

THE PROCESS OF MATURING AS A COMPETENT CLINICAL TEACHER

by

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ABSTRACT

Clinical nursing teachers are a unique group of academics; they are experts in the art of teaching and the clinical aspects of the nursing profession. A relatively large body of published research substantiates the nature and scope of effective of clinical teaching behaviors as perceived by students and nurse educators. There is, however, a topic that is surprisingly absent from this literature; that is, the study of clinical teachers' competence. For the most part, research has not been conducted to determine clinical teachers' perceptions about their combined competence as teachers and as nurses.

The purpose of this study was to describe the process, or processes, by which clinical nursing teachers attain, demonstrate, and maintain competence. Indirectly, this research revealed the factors and situations that either facilitate or hinder the process of becoming competent. A grounded theory design was chosen for this study because this method was most appropriate for exploring a basic social process such as competence. Eleven clinical nursing teachers from three nursing programs in the Lower Mainland of British Columbia were interviewed for this study. Data analysis proceeded according to the method of constant comparative analysis designed by Glaser and Strauss (1967).

In an analysis of the interview results, common themes comprise a three-phased process of maturing as competent clinical teachers. The main theme underpinning all three phases of this process was found to be the development of *self-confidence*. The first phase, *dealing with "self" learning needs*, described a period of adjustment where clinical teachers confronted the difficulties associated with making the transition from a nurse clinician to a clinical teacher. In phase two, clinical teachers *built their teaching style*. The third phase focused on *integrating the complexities* of clinical teaching into their practice as educators. Each phase featured a central focus, key strategies, outcomes, conditions, and facilitative factors. The findings also indicated the maturation

process was situation specific and context bound. Furthermore, clinical teachers may experience either occasional or overall incompetence. Based on the findings of this study, the implications for nursing practice, education, administration, and research were identified.

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This thesis is dedicated to those who aspire to be competent clinical teachers:

may your dreams become a reality.

CHAPTER I: AN OVERVIEW OF THE RESEARCH PROBLEM

Clinical teachers are a unique group of academics; they are experts in the art of teaching while remaining involved with the clinical aspects of the nursing profession. Because nursing is a practice-based profession, clinical teaching is a major component of nursing education. Nursing faculty who engage in clinical teaching have the dual responsibility of demonstrating competence as both teachers *and* nurses (Karuhije, 1986; Morgan, 1991; Wiedenbach, 1969). The issue of clinical teacher competence has been increasingly scrutinized in recent times due to changes in the health system and the nursing education system. These changes have resulted in an increase in the complexity of the roles and responsibilities of clinical teachers. Administrators of post-secondary institutions, supervisors of clinical agencies, and members of professional regulatory bodies want to be assured that students are being accompanied to the clinical setting by teachers who demonstrate competence. Furthermore, present-day students tend to have clearer guidelines for what they consider to be a "quality education". For example, students expect their theoretical and clinical courses to be delivered by competent teachers.

In this chapter, the rationale for and purpose of this study will be presented. To begin, background information pertinent to the proposed study is introduced. Then, after introducing the research problem and research question, I will provide a brief overview of the research literature on competence in the substantive area of clinical teaching. The significance of this study will conclude this chapter.

Background to the Study

As an experienced clinical teacher I have periodically conducted a self-evaluation of competence. In addition, I have observed other clinical teachers' behaviors and found that their actions could be interpreted as either competent or incompetent. Based on these personal experiences, I became interested in exploring both the meaning of and the

characteristics that underpin the nature of competence in the context of clinical teaching. I was also curious to determine whether the contextual and situational nature of clinical teaching had a significant influence on competence.

Specific situational factors of interest were the changing paradigms of education and the changing demands of the health system. For example, during the past two decades, nursing education has experienced a curriculum revolution. This revolution has resulted in significant changes to the structure, purpose, and outcomes of clinical teaching (Bevis & Watson, 1989; Karuhije, 1997; Marcinek, 1993). Specifically, the purpose of clinical teaching has shifted from showing students how to “do” tasks to working with students to learn how to “know” and “understand” concepts and procedures (Wong & Wong, 1987). In relation to the curriculum revolution, clinical teachers are now required to be knowledgeable about educational content, teaching-learning processes, and student-teacher partnerships (Gallagher, 1994; Marcinek, 1993). In addition to the changes associated with curriculum changes, clinical teachers are expected to teach the essentials of nursing practice in a variety of health settings and to support students to meet the academic and social demands of their future workplaces (Wong & Wong). These curriculum and role changes may leave nursing faculty feeling less confident in their clinical teaching abilities. Nursing faculty who have been teaching clinical theory for a long duration may feel especially vulnerable. For example, nursing faculty who have been teaching solely in the classroom setting may be expected to return to the clinical setting. First, these faculty may struggle to be competent in the clinical setting due to a long absence from hands-on nursing practice. Second, they may not have received advanced preparation for their role as teachers in the clinical setting (Karuhije, 1986, 1997; Morgan, 1991; Myrick, 1991). These are two examples of factors that may affect these teachers’ abilities to be competent clinical teachers; however, other examples are likely to exist.

The process of clinical teaching is further complicated by recent changes in the health system, an increase in client acuity, and changing employer expectations (Crotty & Butterworth, 1992). For example, clients admitted to health care settings (i.e., acute care and community) have exhibited increasingly complex conditions requiring complicated interventions. In these instances, clients expect both teachers and students to be knowledgeable in the theoretical aspects of nursing practice while remaining sensitive to their personal needs. Employers, on the other hand, expect nurses entering practice to be able to function as independent practitioners. Modern nurses are expected to demonstrate such skills as assertiveness, an ability to adapt to change, and a willingness to act as a change agent. In addition, employers often expect graduating nurses to function as part of multi-disciplinary teams. One method for transmitting the knowledge, skills, and attitudes of nursing is through clinical teaching. Clinical teachers are often expected to teach students how to nurse through hands-on experience with clients. In other words, clinical teachers have an obligation to prepare students for the real life demands of the nursing profession. In sum, the re-organization of nursing education, prompted by the curriculum revolution, changes to the health system, and an increase in client acuity and employer expectations, have combined to challenge the abilities of those faculty teaching in the clinical setting. In searching to understand clinical teacher competence, I deliberated about the importance of these various factors.

