaching. She stated that she enjoys discussion about curriculum. Activities that require use of nursing knowledge or education knowledge were also high on the list of preferences. Least preferred tasks included "some committee meetings, especially involving activities that are routine tasks."

The attributes of admired colleagues included being good thinkers and scholars. Rebecca said that admired colleagues were "people who you can have a discussion

with and will stimulate your thoughts." She further explained:

They may not always agree with the way you are thinking but will certainly help lead you to information that will tell you how they think and why.

She further described admired colleagues as being non-judgmental, supportive, and stimulating. Admired colleagues were also supportive of change.

When asked about attributes of those least admired Rebecca explained, "I hate to think about that." She said that she tried not to be negative. Attributes that were identified as probable barriers included not being open and rigidity.

Problem Solving Strategy

According to the literature, an essential talent possessed by experts is their ability to solve problems more accurately than other people (Johnson, 1988). For the purpose of assessing problem solving skills, the participants were asked to describe how they deal with a difficult choice or a problem and who they might go to for assistance.

When asked how she solved a problem or made a difficult choice Rebecca described a sequence of behaviors. First, she stated that she tried not to do anything immediately. She explained, "I have learned from the past that I sometimes jump too quickly and I don't have all the information." Her next step was to

find out if the situation was affected by a policy or rule. At this point she said that she might talk to a colleague or administrator about the situation to ascertain its relation to the philosophy. Rebecca explained that this first phase gives her time to reflect. She further elaborated by saying that she considered not only her role in the situation but student factors, which may have had a relation to the situation.

Rebecca illustrated:

Was the problem because I was angry at this student? Was there some personal thing there or was I angry about their professional conduct and that is affecting my judgment? This is the approach I take when the situation is not life threatening.

If the situation is life threatening, she explained that she deals with it right away.

If the situation involved something that was incongruent with her belief system, Rebecca continued by telling the student about her concern. She proceeded to explain what her concern was. At this point, she suggests that both she and the student need time to reflect and recommends setting up an appointment for the following day. She continued:

We need time to think about what happened and what we can do about it. This gives me time to think about it and to collect data about whether there is a rule about this in our program. I will also go to a colleague and ask what would you do if this happened. What are my options? At other times I will say, this is just like something that happened five years ago. This person is like Sally and I did this with Sally. Maybe this worked well for her and the current student is a lot like her. I could try

that. I use the experiences that I have had. Soon not all the problems get to be new. They are problems that I have faced before, so I usually have some experience in dealing with them.

When the time came to meet with the student, Rebecca shared her reflection with the student. She allowed the student to share how he or she felt about the situation and to explain how he or she viewed the ramifications. She explained that the most common example of a student problem was lack of student preparation. This was dealt with using the sequence as described above. Rebecca stressed the importance of considering the potential internal student factors, such as, home problems or financial problems. After the problem was clarified, Rebecca helped the student learn how to prepare. The issues surrounding the problem were discussed and compromise was considered if appropriate.

Goals

Finally, Rebecca was asked several questions related to her professional goals. She was asked questions about where she saw herself in 10 years and what would lead her to make a change in her teaching role in the future.

Rebecca would like to see herself writing and publishing in 10 years. She stated she will probably continue at her current teaching position and continue to revamp her course every two to three years.

A situation that might lead her to make a change would be a faculty decision based on special needs.

Need for intellectual challenge and salary would also be factors that might lead to a change.

Jessica

Jessica was a 62 year old white female with 42 years of nursing experience. She has taught nursing all but four years of this time. Her educational background included completion of an RN diploma program, a baccalaureate in nursing program, and a master's degree in education/counseling and guidance. Her highest degree held is the master's degree in education. She has taught at her current position for 18 years.

Jessica's teaching experience included several non-nursing courses including Anatomy and Physiology at the high school level and a holistic health course at the collegiate level. Her current teaching responsibilities included psychiatric/mental health nursing and nursing research. She is both course and clinical instructor for the psychiatric/mental health course. Psychiatric/mental health nursing was taught to senior nursing students at this college.

Jessica's formal preparation for teaching included six courses, mostly in the area of measurement, evaluation, and advising. She explained that she did not have many courses on actual teaching, but probably learned more from role models in educational teaching.

Course work focused more on how learning took place than on how to teach.

Jessica was a very neat and carefully dressed woman. The researcher would describe her as having a lot of energy. She was actively involved in being a clinical nursing educator and was noted to have unlimited enthusiasm as demonstrated by her voice and activity level. Though she was not casual with the students, the researcher did not detect any hesitation or nervousness on the part of the students as they worked with Jessica. Jessica's students described her as very caring and positive. They stated that they were expected to be prepared for their clinical assignment and participate in or lead group discussions.

The researcher believed Jessica to be creative as she was constantly looking for new experiences for the students and new strategies to teach the theories and concepts. Jessica believed that nursing educators were responsible for preparing the students to be independent practitioners, but felt that this was difficult within legal and safety guidelines. Her goal for students was to facilitate the best learning while not adding to faculty burden. She stressed the importance, for those who teach a clinical course, to have expertise in that area.

Educational Philosophy

Representation of educational philosophy was reflected in descriptive comments about clinical nursing educator roles, definitions of clinical teaching, the ideal clinical teaching situation, what it means to be an expert clinical nursing educator, and the knowledge and skills needed to be an expert. Educational philosophy was further represented by observation of actual clinical nursing roles and demonstration of clinical nursing skills and theory based knowledge.

Jessica indicated that one of the most important parts of her role as a clinical nursing educator was that of role model. She shared her belief in a caring philosophy. She stated that in order to teach caring "you need to role model it, discuss it, and bring it out in the students."

A second important role was that of facilitator. Jessica defined this aspect of her role as helping the students "pull it all together." In describing this role Jessica used the example of holistic client care. She stated that "you need to incorporate all the concepts, not only growth and development, but physiology and a hierarchy of needs." She asserted that a nurse does not just work with a certain part of the client but a whole client.

Jessica facilitated learning by asking the students to present their experiences and share their perceptions with the other students in a seminar format.

When they get out of the seminar they just rave about it. They are excited. I am also excited. I cannot believe the talent that these students have. They leave with learning so much about their own power, feel empowered, and they tax their knowledge and skills to the limit.

Part of the facilitator role included accessing information. Jessica believed that information opens doors, not only for the student, but for the client. She saw her role as assisting both students and clients in discovering sources of knowledge. In addition, she indicated that part of this role involved sharing her knowledge and understanding with the students.

Coaching was used to help students arrive at their own conclusions. Jessica utilized coaching by questioning, encouraging the students to share their observations and interpretations, and by providing keys or clues to foster problem solving.

Nurturing was expounded by the emphasis on an holistic, caring approach, not only with clients, but with students. Jessica explained that for too many years nursing educators have been "hooked on an objective, mechanical education process that was dehumanizing to students." She believed in taking time, listening, and talking with students. She explained by sharing an example from her own experience as a student.

I remember still to this day the nurse who bawled me out because I didn't get my medicines passed on time. I thought, lady, if this is what nursing is all about count me out, because I will never make it. That's not what I am all about, I want to talk to the client, to find out what is going on. I believe in taking this kind of approach with my students.

Jessica described one role, which was quite different from those described by other participants. She described herself as an actress. She explained that she liked to act out concepts and situations.

I love to act. I like to act out stuff, and I think that is part of teaching. In order to act and you have to know and understand how to get peoples' attention. I put the theory in the acting frame to promote learning.

Jessica defined clinical teaching as "guiding, consulting, assembling, and creating an environment for learning to take place." She stated that clinical teaching included surveying all possible settings where nursing could take place and evaluating the opportunities that existed for lived experiences. She explained that each new opportunity provided new possibilities for helping students put new pieces together. Each new opportunity provided a new challenge and way for students to operationalize their learning.

Clinical teaching also included conferencing. Conferencing provided a dialogue for the lived experiences. In the group conferences students extrapolate information to affirm what they have learned. She explained that this was also linked to classroom

learning. In class the students shared what they had experienced and this enhanced learning for all of the students. Jessica concluded that this experience was like a cycle, as new classroom learning was again taken back into the clinical setting.

Jessica described the ideal clinical teaching situation as an environment where there will be more learning taking place, more learning opportunities, and more teachable moments. The experiences would be more positive for the students and would provide more challenges. An ideal clinical experience would provide more of a realistic experience for the students instead of contrived and mechanical. Jessica stated that an ideal clinical experiences would have a small group of students. The ideal provides an opportunity for students to interact and to learn how to connect. She further stated:

In an ideal situation the students build a relationship with their client. They have opportunities to see their client frequently and attend group therapy with the client. The student becomes part of the group therapy. This provides an opportunity for the client to develop trust with the student.

Increased student collaboration with staff would also be a part of the ideal. This would help the student feel respected and more a part of the team. An ideal would include a staff who invited the student to share their thoughts and thanked them for it.

The ideal clinical teaching situation provided more time for conferencing the students. Jessica explained that in most clinical situations there was too much going on and every student's clients were at a different level and function within a different time frame. She stated that her current teaching rotation nears ideal in relation to providing conferencing time.

In chemical dependency all the clients are in group therapy at the same time. They are all in free time at the same time. Therefore, the students and I can do things together that you ordinarily just could never put together and the students want this time. The students want that organized time with this group and this learning setting. In this setting we can get together on case studies and give each other suggestions and I can ask powerful questions and I don't have time to do that on a one-to-one. I can ask them key questions, plus they are creating their care plan, so it is like a double learning situation. This is exciting. We pull it all together to share and discuss, but the time is still too limited.

An ideal learning situation included all students growing as persons. Jessica explained that students often come with their own barriers or baggage. Experience in the psychiatric/mental health setting often brought these factors to the surface. Ideally the students would be able to gain insight about themselves and realign some of their rigid and judgmental beliefs and ways of thinking.

When asked what it means to be an expert clinical educator Jessica responded:

For me to know that I am an expert is very exciting. It helped me first of all to accept it myself. I

haven't always realized that I was an expert and I missed by not knowing.

Jessica continued by explaining a situation which led her to recognize that she was an expert in her area. She described a situation that involved a student who was not successfully meeting clinical expectations. Jessica went to a colleague and shared her concerns, how she had handled it, and her proposed plan. Her colleague said, "you are the expert" in this area, trust your experience and knowledge. Jessica stated that she began to realize that she was indeed the expert. She stated, "we owe the experts to the students and I don't know if I would ever want to teach in any other area." She further illustrated:

We have all these teachable moments that we can make so much of when we are the expert, because it is right there with us. I suppose because we have so much to draw upon and because we are the expert we can create almost anything out of nothing. Every time my students go through chemical dependency, they all learn something in a different way, because I almost always use a teachable moment to draw from it. I think the expert can keep extracting from these experiences. It is just there and you can pull it out. Even if you leave the situation saying I goofed, that was a teachable moment and I didn't use it. That is alright, at least you can learn from that too. That is part of what the expert is to me as I unfold. I think the students are really smart, they know when they have an expert. I think they even mourn a little when they don't have the expert, they mourn the loss, but I don't know if they can articulate that to themselves. It is hard to go through a course when you are mourning.

Jessica continued by expounding on the concern she had about the common practice of faculty teaching in clinical areas where they have little experience.

Jessica described an expert as someone who was "tried and true" and had experienced the clinical setting "inward and outward and had a basic sense of intuition." An expert was willing to continue to learn and bring aspects of their practice into the clinical teaching situation. An expert must be willing to change and learn from experience. Jessica explained that new experiences were interesting and exciting. Change caused some discomfort, but "it is important to be uncomfortable. The more you are uncomfortable, the more you are right on target." She further explained that "by finding out something about myself, some learning is going to take place for me."

Jessica spoke about the importance of having a philosophical basis behind practice and teaching. She stated, "I am hungry for philosophy, I crave it." A philosophical basis provided meaning for practice. Without a philosophical basis practice and teaching "are objective, mechanical, and dehumanizing."

Knowledge needed for Jessica included a strong philosophical and theoretical framework for the clinical specialty taught. She stressed the importance of a solid theoretical basis for clinical practice. She stated that

she had espoused various theories throughout her years of experience. For Jessica this continued to be part of her learning and growing experience and part of becoming an expert.

In addition to providing a theoretical basis for practice an expert needed a sound understanding of the foundation courses, such as, pharmacology, pathology, and physiology. An expert clinical educator needed to have an understanding of medications, lab values, and nursing interventions. Furthermore, an expert must be willing to admit that they do not have all the answers and be willing to continue to learn.

Skills needed include being able to collaborate with the nursing staff and communicate effectively. Other skills described relate more to sensitivity in dealing with people. Jessica explained that insight into oneself, recognition of the teachable moment, and knowing how to challenge the student were all important clinical teaching skills.

Jessica demonstrated the attributes that were described as characteristics of an expert clinical educator. Jessica began with conferencing each student individually on their assignment. She reviewed the previous day's assignment for completeness and correctness. Each student had an opportunity to report on data collected about their client, including history,

medications, treatment, and current problems. During each conference Jessica demonstrated excellent attending skills. She sat at a slight angle to the student, leaned forward, and maintained eye contact.

Each step of the assignment was reviewed. Coaching and facilitating were demonstrated by giving the student an opportunity to speak about each aspect of the assignment. Jessica occasionally asked for an interpretation. In one example, Jessica asked the student, Jennifer, if she understood the diagnosis of paranoid disorder and could make sense out of it in relation to her client. The student did not respond. Jessica asked if the client demonstrated certain characteristics. The student responded with an uncertain answer. Jessica then asked her if she had read the assignment; the student admitted that she had not. Jessica encouraged her to read the assignment and to especially look at the theoretical basis for the problem prior to doing the written assignment and in preparation for her clinical experience. She continued by offering to help the student find appropriate resources in addition to the text. Jessica also offered the use of her own resources.

Jessica continued to coach the student through the conference by providing clues about the client's relationships, perceptions of childhood, and diagnosis.

She facilitated learning by using leading questions or suggestions of what the student should look at to help make connections and arrive at a conclusion. Jessica promoted the student's accountability by asking her to be prepared to share her findings with her classmates at the post-conference.

Jessica next asked Jennifer what she knew about their client's medication. Jennifer admitted that she had not looked it up. Jessica provided constructive feedback by explaining that as a future nurse it was important to understand the action and side effects of her client's medications.

Jessica continued the conference with Jennifer by giving information, supported by theory behind one of the clients physical problems. By providing this basis Jessica helped the student link theory to clinical data and observations. At the completion of the conference, Jessica nurtured the student by providing positive reinforcement and encouragement. Jessica stated that she recognized that Jennifer had good rapport with her clients and good interactive skills. She told her she was doing a good job.

Jessica further demonstrated good communication skills by asking Jennifer how she felt about the experience and then rephrased the student's response. As Jessica continued to discuss Jennifer's client, Jessica

would often be noted to lean slightly forward, nod frequently, occasionally rephrase student comments, and say "yes." Jennifer proceeded to describe the client's rocking behavior. Jessica said, "rocking, what do you think that means?" As the student explained, Jessica would nod and emphatically say "yes, yes!" After the student completed the explanation, Jessica cued her to keep this behavior in mind when she looked up the side effects of the medication.

Throughout the conference with Jennifer, Jessica demonstrated principles basic to the teaching of psychiatric/mental health nursing. A strong emphasis was placed on therapeutic communication skills and viewing the client holistically. Furthermore the importance of principles of pharmacology, pathology, and physiology were brought out as the student was questioned and guided in making connections.

The next student with whom Jessica conferenced complained of not feeling well. Jessica demonstrated nurturing as she told Mary that she needed to take care of herself. Mary decided that she would stay for the morning experience.

As Jessica reviewed Mary's assignment, she encouraged and provided positive reinforcement. Jessica stated that she loved what Mary had done and proceeded to share the assignment with the researcher. She praised

the student for her thorough, neat, and well organized assignment. Jessica continued to stress that Mary had done a good job looking up Schizoaffective Disorder and relating it to her client's needs. Jessica pointed out to the student the way she had classified the client's medications would help her learn them better.

As they began to discuss the current assignment, Jessica encouraged the student to do the talking. Jessica occasionally coached by rephrasing or asking a question. Jessica also picked out key words, such as aggression or delusion, and asked Mary how this tied into the client's diagnosis. Jessica guided Mary in making connections by comments such as, "does your client stay focused or does she get off on a tangent." Jessica appeared to be pulling specific points out of the student explanation and directed them back toward the diagnosis and client needs. As Mary proceeded, Jessica would frequently nod and say "yes" or "good job."

Jessica conferenced the next student in a similar manner. The student, Betty, was asked about her client's symptoms and diagnosis. Jessica asked her, "why did this happen, is it brain functioning or did your client stray from her medication regimen?" Jessica gave clues in her questioning and then allowed the student to link the suggestions with known facts. Jessica was noted to nod, say "yes", and occasionally rephrase what the student

said. Occasionally Jessica asked Betty what she thought about an aspect of the case. Throughout the conference, Jessica continued to consider what the student was saying. Jessica responded with, "Now I am hearing you say. . ." or "Let's look at the big picture."

At the completion of the conference Jessica praised the student for being thorough. Jessica told Betty that she had good communication skills. Jessica was noted to end each conference by summarizing what was accomplished, identifying new goals, and by specifically listing and praising behaviors, which the student did well.

Jessica continued to have an individual conference with each of her students. Each conference followed a similar format as the three described above. Throughout each conference Jessica was noted to help students link theory to practice, guide them in making connections, clarify, and coach them by questioning and offering clues. The quality of each student's work was evaluated as Jessica reviewed their written assignments and constructive feedback was offered to each student. As each student was questioned, Jessica consistently demonstrated good communication skills and offered frequent, specific, and positive feedback.

The final part of the morning was spent in a group conference. Jessica framed the beginning of the conference by saying: "Let's talk about what happened

today and the learning that has taken place." Each student then shared something that happened and how it was handled. Jessica asked the student what they thought or how they felt about it. She encouraged students to share their feelings and give a rationale. She helped link theory to practice and make connections by asking the students if this experience could be used in another situation. Throughout the group conference Jessica asked questions that related clinical experiences back to theory. For example, Jessica asked, "What takes the place of this client's addiction if we take his alcohol away?" Incorrect answers were clarified in a positive way, such as, "You probably mean. . ." or "A better definition might include. . ." When a question was asked that no one responded to Jessica proceeded to teach, giving real examples of how this diagnosis could be recognized or cared for. She described specific features and repeated or rephrased key concepts. Pharmacology, physiology, and pathophysiology principles were used to explain what was happening with clients.

Jessica encouraged the students to lead the conference. Each student presented their case followed by questions and responses from the group. If Jessica noted any student not participating, she would direct a question to them. The researcher's overall impression of the group conference was that of peer-led group process.

Jessica's roles included facilitation, coaching, and nurturing.

Value Perception

Perception of the value of clinical teaching was examined in relation to three areas. The participants were asked whether clinical teaching was valued by administration, colleagues, and students. An additional area of investigation questioned perceived recognition and rewards received for teaching in the clinical nursing setting.

When Jessica was asked whether she believed clinical teaching was valued by administration, she stated no. She believed this was especially true on a campus that housed multiple disciplines. Nursing administration generally valued clinical teaching because that is what nursing is all about, but the other disciplines do not understand the focus and often likened it to a laboratory course.

Jessica explained that nursing administrators have not always valued clinical teaching. She stated that in the past faculty felt devalued because clinical teaching time was not given the same ratio as classroom teaching. She believed that this had changed on her campus because faculty had begun to say, "This is not OK." She stated that nursing educators needed to stress the fact that clinical teaching was "planned for, strategized for, and that the clinical instructor is present every minute."

Jessica blamed nursing faculty for part of the lack of understanding and respect. Too often clinical teaching was viewed as second to classroom teaching. Jessica believed that nursing educators needed to stress the importance of clinical teaching by emphasizing their role, especially to those in other disciplines. She stated that too often we say, "I am in the hospital with the students." She believed that this gave others the impression that clinical nursing educators sit around while the students do the work. Jessica stated:

Clinical nursing educators have been talked into this position and that is why we put up with it for so long. It is because I put it down thinking maybe it is not like being in the classroom.

Jessica believed that clinical nursing educators needed to be willing to say, "No, I cannot come to the meeting, because I am in the clinical setting" or "Our clinicals do not fit in with the overall college schedule." She concluded by saying that, "It is a different type of teaching, but that does not mean that it is less valued."

Jessica expressed the belief that her colleagues valued clinical teaching. Experiential learning is at the heart of nursing education. She stated that being in the nursing education building keeps nursing educators focused on the importance of clinical teaching or supervision. She stated, "I think we understand each

other very much compared to some of the other disciplines."

Though students can often look back and understand the value of clinical education, at the time they are going through the process they do not always appreciate it. Jessica stated that students often allowed their fear and anxiety over the new experience to block their understanding of the focus of clinical education. Students complained about the amount of assignments, which they describe as busy work. Nursing educators need to help the students see the connection and link the written work to practice.

Jessica envisioned the reward of clinical teaching as the contact with students. She stated that it is rewarding for her to hear the student rave about a seminar discussion or get excited about a clinical experience. For Jessica reward was the "a ha" from the student who had a successful morning with a client. Jessica continued, "They are all alert, all alive, and are coming back excited." Student empowerment through learning was valued by Jessica.

Recognition came from the faculty and administration. She explained that her input as an expert was valued on certain committees. She stated that she was also recognized as a pioneer for her exploration of new clinical learning experiences.

Jessica demonstrated value in the clinical setting by respect for each student as an individual. This was continually demonstrated by positive reinforcement for correct interpretations and assignments well done. Regardless of the level of student ability, Jessica found work worthy of praise. Value was also demonstrated by a respectful manner in which clients and their diagnoses were discussed.

Role Orientation

Roles were examined from several aspects of the nursing profession outside of actual teaching. It is believed that these aspects have a direct relation on the qualities exhibited by a person considered to be an expert in his or her field. Role related questions included: Is nursing practiced outside the teaching setting? How is professional and intellectual stimulation received? What are preferred professional tasks? What are the traits of colleagues that are admired? What are the traits of colleagues avoided?

Jessica explained that practice for her involved a case load of clients. She stated that she was licensed as an advanced registered nurse practitioner and practiced in the area of holistic mental health. She is currently taking classes to prepare for certification in this area. She acknowledged that she was in the process of putting together a resume' that explained her

capabilities. She illuminated by saying she did not know if she wanted a private case load or to be part of an agency.

Jessica received professional and intellectual stimulation from colleagues, not only her peers on the faculty, but also colleagues at clinical sites. She also received stimulation from reading journal articles and in preparation for certification. She further explained that she could often include students as colleagues. She described this as the use of open-ended questions and tests that brought out strong, intense ideas in the students. This provided an opportunity for a teaching moment and it also stimulated her to go back and research or clarify their answers.

Attributes of admired colleagues included critical thinking and learning. Jessica explained that she appreciated colleagues who carved out new paths. She explained that they were ready to take risks and learn from new experiences. She stated that this stimulated her learning and growing. Admired colleagues were also respectful, supportive, and modeled caring.

Colleagues that she would seek to avoid were people who "drained her energy." She explained that these people do not allow her to feel free to be herself. They leave you feeling tense and tired. They are in a state of discontent.

Jessica described preferred tasks as including activities that were challenging and involved creating. She preferred tasks that called for an intellectual challenge and expertise. Examples of these tasks included curriculum development and committee work where one can use their abilities.

Problem Solving Strategy

According to the literature an essential talent possessed by experts is their ability to solve problems more accurately than other people (Johnson, 1988). For the purpose of assessing problem solving skills, the participants were asked to describe how they deal with a difficult choice or a problem, and who they might go to for assistance.

Jessica described a process that she utilized when she had a problem or difficult decision to make. She explained that it was important to take time to reflect on the problem. She stated that she found it helpful to be rested and sometimes exercised when she had problem to solve. The next step involved working through resources. She explained that colleagues provided the most valued resource. If the problem involved a student, she would make an appointment with the student to discuss the situation. She explained that the discussion provided an opportunity for the student to clarify the concern or issue.

Jessica illustrated by providing an example of a recent occurrence. She explained that a student came to her and requested that she change the score on a test that was taken several months ago. The student had come up with a different answer and challenged Jessica's choice of a correct solution. Jessica stated that she listened to the student's rationale and reviewed the test and rationale with her. She also discussed the situation with the department chair. Jessica explained that if she co-taught with a colleague, the colleague would have been approached before the chair. The chair was approached about precedent for accepting the type of answer the student proposed. Jessica explained that it was important to make a timely decision and bring closure to this type of situation.

Goals

Finally, Jessica was asked several questions related to her professional goals. She was asked questions about where she saw herself in 10 years and what would lead her to make a change in her teaching role in the future. Jessica stated that she would probably be out of teaching in 10 years. She explained that she would like to have her own clients in the area of holistic mental health nursing.

Circumstances that would lead Jessica to make a change included a restricted and confined environment.

She stated that this would be stagnant and she would not want to sacrifice her beliefs about teaching and learning to maintain this type of environment. She also explained that lack of respect and value would lead her to make a change.

Laurie

Laurie was a 52 year old white female who was a veteran of nursing for 21 years. Laurie had 18 years of teaching experience in nursing, 14 of which have been at her current position. Laurie's educational experience included completion of a diploma program in nursing, a baccalaureate in nursing, and a master's degree in nursing. Laurie has completed all of her course work toward a doctorate in education with a focus on instructional design.

Laurie's teaching responsibilities included pharmacology, physical health assessment, mental health nursing, and fundamentals in nursing. Laurie was course and clinical instructor for both mental health and fundamentals in nursing. Mental health nursing was taught at the junior level and fundamentals in nursing at the sophomore level.

When asked how she was prepared for her teaching role Laurie stated: "You are always prepared a little as you go through school and see instructors that you like or don't like." She explained that you get a feel for

what is good teaching and what is poor teaching. Laurie stated that during her master's program she took as many courses as she could that were related to education and role preparation for teaching. At the university she attended, she received positive feedback from the teaching team she worked with and explained that there was always a good role model and someone with whom to consult.

The researcher describes Laurie as neat and organized in the clinical setting. Students appeared to feel comfortable in demonstrating skills and discussing problems with Laurie in the clinical setting. Laurie was relaxed yet maintained control of the clinical setting.

Educational Philosophy

Representation of educational philosophy was reflected in descriptive comments about clinical nursing educator roles, definitions of clinical teaching, the ideal clinical teaching situation, what it means to be an expert clinical nursing educator, and the knowledge and skills needed to be an expert. Educational philosophy was further represented by observation of actual clinical nursing roles and demonstration of clinical nursing skills and theory based knowledge.

Laurie described her role of clinical nursing educator as a facilitator of learning. Laurie explained that in this role she provided direction for student

learning. She linked theory to practice by assuring that the students' clinical assignments reflected the focus of the materials being presented in the classroom.

Much of Laurie's clinical responsibilities involved functioning as a role model. The course that was being taught at the time of the researcher's observation was a fundamentals in nursing course. The very nature of this course suggested the need for demonstration of skills and behaviors.

Laurie's role also involved coaching. According to Laurie, coaching was done by providing hints and clues to the students as they demonstrated clinical behaviors. Laurie displayed this role by questioning the students while they demonstrated specific clinical skills and behaviors. Questions used appeared to lend clues to the students about what was expected. They also provided an opportunity for the students to correct inappropriate behaviors prior to a final evaluation.

Laurie explained her role as an evaluator. She stated that it was her responsibility to assess student preparation. Laurie further demonstrated this role by frequent constructive feedback during actual student demonstrations.

Nurturing behaviors were viewed as an important part of Laurie's role. Laurie explained that she took care not to overwhelm the students with an assignment while

maintaining client safety. Laurie was frequently noted to listen attentively to student responses, nod frequently, and offer positive reinforcement in the form of words of encouragement.

Laurie defined clinical teaching as guiding students. She stated that she expected the students to come with a knowledge base and it was her responsibility to help them apply it in certain situations. She further explained that clinical teaching was also problem solving and evaluation. Problem solving was described as assisting the students in applying a problem solving process to satisfy client needs. Evaluation involved judging the successful accomplishment of outcomes. She summed up clinical teaching as "more of an experiential kind of a union."

Laurie described an ideal clinical teaching situation to include smaller clinical groups. She stated that ideally she would like to have a clinical group of one or two students. She explained:

You could really observe what they were doing and have time to talk with them and process what had been happening. So you could really have a feel that you knew what they were thinking. You could also get a feel for that student as a person.

An ideal clinical teaching experience would also be free of extraneous variables. Without the limitations of extraneous variables and a large clinical group Laurie explained:

Clinical experiences could be tailored specifically for the students rather than having to worry about patient census for eight students and making sure that all eight of them got an OK experience rather than one or two get an excellent experience.

An ideal clinical experience would also reflect current classroom content.

In response to the question about what it meant to be an expert clinical educator, Laurie explained that "the expert has to be very knowledgeable in the field she teaches." Furthermore, the expert must be able to assist the student to identify the important pieces of information in the practice setting. The expert clinical nursing educator must also be able to guide the students in seeing the relationships or the consequences of the information for the patient.

Laurie stated that an expert clinical educator must have excellent interpersonal skills in order to be able to deal with diversity in students and clients. Laurie explained:

An expert must be able to support the students doing their best, to support them being able to take risks, to support their being wrong, to support them when they make mistakes so they can learn from all of those kinds of behaviors. An expert has to be enthusiastic about what she is teaching and that is what is difficult because you do not always feel this way.

An expert clinical nursing educator must be able to guide students in pulling pieces of information together when they are looking at a complex patient picture.

Laurie explained that an expert needed to be "constantly

diligent in encouraging students to work hard" at pulling information together. She believed that it was too easy for educators to become complacent, hence, the students did not receive the quality of education they deserved.

In regards to knowledge, Laurie believed that an expert clinical nursing educator needed a broad base in nursing. She illustrated by explaining that you don't just have a patient with a psychiatric problem. The patient may have physiological or social factors that affect his mental status. An expert must be willing to admit that he or she may not know everything, but need to know how and where to find information. Laurie explained that an understanding of educational principles was also helpful, though "there are many who may never have had an education course and just intuitively know the sequence of materials and how to capture people's interests."

Important skills needed were identified as good people skills, good interpersonal skills, and good communication skills. Laurie also included the need for conflict resolution skills, and assertiveness. An expert clinical educator needed to have knowledge and ability to demonstrate basic clinical nursing skills. Other skills that Laurie found helpful were the ability to be open to different perspectives, to be tolerant of mistakes, and to find positive attributes in everybody.

The clinical observations with Laurie took place in a skills laboratory. Laurie was working with six sophomore nursing students in a fundamentals course which is usually a basic or beginning course. Fundamentals courses are designed to prepare the students for their first clinical experience with real clients. Throughout the morning Laurie was involved with demonstrating skills and having the students perform return demonstrations. For this experience the students were working in pairs.

Laurie began the lab experience by coaching the students. For example, she said, "If you forget your supplies what would be the consequences?" Several students responded with a correct answer. Laurie reinforced their responses by repeating what they had said.

Much of Laurie's role involved evaluation. Laurie would move about the room nodding and smiling, usually with her hands resting on her hips. Laurie carefully moved from pair to pair, observing correctness of sequence and technique for the skills that they were demonstrating.

An example of guiding a student in making connections occurred with Megan, who was frequently sniffing and needed to be excused. Laurie cued her by asking, "If you needed to leave to blow your nose, then what will you do next?" She allowed the student to

respond with the correct statement of hand-washing. Laurie watched technique and observed all students closely for protocol to prevent contamination.

Another student had brought extra supplies to the bedside. Laurie asked her, "if you brought that in the room and don't use it what are you going to do with it?" The student responded. Laurie continued by asking what were the consequences of her decision.

Laurie demonstrated nurturing with a student who walked away crying. Laurie followed her around a corner from where the other students were working. Laurie talked to the student in a quiet voice so that neither herself nor the other students could hear. The researcher noted the student to say that it was difficult to go on and that she was worried about a test and felt emotional about being pregnant. Laurie stood next to her with her arm around her and the only thing heard by the researcher was, "you know this isn't a life or death situation." Most of the conversation was in a low, calm voice. After several minutes the student washed her hands and returned to the setting. Laurie followed up on the situation during a break time when no other students were in the room. The researcher noted Laurie sitting at an angle and next to the upset student. Laurie was leaning slightly forward, nodding, and speaking calmly and quietly.

Laurie facilitated learning by guiding the students in making connections. As she continued to observe the pairs of student, she would ask the students who were playing the patient role about the experience. For example, Laurie would say, "When she was brushing your teeth, how did you feel?" Laurie would ask questions, such as, what was done, how, and what are the pros and cons. If an error was discovered, she addressed it with a question. The question provided coaching to allow the student to arrive at a correct response.

Laurie frequently used a questioning mode of coaching and guiding. The students were always allowed to respond. Laurie would continue to teach by linking principles to practice. This was demonstrated by presenting a different patient care scenario and asking the student to demonstrate the appropriate skill related to the scenario. The second student in the pair would again be asked for her evaluation of the behaviors demonstrated. The student that did the evaluation was asked to present positive behaviors first. Laurie would provide clues to assist the student in identifying pertinent principles. The student who demonstrated the skill would be provided an opportunity to respond to any idiosyncracies that were identified. Laurie would ask the student what the consequences were. Laurie provided

positive reinforcement and encouragement by frequently nodding and saying "good."

As the demonstrations continued, a student asked Laurie what to do with a torn sheet. Laurie encouraged the student to problem solve by asking her what she would do in a real situation. As Laurie continued to evaluate student demonstrations, she would offer practical suggestions and was frequently heard to say "good work."

The second part of the skills laboratory started with brief instructions on the next behavior. Laurie's manner was very natural and at ease with the students. Laurie presented the material in an enthusiastic manner and the students did not hesitate to ask questions. Laurie responded back to questions with a smile and supportive responses. One student asked if the procedure was uncomfortable for the patient. Laurie responded by asking if any of the students had personal experience with this procedure. She clarified the student's misconception by providing more information about the procedure.

During her discussion with the students, Laurie brought in knowledge from other courses. She identified principles related to physical health assessment, medical terminology, and physiology. She questioned the students offering cues to the correct response. She concluded by reinforcing key points or principles to remember.

Value Perception

Perception of the value of clinical teaching was examined in relation to three areas. The participants were asked whether clinical teaching was valued by administration, colleagues, and students. An additional area of investigation questioned perceived recognition and rewards received for teaching in the clinical nursing setting.

When asked if she believed that clinical teaching was valued by administration, Laurie emphatically responded with "no." She explained that she believed that this was true not only for non-nursing administration but also for nursing administration. She elaborated by saying,

I think it is perceived as the low activity on the scale. It is way down there at the bottom. If you are having problems with staffing, you go out on the streets and you take in a warm body to do your clinical supervision. If you have enough warm bodies, low man on the totem pole, or the person that you are disgusted with or want to punish the most gets that.

Laurie gave an example to illustrate her point. She contended that even though the Board of Nursing stated that baccalaureate nursing programs were supposed to have master's prepared faculty, a college can fudge on this in a lot of ways. She explained that one of the ways this occurred at her facility was by bringing in "warm bodies with bachelor's degrees to do the fundamental clinical teaching." She said this made faculty feel like those

who taught this course were less important and that anyone could teach basic skills.

She further explained that the lack of value was also reflected in how teaching load was figured.

Classroom teaching counts as the most credit. You have to kill yourself off a number of hours in clinical teaching to compensate for that and when they are identifying hours of clinical that contribute to your teaching load, the number of hours that you use for making out assignments don't count. The number of hours that you put in to doing evaluations, writing them, giving them, that doesn't count, and the number of hours you spend grading clinical papers, that doesn't count. So, administration doesn't value that or they don't give you credit for the amount of time that goes into that.

Laurie stated that some of her colleagues valued clinical teaching. She shared an example of a colleague who she believed valued clinical teaching. Laurie described her colleagues as being able to think conceptually, fitting concepts into assignments, and being fair with students.

Laurie reflected that students valued their clinical experience. The students enjoyed their clinical experience and they received a lot of rewards from it. Laurie admitted that clinical educators sometimes overworked the students by assigning them a lot of clinical paperwork. She stated, "We make them process to the point where they may be thinking of how they will write their assignment rather than what they are supposed to be getting out of the clinical." Students frequently

expressed the desire to have more clinical hours in their nursing courses.

Laurie admitted that she did not believe any rewards or recognition were received for clinical teaching. She stated that often times clinical teaching was not recognized when faculty and courses were evaluated. "I have found that when I get my year-end evaluation clinical is often not even mentioned as one of my responsibilities."

Value was demonstrated in the clinical setting by respect for the students. Each student was addressed as an individual with unique concerns and needs. Laurie often stressed the positive observations in relation to the students' practice. Laurie also demonstrated respect for the patient as she guided the students through practice in understanding how the patient would feel and react.

Role Orientation

Roles were examined from several aspects of the nursing profession outside of actual teaching. It is believed that these aspects have a direct relation on the qualities exhibited by a person considered to be an expert in his or her field. Role related questions included: Is nursing practiced outside the teaching setting? How is professional and intellectual stimulation received? What are preferred professional

tasks? What are the traits of colleagues what are admired? What are the traits of colleagues avoided?

Laurie stated that she did not currently practice outside of her teaching responsibilities. She stated that she worked part time for about four years until the recent lay-offs in the hospital. When she was called to work, it was usually for the mental health unit. She stated that she had worked weekends, evenings, and summers.

Laurie explained that she received professional and intellectual stimulation from attending workshops. She qualified this by saying, "The quality of those varies from time to time." She stated that communicating with the hospital staff was often very interesting and stimulating. She explained:

I had two clinical groups, so I was out in the clinical area two days a week plus I would do my clinical preparation on two other days. I became just a fixture there, so I did get a lot of opportunity to communicate with the staff.