To further understand the concept of competence, I began by exploring the existing literature on clinical teaching. While the scope of clinical teaching has long been understood, research related to the meaning of competence in the context of clinical teaching was limited. Beginning in the early 1960's and continuing through much of the 1990's, a majority of the research on clinical teaching was dedicated towards identifying the characteristics of effective clinical teachers and the methods used to evaluate their

effectiveness (Benor & Leviyof, 1997; Bergman & Gaitskill, 1990; Brown, 1981; Fong & McCauley, 1993; Johnson, 1966; Knox & Mogan, 1985; McCabe, 1985; Mogan & Knox, 1987; Nehring, 1990; Reeve, 1994; Wong & Wong, 1987; Zimmerman & Waltman, 1986). While the knowledge generated from this "effectiveness literature" indicated that clinical competence was an essential characteristic of effective clinical teaching, the literature failed to address a critical issue. Specifically, the literature did not include an explanation of *how* clinical teachers achieve, demonstrate, and maintain competence as teachers.

More recent 1990's literature has deviated from issues related to teacher effectiveness to investigate the core competencies required of nursing faculty (Choudhry, 1992, 1992a; Davis, Dearman, Schwab, & Kitchens, 1992). Other authors have attempted to delineate ways of maintaining and evaluating *clinical competence* of nursing faculty (Barnes, Duldt, & Green, 1994; Cox, 1988; Kirkpatrick, 1992; Oermann, 1996; Weitzel, 1996; Yonge, 1986). In short, although much is written in the realm of clinical teaching, the literature was inadequate for addressing my interest in competence. First, the research delineating core "educator" competencies did not address the competence of educators who teach specifically in the clinical area. For instance, many of the research findings referred only to nursing faculty teaching in the classroom setting. Second, the authors who did acknowledge the importance of competence restricted the use of this concept to a narrow view of *clinical competence* of teachers as nurses rather than the more complex competence of clinical teachers as both teachers and nurses. Third, most of the research was based on a behaviorist approach to competence as an end product. This reductionist view failed to address the process, or processes, involved for achieving, demonstrating, and maintaining competence as teachers.

As I broadened my exploration of the literature on competence I found that the concept became increasingly ambiguous. It became evident that the health profession and

education literature used a multitude of terms when discussing competence (e.g., clinical competence, professional competence, teacher competence, interpersonal competence, academic competence, and nursing competence). A preliminary review of the literature revealed that, despite a wide use of the word competence, this concept was ill-defined and in some instances the use of the term competence was confusing and contradictory. The literature also failed to clearly specify which characteristics were essential to comprise competence (Bergman & Gaitskill, 1990; Kirkpatrick, 1992; Maynard, 1996; Nagelsmith, 1995; Reeve, 1994; Roach, 1984; Salvatori, 1996; Scheetz, 1989; White, 1994). To summarize, much of the literature related to nursing, clinical teaching, and competence was based on a collection of preconceived ideas. These ideas are identified as follows:

1. The components of competence are identifiable and objectifiable.
2. Competence is unidirectional as nurses progress from novice to expert. In other words, according to this assumption, incompetence does not exist.
3. Clinical competence is achieved solely through nursing practice.
4. Clinically competent nurses are assumed to be competent teachers.
5. Competence in clinical teaching is synonymous with effective classroom teaching.

While the nature of clinical teaching has frequently been scrutinized, the primary area of attaining, demonstrating, and maintaining competence has not been a focus of study. Due to the paucity of literature currently available on clinical teacher competence, many of the questions I had regarding this topic could not be answered.

Problem Statement

A brief overview of the literature on clinical teacher competence reveals a number of inconsistencies in the definitions, characteristics, and related concepts that underpin the essence of competence. These inconsistencies indicate that the nursing profession has

made limited progress towards understanding the process of becoming a competent clinical nursing teacher.

Purpose

The purpose of this study was to describe the process, or processes, by which clinical nursing teachers attain, demonstrate, and maintain competence. Indirectly, this research was directed towards uncovering the factors that facilitate and the situations that affect the process, or processes, of becoming competent.

Research Question

The specific research question directing this study was: What is/are the process, or processes, described by nurse educators for attaining, demonstrating, and maintaining competence in their role as a clinical teacher? Grounded theory methodology was used to explore this question.

Literature Review

The purpose of grounded theory is discovery. Consequently, the direction of a literature review is to establish the diversity and scope of the previous research on the substantive area to be studied. At the same time, the researcher attempts only to briefly review the literature to avoid complete immersion (Glaser & Strauss, 1967; Strauss & Corbin, 1990). Ideally, when researchers are effective in their analysis, "new categories will emerge that neither we, nor anyone else, had thought about previously" (Strauss & Corbin, p. 50). Thus, the literature review allows the researcher to identify pre-existing concepts which may be used to extend the developing theory. Complete immersion is avoided during this process to prevent the researcher from becoming confined or creatively stifled by the existing knowledge available on the substantive area being studied (Strauss & Corbin).

The following represents a review of the literature as a method for exploring the phenomenon of *competence* in clinical teaching. The databases utilized in the literature

search included the Cumulative Index to Nursing and Allied Health Literature (CINAHL) (1960 to 1998), HealthSTAR (1975 to present), and the Education Resources Information Center (ERIC) (1990 to present). The literature used in this study was screened according to the following parameters:

1. Research and anecdotal literature providing relevant descriptions (e.g., attributes, antecedents, and consequences) of clinical teacher competence.
2. Research and anecdotal literature providing sufficient information on related concepts relevant to extending the current theory on competence.
3. Research studies providing data on competence of teachers and students in nursing and other disciplines (e.g., medicine, dental hygiene, occupational therapy, and education).