There was also a lot of interaction among the faculty though "there is often not a lot of stimulation that goes on within our faculty group." She stated that the faculty does not have a lot of opportunity for contact with the other college departments. Laurie stated that she received professional stimulation from the classes she attended. She stated, "I thoroughly enjoy taking the classes because of the interaction with the professor and

the other people." She declared that she would also like to become certified in the area of aging, as it was an endeavor that could count toward scholarly activity.

When asked about the attributes of admired colleagues Laurie described one person in particular. Laurie explained that this admired colleague was able to think conceptually, was organized, and taught well. She was not prejudiced, dealt fairly with students, did not hold a grudge, nor was she vengeful. Another colleague was described as a joy with whom to work. Laurie stated that the colleague had a talent for making connections. Laurie explained, "She was able to make connections from one area to another and sometimes just gives me little pieces of information that turn on the light." Laurie further elaborated with an example.

I was teaching a women's health course and I was talking about medical practices and medicalization of some of child-bearing. I talked a little bit about episiotomies. The area that she works in is community health. She was able to provide me with studies that were done in Europe where they don't do episiotomies. Mid-wives do a lot of massage so that episiotomies are not necessary. She was able to provide and elaborate on a different perspective.

Laurie described attributes of people that she preferred to avoid. These included prejudice, favoritism, unfairness, and a closed mind.

When asked about professional tasks preferred, Laurie began by saying that she "hated meetings with a passion."

I hate meetings where you just meet to be meeting and you do something in two hours that you could have done in fifteen minutes.

Laurie explained that she liked putting together courses and reviewing text books. She stated that she would like to try designing a learning program. Laurie liked clinical teaching, especially at the end of the semester when "you feel comfortable that the students are not going to kill somebody or do something stupid that upsets the staff." Laurie enjoyed seeing the students become independent and self-directed and starting to intervene appropriately on their own. She stated that she would like student advising if more time were allowed for it. Committee work was enjoyable if it involved working with faculty on a task that needed to be done and got done. As a whole, Laurie did not enjoy committee meetings where the goal was to find work or make more work.

Problem Solving Strategy

According to the literature, an essential talent possessed by experts is their ability to solve problem more accurately than other people (Johnson, 1988). For the purpose of assessing problem solving skills, the participants were asked to describe how they deal with a difficult choice or a problem and who they might go to for assistance.

Laurie stated that if at all possible she tried not to make a decision immediately. She explained that it

was important to reflect about the concern and then talk with a trusted colleague about it. She expected the colleague to support any decision that was made and to provide an honest opinion even though it may counter what Laurie tells her. Occasionally decisions needed to be made about students that involved consulting with an attorney. On some decisions it was important to consult with the Dean "as you would hate making decisions that he reverses."

Laurie described a difficult problem that she had encountered with a black student in her fundamentals course. She stated:

The student came to me with a reputation, and not a good one. A reputation of being a liar, of not doing well, and a reputation that she would not succeed in nursing. She is from the South, her educational background is very poor, she doesn't help it along any in that she just does marginal work all the way along. She doesn't know how to subtract, multiply or divide and doesn't know where the decimal points go. I tried to work with her and she got outside tutoring for her math. She finally decided to give it a try. In her last couple of projects she was doing better. The last half she was getting a C. The last project that she wrote up, about health issue, was very well done. She got an A on that. Her grade was up to about 69.7. The concern was whether to pass her or not. I passed her and I know I will probably hear about it again. Before I made the decision I talked and spent a lot of time with the nursing chair. I spent a lot of time thinking about it. One of the factors was that I felt like I shouldn't be forced to make a decision based on her history and that she should have the opportunity like everyone else.

Goals

Finally, Laurie was asked several questions related to her professional goals. She was asked questions about where she saw herself in 10 years and what would lead her to make a change in her teaching role in the future. Laurie stated that she would like to be retired. She stated that she could retire in 10 years.

Issues that might lead Laurie to make a change in what she was doing included not enough students, closing of the program, and intolerable working conditions. She stated that she would probably try to find another teaching position. She explained that even without having completed a doctorate, she had enough experience to be able to go somewhere else and teach. With hesitation Laurie said that she could "probably make the effort toward the PhD." When asked to explain what she meant by intolerable working conditions, Laurie elaborated. Intolerable working conditions included constant dissent. It included an environment where you "always have to watch your back and your decisions are always second guessed." An environment like this has little positive going in it.

Andrea

Andrea was a 41 year old white female with 19 years experience as a nurse. Andrea's experiences included staff nursing and administration. Andrea's specialty was

critical care nursing. Critical care nursing was taught to senior nursing students at this college. Andrea has taught nursing for six years, all of which have been at the current position. Prior teaching experience included staff development.

Andrea's educational experience includes a baccalaureate in nursing and a master's degree in nursing. Her master's degree had an administration focus. Andrea stated that she did not have formal courses in teaching. Andrea stated that her preparation for teaching was basically "learning by doing." She explained that her first teaching course involved teaching a summer class while continuing to work in the hospital. She stated that she agreed to teach the summer course because she believed that it would help prepare her for a new teaching position that fall. She admitted that she "thought it would be the best way to learn, because you can make all kinds of mistakes and not too many people would notice." Andrea went on to explain that "unfortunately there was no one around to help and obtaining equipment and materials was a problem."

When she started full time the following fall, she was teamed with another faculty person. Andrea stated, "The person I worked with tended to do more than guiding but wanted a controlling influence." Andrea acknowledged

that it took her several years to get beyond that because "I really thought that was the only way of doing things." Andrea explained that she has had opportunities to observe other people and figure out her own teaching style.

Andrea was attracted to teaching when she went back to school for a master's degree. She stated that she was familiar with management and thought it would be useful to have classes in that area. Once she completed her program and began working in the area, she found that "it really wasn't for me." She explained that she had "done bits and pieces of education" with her involvement in staff development. She began to think that working with nursing students would be an obvious next step. She stated that she enjoyed thinking through things and trying to put them in a teachable form. She admitted that no one told her what would be helpful in teaching. She basically learned that on her own.

Andrea was very neat and well dressed. The researcher noted her office to be organized and orderly. Upon initial contact Andrea appeared tense and hesitant. She was not noted to smile a lot though she maintained good eye contact and gave the researcher full attention. The researcher experienced similar perceptions on the clinical unit. Most students spoke openly with Andrea.

The researcher did not note any obvious student or teacher tension during interactions.

During the clinical observation phase of the data gathering the researcher was asked the purpose of the study by one of Andrea's students. The interest in expertise was explained to the student. The student stated that she believed Andrea was very much an expert and a role model to her students.

Educational Philosophy

Representation of educational philosophy was reflected in descriptive comments about clinical nursing educator roles, definitions of clinical teaching, the ideal clinical teaching situation, what it means to be an expert clinical nursing educator, and the knowledge and skills needed to be an expert. Educational philosophy was further represented by observation of actual clinical nursing roles and demonstration of clinical nursing skills and theory based knowledge.

Andrea's role as a clinical nursing educator involved helping students focus on the type of patients that "we are covering in class." She stated that her goal was to facilitate the application of theory to practice. Assignments were made in an attempt to correspond to concepts and theories covered in class. Post conferences were spent reviewing research articles

that apply to the area under study. She also focused the discussion on new or unforeseen experiences.

Andrea explained that she spent a lot of time assisting the students in interpreting assessment and laboratory findings.

I want them to understand what it means to their patient and what it might mean to another patient. I have them follow through on the medications. Why give the patient this medication? Is it working for the patient? Why did they switch the medication? Is there any relevance between the two? The students need more work in pharmacology so I try and spend time doing that.

Andrea related that there are a lot of skills in her area of expertise, that is, critical care nursing. Andrea's position involved role modeling, in that behaviors and skills were demonstrated to the students. Her role also involved coaching as students were given cues and assistance as they evidenced a particular skill or behavior. Evaluation also played a major part in Andrea's role. With an abundance of critical skills practiced by the senior nursing students, Andrea was frequently in the position of judging and giving constructive feedback.

Andrea defined clinical teaching as application and more individual than classroom teaching. She explained, "In class we get them to think about things, but nursing is more of a hands on profession" where the students discover how to apply what they learn. "Students expect to see, feel, and hear; that is how they learn."

Clinical teaching is more "one-on-one." The clinical teacher can work with the student on an individual basis.

It is a lot easier to figure out what somebody knows than what they don't know and how they are thinking when you are working one-on-one rather than when you are dealing with a group of 25 to 30 students.

Clinical teaching gives the educator an opportunity to develop more of a collegial relationship with the students. It is easier to identify areas where they may need more of an understanding or explanation.

An ideal clinical teaching situation for Andrea would involve a "particular week in which all the patients would be the exact type of patients you just finished telling them about." Ideally, patient situations would encompass a variety of concepts that have been discussed and an opportunity to integrate those ideas. An ideal clinical situation would give the students more of an opportunity to problem solve. Andrea summed up her definition of ideal as:

Staff you can get along with, inquisitive, interested, enthusiastic students, and the perfect patients, not necessarily happy perfect but connected with theory.

Andrea described an expert as knowledgeable and willing to learn. She explained that "it is not necessary to know all the answers, but be able to help others find the answer." She stated that she had worked with staff who felt compelled to give an answer. Andrea expounded: "They were not always the right answers, and

I think that is dangerous." An expert needed to be willing to read and to search for answers. Andrea went on to explain:

The staff work there every day, they have had more actual experience and an intuition about what is going on. I have the theory and applicability without the day-to-day experiences, so that is why I rely on them. That is why it is important for a clinical educator to develop that relationship.

Andrea summed up the attributes of a clinical nursing educator as including a theory base, experience, and good interpersonal skills. An expert needed to be able to guide the students. She elaborated by using an example of a part time clinical teacher.

I think the concern has always been that the part time clinical teacher does not have the loyalty and they are not really teaching the course and are not sure how to apply what is learned in class to the clinical setting.

Andrea believed that the ideal situation would include an educator who not only taught the course but was actually working in the clinical area outside her teaching responsibility. She explained that this provided more continuity and flow for the students. This blend provided a better learning experience. An expert needed to be able to apply what was taught in the classroom. Again the importance of clinical practice was stressed.

Andrea believed that an expert needed at least several years of experience in the practice setting. Continued practice was essential as it keeps one up on the changes. The students then perceived the educator as

"an expert rather than some one that talks about what is in the book or uses that one example for every single class."

She stated that people skills were valuable in working not only with students but nursing staff. It was important to be able to recognize that people have factors in their lives that have an impact on their practice. You need to know how to be patient and encourage the student. Having good relations with the staff facilitates connecting the students to the staff as a resource.

As Andrea examined her own attributes, she explained that listening skills were important. She stated that an expert also needed to be able to provide examples of real experiences to reinforce learning. Patience was an important attribute in that a clinical educator must be willing to give students a chance to succeed without jumping in and doing it for them. Other attributes identified included the use of humor and of self expression through writing or literature.

Attributes described by Andrea were easily identified in the clinical teaching setting. Andrea began the clinical morning talking with each student about their assignment. The students were expected to identify their patients' diagnosis, medications, and plan of care for the day. As Andrea went from room to room

she facilitated student learning in many ways. Generally a questioning technique was used. Students were asked to explain treatments and medications. Andrea was noted to give the students an opportunity to respond. Positive reinforcement was offered in the form of verbal responses, such as, "good work" or "yes, yes."

Facilitation was demonstrated in a situation with Janice. Janice was asked about her patient's need for teaching. Janice did not respond correctly. Andrea did not tell her she was wrong or give her the answer. Andrea facilitated Janice's learning by asking several questions to help her link principles to the practice situation. Questions were carefully asked to elicit the correct answers from the student. Andrea utilized questioning to assist Janice in doing problem solving. During the questioning and problem solving Andrea was observed to emphasize key concepts and would ask the student to repeat the same. The process was continued to assist Janice to put the pieces into a perspective.

During this episode Andrea was evaluating Janice's preparation. Little information was presented by Janice with much encouragement from Andrea. The student was noted to frequently change the subject and offer excuses for herself. Andrea concluded the episode by explaining in a calm manner the importance of coming to the clinical unit prepared. Andrea explained to Janice that there

were certain behaviors with which she was expected to have experience.

During the above incident another student came up to the researcher and explained that Janice was very high strung and this type of incident had happened before. The student stated that Andrea was very calm and patient with Janice or any student in a similar situation.

Coaching was noted as Andrea continued to question her students. If the student did not respond or responded incorrectly Andrea would offer cues. One example involved Amy. Amy was responsible for initiating intravenous therapy. This is a procedure that students generally have little opportunity to practice. Andrea began by assisting Amy in gathering supplies. Amy proceeded to review the procedure before beginning. During the procedure Andrea remained at Amy's side but did not attempt to take over when progress seemed slow. During the procedure Andrea coached by reiterating the steps of the process or by reinforcing what Amy was doing. Throughout the procedure Andrea remained attentive, offering nurturing in the form of positive comments not only to the student but to the patient.

Amy was unsuccessful in initiating the intravenous therapy. Hospitals have policies that limit the number of times a nurse can attempt to insert a needle without having someone else trying. For this reason Amy did not

attempt the procedure again. At this point Andrea role modeled the skill by initiating the procedure. Correct protocol was followed and Andrea used this opportunity to reinforce learning by offering practical suggestions and specific knowledge as Amy observed.

Role modeling was demonstrated with the student Scott. Scott was involved in preparing his patient for a cardiac catheterization. Andrea demonstrated how to find certain heart sounds and instruct the patient for the procedure. She also demonstrated the attributes of facilitation and coaching. These were evidenced by her questioning strategies and by giving clues to the students. Scott was always given an opportunity to respond before clues were given. As Scott responded Andrea would reemphasize key aspects of his answer and elaborate by giving more information on important points. Andrea concluded this interaction by evaluating the accuracy of Scott's documentation for what had been done.

While conferencing with the student Clara, Andrea discovered that medications were given to the patient without having them checked by Andrea. Andrea has a policy that all medications be checked with her before administration. Andrea approached her by saying, "So tell me about the medications that you gave to your patient?" Instead of scolding her Andrea reminded Clara that she must double check medications with her

instructor before giving. Andrea questioned Clara about her knowledge of medication actions and the specific protocol for certain medications.

As she continued to evaluate Clara's preparation for patient care Andrea probed for student understanding by asking, "Now what else can you tell me?" or "What might be more immediate needs of your patient?" During the questioning Andrea offered clues that linked the theory behind the diagnosis to the practical needs of the patient. At one point Andrea offered specific knowledge by explaining the pathophysiology of the patient's disorder in relation to what Clara should be expected to observe.

At the completion of the above situation Andrea explained to the researcher about a previous situation with Clara. Andrea stated, "She thinks I hate her." Andrea proceeded to relate an experience that had occurred in the skills laboratory. Andrea stated that Clara was not prepared and was confronted by her. Clara had expressed the belief that Andrea was picking on her. Andrea stated that she had stressed the importance of preparation and aided her in problem solving how to organize her plan for care. Andrea expressed the belief that Clara now tries to avoid her and that is probably why Clara did not check her medications with Andrea prior to giving them.

Value Perception

Perception of the value of clinical teaching was examined in relation to three areas. The participants were asked whether clinical teaching was valued by administration, colleagues, and students. An additional area of investigation questioned perceived recognition and rewards received for teaching in the clinical nursing setting.

Andrea explained that she did not feel clinical teaching was valued by non-nursing administration. She maintained that administration does not understand what is involved. She stated that it was often compared to a biology or chemistry laboratory experience. "That is like comparing apples and oranges, it doesn't make sense." Administration does not recognize that a three or four credit hour course not only means two to three hours in the classroom but an additional six to twelve hours in a clinical setting per week. In addition to the actual time on the clinical unit much time was needed for student orientation, making out assignments, conferencing, and correcting clinical assignments. Andrea believed that nursing needed to take more responsibility in making administration aware of "what we are all about." Clinical teaching was valued and understood by nursing administration at Andrea's college

as their department was small and the faculty work closely with the nursing administrator.

In reply to the question, was clinical teaching valued by colleagues, Andrea responded with both yes and no. She explained:

I am concerned that we can articulate that we value something, but how we really feel about something shows up another way. We all talk about it in our meetings. We say that clinical teaching is valuable and we want some really qualified people teaching it. The same people are trying to get out of it or bitch about it all of the time. I believe that some faculty make an intense effort not to do clinical teaching. My thought is that it is not necessarily because they do not value it but because they are not confident of their own abilities. Part of the problem is that they have had no clinical experience.

When asked whether she believed students valued clinical teaching Andrea answered both yes and no. She explained that often they do not recognize the value until they are ready to graduate. She stated, "They complain about not being able to miss clinical yet at the end they panic that they have not had enough experience." They do not understand that they need the practice to prove themselves.

Andrea described the reward for clinical teaching as being more personal. It was a recognition of the importance of preparing students for nursing practice. Value also came through observing students feel good about what they were learning. No material rewards or recognition were received. Among nursing faculty and

administration "you receive a pat on the back as they realize how much work is involved."

Andrea demonstrated value in the clinical setting by respect for students and patients as individuals with unique needs. This was manifested by properly addressing students and patients, by therapeutic communication skills, by respecting confidentiality, and by maintaining availability to students.

Role Orientation

Roles were examined from several aspects of the nursing profession outside of actual teaching. It is believed that these aspects have a direct relation on the qualities exhibited by a person considered to be an expert in his or her field. Role related questions included: Is nursing practiced outside the teaching setting? How is professional and intellectual stimulation received? What are preferred professional tasks? What are the traits of colleagues what are admired? What are the traits of colleagues avoided?

Andrea stated that she usually worked summers and at least once a month in the telemetry unit as that was where she had the majority of her students. Andrea reported that professional stimulation came mainly from clinical practice. She stated, "I come out feeling good about what I am actually doing, this is why I became a nurse." She also identified feeling good about observing

the students feel good about what they have seen and done. Other sources of professional and intellectual stimulation were in preparing for class and attending conferences.

Attributes of admired colleagues included creativity. She stated that she had a couple of colleagues who were creative in that they did not teach classes the same way every year. Andrea also admired the ability to "remain calm and take time to reflect on situations without jumping right in."

Rigidity, inflexibility, lack of openness, and reluctance to change were attributes of least admired colleagues. Andrea stated, "Some people won't change anything unless it is their idea." She explained that one particular person was very controlling and difficult with whom to teach.

Preferred professional tasks included some committee work. Andrea preferred committee work in which the faculty maintained flexibility to organize and to make decisions. Committee work that became "nit-picky" was not appreciated.

Problem Solving Strategy

According to the literature an essential talent possessed by experts is their ability to solve problems more accurately than other people (Johnson, 1988). For the purpose of assessing problem solving skills, the

participants were asked to describe how they deal with a difficult choice or a problem and who they might go to for assistance.

Andrea identified several processes that she used in problem solving. She stated that she did not jump right in but took time to reflect on the concern. She often went to a colleague and "talked it out." She explained, "I am a verbal person, so I usually do better by talking about it."

Andrea described an example of a situation that she had to deal with during the previous semester. She explained that she had a student who was working with a preceptor. The student was expected to put in a specific number of hours by mid-term. According to Andrea the student proceeded to avoid her and when confronted she discovered that his hours were lacking. She explained that this angered her so she proceeded to discuss it with a colleague before acting. After reflecting on the issue Andrea stated:

I finally sat down and wrote something up and had him come in. We had a discussion about it and we developed a contract together of how he was going to meet his clinical objectives for the semester. We both signed. Basically I made it clear to him what was necessary for him to complete in order to pass the course. Actually I use contracts a lot when I am really seriously concerned, because I think it is probably a very clear warning to them that this is what is going to happen to them if they don't do what I expect.

Goals

Finally, Andrea was asked several questions related to her professional goals. She was asked questions about where she saw herself in 10 years and what would lead her to make a change in her teaching role in the future.

Andrea stated that she would like to become certified in advanced practice and work with the elderly. She stated that she also had not ruled out the possibility of completing a doctoral degree. She explained that she had taken some of the course work and enjoyed it enough that it would be worth while to finish. She stated that she would receive a sense of satisfaction by completing a doctoral degree.

Andrea described what might lead her to make a change in her teaching role in the future. She explained that a different faculty with different teaching styles or a different course assignment would lead her to reflect on her role. Andrea also stated that input from student evaluations of her teaching would have an impact. She explained that she reviewed student evaluation and took them very seriously in relation to her role in their learning process.

Patricia

Patricia was a 62 year old, white female and a veteran of nursing for 43 years, 29 of which have been in nursing education. Patricia has been in the current

teaching role for 12 years. Her educational preparation included completion of a diploma program in nursing, a baccalaureate in nursing, a master's degree in education, a master's degree in nursing, and a doctorate in education. Teaching experiences outside nursing included high school science, as she has a secondary teaching certificate.

Patricia's current teaching responsibilities included nursing research, medical ethics, and obstetrical nursing. Obstetrical nursing involved both classroom and clinical teaching and is taught to senior nursing students.

Patricia stated that she was attracted to nursing education as she always liked to teach. She stated that at one time she debated about becoming either an English teacher or a nurse.

In regards to teaching preparation, unlike the other participants, Patricia has a secondary teaching certificate, so received experience as a student teacher. She stated that she had a major in science and a minor in psychology. She taught high school chemistry and psychology.

Patricia explained that because of her experience and preparation she believed that nursing education is doing the student an injustice by not requiring their educators to have had teacher preparation. Patricia

stated that many nursing educators do not have any teaching experience, which means "they tend to teach the way they were taught." She stated that they have no theory behind what they are doing and so consequently, do not try a variety of teaching methods. She expounded, "They only kind of lecture and test and they don't even want to venture away from that."

Patricia was very neat and well dressed in a woolen suit. She explained to the researcher that her suit was made from cloth that she wove from her own sheep, which she sheared. Patricia was extremely enjoyable to interview. She demonstrated much enthusiasm by use of voice inflection and hand gestures. She maintained good eye contact, would lean toward the researcher, and always had a smile on her face.

During observations students and colleagues were noted to frequently seek her advice or instruction. Both students and colleagues appeared comfortable in approaching Patricia for assistance.

Educational Philosophy

Representation of educational philosophy was reflected in descriptive comments about clinical nursing educator roles, definitions of clinical teaching, the ideal clinical teaching situation, what it means to be an expert clinical nursing educator, and the knowledge and skills needed to be an expert. Educational philosophy

was further represented by observation of actual clinical nursing roles and demonstration of clinical nursing skills and theory based knowledge.

Patricia described her position as a clinical nursing educator as mainly role modeling. She explained,

The first time I have them on the clinical unit I role model. Then what I do is let them do it with my guidance. Finally I let them do it alone. If they have problems, then I expect them to come to me. I try to lean away from modeling at that point, so they can continue to grow.

Patricia defined clinical teaching as application of theory to practice. She illustrated by comparing clinical practice to a chemistry laboratory.

You go to the class, you get the theory, that is you mix this with that, such and such will happen. Then the students go to clinical and practice what they have learned and by golly such and such happens. If it doesn't happen then you ask why not. In chemistry either it wasn't heated or we mixed too much of some substance. In the clinical area there is a theory that now we are going to see if it works. It can be therapeutic communication. It can be what you expect the appearance of the baby's umbilicus to look like at a certain number of days after birth. It can be how the fundus of the mother's uterus appears on the third day postpartum. This is what I am trying to do in the clinical area, that is, to test the theory of what they have learned. Let them actually practice it and see if it really happens. If it doesn't happen what is different? I want the students to tell me. I want them to say, I tried this and it didn't work. I want them to discover why it didn't work.

Patricia described an ideal clinical teaching situation as one in which all the patients have the same diagnosis. She explained that this made it easier to illustrate specific, basic concepts, for example, the

pathophysiology of pneumonia at the cellular level. If all of the students had the same type of patient it would be easier for them to relate the theory discussed in the classroom to practice.

Patricia depicted an expert clinical educator as one who can view the whole picture. She explained that an expert "would not get hung up on one or two signs." An expert "can see all the learning situations that are available, not just the ones that are clearly visible to anyone." She stated that this was what she tried to get the students to do, that is, use critical thinking and look at the whole picture. She illustrated by stating, "My favorite question is what is the underlying assumption?" She explained, "I found that those key words help me to help them focus on what it is that they really need to look at." Otherwise the students would become confused with an abundance of data that they are not able to sort out and use.

Attributes of an expert clinical educator included knowledge. An expert needs to be curious and to be willing to continue to learn and grow in their knowledge base. Curiosity is an important attribute to model to the students. By being curious it is hoped that students will see that every patient provides an unique experience. "I want them to be able to see the different things that each patient can present to them."

Clinical educators need to possess an in depth knowledge of the specialty area that is taught. In addition, clinical educators need to have a good knowledge base in the foundation courses, such as, physiology and pathophysiology. "You need to be able to go back to the cellular level, then everybody will understand it."

Interpersonal skills were identified as important attributes of an expert clinical educator. It is important to be able to work with nursing staff who have the ultimate responsibility for the patients. Interpersonal skills are needed to work with a "variety of people each with their own agenda."

Patricia began her clinical day much as the other participants. The morning began by a conference with the students. The conference involved each student discussing their patient assignment, diagnosis, and the plan of care for the day. Throughout the conference Patricia facilitated learning by calling the group's attention to certain concepts. She pointed out how the particular diagnosis, symptom, or concern related to theories or principles discussed in class and how they related to the principle of physical assessment, physiology, or pathophysiology.

Students were evaluated using a questioning format. Patricia coached students by giving clues, for example,

"She had a pain pill at 6:00 a.m. so what does that make you think?" or "Is it our job to wait until she asks for another pill?"

Patricia also used patient scenarios as a teaching tool. She described one of the patients in a different situation and asked for student interpretation. When no one volunteered to respond, Patricia called on an individual. The student's responses were reinforced with "good" or "yes." Patricia reemphasized the key points by repeating them and linking them to principles.

During the conference correct answers frequently received a positive response from Patricia. When responses were incorrect Patricia restated the question often giving clues and more specific information to help lead the student in problem solving. In situations that involved in depth explanations Patricia would provide the basic structure of the discussion by giving a brief overview of the pathological process involved and by offering more specific information about concepts that were deemed difficult to understand. Throughout the conference Patricia responded to student comments by smiling, nodding, saying "yes, yes," and by hand gestures.

After the conference students proceeded to begin their patient care assignments. Throughout the morning Patricia made rounds of the assigned patient rooms.

Students were also questioned about their knowledge of medications. The students were responsible for knowing medication action, side effects, dosages, and any special considerations which might affect their patients.

Patricia expected the students to come to her before giving the medications. Patricia allowed the student to proceed with their explanation about the medications. If they appeared to be stumped she would offer a clue or key word to guide their discussion.

Value Perception

Perception of the value of clinical teaching was examined in relation to three areas. The participants were asked whether clinical teaching was valued by administration, colleagues, and students. An additional area of investigation questioned perceived recognition and rewards received for teaching in the clinical nursing setting.

When asked if she believed clinical teaching was valued by administration, Patricia stated, "We don't get credit for it." She explained that she did not believe that it was valued by nursing as we put our least prepared people in the clinical area. She declared:

What we should do is let them teach the theory and have the most prepared faculty be in the clinical area, because that is where it is such an uncontrolled situation. We don't do that. We have our expert that teaches them the theory and then we hire somebody with far less experience in education to handle the clinical. So we miss a lot of what we could be doing.

Again Patricia stressed that it is nursing who does not value clinical teaching.

Patricia explained that part of the problem was in how nursing credits clinical teaching. She explained that at her college faculty received one hour teaching credit for each three hours in the clinical setting. She illustrated, "If we would do three to one for theory, and one to one for the clinical area we might have a better idea of what is important and have more people willing to do it." Patricia further explained that often faculty would rather teach theory not in their area of expertise than teach a clinical course, as clinical teaching takes much more time and preparation. More credit is given for teaching the theory.

Patricia stated that not all of her colleagues value clinical teaching. She explained that most would prefer to teach a theory course that does not have any clinical. She qualified this by saying, "I don't know if it is lack of value as much as it is the amount of time and preparation involved."

Patricia asserted that students value clinical. "They love it, they want more of it." The reward for clinical teaching came in seeing student growth and understanding. Very little reward or recognition was received in any other way.

Role Orientation

Roles were examined from several aspects of the nursing profession outside of actual teaching. It is believed that these aspects have a direct relation on the qualities exhibited by a person considered to be an expert in his or her field. Role related questions included: Is nursing practiced outside the teaching setting? How is professional and intellectual stimulation received? What are preferred professional tasks? What are the traits of colleagues what are admired? What are the traits of colleagues avoided?

Patricia stated that because of her schedule it was difficult to work for the hospital. She stated that she was involved in emergency care, that is, "I run with our local ambulance service." She explained, "That keeps me alert." She is involved in this activity during evenings and on weekends.

Professional stimulation came from intellectual discussion, especially with her sister. Patricia was in an unique situation as she has an identical twin sister. Both have been involved in teaching at the baccalaureate and master's level. Both of them have the same academic preparation. Patricia illustrated with an example of a recent situation.

There was a time this Spring when I called my sister and I said I have just absolutely got to have an intellectual discussion with somebody. I read an article in Image on nursing diagnosis and the

classification of it. I thought we could use it for teaching and I just hungered for that type of a discussion. I tried to have it with a few colleagues. I am stimulated by research articles and mostly by discussion with my sister. We can walk in the woods and really get down to some really nitty-gritty hefty arguments and about the profession. Then we can still come out friends.

Patricia explained that she loved research and was very interested in it. She said that she doesn't often find people to talk to who share that love. She stated, "Most people think it is a necessary evil."

Attributes of admired colleagues included being flexible and even tempered. Patricia also admired the academic abilities of certain colleagues. She explained, "I admire people who get the whole picture quite rapidly."

Attributes of people to be avoided included inflexibility and inability to see the whole picture from anybody else's point of view but their own. She explained that she also had a concern about colleagues who were always trying to find blame for a problem. She contended,

We need to be more interested in how we are going to solve the problem. If you have a problem, what are you going to do?" You begin to get into the rut of covering your tracks each time, leaving a paper trail so that you can prove that you were not working with that type of person. This is very distressing.

Preferred professional tasks included research and curriculum development. Patricia explained that she

loved to create courses to teach. She likened it to building a doll house.

Problem Solving Strategy

According to the literature an essential talent possessed by experts is their ability to solve problems more accurately than other people (Johnson, 1988). For the purpose of assessing problem solving skills, the participants were asked to describe how they deal with a difficult choice or a problem and whom they might go to for assistance.

Patricia described the sequence she used in dealing with difficult situations or problems. She elucidated:

I usually try to list it and reflect on the situation. I list the positives and negatives, usually on paper. I then identify the underlying assumptions. I look at why the situation is creating a problem for me. I consider what is happening. Lots of time it is the unknown or a threat to ego. The next step is to discuss it and get it out in the open.

Patricia felt that when she had a difficult situation to deal with she most often went to her sister. She explained, "My sister is my colleague and she will give me honest feedback."

Patricia shared an example of a recent difficult situation with which she was involved. The situation concerned selection of a new faculty member. She explained that she was not in support of the person under consideration. Patricia proceeded by explaining her opposition to the selection committee. She stated that

her concerns were related to experiences with the individual. She reassured the committee that after they reviewed her concern, regardless of their decision, she would support their choice.

Goals

Finally, Patricia was asked several questions related to her professional goals. She was asked questions about where she saw herself in 10 years and what would lead her to make a change in her teaching role in the future.

Patricia explained that in 10 years she hoped to be healthy and living out in the country. She wanted to continue to raise sheep and goats. She enjoyed the "birthing experiences in the Spring when they kid or lamb." She stated that she and her sister shear over 100 sheep every Spring.

Discontentment would lead Patricia to make a change. She explained that an inability to make an impact on students or differing administrative and program philosophies would lead to frustration. When you work in this type of situation "you began to see yourself as a pawn. When you are not doing your role the way you would like, you are more willing to say goodbye."

CHAPTER V

A CROSS-CASE SUMMARY AND ANALYSIS OF DATA

The major purpose of this research project was to identify and describe the qualities of clinical nursing educators who were perceived and identified as being expert clinical practitioners by peers. A practical aim of the study was to provide a description of the attributes of a clinical nursing educator, which could be used as a vehicle for faculty selection, development, and improvement.

To explore the expertise of clinical nursing educators, data obtained during semi-structured, in-depth interviews and observations were summarized and analyzed using the five major categories that provided the framework for questioning. Each category was further divided into specific sub-categories. Areas that concur or differ from the research literature were noted.

The data indicated that this group of educators shared characteristics in the five major categories:

1. Educational Philosophy
2. Value Perception
3. Role Orientation
4. Problem Solving Strategy
5. Goals

Educational Philosophy

The participants' descriptions of themselves and the qualities of other educators revealed that they espoused similar educational philosophies. Representation of educational philosophy was captured through observation of the participants in their natural setting and through interviews. Participants reflected on descriptive comments about clinical nursing educator roles, definitions of clinical teaching, the ideal clinical teaching situation, what it means to be an expert clinical nursing educator, and the knowledge and skills needed to be an expert.

Clinical Nursing Educator Roles

Diverse roles and role behaviors were described and demonstrated by the participants. The participants identified several clinical teaching roles, which correspond to those identified in the literature (Irby, 1986a; Mogan & Knox, 1987; Nehring, 1990; Ullian et al., 1994). The most commonly occurring roles included facilitator, role model, coach, evaluator, and nurturer.

The importance of role modeling was stressed throughout the interviews and observations. One participant described role modeling as "letting them see how I would approach a case." She further facilitated their clinical nursing experience by "letting them do it with my guidance." Another participant suggested that

she spends a lot of time role modeling with students and clients, letting the students see what works in specific situations and relationships. This corresponds to Irby's (1986a) definition, that is, a purposeful activity that demonstrates the knowledge, skills, attitudes, and behaviors that students should acquire.

Though the participants rarely used the expression "supervision," supervisory behaviors identified in the literature (Irby, 1986a; Ullian et al., 1994) could be likened to behaviors described and modeled by the participants. Supervision included providing structure for learning, promoting problem solving and critical appraisal skills, observing and offering feedback, and offering support and encouragement.

In describing supervisory behaviors the participants often used the terms coaching and facilitating. The facilitator role was described as helping the student link theory to practice and "bringing it all together." One participant suggested:

What I really feel that I do is help to guide the students in making connections, linking their theory to their practice, helping them work through what they are seeing with their assessment and helping them build on that.

Assignments were made to help the student "process what has been learned" and were "related to theory." Another participant suggested "I try to focus them on the type of patients that we are generally covering in class."

A second participant saw herself as a resource for the students. She stated that in clinical the students come with a lot of their own knowledge about health, nursing, and relationships. "I might help clarify those sorts of things for them or help them apply them in a different setting."

Coaching was utilized in assisting the students in client and assignment selection. Much time was spent exploring available clients prior to working with the students in the clinical setting.

I usually try to give them an opportunity to select clients that they believe would be the most beneficial to them, but sometimes I need to suggest . . . someone who will help them learn about what it is like to be poor or have a chronic illness or something like that. So I guide them a little. I try to also help them think about and emphasize some of the things we talked about in class or read about and how they might use them with the clients they are working with or some to the things their clients have said.

In the role of an evaluator it was a big challenge to "be a coach and a judge at the same time." It was necessary, in the role of an evaluator, to gain their trust, and get them to perform because they want to perform well for themselves, not because they are concerned about their evaluation. You need to know how to "give constructive feedback without the idea that you are picking on them or being overly harsh on them."

Though the term nurturing did not appear in the literature review, behaviors associated with the term

were described throughout (Pugh, 1988; Rauen, 1974; Ullian et al., 1994). Nurturing could be compared to providing a caring and supportive environment in which the clinical educator offered praise and positive reinforcement. In this study nurturing was provided by listening, encouraging, and providing positive reinforcement. The student needs to know that you care for him or her as a person and that "we are in it together." One participant stated:

A lot of time is spent listening to students about what happened during their home visit, the things that occurred, and what they did that was wonderful, and what they might want to work on the next time.

Another participant, who works with beginning students, expressed the need to "get them to calm down and focus on the things that they really do know." The clinical educator needs to know how to give students constructive feedback in a way that is not going to crush their spirit or to make them feel that you are hostile and they need to be hostile also. You need to know how to figure out the "right touch for each student." She further likened her role to parenting as students' growth and development is nurtured. She admitted that she does not like to use the expression "parenting," but believed that parenting techniques were especially helpful in assisting the beginning students in the growth process.

Overall, the participants modeled the roles that they identified. Facilitation was demonstrated by using

clarification and linking theory to practice. The participants employed techniques, such as, using examples, scenarios and asking leading questions about the clients, a treatment, or a medication. All of the participants were noted to use clues to help the students sort out the information. For example, one participant might say, "have you thought about this" or "how does that work or come into play in this situation" or "what other information do you need?"

All of the participants role modeled as they demonstrated skills and behaviors. Two of the participants were especially adept at modeling empathetic communication skills toward clients.

Coaching was used by all of the participants as they assisted the students' work through procedures. Again the participants used clues or cues to keep the students on course. The participants were frequently noted to talk the students through a procedure prior to a demonstration or execution of the activity.

Evaluation was employed by all participants as they repeatedly used questioning and constructive feedback with the students. Much of the evaluation was done by individual conferences with the students. The apparent goals of the conferences were to determine student preparation for and understanding of the day's expectations. Students were generally asked to explain

their plan for the day and the rationale behind selection of interventions. All of the participants were noted to use constructive feedback as they evaluated students' preparation or assignments.

Nurturing seemed to be ingrained in the practice of all the participants. Nurturing was demonstrated by listening, encouraging, and use of positive reinforcement. Two of the participants displayed nurturing behaviors as they evaluated students who appeared to be ill. Nurturing behaviors were also demonstrated with clients in two of the clinical situations. One participant never failed to identify a specific positive behavior demonstrated by each student regardless of the amount of preparation exhibited.