Introduction

The accumulation of knowledge relating to the meaning of competence has continued to grow since the concept was first introduced in the early 1900's. The attributes associated with competence, both in everyday language and in professional usage, vary depending on the context in which the term is used. Consequently, conceptual ambiguity currently exists. To provide clarity for understanding the scope and nature of clinical teacher competence, the literature will be organized according to a concept analysis framework. This framework is based upon a design created by Walker and Avant (1995).

Usage of the Concept "Competence"

A literature review of numerous disciplines (e.g., nursing, occupational therapy, education, psychology, health care ethics, and mental health) indicated that various definitions of competence are used in similar but distinctive ways. At the same time, most of the literature was competing to identify one correct definition of competence rather than considering the complementary benefits of incorporating a number of these perspectives to define competence. This review of the definitions of competence led to the identification of

two central methods for categorizing the meanings of competence (Ford, 1985). Only the core ideas within each of the two categorical methods will be identified. They are:

1. Defining competence in five distinct ways: motivational, self-evaluative, behavioral, behavioral effectiveness, and trait.
2. Conceptualizing competence as an end in itself or a state-of-being.

Defining Competence

There are five interrelated but somewhat distinct definitions of competence currently used in the literature.

Motivational Definition. White's 1959 theory of competence motivation was used by Schwammle (1996) to gain a deeper understanding of the factors involved in personal competence. This motivational definition of competence was based on the premise that being or becoming competent was dependent upon an individual's perception of "self" as an effective controlling agent (Ford, 1985). Specifically, White's theory stated: (a) the environment has an effect on an individual and vice versa, (b) an individual has a desire to be competent in their environment, and (c) the results of competence are feelings of efficacy (Schwammle). Thus, development of competence refers to not only an individual's ability to deal with his or her surroundings, but also to his or her degree of motivation and interest in becoming competent (i.e., efficacy) (Schwammle). In other words, having a desire to become competent strengthens an individual's confidence and his or her subsequent development of competence. Similarly, Gatz et al. (1982) defined the attributes of personal competence as being self-efficient and having a sense of inner control. These facets of competence referred to an individual's subjective evaluation of whether he or she was capable of producing some set of desired environmental effects. Therefore, in the determination of competence, the motivational definition considered the existence of various internal influences (e.g., self perceptions, beliefs, values, and expectations) and external

influences (e.g., demands or situational characteristics such as time, place, persons, and history) which affect motivation, interest, and the desire to succeed (Burrows, 1989; Schwammle). In sum, the motivational definitions of competence refer principally to an individual's directive function.

Behavioral Definition. In the literature, competence was also used to refer to a repertoire of behaviors. In this usage, attainment of the specified behavioral abilities or capabilities leads to successful outcomes, that is, competence. Various definitions of competence included behavioral characteristics such as knowledge, values, attitudes, motivation, energy, and judgement (Burrows, 1989; Butler, 1978; Kirkpatrick, 1992; Nagelsmith, 1995; Registered Nurses Association of British Columbia [RNABC], 1990; Roach, 1984; Scheetz, 1989; White, 1994; Yonge, 1986). For the purposes of identifying the behavioral characteristics of *clinical competence*, the definition of competence was modified to include clinical skills, knowledge and application of theory to practice, interpersonal attributes, problem solving and clinical judgement, and technical skills (Brown, 1981; Knox & Mogan, 1985; Neufeld, 1985; Scheetz, 1989). According to Yonge (1986), additional attributes of clinical competence were utilization of the nursing process and confidence as a nurse. Oldmeadow (1996) stated ethical and moral views also comprise the characteristics of clinical competence.

While no links are explicit in the literature between critical thinking and competence, some authors supported the premise that critical thinking was necessary for the overall development of competence (Brookfield, 1987; Maynard, 1996; RNABC, 1996; Toliver, 1988). The skill of critical thinking includes two concepts: reflection and openness to learning. Reflection was described as important for developing competence because it provides an opportunity for individuals to challenge, refine, or disclaim their decision-making patterns. In turn, these new insights would be applied to subsequent encounters with similar

situations leading to further development in clinical teacher competence (Paterson, 1997; Saylor, 1990). In Paterson's opinion, a clinical teacher who significantly improved his or her teaching abilities was an individual who was willing to reflect on his or her performance. Hence, the notion of perfect competence is contrary to the idea of "reflective thinker" (Schon, 1987).

In the nursing profession, the identified repertoire of behaviors indicative of competence was also expressed through actions and interventions. Thus, an individual who possesses the requisite skills and knowledge must also be able to apply and integrate them to competently perform the activities required in a designated role (Burrows, 1989; Canadian Nurses Association, 1993; Kirkpatrick, 1992; Nagelsmith, 1995; RNABC, 1990). As well, for competence to occur, an individual must be cognizant of the actions required to perform within a given role and must understand the nature of the task or role (White, 1994). Accompanying competence were varying degrees of power, authority, respect, and trust (Covey, 1995; White).

Behavioral Effectiveness Definition. Included in the behavioral definitions of competence, was literature that makes reference to the effectiveness of one's behavior in various contexts (Ford, 1985). According to this definition, competence as a clinical teacher was demonstrated when an individual successfully adapted to a given set of role demands. Thus, the central theme of the behavioral effectiveness perspective was that an individual must have accomplished some specified set of objectives (e.g., teaching, research, and nursing) within certain boundary conditions as defined by a given role (e.g., professional expectations, student expectations, or employer expectations) to be considered competent.

Through a comprehensive review of 14 nursing research studies written from 1980 until 1998, many authors have attempted to identify a list of necessary behaviors by which a clinical teacher could be evaluated as effective. When the clinical teacher was effective, he

or she was assumed to be professionally or clinically competent. Also, the nursing literature sought to determine how much and what type of nursing practice and expertise was necessary to ensure teacher competence. Absent was the recognition that the integration and application of teaching-learning theory is a significant component of clinical teacher competence. Furthermore, this perspective of competence does not consider situational factors such as the level of student, the stability of teaching assignments, and the teacher's familiarity with the clinical agency. Primarily, the behavioral effectiveness literature emphasized the significance of nursing or clinical competence.