Clinical Teaching Definitions

Definitions of clinical teaching correspond to those identified in the literature (Stritter et al., 1975). The nursing educator guides and directs the performance of a student (Pohl, 1968). Clinical teaching was described by a participant as helping the student put "theory into practice and making those connections." It included "facilitating students to apply their theory, cognitive, affective, and psychomotor" concepts to practice. Other definitions of clinical teaching included: (a) helping the students "pull all of these things out of their brain and make them real and to

actually help them get it done;" (b) "Helping the students come to some understanding about what it is like to be a . . . nurse;" and (c) helping the students see, feel, and hear, as nursing is "a hands-on profession."

Clinical teaching involved "guidance that is given to students that is very application based." Clinical teaching is "helping and guiding them in applying their knowledge base to certain situations and then problem solving and evaluating." One participant eloquently described clinical teaching and nursing as a "more experiential kind of union."

Another participant compared what was done in clinical to what was done in the chemistry lab.

You get the theory that if you mix this with this, that will happen and so then you go to the chemistry lab and you mix that with that, and by golly it does happen, or it doesn't and if it doesn't then why didn't it. It either wasn't heated or we mixed in too much of something. So, when we go into the clinical area there is a theory that now we are going to see if it works. It can be therapeutic communication. It can be what you expect the fundus of the mother to be at the third day postpartum. That is what I am trying to do in the clinical area, that is, to get the students to test the theory of what they have learned and therefore, if it doesn't happen, if something is different, I want them to tell me, "I tried this and it didn't work." It's not that they are in error, that is, like chemistry, what might have happened differently. Why didn't it happen and it should have and so I try to keep my labs (clinical) really a lab of the theory.

Ideal Clinical Teaching Situations

What was considered ideal varied somewhat in relation to the level of students and the specialty

taught. The most common preferences were for more time, a small student teacher ratio, such as, two or three to one, a cooperative nursing staff, elimination of extraneous variables, and the "perfect patient."

All of the participants expressed a concern for lack of time. Three of the participants acknowledged the desire for more preparation time, not only for themselves but for the students. One participant stated it succinctly as "an ideal clinical situation would be that both the student and I were prepared." In addition to preparation time, three participants expressed the desire for more post-conference time so that more teaching could be done.

An ideal clinical teaching situation included a small faculty student ratio. One-on-one would be desirable in some situations. What was difficult, according to one participant, was "when you have seven or eight students in a clinical area." She further explained that she did not always feel like she did a good job in trying to help them all make the connections.

You could observe what they were doing and have time to talk with them and process what had been happening, so that you really have a feel and you really knew what they were thinking. You could get a feel for that student as a person.

Extraneous variables included lack of preparation, low census, irritable patients, uncooperative staff and physicians, absences, and clinical emergencies. Without

the concerns for extraneous variables you could "tailor the learning experience specifically for the student . . . to receive an excellent experience."

One participant amply described staff relations when she commented that "part of the learning experience is how you get along with the staff." She further explained that this involved work on her part. She believed that she made an "effort to talk to them and ask for their feedback." She went on to say that:

It really helps with the learning situation because the staff are ultimately responsible for the patient and even if you are there, and they are uncomfortable with you or the student. They have a tendency to kind of jump in and do it and not allow the student to try it out for themselves.

In her effort to get to know the staff, she felt that they were more comfortable with her, and in fact, were willing to find learning experiences for the students.

An ideal clinical teaching situation would allow you to "hand pick" the patients.

I would make things sensibly progressive from one patient to another and not have them meet a grumpy patient until they were ready. I would have all their patients be talkative so they could do functional health patterns, not too uncontrollable, particularly now since patients are so acute. The idea would be to progress them from simple to complex.

Another participant expressed the desire to have a "client who was receptive to the student and very open to having a relation with the student." An ideal client would have some "dynamic things going on" that would be

helpful to the student. She further explained that by dynamic she means not "acutely ill . . . but with some issues that . . . the student could help the client with" and that the client was "willing to have the student help them with."

Four participants expressed the desire to have more control over the patients' diagnoses. "For a particular week all the patients would be the exact type of patients you just finished telling about." One participant expressed the desire for all of the patients to have the same diagnosis.

Expertise in Clinical Teaching

Sternberg and Horvath (1995) suggested three basic features to be considered in the prototypical view of teaching expertise. The first difference was in the area of knowledge--experts use domain-specific knowledge more effectively in problem solving than do novices.

As identified by Benner (1984) an expert clinical educator has to be knowledgeable in the field. He or she has to be able to "assist the student to identify the important pieces of information in a situation and see the relationships or consequences." One participant shared an example of a discussion she had with a colleague regarding a student issue. The essence of the discussion focused on the point that she was in fact the expert in the clinical area. In listening to what her

colleague said she came to realize that she "was the expert and had a lot to offer." She continued by saying that "we owe the experts to the students" and clinical courses should be "taught by an expert" in that area.

The participants agreed that experience was a big criterion. One participant cited the literature regarding the need for a specified number of years of experience (Benner, 1984; Freedman, 1979). She stated that she was not so entrenched in the specific criteria, that you needed to be in a position a specified number of years. She did say that you can't become an expert in one year, because "expertise means that you have situations that occur and you learn from those and you gain new knowledge each time." Four participants agreed that a person is not necessarily an expert because they have taught for 25 years.

As supported by the literature, one participant suggested that experts need to possess a willingness to "reflect on and learn from their experiences" (Kitchener & King, 1990). You have to look at what worked and what didn't work and how you can do things differently. An expert must be willing to accept feedback and grow from it.

An expert has to have a feeling for scholarship or has a commitment to scholarship. If you say that you are going to be an educator then you have to accept that role of being a scholar. Knowledge is not static, and you have to be willing to say you don't know everything. You must realize that you

are never going to know everything and you might as well be up front about that. There is no way that you can know everything about everything, but part of your role is to become a scholar, to find out what those things are and what the issues might be.

Five participants supported the notion that it is not necessary to have all the answers, but a willingness to find them and help students do the same. An expert needs to be willing to use other resources, such as the nursing staff, to find the answers.

The participants shared the belief that an expert needs to be flexible and open to change. The major concern shared by all the participants was a lack of flexibility in some colleagues. In order to work with people with diverse backgrounds, perspectives, and values willingness to change is essential.

Knowledge and Skills Needed to be an Expert

Nursing educators must be proficient not only in nursing, but also in teaching (Bergman & Gaitskill, 1990; Brown, 1981; Karuhije, 1986; Pugh, 1988). All of the participants believed that an expert clinical nursing educator needed a solid theoretical basis in both nursing and teaching. This corresponds to knowledge components identified by Irby (1994) to include: clinical knowledge of (a) medicine; (b) patients; (c) context of practice; (d) educational knowledge of learners; and (e) principles of teaching. Several participants suggested a broader base to include liberal arts and sciences. Specific

areas that provide a basis for nursing included physical health assessment, pathophysiology, and pharmacology.

A major concern in nursing education is the lack of educational preparation of nursing educators before being placed in the clinical teaching setting. As identified in the literature most nursing educators lack formal instruction in teaching and often determine how to teach (or not teach) based on examples of teachers in their own nursing education experience (Fitzpatrick, 1991; Meleca et al., 1981). Though most of the participants have not had formal education courses, several identified the importance of understanding educational principles. One went on to say:

I think that these educational principles help, but I think that there are expert clinical instructors out there who may never have had an education course and just intuitively know the sequence in which you should present things and how to capture peoples' interests, and how to make students learn differences and similarities. I think education principles are helpful, but they are primarily helpful if they run parallel to what you believe anyway.

One participant suggested that it would have been useful to have had an opportunity to go back and take education classes after she received her nursing masters and started teaching. She went on to say that this can present a problem with time and money. Furthermore, "getting in a different discipline does pose a problem and it is hard to keep up in nursing as you focus on other things." She stressed that though she believed

education classes were valuable, it was essential to keep up on your own profession and updated in your specialty areas.

In relation to nursing knowledge the participants' answers reflected the level of students and specialty taught. One suggested a "deep knowledge of the type of patients being cared for." Several stressed the importance of a broad nursing knowledge. As one participant stated, "you just don't get the patients with one type of problem." You may be caring for a patient in a cardiac unit and find out that there is a psychiatric basis for the problem or a patient admitted to a psychiatric unit may be demonstrating psychotic symptoms because of a brain tumor or a diabetic problem. All of the participants agreed that theory-based knowledge needed to be combined with experiential knowledge (Benner, 1984).

The second feature described by Sternberg and Horvath (1995) in the prototypical view of teaching expertise is that of problem solving efficiency--experts accomplish more in less time than do novices. The third difference is related to insights--experts are more likely to arrive at unique and suitable solutions to problems than are novices. All of the participants identified the importance of critical thinking and

problem solving ability (Bransford & Stein, 1993; Crandall, 1993).

I think you have to have some fundamental knowledge about what it is to be a scholar . . . You need to be a critical thinker, and that is something that you can learn . . . When I think about these characteristics I think that most of them would come after a masters degree. Then you would have experience in writing, critical thinking, getting knowledge about how to be a scholar. I think that would be a minimum.

As one participant reflected, "you need the ability to think, broader rather than narrower, thinking more conceptually."

The importance of effective interpersonal relationships with students was emphasized throughout the literature on teaching (Bergman & Gaitskill, 1990; Jacobson, 1996; Mogan & Knox, 1987; Nehring, 1990; Pugh, 1988). Attributes identified in the literature included conveying confidence in and respect for students, encouraging students, providing support and encouragement to students, and having realistic expectations of students. The skills needed include a thorough knowledge of people skills and nursing practice skills. One participant summed it up in her response.

Good people skills, good interpersonal skills, good communication skills, conflict resolution skills, assertiveness, and I should probably say good nursing skills.

You need the "interpersonal skill to work with a variety of people each with their own agenda." You need even more "skill to be able to work with staff." An expert

needs to be non-judgmental and have "your body language concur with what you are saying."

An expert clinical nursing educator has to have "excellent interpersonal skills to be able to deal with students." The expert needs to be able to support the students in doing their best and in taking risks. He or she must be able to support them when they make mistakes and to help them learn from the experience.

An expert needs to be open to facts and ideas. "Being open is a skill." An expert is open to "learning from your experiences as a skill."

An expert clinical nursing educator needs "all of the basic skills that the new practitioners need to come out with."

I feel that we teach starting by these . . . and students get real concerned because they haven't done it in clinical and they don't always get an opportunity. But I tell them it's not the absolute most important thing. You can learn that when you are out there. It's the idea that you have seen the technique, you know what the process is and so on. I don't know that the educator has to be proficient at starting IV's and that sort of thing, but certainly knowing the techniques and how to teach are important.

One participant suggested that an expert needs the skills that are acquired at the bedside. More specifically you need an understanding of the skills used in the specialty area in which you teach.

The participants demonstrated a strong knowledge base in nursing during the clinical observations.

Knowledge base was illustrated by the questions that were asked of the students. The participants generally questioned students about the relation of theory or principles to a clinical situation. All of the participants asked pertinent questions about principles of physical health assessment, pathophysiology, pharmacology, and/or nursing foundations.

On three occasions participants appeared not to have an answer to students' questions. All three participants proceeded to help the student find the information in available resources. The new information was viewed by both the participant and the student. The participants assisted the students' learning by clarifying or interpreting the new information and applying it to the current client situation.

Several of the participants were proficient at demonstrating critical thinking and problem solving. This was evidenced by helping the students view data in a logical pattern and by providing cues to guide their thinking. This behavior could also be interpreted as modeling those two aspects of scholarly thinking for the students.

Teaching and learning principles were exhibited by all of the participants. These were demonstrated by the use of questioning techniques, repeating to reinforce learning, using more than one strategy to teach a

concept, and by assisting the students to problem solve. Theory was linked to practice through explanations and questioning.

For the most part, specific nursing skills were not directly or completely demonstrated by the participants. As the majority of the students were seniors, ability to perform basic skills was assumed by the researcher. New skills practiced by the students usually involved guidance from the participants. On one occasion a participant demonstrated the skill of initiating an intravenous infusion, though this was done after the student had attempted the skill first.

Attitude, Value, and Belief Perception

The term attitude has various meanings. Criteria delineated by McGaghie et al. (1995) include:

- (a) evaluation constitutes a central aspect of attitude,
- (b) attitudes are represented in memory, and
- (c) affective, cognitive, and behavioral antecedents and consequences of attitudes can be distinguished.

Attitudes have also been defined as inclinations or dispositions to respond positively or negatively to a person, object, or situation (Shelly & Miller, 1991). Attitudes are assumed to guide role judgments and behaviors.

Values are defined as beliefs or ideals to which an individual is committed and which guide behavior. Values

are reflected in attitudes, personal qualities, and consistent patterns of behavior (Shelly & Miller, 1991) and may be held in common by members of a social group. Personal qualities are innate or learned attributes of an individual. Professional behaviors reflect the individual's commitment to specific values. Behaviors can be defined as observable social acts performed by an individual (Hardy & Conway, 1988). According to Hardy and Conway, values generally refer to abstract but stable aspects of an individual's overall belief system, whereas attitudes are more specific and usually indicative of the values held.

Beliefs represent the intellectual acceptance of something as true (Chitty, 1993). Beliefs are opinions that may be, in reality, true or false. They are based on attitudes that have been acquired and verified by experiences.

A role is a set of shared expectations focused upon a particular position (Hardy & Conway, 1988). A role consists of several components which include: values, attitudes, and behaviors.

Attitudes toward practice are a reflection of the socialization process which occurs in education (Watson, 1986). Role socialization involves the internalization and shaping of specific values and attitudes and the

acquisition of skills for the enactment of appropriate behaviors.

An area of concern to faculty is the degree to which their own values and attitudes influence their students. Nursing educators are significant persons in the students' environment and contribute to the professional values that they develop (Ferguson & Calder, 1993). Because values are modeled and affirmed by significant persons, role modeling is a primary means of transmitting values into a profession.

Perception of the value of clinical teaching was examined in relation to three areas. The participants were asked whether clinical teaching was valued by administration, colleagues, and students. An additional area of investigation questioned perceived recognition and rewards received for teaching in the clinical nursing setting.

Is Clinical teaching Valued by Administration?

As a whole the participants believed that clinical nursing was not valued by administration outside the nursing arena. One participant maintained that nursing clinical experience was compared to a science lab, that is, a clinical experience is like an assigned lab for a chemistry class.

So chemistry lab goes from 3:00 to 6:00 and your nursing lab (clinical) is scheduled 3:00 to 9:00. Well they think you are there from 3:00 to 9:00, six hours. Well, you go out at 1:30 and you don't get

out of there until 10:00 or 10:30 and those hours are not seen as part of that clinical experience. They say, well there is prep time for chem labs and so on - totally different. You're not dealing with a test tube, you are dealing with live human beings with all of the legal ramifications that go with liability. So I don't know if that is really understood, that is, an appreciation for the clinical and the importance of that time.

Another participant contended that clinical teaching in nursing was perceived as the "low activity on the scale."

If you are having problems with staffing, you go out on the streets and you take in a warm body to do your clinical. If you have enough warm bodies, low man on the totem pole, or the person that you are disgusted with or want to punish the most gets that.

Four participants expounded that credit was not given by administration for clinical teaching. One suggested,

I don't think it is valued by nursing. We tend to put our least prepared people in the clinical area. What we should do is let them teach the theory and let the most prepared be in the clinical, because that's where it is such an uncontrolled situation. but we don't do that. We have our expert that teaches them the theory and then we hire somebody with far less experience in education to handle the clinical.

She further emphasized that it is "nursing that does not value clinical teaching."

Her sentiments were echoed by a second participant,

We usually do three hours of contact for one hour of credit for the clinical and one for theory. If we would do three to one for theory, and one to one for the clinical we might have a better idea of what's important and we would also have more people willing to do it. Faculty would rather do a theory course, even if it is not in their area of expertise,

because it takes less time and they get more credit for it.

Several participants expounded on the fact that clinical teaching time was not given the same ratio as classroom time when teaching load was considered.

You have to kill yourself off a number of hours in clinical teaching to compensate for that and when they are identifying hours of clinical that contribute to your teaching load, the number of hours that you spend making out assignments doesn't count. The number of hours that you put in doing evaluations, writing them, giving them, that doesn't count. The number of hours you put in grading papers, that doesn't count.

She summarized by saying that this points to the fact that administration does not value or give credit for your clinical teaching responsibilities.

One participant did not share this belief. She believed that clinical teaching in nursing was valued by nursing administration. She identified a commitment to the philosophy that nursing was embedded in practice. From her perception, the issue of lack of value comes from outside the nursing profession.

Is Clinical Teaching Valued by Colleagues?

The participants expressed differing perceptions of the value placed on clinical teaching by their colleagues. As a whole the participants believed that their colleagues would articulate the value of clinical teaching though several expressed the concern that this might not be demonstrated in their behavior. One participant expressed the concern that "even though we

articulate that we value something, how we really feel shows up another way."

Three participants remarked that many of their colleagues would prefer to do a theory-only course, that is, one that doesn't have any clinical component. One participant believed that something needs to be done "to place more value on it." Another participant stated that some of her colleagues would make an "intense effort not to do clinical."

Concern was expressed that nursing educators frequently talk about how much they value clinical nursing. Nursing educators say that they want the most qualified people to do the clinical teaching.

The same people are trying to get out of it or bitch about it all of the time. For example, this is my last clinical day, I am so tired of it. I can't stand it any more. Yes, it is draining. It takes a lot more energy to work one-on-one with eight people than it does to teach 40 people in a classroom.

She attributed part of the negative attitude to stress; however, she felt that part of the attitude reflected a lack of value.

Is Clinical Teaching Valued by Students?

All of the participants agreed that students valued clinical teaching. As a whole the participants believed that the students enjoy their clinical experience, feel rewarded from it, and would like more clinical hours. One participant shared comments from her students. She explained that the students say you can read and reread

the theory and content but you need the opportunity to apply the materials to a real situation and client before you can fully understand it.

Another participant hypothesized that students see clinical experience as the most important part of their education. She stated:

They are good consumers of education. They want to get the most that they can from the clinical experiences that they have.

She believed that this applies to the majority of students.

Only one participant maintained that some students do not value clinical experience. She explained that often the importance of clinical isn't realized until the senior year. At that time the students begin to panic that they do not know enough and have not had enough experience. On a daily basis students complained when told they can not miss clinical. Students complained when told there was a limited amount of time they could miss.

Then they wonder why they can't pass this class. Well, it's because they haven't really proven themselves in clinical. So I don't really think they understand until they actually get out there.

Four participants expressed the desire to provide more clinical hours for the students. One participant apologized that sometimes we overwork the students with clinical paperwork.

They have to write and process to the point that they may be thinking of these things rather than what they are supposed to be getting out of clinical. They should be in the hospital more hours and at the computer fewer hours.

For the purpose of this research the position was held that values denote a commitment and guide behavior. Behaviors are defined through observations. Beliefs are based on attitudes and verified by experiences. Expressed attitudes can be indicative of values held.

Value was demonstrated by all of the participants by preparation prior to scheduled clinical time and by willingness to share their practice with the researcher. Value was also demonstrated by the participants' manner with clients and students. Students and clients were treated as individuals. Client problems and diagnoses were discussed in a respectful manner. Generally, the participants made sure that not only clients' but students' needs were accounted for before their own. Other examples of value were demonstrated by following protocol for procedures and by limiting breaks to assigned times.

Rewards and Recognition Received for Clinical Teaching

Five of the participants said they believed little or no recognition or reward was received for clinical teaching. Several participants mentioned that students were never asked to evaluate their clinical experience. All of participants believed that recognition came from

the value placed on clinical teaching by their colleagues and the students.

One participant responded with an overwhelming yes to the question. She believes the reward comes from the student.

I feel more reward in clinical than I do in the classroom. I am able to see the direct correlation of the thing that I have helped them deal with come to completion. In the classroom setting you talk about the clinical, so I guess I get more rewards from clinic.

Role Orientation

Roles were examined from several aspects of the nursing profession outside of actual teaching. It is believed that these aspects have a direct relation on the qualities exhibited by a person considered to be an expert in his or her field. For the purposes of this study, role related questions included: Is nursing practiced outside the teaching setting? How are professional and intellectual stimulation received? What are preferred professional tasks? What are the traits of colleagues who are admired? What are the traits of colleagues who are avoided?

Practice Outside of Teaching

All of the participants currently practice or have practiced outside the teaching setting within the last several years. Of those who currently practice outside of their teaching role, the area of practice was directly related to their teaching specialty. Since all of the

participants work full time in their teaching role, outside practice was usually done during the summers or on an as needed basis during weekends. One participant mentioned that with recent cost cuts in health care, it has become more difficult to practice on a part-time basis. Several participants did stress that teaching is "a real job" and that "education is my practice."

Professional and Intellectual Stimulation

Professional and intellectual stimulation was received by all of the participants from a variety of sources. All of the participants identified colleagues and reading as the main sources of professional and intellectual stimulation. One participant suggested that she received a lot of professional stimulation from her colleagues as many of them were "good thinkers." She felt that she could share ideas with them and receive beneficial feedback. One participant suggested her sister, who is also a nursing educator, as her prime source for "intellectual discussion." She stated that after reading research articles she often hungered for a stimulating discussion. She felt that this was difficult to obtain with many of her peers. She stated:

I can take a walk in the woods with her and we get down to some really nitty gritty and hefty arguments. We can talk about the profession and then come out friends, of course.

Another participant suggested that she received a lot of stimulation from reading professional journals.

She finds reading provides useful ideas that can be implemented in her classroom teaching and practice as an educator.

Several identified membership and involvement in professional organizations, attendance at conferences, and networking as means to obtain professional stimulation. The value of attendance at conferences was qualified by the response, "the quality of those varies from time to time."

One participant identified clinical practice as a source of professional stimulation. She stated that "I come out feeling so good about what I am actually doing, like this is why I became a nurse."

Another participant indicated that she "thoroughly enjoyed taking classes because of the interaction of the professor." She further mentioned an interest in becoming certified in a nursing specialty. She felt that she would enjoy this as scholarly activity, though attending classes is hard to balance with teaching workload.

Preparing for teaching was identified as intellectually stimulating by several participants. One suggested that it keeps her up on what is going on in the profession.

Preferred Professional Tasks

When asked what professional tasks were preferred the participants overwhelmingly responded with "teaching." When the participants were probed to consider tasks beyond their immediate teaching responsibility most stated that discussion about curriculum development was preferred. One participant likened curriculum development to "building a doll house." Another participant enjoyed activities that required using nursing or education knowledge.

Two participants mentioned research as a preferred professional task. One participant proclaimed "I love research, and I am very interested in research though a lot of educators think it is a necessary evil."

One participant identified advising as a professional task included in her job description. She stated that "advising would be fun if it were not so darn time-consuming at a busy time of the term."

As preferred tasks were discussed, most of the participants mentioned tasks that they would like to avoid. The unanimous response was committee meetings. One participant sufficiently elaborated on this by blaming the problem with meetings on the fact that nursing is a female profession. "Women do a lot of nit-picky stuff at meetings that men would never tolerate."

Along with meetings, routine tasks were mentioned as not very exciting.

Another participant said that the good thing about committee work was working with colleagues. The key to preference for committee work was related to the task that needed to be accomplished and the problem solving approach of the members.

Attributes of Admired Colleagues

One participant thoroughly summarized the sentiments of all of the participants as she described the attributes of admired colleagues.

Good thinkers, good scholars. They are people who you can have a discussion with and who will help stimulate your thoughts. They may not always agree with the way you are thinking but will certainly help lead you to information that will tell me how they think and why. Often times if we don't agree we can come to some compromise about how that might work. People who are non-judgmental of my incomplete thoughts.

Admired colleagues were willing to listen, to share, to be supportive, and to be flexible. One participant expressed admiration for the creativity of several of her colleagues. She stated that she "admired their creativity because they do not teach classes the same way every year." Another participant identified ability to think conceptually, organization, and fairness with students as admired attributes.

Attributes of Least Admired Colleagues

The participants overwhelmingly responded that inflexibility and having a closed mind were the attributes of colleagues that they would prefer to avoid. These colleagues were described as seeing their way as the only way to view a situation. Prejudice, favoritism, and unfairness were also mentioned as attributes of the least admired colleagues.

Problem Solving Strategy

According to the literature, an essential talent possessed by experts is their ability to solve problems more accurately than other people (Johnson, 1988; Sternberg & Horvath, 1995). For the purpose of assessing problem solving skills, the participants were asked to describe how they deal with a difficult choice or a problem, and whom they might go to for assistance.

All of the participants described similar strategies used to solve problems or make difficult decisions. As the literature suggests, reflective judgment is the outcome of growth in domain-specific knowledge (Kitchener & King, 1990). The importance of time to reflect was paramount except in life-threatening situations. One participant suggested that "if I jump too quickly I do not have all the information that I need."

The second strategy used by the participants was to look at the whole picture. In looking at the whole

picture information was gathered about the problem. The participants made a written or mental list of factors that affected the problem, identified both the positive and the negative, identified underlying assumptions and ramifications of the decisions, and obtained objective information about rules that might affect the issue.

All the participants stated that they might discuss the problem with a trusted colleague. Colleagues play the role of a sounding board. The participants go to a colleague basically for "the support and an honest opinion."

The importance of experience in decision making, as identified in the literature, reverberated throughout the participants' responses (Bransford & Stein, 1993). One participant adequately put it when she said:

Lots of times I will say, this is just like something that happened five years ago. This person is like Sally and I did this with Sally. Maybe this worked for her and the current student is a lot like her. I use the experiences that I have had. Pretty soon, not all the problems get to be new. They are problems that I have faced before, so I usually have some experience in dealing with them.

If the problem involves a student, the participants first acknowledge that the situation has occurred. Next they talk with the student about the importance of not making a hasty decision. Finally an appointment is set up with the student for the following day. The participants stressed the importance of the need to

reflect and to consider all the factors before discussion with the student.

Other resources utilized in problem solving are related to the nature of the problem. Three participants mentioned the importance of talking with the Dean or an attorney if the issue involved a potentially legal concern.

The participants were also asked to share examples of difficult problems or choices in which they were involved. One participant used the situation of the selection of a new faculty member whom she did not support. She stated that she objectively and honestly presented her concerns and convictions. Once her concerns were expressed she told the committee "they could rest assured that I would support them all the way."

Another participant shared a problem she had with a marginal student. She explained that when the student came to her course she already had the "reputation of being a liar, and of not doing well" with a low potential for success. She stated that she worked with the student and she received outside tutoring. The student made improvements and did well enough in her work that even though her final course score was only 0.2 above the minimum passing score, the participant labored with whether she should pass the student or not. She stated

that she spent much time reflecting on the issue and discussing her decision with the Dean. She stressed that "one of the factors was that I shouldn't be forced to make a decision based on history" despite the objections of other faculty members.

Examples described by other participants reflected clinical choice of actions undertaken by students. All of the participants stressed the importance of sharing the concern with the student, taking time to reflect, collecting data, and taking time to help the student look at the issue and learn from the experience.

Goals

Finally, the participants were asked several questions related to their professional goals. They were questioned about where they saw themselves in 10 years and what would lead them to make a change in their teaching role in the future.

Two of the participants said that they would probably be retired in 10 years. Three participants suggested that they were considering working on a doctoral degree. Four of the participants could see themselves still teaching. All of the participants suggested continued learning, personal growth, and frequent changes in teaching process and content. One participant stated that she would like to be writing and publishing in addition to continued teaching.

The participants revealed several things which might lead them to make a change in their teaching role: a faculty decision based on special needs of the college, opportunities for intellectual growth, and salary. One participant suggested that policies by the college or the department that would limit her in how she practices might lead her to make a change. She further stated that if she had a "philosophical difference with the faculty or department chair" it would be more difficult to remain in the same position. She believed that it is important for the faculty to "be together and have the same philosophy in your curriculum."

Summary

The purpose of this study was to identify and to describe the attributes shared by clinical nursing educators who were perceived and identified by their peers as representing expertise in clinical nursing. The data were gathered through semi-structured interviews and observations with six clinical nursing educators. Interview data were analyzed using the constant comparative method (LeCompte & Preissle, 1993). Data were initially viewed within the framework of the interviews. The descriptive data obtained from the transcribed interviews formed the foundation for the narrative report in this chapter. The demographic data

provided personal data to complement the interview analysis.

The analysis of the data appeared to indicate that the participants shared attributes and beliefs in five categories:

1. Educational Philosophy
2. Value Perception
3. Role Orientation
4. Problem Solving Strategy
5. Goals

CHAPTER VI
SYNTHESIS OF DATA

To explore the expertise of clinical nursing educators, data obtained during semi-structured in-depth interviews and observations were analyzed to determine pervasive themes. Within the context of the research questions, four themes were identified. Themes are presented and examined in this chapter along with areas that concur or differ from the research literature.

For the purpose of this study the term "theme" relates to the structuring of similar data that fall into categories (Brink & Wood, 1983) and are grouped around a central focus or issue. The formulation of themes provides a means for identifying the recurring messages that pervade an educational work (Eisner, 1991). Themes represent the dominant features or qualities of persons, patterns of behaviors, situations, or objects that define identity. In the qualitative study of an educational setting themes are extracted from what has been encountered and provide a summary of the essential features (Eisner, 1991). They also provide clues to the perceptions of other situations similar to the ones from which the themes were extracted.

To some extent the themes derived from this study arose logically within the context of the interview design and field observations, although the ultimate

decision regarding theme development was based on the intuition, sensibilities, and practical experience of the researcher within the nursing profession. Explication of the themes involved an analysis of the coding labels, sorting, categorizing, and integrating data into explanations or connections and relationships.

This chapter describes and discusses the overarching themes, which represent expertise in clinical nursing educators. These themes, which emerged during the course of the study, can be used to define and describe a framework for viewing expertise in clinical nursing educators.

The literature existing at the outset of this research focused on characteristics of effective teaching. The studies were typified by an attempt to determine general categories of effective clinical instruction. The study designs were predominately descriptive and frequently involved the use of rating scales or surveys of students. Few studies used qualitative methods.

Characteristics of effective clinical teaching were found in research that compared classroom and clinical instruction. According to Irby (1978b), the factors that represent effective classroom teaching, also are common to clinical teaching, tend to reflect instructor presentation, enthusiasm, knowledge, and relations with

students. Factors suggested as unique to clinical instruction involve clinical supervision, clinical competence, and modeling of professional standards and values.

The literature also provided several models for viewing domain-specific expertise (Benner, 1984; Irby, 1986a; Shulman, 1987; Sternberg & Horvath, 1995). A distillation of common characteristics of those models suggests that experts across a variety of fields tend to (a) excel mainly in their own domain; (b) have the ability to solve problems more accurately and efficiently than novices; (c) possess strong self-monitoring ability; (d) are highly motivated; (e) perceive broad meaningful patterns in their domain of knowledge; (f) develop expertise through problem solving experience in the domain; and (g) develop knowledge through experience.

Such research and models of expertise were taken into consideration when entering the field of investigation in this study. Though they suggested avenues for investigation, they proved to be inadequate in attempting to understand the complexity of expertise in clinical nursing educators. Not all observed and espoused behaviors fit neatly into the categories contained within the models described in existing literature. In addition, there seemed to be more to the clinical teaching roles and knowledge base than that

which was described by the models. In order to obtain a holistic understanding of expertise in clinical nursing educators, the data were explored for themes which were interpreted to be crucial to the understanding of expertise in clinical nursing educators.

Themes

In accordance with the grounded-theory method (Bogdan & Biklen, 1992) and the purpose of this study, the goal of interpretive analysis was to focus on the participants' qualities and patterns of behavior. Upon examination, qualities of persons and patterns of behaviors emerged and were used for describing expertise in clinical nursing educators. These qualities and patterns of behaviors were perceived by the researcher to represent four themes. The themes were: commitment, reflection, intuition, and integration. The following sections explore each theme.

Commitment

Why do nurses choose to become educators? Although the reasons may vary across circumstances, many nurses enter nursing education because they want to help students learn. This strong sense of mission underlies professional commitment (Hoversten, 1992). Research also indicates that teachers often have a strong desire to serve people and make a difference in their lives (Schwab, Jackson, & Schuler, 1986). Both teachers (Roark

& Davis, 1981) and nurses (Benner et al., 1996) are motivated by the desire to serve though obstacles may make it difficult for educators to carry out their mission and may threaten job satisfaction. Watching students grow and develop into professional nurses makes teaching meaningful and worthwhile for many nursing educators.

Professionalism implies commitment, and commitment, in turn, is an indicator of a high degree of professionalization (Moloney, 1992). Commitment to a calling involves accepting appropriate norms and standards. Expert nursing educators with a high degree of commitment are inwardly motivated by their conscience to develop their full potential and be visibly active in furthering the goals of the profession (Moloney, 1992). Their commitment reflects a lifestyle that values the development of knowledge, guides the conscience, and monitors professional behaviors.

The six participants in this study all have a strong sense of mission which has sustained their commitment to teaching and the profession of nursing. The importance of enjoying your work and accepting a professional responsibility to do what needs to be done were identified as essential aspects of being an expert. Working with students was distinguished as the most satisfying and rewarding part of their professional

responsibilities and all of the participants expressed the desire to remain in this role. All of the participants in this study have a desire to share knowledge of the nursing profession with students. One participant expressed the belief in a commitment to the philosophy that nursing knowledge is embedded in practice.

Commitment to the importance of clinical teaching arises out of the shared experiences and practice of the experts in this study. This commitment in clinical teaching and education gives impetus to their practice in the midst of adversities, such as lack of administrative and colleague support, lack of recognition, lack of time, and lack of reward. A commitment to clinical teaching is recognized through the willingness of the participants to reflect on their thoughts and feelings and to allow the researcher to observe their clinical practice.

Commitment contributes to a degree of job satisfaction. The most critical element of job satisfaction, according to researchers, is the relationship between teachers and students (Conley, Bacharach, & Bauer, 1989; Feitler & Tokar, 1985; Strahan & Van Hoose, 1988). The primary rewards received from working with students are highly valued and correlate with increases in teacher satisfaction (Blase, 1982).

It is the conviction of the researcher that all of the participants expressed a strong commitment to clinical teaching and shared the belief that clinical practice was the most important part of professional nursing education, though it was often not viewed as such by colleagues and administration. This lack of shared value has led to limited recognition and rewards. All of the participants explained that the most important reward was not measurable but related to observing student growth. This intrinsic reward provides motivation to continue to teach what is valued and to practice and grow in the profession in order to increase expertise.

Commitment, as reflected in behaviors, provides the passion for mastery of the practice and the flame that fuels professional growth. Simply put, commitment develops from personal and professional experiences, continued acquisition of knowledge as a part of growth, and provides the motivation to excel in the practice arena. In order to develop to their full potential the expert has to have a commitment to scholarship. As one participant explained, "If you say you are going to be an educator than you must accept the role of being a scholar." Knowledge is not static and an expert must be a life-long learner. As was espoused by the participants, an expert believes in life-long learning. This was modeled by a willingness to learn and an

openness to change. As stated by one participant, the expert does not necessarily know all of the answers, but demonstrates an eagerness to seek answers. Willingness to learn and grow was observed by consultation with peers and exploration of resources. Expressed interest for growth included obtaining additional education, participation in research, and remaining current through reviewing appropriate literature.

As an advanced stage in cognitive development, willingness to act according to values and beliefs represents a commitment to personal and professional life (Perry, 1970). This complexity in thought and problem solving involves an acceptance of diverse perspectives, ability to deal with ambiguity, willingness to take risks, independence in practice, and responsibility to practice. Experts, in manifesting commitment, have established their own identity. This identity entails an ability consider multiple points of view and to make independent judgments.

Reflection

A fundamental process in developing one's identity as an expert and a complexity in thought and problem solving involves reflective thinking. The process of reflection is an integral part of our daily activities. From the time we get up to the time we retire, we replay in our minds the days events, often analyzing and

reexamining what has occurred. Reflection is a set of processes through which a professional learns from experience (Shulman, 1987). Boud, Keogh, and Walker (1985) note that "reflection comprises of those intellectual and affective activities in which individuals engage to explore their experiences in order to lead to new understandings and appreciation" (p. 19). Their definition implies that reflection is goal-oriented, that feelings and cognitive abilities are interwoven, that the individual is in control of the activity, that reflection can take place in isolation or in association with others, and that reflection is not an end in itself, but preparation for new experiences.

Learning through reflective processes has been explained by Kolb (1984) within the terms of an experiential learning theory. The theory suggests that learning, change, and growth are facilitated by a series of processes. These processes involve direct experiences, reflection on the experience, and abstract concept formation from which behavior (active experimentation) may be modified to aid new experiences. Similarly, reflection has been viewed as the link between theory and practice (Schön, 1987).

As supported by the literature, experts in a domain possess a willingness to reflect on and learn from their experiences (Kitchener & King, 1990). The participants

in this study stressed the importance of considering what worked, what didn't work, and how things could be approached differently. One participant explained,

I reflect on the experiences that I have had.
Pretty soon, not all the problems get to be new.
They are problems that I have faced before, so I
usually have some experience in dealing with them.

Experts in a domain use similar strategies to solve problems or make difficult decisions. As the literature suggests, reflective judgment is partially the outcome of growth in domain-specific knowledge (Kitchener & King, 1990). In this study, reflection was frequently referred to as the participants described problem solving processes. One participant stated that the importance of experience and time to reflect are paramount in problem solving.

All of the participants espoused the importance of reflecting on the whole picture in a situation. In looking at the whole picture, information is gathered about the problem. As the expert reflects, written or mental lists are made, which identify the factors that affect the problem, identify both the positive and the negative, identify underlying assumptions and ramifications of the decisions, and view objective information in regards to rules that might affect the issue.