Self-Evaluation Definition. Many regulatory and licensing bodies of the nursing profession used the self-evaluation definition to delineate behavioral competencies expected of all nurses in various settings and practice dimensions (e.g., practitioner, researcher, administrator, and educator). These specific competencies provided evaluative criteria for establishing regulatory guidelines for determining nursing competence. The underlying assumption of this definition was the importance of safeguarding the public. When individuals are deemed competent they are licensed to practice within a specific professional body (RNABC, 1990, 1992, 1996). This definition implied that when a clinical teacher meets the required standards of nursing practice they are also deemed to be a competent nurse educator. This notion of competence was based on the threshold approach to evaluation. The threshold approach indicated there was a single cut-off point for determining whether a clinical teacher was either competent or incompetent (White, 1994). Although Butler (1978) affirms the notion that a minimum standard of competence was necessary, he also believed individuals may surpass the standards of adequacy in a designated role and setting depending on their level of knowledge, skills, values, and attitudes.

Trait Definition. In addition to the identification of behaviors, several authors have identified ways in which various functional or behavioral components of competence could be organized into three domains: cognitive domain, psychomotor domain, and affective domain (Appendix A) (Maynard, 1996; Roach, 1984; Salvatori, 1996; White, 1994). According to these authors, "overall competence of the professional was determined by the demonstration of a combination of behaviors in all three domains" (Salvatori, p. 261). This definition of competence was the most inclusive; however, it failed to acknowledge relevant contextual and developmental considerations (Ford, 1985).

Conceptualizing Competence

As discussed, there are a number of ways to define competence. The motivational, behavioral, behavioral effectiveness, self-evaluation, and trait definitions tend to be limited in scope. Conversely, other authors equate professional competence as either an end (i.e., product) or a state-of-being (i.e., process).

Product. As previously identified, competence was historically viewed as a product. This perspective suggests that the outcome of an individual's performance or ability within his or her environment eventually results in the desired end in itself; that is, competence. In other words, authors often refer to competence as a product or an outcome (Burrows, 1989; Butler, 1978; Ford, 1985; Know & Mogan, 1985; Nagelsmith, 1995; Scheetz, 1989). In the professional health literature, this perspective of competence was commonly used to identify competent nurses and students (Burrows, 1989; Jameton, 1984; Kirkpatrick, 1992; Oldmeadow, 1996; RNABC, 1990; Salvatori, 1996; Scheetz, 1989). As discussed in the five previous definitions, the product perspective of competence limits its meaning to ways of "knowing" and "doing" through the identification of behavioral criteria. On the other hand, opposing views suggest competence is more complex than merely being observable and measurable behaviors (Ford, 1985).

Process. According to the literature, the determination of an individual's competence was both subjective and objective in nature. From a subjective point of view, competence as a process referred to an individual's state-of-being at any point in time for a given situation and context. Each individual holds a view about his or her own competence. Each individual must determine whether, at a particular moment in time, he or she was acting in a competent manner. Simply put, a person's view of his or her own competence may vary both in the way he or she sees him or herself and in the way others perceive him or her (Slunt, 1993).

To be competent, personal knowing about one's self was necessary. A component of personal knowing was reflection. Reflection included recognizing one's learning needs, determining the actions necessary to enhance one's abilities, and gaining meaning from experiences. According to Slunt (1993), personal knowing inevitably leads to competence. In this context, competence was an evolving process of growth and development influenced by interactions with the self (i.e., internal circumstances) and the environment (i.e., external circumstances) (Cohen, 1993; Slunt). In addition, to fully understand one's self, an individual must be motivated, energetic, and dedicated to lifelong learning (Roach, 1984).

According to the process perspective, competence was viewed as a goal to be achieved and never an end in and of itself. In this evolving process, anxiety and tension as well as plateaus of comfort and a sense of empowerment are found. In sum, the state-of-being meaning of competence includes both the knowledge and the skill for competent performance *and* the attempt to understand one's self and others (Slunt, 1993).

Summary

In most cases, competence was defined in the literature as an achievement; that is, the attainment of personally or socially desired outcomes in some set of relevant contexts. Nearly all authors placed the responsibility for attaining and maintaining competence on the

individuals themselves. There was the view that one must do something to be competent. In this stance, competence refers to an end in and of itself (i.e., product). Conversely, a select number of authors recognized competence as a human activity that evolves with time and is relative to various situational and contextual events. This latter perspective infers that competence depends on external factors beyond an individual's control and is, to some degree, situation specific and contextually determined (Jameton, 1984). In the next section, the attributes, antecedents, and consequences identified in this literature will be presented as they pertain to clinical teacher competence.

Defining Attributes

Defining attributes of a concept are abstract and universal characteristics that appear over time and are frequently associated with the concept (Walker & Avant, 1995). In the literature review, the attributes of competence were dependent upon the context in which the word was used. All definitions and conceptualizations of competence were valid and useful for examining the attributes of clinical teacher competence. The defining attributes are:

1. An actual, or potential, state of or ability to integrate and apply a blend of attributes identified in the cognitive (knowledge) domain, psychomotor (skills) domain, and affective (values) domain (Appendix A) as required in the professional role.
2. An evolving process of continual development. This means a person will continue to develop to suit various contexts.
3. An ability to deal with one's surroundings which are influenced by personal (internal) circumstances and environmental (external) circumstances.
 - Internal factors (e.g., self perceptions, beliefs, values, and expectations)
 - External factors (e.g., demands or situational characteristics such as time, place, persons, and history)
4. An ability to learn and to gain meaning from one's experiences through critical thinking, problem-solving, and reflection. Inherent in this attribute is an openness to learning, an attitude of inquiry, a willingness to improve, and an ability to gain insight.
5. Motivation, interest, energy, and commitment.