The importance of experience in decision making, as identified in the literature, is also evident in the

practice of experts (Bransford & Stein, 1993). Without reflection, experiences would remain unexamined, with the full potential for learning not fully realized (Stockhausen, 1994). An expert may recall a similar situation that happened in the past. According to one participant, after extensive experience most problems are not new but have been faced before. Hence, experience can be called upon to deal with them. Another participant explained that more is learned from reflecting on previous experiences than from books. "I can reflect on what worked and what didn't and apply those to the new situation."

The participants in this study espoused, and were observed to use, similar patterns of problem solving. Variations were observed in the degree of comfort experienced by the participant when problem solving with students. This was assumed to be related not only to the background of knowledge and experience to reflect on, but also on the acuity of the patients in the setting in which the problem occurred.

Reflective practice can not be viewed in a void, but must be considered in light of intuition and the integration of knowledge. When the expert reflects he or she operates within a context and draws on a repertoire of integrated knowledge, adapting it to the present and adding to what will be available for future inquiry

(Schön, 1983). Reflection also consists of a restructuring and testing of intuitive understanding based on experiential phenomena. Reflection, in combination with intuition, involves an awareness of which issues need to be considered. Reflection is influenced by past experiences and allows the expert to view a new situation through previous learning. Intuition, guided by skilled know-how leads to the process and knowledge needed to make judgments.

Intuition

Not all problem solving involves use of a conscious and logical sequence of steps to identify the problem and arrive at a solution. Problems are also solved through intuition, an understanding in which the individual is unaware of how it occurred. Expert practice is characterized by an intuitive link between identifying the prominent issues in a situation and responding to them. This is evident through observing the expert in a practice situation. Intuition is characterized by immediate apprehension of a situation and is related to acquaintance with similar experiences (Benner et al., 1996). Apprehension is often the recognition of a familiar pattern. For example, Benner describes contextual and relational "cues" identified by the nurse in pointing out immediacy of client needs. Rew (1988) identified three aspects of intuition: knowledge that is

received in an immediate way, perceived as a whole, and not arrived at through a conscious, linear analytic process.

In considering the fact that nursing and teaching are predominately feminine professions intuition can also be considered in light of related literature. Belenky, Clinchy, Goldberger, and Tarule (1986) have contributed important perceptions to the understanding of women's ways of knowing. Belenky et al. use the category "subjective knowledge" to refer to knowledge arrived at through intuition. They describe subjective knowledge as residing within the person and being more powerful than the answers offered through the outside world. Bevis and Watson (1989) described intuiting as sensing and interpreting on a personal level. Intuitive perception goes beyond viewing persons and conditions as a categories. Intuitive perception implies appreciating the individuality of each person and event within the concept of holistic caring. Caring is the moral imperative of both nursing and teaching, and the definition of caring implies providing for the unique and distinctive needs of each human. Intuitive knowledge increases the sensitivity, strength, and self-valuing of the expert.

Nursing and teaching are professions that rely on theoretical understanding, though with experience in a

domain, the expert responds automatically to certain situations. Knowing what needs to be taught and how has been experientially learned and shapes the educator's teaching and nursing practice. Thus, although the expert nursing educator will find that he or she relies on fewer rules in applying theory to practice, practice will be improved, not just by experience, but by a deeper understanding of theory.

Expertise, as demonstrated by the participants in this study, denotes a professional mastery. Professional mastery, referring to knowledge embedded in practice, is a medley of theory and experience. Viewing professional mastery from this perspective differs from listing basic skills needed by clinical educators. Exemplars given illustrate nursing performance that represents a multiplicity of skills. Clinical knowledge occurs over time and nurses lose track of what they have learned. The experts in this study, with extensive experiential backgrounds, rely on an intuitive grasp of a situation without consideration of a large range of alternatives. Therefore, much of their professional mastery can only be observed as particular situations arise.

Intuition played a key role in how the participants of this study made clinical judgments. When they had an intuitive feeling about a client's condition or a student's concerns, they acted on that intuitive

response. They respected the intuitive feelings they had about situations and believed that it was important to be sensitive to the intuitive side of themselves. They used intuition to guide the clinical judgments they made.

The participants in this study looked at the clinical situation as a whole, rather than an accumulation of parts. These experts viewed each situation as a whole and developed judgment without being able to describe how they thought about the process of making the decision. Each participant described situations where they, "just had a feeling that things were not right." One participant described gathering information through your senses and seeing how you feel about it. Another participant explained that it is not something where you can sit down and list what you have done, "you just don't consciously stop and think about what you are doing." Benner (1984) described this phenomenon as the nurses' use of practical knowledge, which is often tacit, based on past experiences, and dependent on the context of the clinical situation.

Experience is seen as key to developing intuition. In relation to intuition, experience, as a source of knowledge, does not refer to the mere passage of time. Rather, experience is the refinement of theory through actual practice situations. Though theory represents formal knowledge, clinical experience is more complex and

illustrates realities that can not be captured by a theory alone. The participants in this study with the greatest amount of both teaching and nursing experience demonstrated more of an intuitive and spontaneous approach to practice, which allowed the students to view nursing practice more realistically.

All of the participants in the study may not exhibit the same degree of clinical expertise. It would seem that an obvious reason for differences in expertise was variation in number of years of experience. Experience may not always be the most important predictor of expertise. Other factors, which might have a more significant impact, include practice opportunities, motivation, and clinical context.

"Intuition is a skill rooted in our natural sensibility to hidden patterns and developed to effectiveness by a process of learning" (Polanyi, 1969, p. 118). Unspecifiable clues can be sensed, mobilized, and integrated in response to hidden meanings and eventually embodied into recognizable concepts or ideas. Intuition represents an integrative act that can take place at any stage of inquiry. Integration does not evolve without intuition. In the natural transition between intuition and integration, clues or signs are driven forward by the imagination in a search for

hypotheses and solutions, thus integrating the unspecifiable with recognizable forms of knowing.

Integration

Commitment to the profession, reflection, and intuition lead to a deeper understanding of the entity of clinical practice. This mastery of understanding can be defined as the integration of knowledge. All of the participants in this study appeared to have integrated knowledge, skills, and experiences from the professions of nursing and teaching. The significance lies, not in specific components of knowledge as previously identified, but in the integration of knowledge components. Integration denotes a blending or unification. Defined as a horizontal relationship, integration involves the organization of experiences that help students get a unified view of the situation and behavioral expectations in relation to the components that are taught (Tyler, 1949). Taba (1962) stated ". . . learning is more effective when facts and principles from one field can be related to another, especially when applying this knowledge" (p. 298). Integration also implies creating a unity of knowledge (Oliva, 1992). This interpretation emphasizes integrating knowledge and behavior.

Though the extent of integration varies in relation to the years of experience and the context in which the

knowledge occurs, there appeared to be common foundations which underpin expert practice. Expertise in clinical teaching can only be exemplified by practitioners who have embodied a solid knowledge base and practices for demonstrating it.

The expert clinical nursing educator possesses a solid theoretical basis in both nursing and teaching. This corresponds to knowledge components identified by Irby (1994) to include: clinical knowledge of (a) medicine; (b) patients; (c) context of practice; (d) educational knowledge of learners; and (e) principles of teaching.

Expert nursing educators demonstrate an understanding of and the ability to transfer the basic knowledge of nursing to multiple and diverse clinical situations. Basic nursing knowledge refers to the fundamental physical sciences, nursing foundations, physical health assessment, pathophysiology, and principles of pharmacology. This basis was commonly shared among the nursing educators identified as experts in this study. A broad based nursing knowledge was integrated into a variety of settings as the nurse does not always care for the patients with one type of problem. As stated by one of the participants, you may be caring for a patient in a cardiac unit and find that there is a psychiatric basis for the problem or a patient

admitted to a psychiatric unit may be demonstrating psychotic symptoms because of a brain tumor or a diabetic problem. A broader base includes application of liberal arts and sciences, specifically, the fundamentals of psychology and sociology, communication arts, humanities, and the natural sciences.

In order to integrate knowledge, theory-based information needs to be blended with experiential learning (Benner, 1984). For example, in relation to nursing knowledge, level of students and specialty taught are important considerations. Expert clinical nursing educators need in-depth knowledge of the type of patients being cared for. Though the nature of the specialized knowledge will vary, the importance and commonality lie in the need for knowledge and experience in the specialty taught. All of the participants taught clinical nursing courses in which they practiced. All of the experts remained current in their specialty by continued practice and/or knowledge update.

Parallel to the components of basic and specialized knowledge is the concept of skills. Expert clinical nursing educators demonstrate the basic skills that the new graduate or practitioner is expected to attain. The expert possesses the skills that are acquired at the bedside. In addition, experts in this study demonstrated

practice of the skills needed for the specialty area that was taught.

Beyond content expertise, teaching involves connecting the learners with the subject matter. This involves understanding the learners' prior knowledge and experiences. Teachers' knowledge of learners' needs, motivations, and abilities also influences teaching styles. Interaction between understanding the learners and a knowledge of the subject matter leads to effective instruction.

Knowledge of the learner was observed to vary to some extent among the participants in direct relation to the years of experience and educational background. This suggests the importance of experience, reflection on practice, and life-long learning in the portrayal of expertise. Experts reflect on practices and learn from previous experiences. This was demonstrated by increased comfort during teaching-learning interactions. The three participants with the greatest number of years of teaching and nursing experience appeared more at ease and intuitive in their interactions with students.

Knowledge of students also emerges from teaching experience. Expert nursing educators recognize the knowledge base of the student as an individual and where he or she is in the learning process. This is acquired through experience, developing rapport, questioning, and

observing. The participants in this study frequently questioned students about what they have done, what they were observing and planning to do, and their rationale for behaviors. With a general knowledge of adult learners, combined with particular knowledge of specific learners, the expert educator is able to effectively diagnose the learners' needs.

In addition to knowledge of the subject matter and the learners, an expert educator needs to possess a knowledge of the general principles of teaching and learning. Expert educators have general conceptions about how students learn and what can be done to enhance the learning. These conceptions develop from reflective experience and observation. The most commonly observed and articulated general principles of teaching were: (a) actively involved learners, (b) connected the case to broader concepts, (c) was practical, and relevant, (d) demonstrated immediate application, (e) provided feedback and evaluation, (f) provided realistic experiences, and (g) met individual learner needs.

Though not specifically identified in the nursing literature, knowledge of context also affects teaching. Context includes the setting, acuity of client needs, client numbers, size of the community, size of the program, number of students in the clinical group, and the level of the students. Five very different clinical

contexts were evident in the teaching of the six participants. Though there were similarities in what was taught and how it was taught, the variations in context required different degrees and types of clinical mastery. In one context, clinical mastery included an extensive knowledge and ability to assess and care for coronary-artery by-pass clients. Another participant was expected to demonstrate and teach the principles of intervenous therapy. In still another context, clinical mastery involved an extensive working knowledge of psychiatric interaction skills and counseling.

Context also varies in relation to the size of the community. The physical, social, and environmental nature of the clients' needs in a large metropolitan community can vary significantly in comparison to those of a homogeneous farming community in a sparsely populated part of the state.

Though all of the participants were employed in private baccalaureate nursing programs, the size of the program can affect the nature of the teaching role. Educators from programs which employ smaller numbers of faculty may experience less flexibility in planning and undertaking their teaching responsibilities in relation to other faculty requirements. The participants from the program with the smallest student population appeared to have less teaching flexibility and increased apprehension

about job security. Though the faculty-student ratio is controlled by accreditation and state licensure standards, interpretation and methods of meeting those requirements are not always comparable. In a larger metropolitan community, more fully qualified faculty may be available for faculty roles than in a small sparsely populated community. This may lead to hiring less qualified and less experienced faculty to fill teaching positions. This is accomplished through waiving requirements dependent upon completion of educational requisites of the faculty member or by assigning the less qualified faculty to the role of "clinical instructor," hence this person may be responsible for a clinical teaching assignment though will not teach the corresponding theory course.

Though six components of knowledge have been described, the key to expertise lies in their integration. The variability in the demands, resources, and constraints of each expert's situation cautions against context-free generalizations. Hence, much of this attribute of expertise will be missed if the nurse educator is studied only from the perspective of one component of knowledge and in one setting.

Summary

The analysis of the data appeared to indicate that the subjects shared characteristics in varying degrees in four thematic areas:

1. Commitment
2. Reflection
3. Intuition
4. Integration

These characteristics of the expert clinical nursing educator illustrate a harmonious interrelatedness. Expert clinical nursing educators, in manifesting commitment, have established their own identity. A fundamental process in developing one's identity as an expert and a complexity in thought and problem solving involves reflective thinking. Reflective practice can not be viewed in a void, but must be considered in light of intuition and the integration of knowledge. When the expert reflects he or she operates within a context and draws on a repertoire of integrated knowledge, adapting it to the context and adding to what will be available for future inquiry.

All of the participants sustained their commitment to teaching by on-going, personal and professional growth, facilitated by change and challenge. Reflective thinking characteristic of these nursing educators nourished their sense of mission and belief in the

educational process. The expert practice of these clinical educators was characterized by intuitive links between ability to read situations and ways of responding. Knowledge components were integrated in relation to the resources and demands of the settings observed and maintained by knowledge development and experience.

CHAPTER VII
SUMMARY, CONTEXTUAL CONDITIONS, RECOMMENDATIONS,
AND POSTSCRIPT

The purpose of this study was to identify and describe the qualities of clinical nursing educators who were recognized as expert clinical practitioners by peers. A practical aim of the study was to provide a description of expert attributes, which could be used as a vehicle for faculty development and improvement in clinical nursing education.

Attributes were identified for six nursing educators who were perceived as being expert in clinical nursing education by their peers in three Midwestern baccalaureate nursing programs. Although the study was limited in scope, the findings provide support for the development of a model of clinical teaching and have implications for the identification, training, placement, and roles of clinical nursing educators.

Summary

This study was exploratory and non-experimental. A qualitative approach was used in this study. Through observations and interviews, beginning descriptions and explication of dimensions of expertise of clinical nursing educators were achieved.

The population for this study was selected from nursing faculty of 10 private baccalaureate nursing

programs in one Midwestern state. Only full-time faculty involved in clinical nursing education as part of their faculty role were chosen. Initial surveys were sent to all nursing educators at the 10 private baccalaureate nursing programs in the state. Six of the 10 programs returned completed surveys. A sample of six teachers was chosen from three of the nursing programs that responded to the survey. All of the participants were Caucasian females with a minimum of five years teaching experience.

The specialty areas taught by the participants represented both diversity and similarities. Of the six clinical settings observed, specialty areas included: critical care, acute care, community health nursing, psychiatric/mental health nursing, obstetrical nursing, and a foundations course. Five of the six areas involved senior nursing students, while the sixth area involved sophomores in their first clinical course. The participants were observed in a variety of settings including community agencies, client homes, hospitals, and laboratory settings, with a diversity of acuteness and urgency.

Data were gathered through semi-structured interviews and observations. The constant comparative method was used in analysis and interpretation of the data. Whereas many unique factors influenced the personal attitudes and histories of the participants,

commonalities emerged. The following research questions were addressed.

1. Which knowledge, skills, and attitudes of clinical nursing educators were reported by or observed for faculty identified as expert clinical practitioners?

The participants in this study integrated knowledge, skills, and experiences from the professions of nursing and teaching. The common knowledge foundations that underpinned their expert practice included: a solid theoretical basis in nursing and teaching, a broader base to include liberal arts and sciences, knowledge of the learner, fundamental nursing knowledge, specialty knowledge, and contextual knowledge. Knowledge components were integrated in relation to the resources and demands of the settings observed and maintained by knowledge development and experience.

Reflection is a process through which a professional learns from experience. Reflective thinking, characteristic of these nursing educators, nourished their sense of mission and belief in the educational process. The participants in this study described the use reflective thinking as part of their problem solving process. Through reflective thinking the experts were able to explore their experiences in order to arrive at a new understanding of a situation. Reflective thinking

leads to learning, change, and growth and helped the experts link theory to practice.

The expert practice of these clinical educators was characterized by intuitive links between ability to read situations and ways of responding. With experience in the domain the experts responded automatically in certain situations. Through this intuitive grasp, the experts apprehended situations and related them to similar experiences. Knowing what needed to be taught and how shaped the experts' teaching and nursing practice.

The experts in this study demonstrated the basic skills acquired at the bedside. Skills required of the specialty area taught were also deemed essential. All of the experts believed that it is was important to understand, and in some cases demonstrate, the skills required of the graduate preparing to enter the work force.

Attitude was demonstrated by the value placed on experiential learning. All of the experts espoused the belief that clinical learning was the most important part of a professional nursing education. This was demonstrated by a commitment to clinical education in the face of adversities. The experts explained that colleagues and administration, though espousing a belief in clinical teaching, often did not demonstrate this in practice. This lack of shared value has led to limited

recognition and rewards. All of the experts explained that the most important reward was not measurable but related to observing student growth. This intrinsic reward provided motivation to continue to teach what is valued and to practice and grow in the profession in order to increase expertise.

2. Which, if any, similar knowledge, skills, and attitudes do expert clinical educators share?

The participants in this study possessed similar knowledge, skills, and attitudes though the extent of each varied in relation to personal and professional history, education, and experience. The extent of integration varied in relation to the years of experience and the context in which the knowledge occurred. All of the experts have taught for a minimum of five years. The number of years of experience in nursing ranged from 17 to 42 with a mean of 28. The number of years in nursing education ranged from five to 37 with a mean of 18. The number of years at the current position ranged from five to 18 with a mean of 12. The age range of the participants was 39 to 62 with a mean of 51. Two of the experts have a doctorate in education, one expert has all of her course work completed toward a doctorate in education, and one expert has taken 12 hours toward a doctorate in family therapy. Five of the participants

have their master's degree in nursing and two have a master's degree in education.

Context included setting, acuity of client needs, client numbers, size of the community, size of the program, number of students in the clinical group, and the level of the students. Five very different clinical contexts were evident in the practices of the six participants. Though there were similarities in what was taught and how it was taught, these contexts created variations. The variations in context require different degrees of clinical mastery in relation to the knowledge and skills needed.

Context also varied in relation to the size of the community. The physical, social, and environmental nature of the clients' needs in a large metropolitan community can vary significantly in comparison to those of a homogeneous farming community in a sparsely populated part of the state.

Though all of the participants were employed in private baccalaureate nursing programs, the size of the program also affected the nature of the teaching role. Educators from programs which employ smaller numbers of faculty may experience less flexibility in planning and undertaking their teaching responsibilities in relation to other faculty requirements. The participants from the program with the smallest student population had less

teaching flexibility and increased apprehension about job security.

In relation to intuition, experience, as a source of knowledge, does not refer to the mere passage of time. Rather, experience is the refinement of theory through actual practice situations. The participants in this study with the greatest amount of both teaching and nursing experience demonstrated more of an intuitive and spontaneous approach to practice, which allowed the students to view nursing practice more realistically.

All of the participants in the study did not exhibit the same degree of clinical expertise. Reasons for variations in expertise might include the number of years of experience, practice opportunities, motivation, and clinical context.

3. Which professional beliefs, backgrounds, and educational experiences describe clinical nursing educators who are perceived and identified as expert clinical practitioners?

All of the participants shared a belief in the significance of experiential learning. Clinical experience was described as the most important part of nursing education at the undergraduate level. The expert clinical educators saw their role as guiding students' learning and helping them connect theory to practice. The experts believed it was their responsibility to

assist students in seeing what it was like to be a nurse, that is, to see, feel, and hear, as nursing is a "hands-on" profession.

These beliefs formed the basis for the commitment demonstrated by the participants. Commitment was viewed as a professional responsibility to serve clients and make a difference in the lives of students. The expert clinical nursing educators are inwardly moved to develop to their full potential and remain active in furthering the goals of the profession. All of the experts sustained their commitment to teaching by on-going, personal and professional growth, facilitated by change and challenge.

The importance of professional background and experience was emphasized by the experts' belief in experience and commitment to scholarship and life-long learning. Expertise involves experience in the profession. Though stage theories suggest a specified number of years of experience as criteria for expertise, it is the belief of the researcher that one can not become entrenched in this criteria. A person may not become an expert in one year, but 25 years of experience does not guarantee expertise. The key, as demonstrated by the experts in this study, was the ability to learn and gain knowledge from experience. This growth is partially the result of reflective practice.

In addition to reflective practice, the participants stressed the importance of continued learning. This was illustrated by the educational levels attained and pursued by the participants. All of the participants aspire to growth through involvement with research, advanced practice certification, advanced degrees, and professional development activities.

This study provided rich descriptions of the beliefs and practices of six experts in clinical nursing education. These descriptions provide a structure for viewing clinical nursing education through participant reflection and performance in practice. The study demonstrated that commonalities can be identified among clinical nursing educators across diverse specialized settings. Where confirmation by observations of behavior could be made, the results supported the congruence of self-reports with action.

Unlike other related research in nursing which lists the characteristics of effective or good teaching, this study goes a step further by describing the characteristics and teacher roles of clinical teachers observed in rich practice. Research studies which list the characteristics of effective teachers provide no clear or real picture of the person designated as an expert (Streubert & Jenks, 1992). Most research on clinical expertise is reported from the perspective of

the student and/or faculty in general. Other studies depict the expert in a void unrelated to real practice or attempt to fit persons into a stage theory. In contrast, this study was undertaken from the perspective of the persons considered by their peers to be expert clinical nursing educators. It focused on an in-depth understanding and definition of the attributes demonstrated through clinical educator roles and expressed in beliefs about the importance of clinical nursing education.

Previous qualitative case studies have attempted to define the expert in clinical nursing practice (Benner, 1984; Benner et al., 1996) and in clinical medical education (Irby, 1978a; Irby, 1994; Irby et al., 1991). None, however, have addressed the expertise of clinical nursing educators (Bevis & Watson, 1989).

Contextual Conditions

The study was limited by several factors. The sample was selected from private baccalaureate nursing programs in one state. Participation was voluntary and the number of participants involved was small. Observations were made during only one semester, limiting the potential opportunity to observe the participants teaching a different course with different levels of students. Interviews were conducted in May and June of one year. The assignments of the participants varied in

that two were completing spring semester, two had begun summer vacation, and two were preparing for a summer course. Variations also occurred in the number of hours of observations in relation to clinical schedule, type of clinical unit, and in two cases, transportation needed between clinical sites, which provided additional time to talk with the participants. The nature of the questions used in the interview limited the study in that they guided questioning along specific lines of thought. The notion of expertise described in this study is based on the expectations that the six participants selected were "relatively expert" compared to those faculty who could have been nominated for the study. Finally, it must be noted that the intent of the researcher was not to generalize findings, but to explore whether there were common attributes among the experts studied.

Recommendations

The identification of characteristics shared by expert clinical nursing faculty can enhance the quality of clinical nursing education and contribute to the clinical competence of nursing graduates. Faculty, administration, and students can benefit from better understanding of the knowledge, skills, attitudes, and beliefs possessed by expert clinical nursing faculty.

The following recommendations were developed out of an analysis of the findings in conjunction with

understandings drawn from the literature and from the personal experience of the researcher.

Recommendations for Nursing Education Administration

1. Implement mentoring of new faculty with an expert clinical educator. Include the responsibility for mentoring in the faculty expectations for the ranks of associate professor and professor.

2. Implement policy changes that maximize standards of excellence in clinical teaching performance in position descriptions and promotion policies. The responsibility to be an effective role model should form the basis of a clinical nursing educator's job description. Use the behaviors identified in a job description to form the basis for evaluation of performance. Include a clinical component in performance evaluations.

3. Acknowledge nursing education's difference from other disciplines when establishing work-load guidelines for faculty. Allocate workload credit for the time spent on the clinical unit. Award more credit for a teaching load that includes a clinical or laboratory assignment. Credit could be given not only for the clinical contact hours, but for preparation and planning time. Credit could provide more incentive for clinical teaching.

4. Implement hiring policies which use interview questions based on criteria identified from this study.

5. Require a minimum of educational preparation and experience in the clinical specialty taught. Preparation and experience should include not only nursing but teaching. Nursing educators need preparation and experience to integrate the components of knowledge into the practice setting. Eliminate devaluation of clinical teaching by refraining from the use of the "walk on" for clinical teaching. The role model aspect of clinical teaching requires more emphasis at the graduate level of education. When graduates assume faculty positions, their education should have prepared them to take on the responsibility of being a nurse role model.

Undergraduates should benefit from the expertise of the most prestigious and qualified faculty. Their examples will serve to shape the future attitudes and expectations of graduate nurses as they practice nursing.

6. Revise orientation programs for new faculty to include time for discussion and reflection on clinical judgments. The respondents in this study believed that talking with experienced colleagues about clinical issues was an important way to learn from experience.

7. Provide a prototype or model of expertise in clinical nursing education to guide administrators. This model could be used to explore clinical nursing issues, such as commitment, reflective thinking, and the enactment of teaching and learning through inservice or

provision or release time for furthering education. Creation of staff development programs or committees are encouraged to update and/or to reinforce clinical teaching skills among faculty who need or desire such programs.

Recommendations for Nursing Education Faculty

1. Encourage expert clinical nursing educators to share their clinical experience with others. Learning from others enhances the knowledge and skill needed for clinical decision making.
2. Establish a mechanism for faculty sharing. Set aside a time, other than formal meeting times, for faculty dialogue in the form of a round-table discussion. This discussion time could stress a belief in the importance of sharing experiences and the learning that develops from interaction with colleagues. During this time the value of reflection could be encouraged by discussing concerns, issues, and successes, all of which are essential for faculty growth.
3. In an ideal situation the clinical and classroom teacher in undergraduate nursing education should be the same person. In reality, this can not always be accomplished out of consideration for faculty work-load and class size. To assure continuity between classroom and clinical settings, a dialogue needs to be established among faculty. The faculty responsible for teaching the

theory should keep clinical faculty informed of what is being covered in class. This can be done by providing a syllabus, schedule, or outline of content. The faculty responsible for clinical teaching only could monitor or audit the course and/or set aside a time to dialogue with the theory faculty regarding appropriate assignments in relation to content covered.

4. Increase emphasis on the importance of clinical teaching through faculty development committees. Too often classroom teaching has become a symbol of increased status while clinical teaching has come to be viewed as a punishment. Develop demonstration projects to showcase undergraduate clinical education. Recognition of clinical expertise can lead to increased professional commitment among its members.

5. Develop a model of expertise in clinical nursing education. A professional model of clinical nursing expertise, to include the concepts of commitment, integration, intuition, and reflection, could be used as a self-examination vehicle and may set the stage for setting goals for improvement.

Recommendations for Graduate Preparation Programs

1. Seek opportunities for dialogue with graduate nursing programs and professional groups concerned with the preparation of clinical nursing educators and the advancement of teaching. Encourage master's and doctoral

programs in nursing to provide content essential to the development of the expert clinical educator role. Characteristics of the expert clinical nursing educator could provide criteria for the selection of preceptors used for the practicum experiences in graduate programs.

General Recommendations

1. Create incentives and rewards for excellence in teaching, especially undergraduate clinical teaching, and regard these as equal to research accomplishments. Broaden the definition of scholarship to include scholarly teaching.

2. A model of excellence of clinical faculty role performance could be endorsed by education leaders. This model could set forth minimal and common expectations for teaching, scholarship, and service and provide for flexible and tailored paths to accommodate the talents and interests of faculty with differing capabilities. A recommendation could be submitted to state and/or national nursing organizations for the establishment of an award for clinical nursing education excellence.

Recommendations for Future Research

The following questions were generated by this study and may be useful to others interested in research in the area of expertise in clinical nursing educators.

1. How do novices become expert clinical nursing educators? What kind of support do they need?

2. What are the perceptions of expert clinical nursing educators about how intuition is developed, how it is used, and the consequences of using intuition in making clinical judgments?

3. How does a clinical nursing educator's commitment to the profession affect the development of expertise? How do nurses develop a commitment to the profession?

4. How does gender influence the expertise in clinical nursing educators? Do male clinical nursing educators demonstrate a different set of characteristics than do female nursing educators?

5. What are the perceptions of expert clinical nursing educators about institutional support or impediment to the development of expertise in clinical teaching?

6. How does cultural background influence the expertise in clinical nursing educators?

7. What is the impact of a clinical teaching model on faculty and student development?

8. How does clinical context influence the expertise of clinical nursing educators? Do different contextual expectations require a unique set of characteristics?

Postscript

Numerous studies have been conducted on clinical teaching in the past three decades. These studies have shed some light on selected issues, yet they have failed to explore the expertise of clinical nursing educators.

Clinical nursing educators have a tremendous responsibility for helping students understand the dynamics of what it means to be a nurse. An essential aspect of learning is in emulating a nurse role. As the consumer, the student receives much of his or her professional socialization through interaction with clinical nursing educators. Nursing education must strive to provide expert clinical nursing models to enhance learning of the nurse role and to contribute to the competence of future graduates.

The future of nursing and nursing education is evident today. The health care crisis of the 1990s is in relation to quality health care, its affordability, accessibility, and availability for all citizens in the country. The consumer demand for quality compels governmental bodies to develop health programs that provide for the basic affordable health care needs of all citizens. In light of the current era of accountability and cost constraints, nursing education is vulnerable to budget cuts and nursing practice is subject to utilization of less qualified providers, often in the

place of a nurse. Any effort to reform health care must address the education of health care professionals. The skills, attitudes, and values of health care professionals have an impact on health care. The kind of care these individuals provide determines to a great extent the quality, availability, and cost of health care.

Change in the future relates to where students will have their practice experience and the knowledge and competencies they will need to practice. Constancy rests with the intent of the preparation, that is, to provide holistic care to clients in order to promote optimal health. For the educators, the source of consistency remains in the purposes for the use of the experiential learning in preparation of tomorrow's graduate nurses.

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Appendix A

Letter of Introduction

April 18, 1995

1~

2~

Dear 3~ and Nursing Education Colleagues:

As a part of the Doctorate of Education requirements at the University of Northern Iowa, I am studying attributes shared by nursing educators who are perceived and identified by their peers as being expert in clinical nursing education. The study will also provide participating educators with insight into their own philosophy of clinical teaching and learning, problem solving strategies, knowledge, skills, and competencies which set them apart as experts in their field. I hope you will find the study of sufficient interest to participate by completing the attached surveys. If you choose to participate, names submitted on the surveys will be known only by myself. Once the final selection is made of nursing educators to interview the initial surveys will be destroyed.

This initial survey is being sent to all private baccalaureate colleges of nursing in Iowa (with the exception of RN-Completion only programs and my own institution). From the names submitted by each program approximately six educators will be invited to be interviewed and briefly observed in a clinical setting.

The study focuses on describing the characteristics of expert clinical nursing educators. Therefore, the methods and instruments do not evaluate teachers or schools. I assure all participants that data will be confidential. Any publication resulting from this study will generalize findings and protect the identities of individuals and institutions. Individuals will not be identified by name or characteristics.

Furthermore, I will be prepared at the conclusion of the study to share all results with any interested participants. In this way, I hope to reciprocate your cooperation in this research project.

Again, I will appreciate your choosing to contribute to this research by completing the survey and returning it to me in the envelope included. In you have questions about the study, you may contact my dissertation advisor,

Dr. Roger Sell, The Center for Enhancement of Teaching,
the University of Northern Iowa, at (319) 273-5858, or
myself at my office during the day (319) 235-3789 or my
home during the evening (319) 827-1029.

Sincerely,

Nancy Kramer

Appendix B

Faculty Ranking**PURPOSE:**

The purpose of this study is to identify and describe the qualities of clinical nursing educators who are perceived and identified as being as being expert clinical practitioners by peers in baccalaureate nursing programs in Iowa.

DIRECTIONS:

Select up to three (3) clinical nursing educators in your nursing program whom you perceive as exhibiting characteristics of expertise. Only full-time faculty, those working $\geq 75\%$ or 30 hours, with a minimum of five years teaching experience, and involved in clinical nursing education as part of their faculty role may be included. Adjunct, part time, or faculty whose only responsibility is clinical teaching should not be listed. Do not name yourself on this list. Rank your choices 1 to 3, with "1" indicating your first choice. In addition, list two or three characteristics which you believe distinguish selected faculty as expert clinical nursing educators. These need not reflect the concepts included in the above definition.

1. Name _____
Characteristics _____

2. Name _____
Characteristics _____

3. Name _____
Characteristics _____

Appendix C

LETTER OF INFORMED CONSENT

May 10, 1995

I am a doctoral student at the University of Northern Iowa. The subject of my doctoral research is: "Expertise in Clinical Nursing Educators: An Exploratory Study." The purpose of my study is to identify and describe the qualities of clinical nursing educators who are perceived and identified as being expert clinical practitioners by peers in baccalaureate nursing programs in Iowa. I am interviewing clinical nursing educators from private baccalaureate programs in Iowa, who have been identified by their peers as exhibiting characteristics of expert clinical teaching.

As part of this study, you are being asked to participate in a minimum of two in-depth interview over time. The interviews will focus on your educational philosophy, professional goals, role orientation, and problem solving orientation. As the interviews proceeds I will ask questions to guide the interview, to clarify, and to amplify, but mainly my part will be to listen as you reflect on you practice and experience.

Interviews will be audiotaped and later transcribed by me. In all written materials and oral presentations in which I might use materials from your interview, I will not use your name, names of people you have identified, or the name of your college. Transcripts will be typed with initials for names, and in final form the interview material will use pseudonyms.

As part of this study, you are being asked to participate in one clinical teaching observation. The observation will be arranged to take place during a regularly scheduled clinical teaching time. The observation will take approximately one hour. I will use fieldnotes to document my observations of the clinical setting. No student, client, or staff names will be used in my documentation. The name of the clinical facility will not be used in my documentation.

You may at any time withdraw from the research process. You will be offered an opportunity to review the transcript of your interviews, the clinical observation, and my analysis of the data. You may withdraw your consent to have specific excerpts used if you notify me after you have reviewed the materials.

If you have any questions or concerns about the research and/or subjects' rights, you may contact the Human Subjects Coordinator, University of Northern Iowa, (319) 273-2748.

Questions may also be directed to me (319) 827-1029 or my dissertation chair Dr. Roger Sell, Center for the Enhancement of Teaching, University of Northern Iowa, (319) 273-5858.

You are making a decision about whether or not to participate. Your signature indicates that you have read the information provided above and have decided to participate. You may withdraw at any time without prejudice after signing this form should you choose to discontinue participation in this study.

I am fully aware of the nature and extent of my participation in this project as stated above and the possible risks arising from it. I hereby agree to participate in this project. I acknowledge that I have received a copy of this consent statement.

(Signature of the subject)

Date

(Printed name of subject)

(Signature of investigator)

Appendix D

DEMOGRAPHIC DATA RECORD

Date of interview _____ Location of interview _____

Time of interview _____

Informant code number _____ Age of informant _____

Gender of informant _____ Ethnicity _____

Number of faculty _____ Student population _____

Type of faculty evaluation used at program:

Administrative _____ Peer _____ Self _____ Student _____

Educational preparation:

(this will include all preparation from the basic or initial nursing program to terminal degree held or degrees in progress)

Area of major study in highest degree held

Total number of years experience in nursing _____
(briefly describe, i.e., clinical experience and area, management experience, other, and number of years of each)

Total number of years experience in teaching nursing _____

Total number of years experience in teaching other than nursing _____

Total number of years at current position _____

Specialty area(s) taught

Appendix E

INTERVIEW GUIDE

During the next hour and a half to two hours you will be asked questions related to your views on teaching and learning, your interests and background, and your educational experiences and relationships. There are no right or wrong answers. I am simply trying to find what attributes are shared by clinical nursing educators like yourself who are perceived by their colleagues as exhibiting expertise in clinical nursing education. If at anytime you feel you want to add more information than the questions call for, please do so.

With your permission I would like to tape-record the session, so that your responses are recorded accurately. These tapes will be transcribed, erased, and the notes used for categorizing teacher responses. At no time will your responses be identified with your name. Confidentiality will be maintained.

Educational Philosophy

1. Please tell me about what you do in your role as a clinical nursing educator.
2. What attracted you to nursing education?
3. How were you prepared for your role?
4. How would you define clinical teaching?
5. Describe the ideal clinical teaching situation.
6. What do you value about clinical teaching and learning?
7. What do you think it means to be an expert clinical nursing educator?
8. What attributes would you expect an expert to possess?
9. What do you think distinguishes an expert clinical nursing educator from one considered as average?

10. What knowledge is needed?
11. What skills are needed?
12. What characteristics do you have that you think might lead others to identify you as an expert clinical nursing educator?

Value Perception of Clinical Teaching

13. Is clinical teaching valued by administration?
14. Is clinical teaching valued by your colleagues?
15. Is clinical teaching valued by students?
16. What rewards or recognition are received for clinical teaching?
17. How do you think faculty affect students' clinical competence?

Professional Role Orientation

18. Do you practice nursing outside the teaching setting?
(request area and frequency)
19. Where do you receive most of your professional and intellectual stimulation?
20. What are the attributes of colleagues that you admire?
21. Attributes of those you avoid?
22. What kinds of professional tasks do you prefer?
(probe for reasons)

Problem Solving Strategies

23. When you have a problem or a difficult choice to make as an educator, how do you go about solving it?

What do you do?

To whom do you go?

Could you give an example of how you have handled a problem or made difficult choices?

What steps did you follow?

24. What type of instructions do you prefer when teaching and developing the curriculum?
(detailed/specific or general)

Please explain.

25. How do you feel about experiences in which you are certain of your ability to perform?

Which you are pressed to the limit of your ability?

Closing Questions

26. Where do you see yourself in ten years?
27. What would lead you to make changes in your teaching role in the future?
28. What have you learned from this interview about your experience as a clinical nursing educator?
29. Do you have any suggestions that might help improve the interview and questioning strategies used?
30. Would you be willing to be contacted again for further questions or clarifications?
31. Would you be willing to allow me to observe your clinical interactions with students in a client setting?

Thank you for your time and willingness to participate. If you would like, I will provide you with a copy of the transcribed notes of this interview. A final copy of the research will also be available to you at your request. If you have any questions or concerns regarding the research or your participation in it do not hesitate to contact me.