6. Enduring feelings of anxiety and tension, comfort, and a sense of empowerment.

In short, competence is the actual, or potential, state of and ability to integrate and apply a blend of attributes identified in the cognitive, psychomotor, and affective domains through an evolving process. This process requires an individual to gain meaning from his or her experiences. Motivation, interest, energy, and commitment are required to help an individual deal with the internal and external factors that influence his or her state-of-being competent. Furthermore, competence is not a constant state. Rather, feelings fluctuate between anxiety and tension, comfort, and a sense of empowerment.

Demonstration Cases

Demonstration cases provide clarity to the defining attributes by applying them to everyday examples. Application is important for determining whether the identified attributes are accurately illustrative of the concept (Walker & Avant, 1995). An example of each type of case – model, contrary, and related – will be presented.

Model Case

In this case, the descriptive attributes of competence are applied.

Martha is a clinical teacher who has been on the same hospital unit teaching senior nursing students for the past five years. This unit specializes in the care of people undergoing cardiovascular surgery. Martha was an in-service educator and nurse on the unit before becoming a clinical teacher. Martha recognizes that she has grown a great deal as a clinical teacher during this time and has reflected on her teaching. She is now confident that she is able to meet most students' needs. Martha dedicates a significant amount of time to keeping current with recent literature on ways to help students learn. When asked how she has changed since she began teaching, Martha states, "I think I am much better at making decisions about evaluating students' performances. I believe teachers at different phases in their careers are competent in different ways. When I was a younger teacher I was a different teacher." Students describe Martha as an energetic and highly motivated teacher who works well with both patients and students. Students consistently say they learn a lot from her.

Specific attributes illustrated in this case include competence as an evolving process, gaining meaning from experience, demonstrating energy and motivation, and comfort with

the clinical teaching role. By reading about Martha's past practitioner and educator experience one would assume she has the prerequisite cognitive, psychomotor, and affective abilities necessary for clinical teaching. However, specific information is needed to determine the application and integration of Martha's abilities. An expressed outcome of Martha's competence is the students' comments that they have learned a great deal from her.

Contrary Case

The following contrary case exemplifies attributes that do not apply to the concept under analysis.

Beth has been hired on contract for one year to teach first year nursing students on a surgical floor. She has approximately 20 years of hospital-based and administrative nursing experience; however, prior to this appointment she had no experience as a teacher. Four months go by without incident. Beth is observing a female student prepare a specified dose of ventolin via nebulizer. Beth notices the student has calculated the wrong dose of ventolin but says nothing. The student proceeds to the client's bedside to administer the drug. After the student administered the drug Beth tells the student that she has administered the wrong dose. Beth, in a casual conversation to another instructor, boasts that she allowed the student to administer the wrong dosage to help the student to "learn a lesson". Beth believed this was an acceptable approach to help a student learn.

In this case, Beth's behavior is not indicative of the defining attributes of competence. For example, Beth did not apply or integrate the knowledge, skills, and attitudes necessary (e.g., medication administration and the principles of teaching-learning) to function competently as a clinical teacher. Beth's unacceptable behavior prompts others to question her moral and ethical standards. Why? In this case, the client was unharmed by an inaccurate dosage of ventolin. However, what would occur when Beth permits students to "learn a lesson" by administering an incorrect dosage of intravenous narcotic medication? In this instance, severe medical consequences could occur. Clearly, both examples of permitting an incorrect dosage administration do not reflect Beth's personal nursing abilities.

However, both examples do plainly demonstrate Beth's use of inappropriate moral and ethical judgments, and her inability to apply the principles of teaching and learning.

Related Case

Related cases illustrate examples which are related to the concept of interest; however, they do not contain all of the defining attributes (Walker & Avant, 1995). Other concepts commonly associated with competence include performance, experience, expertise, effectiveness, and caring.

Performance. Conceptual ambiguity exists between competence and performance. For example, in a review of the literature, While (1994) revealed that distinctions are rarely made between the constructs of competence and performance. According to While (1994), performance was seen as a means by which competence was demonstrated. Thus, *competence* refers to an individual's potential. Potential is what an individual knows and can do under ideal circumstances. On the other hand, *performance* refers to the actual behavior enacted during a real life situation (While). This view of competence and performance was often supported in the nursing literature. For example, student performance is usually measured with the intent of determining competence. Moreover, professional licensing bodies often deem nurses as being competent to do a specific action within his or her role; however, what follow-up is conducted to determine how well the nurse actually performs in the real life setting? Despite the merit of this view, other authors challenge While's (1994) distinction between competence and performance. For example, some authors define competence as the actual ability to apply and integrate the knowledge, skills, attitudes, values, and judgments necessary for the current situation (Burrows, 1989; Butler, 1978; Nagelsmith, 1995; RNABC, 1990; Roach, 1984; Schwammle, 1996).

Experience. Experience (e.g., nursing practice, teaching, and formal education) provides a venue for a clinical teacher to acquire, integrate, and apply the necessary

knowledge, skills, and attitudes necessary for competence (Benner, 1984; Brunke, 1997; Jameton, 1984; Maynard, 1996; RNABC, 1996). Yet, measuring experience in terms of actual time spent in practice is insufficient for identifying one's competence as a clinical teacher (Benner; Watson, 1991). Rather, experience acquisition occurs when preconceived ideas and actions are challenged, refined, or rejected. Thus, experience prompting higher levels of cognitive reasoning (e.g., critical thinking, problem-solving, and reflection) and self-awareness are conditions necessary for the development of competence through experience (Benner; Saylor, 1990; Watson). Several authors have stated that nursing practice is a necessary requirement for being able to teach in the clinical setting; however, the nursing literature fails to empirically substantiate this claim.

While one anticipates that the passing of time is necessary for competence some aspects of competence may, in fact, deteriorate with experience. For example, as the skills of an individual's role become more rote and less lively he or she may continue to use the same skills. For experience to have impact on clinical teaching practice, it must reflect continuous professional development (e.g., gaining meaning from an event or situation) rather than the completion of a series of repeated activities over time (Gee, 1995).

Expertise. In the literature, the development of expertise is based on an individual's ability to gain meaning from personal experiences. By experiencing a variety of situations, it was assumed, expertise will be developed. In time, expertise will contribute to the evolving process of competence (Benner, 1984; Saylor, 1990). In Benner's conceptualization of expertise, nurses are not categorized as either competent or incompetent. Rather there are five degrees of expertise which nurses strive towards. As well, these degrees lie on a graduated continuum which includes competence. In a broad sense, Benner's continuum is conducive to the development of a clinical teacher's competence because it allows for, encourages, and explains the continual improvement in one's abilities. Next, the gradient

approach accounts for the variability and individuality of the participants' abilities, their professional learning needs, and various situational factors. Finally, according to Benner, competence is only one component of developing expertise.

Effectiveness. All nursing studies exploring the effectiveness of a clinical teacher are descriptive in nature and sampled various groups of nursing students and nursing faculty. Specifically, the literature on this topic was extensive in two areas: (a) identifying the qualities and characteristics of effective teachers and (b) evaluating the successfulness of a clinical teacher based on these qualities (Benor & Leviyof, 1997; Bergman & Gaitskill, 1990; Brown, 1981; Knox & Mogan, 1985; Mogan & Knox, 1987; Nehring, 1990; Oermann, 1996; Reeve, 1994; Sieh & Bell, 1994; Van Ort, 1983; Zimmerman & Waltman, 1986). The characteristics of effective teachers included two elements: competence and character. This approach to determining personal and professional success was similar to Covey's (1995) belief that effectiveness was achieved through a combination of strong character (e.g., integrity and maturity) and high competence.

In spite of the methodological problems (e.g., no consistent research tools and small sample sizes) encountered by researchers studying clinical teacher effectiveness, two tentative conclusions were reached: (a) a clinical teacher was required to be knowledgeable about the substantive area of nursing practice in which he or she teaches and (b) a clinical teacher must exhibit competence as a clinician (Oermann, 1996). Once again, this research acknowledges the importance of a clinical teacher exhibiting competence in nursing practice. It does not, however, recognize the importance of being a competent teacher. In addition, this research fails to acknowledge the process, or processes, by which a clinical teacher becomes competent.

Caring. In the nursing literature a connection has been made between competence and caring (Cohen, 1993; Girot, 1993; Halldorsdottir, 1997; Paterson & Crawford, 1994;

Roach, 1984; Slunt, 1993). Professional caring behaviors in nursing were explicitly manifested through such attributes as compassion, competence, confidence, conscience, and commitment (Roach, 1984). From this perspective, demonstrating one's nursing competence is shown through professional caring (Halldorsdottir; Roach; Slunt). Paterson and Crawford's research findings further supported the view that caring is the context in which competence exists. To be competent in a humane fashion individuals must demonstrate a blend of compassion and competence (Roach). Based upon this body of literature, one can conclude that teacher competence is an element of professional caring. Furthermore, a caring environment is conducive to the development and maintenance of competence as a clinical teacher.

Antecedents

Antecedents are consistent predecessors to the occurrence of the concept. Several antecedents for competence were identified in the literature review:

1. Acquisition of abilities within the cognitive (knowledge), psychomotor (skills), and affective (values) domains through a combination of life experiences and formal education.
2. Expertise in the discipline of practice (e.g., nursing).
3. Cognitive ability to make judgments.
4. Desire and perceived ability to succeed. This includes self-efficacy.
5. Positive perceptions of one's self and an inner sense of perceived control.
6. Self-confidence
7. Awareness of the role requirements and expectations, including knowledge of the nature of the required task, or tasks, at hand.
8. Ethical and moral judgment.

Consequences

Consequences are consistent events or effects succeeding an occurrence of the concept (Walker & Avant, 1995). Several consequences resulting from competence were identified in the literature review:

1. The completion of desired effects resulting in successful outcomes (e.g., promotion, student learning, or fulfilling role requirements).
2. The achievement of a higher professional status accompanied by respect, power, and trust.
3. The attainment of credibility both as a teacher and as a nurse.
4. The request, or requests, for one's consultation by other professionals and colleagues.
5. The opportunity to act as a positive role model or mentor for students and colleagues.
6. An elevated perception of one's self-control and self-confidence.

While some authors indicate these consequences arise as a result of competence, many researchers identified these consequences as either personal implications or student-related outcomes. The literature also did not address the consequences of competence in relation to the agency staff and clients, the nursing profession, or the educational institution, including other clinical teachers.

Empirical Referents

The use of empirical referents is a strategy for measuring or determining the existence of the concept (Walker & Avant, 1995). Much of the literature pertaining to the use of referents to assess competence was based on the evaluation of students' performance in the health-related professions and the maintenance of competence in the nursing profession (e.g., clinical competence) (Burrows, 1989; Milligan, 1998; Salvatori, 1996; Scheetz, 1989). Evaluation tools used to measure student competence have sought to determine a list of criteria (e.g., domains) which a student must meet or exceed. Thus,

evaluation of clinical competence was measured according to certain levels attained within the cognitive, affective, and psychomotor domains (Oldmeadow, 1996; Scheetz, 1989).

In the search for effective clinical teaching criteria, a number of instructor rating scales were developed. Included in these rating scales was a sub-component entitled clinical competence. Clinical competence was also referred to as professional or nursing competence (Bergman & Gaitskill, 1990; Brown, 1981; Knox & Mogan, 1985; Nehring, 1990; Reeve, 1994; Van Ort, 1983; Weitzel, 1996). It is important to note, however, that such evaluations fail to acknowledge or measure teacher competence. In fact, these tools are often based on the students' evaluations of their teacher's effectiveness (Benor & Leviyof, 1997; Brown; Knox & Mogan, 1985; Mogan & Knox, 1987; Nehring). This was not to say that students can not evaluate faculty, but rather student assessments should focus on the teaching-learning process and not the teacher's clinical competence (Ward-Griffin & Brown, 1992; Whitman, 1990).

Another form of evaluating the competence of clinical teachers was examining the outcomes of various situations (e.g., student learning and client safety). Various descriptive studies have sought to identify linkages between specific teacher behaviors and student learning outcomes (Karuhije, 1997; Krichbaum, 1994; Kramer, Polifroni & Organeck, 1986; Wills, 1997). Krichbaum identified certain teaching behaviors (e.g., asking appropriate questions; helping students organize their learning; and providing specific and timely feedback) as significant influences on cognitive learning and performance outcomes. The findings of Krichbaum's study indicate that the competence of clinical teachers does affect the students' learning to some extent. However, there is inconclusive evidence to pinpoint exactly what effect a teacher's competence, or lack thereof, has on student outcomes. Furthermore, while the effects of teacher competence on student learning are important, consideration must also be given to the other individuals and groups who may also be

affected: the clinical agency (including both its staff and clients); the educational institution (including co-workers as other colleagues); and professional regulatory and licensing bodies.

Relatively new to the literature was the recognition of the important role clinical colleagues play in the evaluation process for clinical teachers (Whitman, 1990). In an exploratory study, Whitman asked clinical colleagues to identify which clinical teaching behaviors were important, observable, and measurable for evaluation purposes. A list of 60 clinical teaching behaviors were categorized as nursing skills, interpersonal skills, and instructional skills. Of these three categories, clinical colleagues were better able to observe and evaluate nursing skills and interpersonal skills than instructional skills. Specifically, clinical colleagues could not observe and evaluate many instructional behaviors. In fact, only 5 of 22 instructional behaviors achieved consensus by clinical colleagues (Whitman). Wellard, Rolls, and Ferguson (1995) also found inadequacies with the colleagues' contributions to teachers' evaluations. While collegial evaluations of a clinical teacher appear to be deficient in some respects, the colleagues' contributions to the evaluations of the teachers' nursing and interpersonal skills were beneficial.

In sum, the nursing literature identified the most common forms of clinical teacher evaluations as peer evaluation, self-evaluation, student evaluation, and administration evaluation (Harwood & Olson, 1988; Ward-Griffin & Brown, 1992). Absent from the previous empirical referents were measures designed to assess a clinical teacher's competence as both a teacher and as a nurse. Moreover, the aforementioned methods of assessing competence were primarily based on behavioral criteria. The research has failed to identify a state-of-being criteria for measuring competence. These criteria have been difficult to establish since evaluating competence from the perspective of "what one is" can be

subjective and unreliable. Adding to these evaluation difficulties was the isolating nature of clinical teaching.

Summary

A brief overview of the research and anecdotal literature pertaining to competence has been presented in this section. This section has identified the defining attributes, antecedents, consequences, and empirical referents that underpin the concept of competence. Demonstration cases were also used to clarify and illustrate the defining attributes relevant to clinical teacher competence. While most defining attributes are product and performance based, some conceptualizations of competence as a process were acknowledged. However, no current empirical studies have explored the process, or processes, by which clinical teachers attain, demonstrate, and maintain competence. Since concepts provide the building blocks from which theories can be built, the results of this concept analysis provide directions for future research in the area of clinical teacher competence.

Significance of the Study

A review of the literature and an analysis of the concept of competence revealed that limited research has been conducted on this issue. As the roles and responsibilities of clinical teachers continue to change, the process by which clinical teachers attain, demonstrate, and maintain competence remains relevant and important in today's world.

Due to the practice-based nature of the nursing profession, clinical teachers have a professional obligation to students, clients, agency staff, educational institutions, and the nursing profession. Clinical teachers are expected to teach students how to nurse through hands-on experience with clients. When clinical teachers are not capable of demonstrating safe and competent nursing practices they can not effectively teach students the fundamentals of the profession. This lack of nursing competence also compromises the

safety of clients. To facilitate student learning clinical teachers must also be competent teachers. Clinical teachers must be able to apply and integrate theoretical knowledge (e.g., learning processes and evaluation) relevant to teaching-learning theory. Knowledge and insight gained from this study could be used to assist clinical teachers in maintaining the degree of competence necessary to continue their roles.

The study results will provide baseline data for understanding the process, or processes, by which clinical teachers use theory to guide their professional practice in a competent manner. Understanding the competence process could be used to help orient new clinical teachers and to support the ongoing development of current teachers. As well, this research could provide insight into competence as a process that is inclusive of elements of both teacher and nursing competence. Finally, this study may provide valuable data to assist academic administrators with the evaluation of clinical teachers (Wong & Wong, 1987).

Definition of Terms

A list of definitions has been provided to clarify the meaning of various terms used throughout this thesis.

Clinical Agency

The clinical agency refers to the entire agency to which a clinical teacher and his or her students is assigned. The clinical agency includes the specific unit, or ward, within the agency and the health professionals employed within the agency. These health professionals are referred to as agency staff.

Competence

This definition of competence was based upon the defining attributes section of the literature review in Chapter I of this document. Competence is the actual, or potential, state of and ability to integrate and apply a blend of attributes identified in the cognitive,

psychomotor, and affective domains through an evolving process. This process requires an individual to gain meaning from his or her experiences. Motivation, interest, energy, and commitment are required to help an individual deal with the internal and external factors that influence his or her state-of-being competent. Furthermore, competence is not a constant state. Rather, feelings fluctuate between anxiety and tension, comfort, and a sense of empowerment.

Clinical Competence

In the literature distinctions are made between terms such as competence and clinical competence. For the purpose of this research, clinical competence refers to a registered nurse's competence in a clinical setting.

Clinical Teacher

A clinical teacher is a registered nurse who teaches undergraduate nursing students in a wide range of practice settings. A clinical teacher is employed by an educational institution or faculty and may be referred to as a "teacher" or an "instructor". A clinical teacher is an individual who has completed, at minimum, a baccalaureate degree in nursing.

Clinical Teaching

Clinical teaching is a dynamic and interactive process. It is a type of teaching that occurs in the proximity of a client (e.g., individual, family, group, community, and population) and in a variety of health-related settings.

Learning Environment

The learning environment refers to the context in which learning and clinical teaching occurs. This environment may vary depending on the clinical course and the clinical

agency. However, the learning environment is not inclusive of the learning that occurs in the classroom or laboratory setting.

Neophyte Clinical Teacher

A neophyte clinical teacher is an individual who is new to clinical teaching; he or she is a beginning instructor.

Organization of the Thesis

The thesis is organized into five chapters. This chapter has introduced the purpose and significance of the proposed research. Also, a review of the literature pertinent to the research problem was presented according to a concept analysis framework. Chapter II includes a discussion of the research design, sample characteristics, method used to collect and analyze the data, strategies used to ensure rigor, ethical considerations, and the limitations of the study. The results of data analysis will be presented in Chapter III. Selected findings of this study will be discussed in Chapter IV. Finally, Chapter V will present a summary of the study, and will conclude with a discussion of the implications of the study for nursing.

Conclusion

Nursing is a practice-based discipline. One method for passing on the knowledge, skills, and attitudes associated with nursing is through clinical teaching. To safeguard quality nursing practice it is necessary to ensure that clinical teachers are competent. While the concepts and issues that encompass competence have been explored in research, the explicit nature of the process, or processes, of becoming a competent clinical teacher have not been explored. Through a grounded theory methodology, I set out to describe the process of attaining, demonstrating, and maintaining competence as a clinical teacher.

CHAPTER II: RESEARCH METHOD

The Qualitative Approach – Grounded Theory

The grounded theory method of research was used to generate new knowledge of the processes of attaining, demonstrating, and maintaining competence as clinical teachers. Grounded theory is an inductive mode of research used for the generation of theoretical concepts about phenomena and the exploration of basic social processes (Glaser & Strauss, 1967). Grounded theory, through a method of constant comparative analysis, seeks to generate theory from data. Consequently, theory development is viewed as a continuous process of simultaneous data collection, coding, and data analysis. During this developmental process, conceptual categories and conceptual properties emerge along with tentative hypotheses (Glaser & Strauss). It is these conceptual categories, properties, and hypotheses that form the basis for substantive or formal theory. Thus, the purpose of grounded theory is to generate theory from data derived from empirical evidence rather than to test existing theory. Theory grounded in data is of particular importance because it increases the chance that theory and the empirical world will match (Glaser & Strauss). In this study, the primary source of data were derived from formal, unstructured, audio-taped interviews with 11 participants. This researcher supplemented the interview data with her research notes (e.g., think notes and memos) compiled throughout the research process.

Included in this chapter will be an overview of the selection of participants and the sample characteristics. Next, data collection procedures will prove a basis for the next step, data analysis. Following a description of the analysis process, issues of rigor and limitations to the study will be presented.

Participant Selection

In grounded theory, the researcher generally chooses participant groups that will compliment the needs and nature of the study. This is achieved by applying the principles of

theoretical sampling. Theoretical sampling is a process through which the researcher concurrently collects, codes, and analyzes the data and then determines which data to pursue next and where to locate it (e.g., what type of participant is needed and what is the theoretical purpose). In short, theoretical sampling allows the researcher to seek out key participants based upon their potential ability to facilitate the generation of conceptual categories and their properties (Glaser & Strauss, 1967; Robertson & Boyle, 1984). With theoretical sampling, specific sampling decisions evolve throughout the entire research process (Glaser & Strauss). When the emerging theory requires it, theoretical sampling allows the researcher to select from the volunteers with differing characteristics (e.g., educational backgrounds, philosophical perspectives, and years of experience). Both theoretical sampling and the following criteria were used to guide the researcher in the selection of participants. The participants were to be:

1. Employed by an accredited educational institution.
2. Currently working as a clinical teacher or had done so in the past six months.
3. Working within the Lower Mainland of British Columbia.
4. Fluent in the use of the English language.
5. Educated at or above the baccalaureate degree in nursing level.

Since the primary goal of grounded theory is richness of data, data collection is usually terminated when *theoretical saturation* occurs. Generally speaking, theoretical saturation happens when no additional data are found to further develop categories and their respective properties, and no new themes evolve (Glaser & Strauss, 1967). Based on the need for theoretical saturation, the emphasis of sample selection is based on the appropriateness of participants' experience and the accuracy of the data (i.e., quality) rather than the kind of evidence and the number of cases (i.e., quantity) (Glaser & Strauss).

Sample

Participants for this study were recruited through three nursing programs in the Lower Mainland of British Columbia. Permission was obtained from the director of these nursing programs to distribute a letter of invitation to participate (Appendix B). The letters of invitation were distributed via the mailboxes of clinical teachers in the three nursing programs (Appendix C). Clinical teachers interested in participating were asked to contact either the researcher or the thesis supervisor. To determine the appropriateness of the potential participant, the selection criteria for the participants were reviewed and data needs were considered. Once suitability was determined a mutually agreed upon meeting location was designated. During the first interview session, the research study was explained in detail, a signed consent was obtained (Appendix D), and future interview times were discussed with the participants. The total sample was comprised of 11 participants who met the stated criteria and agreed to participate in several audio-taped interviews.

A description of the sample is provided in Table 1. Participants in this study ranged in chronological age, years of experience (e.g., clinical teaching and nursing), educational backgrounds, philosophical perspectives, and level of students (e.g., first year, second year, third year, and fourth year) being taught. Forty-five percent of the participants were employed as clinical teachers for 20 to 29 years. Every clinical teacher in this category had six years or less of experience as clinicians prior to commencement in clinical teaching. All participants taught in a wide range of clinical agencies and substantive areas of nursing practice with various undergraduate student groups. In teaching various undergraduate student groups, 90% of participants taught two or three levels of students during their careers as clinical teachers.

Table 1

Demographic Characteristics of Study Participants

Characteristic	N
Gender	
Female	11
Level of Education Upon Initial RN Registration	
Diploma in Nursing	7
Baccalaureate Degree In Nursing	4
Current Level of Education	
Master's Degree in Nursing	7
Master's Degree in Nursing in Progress	1
Master's Degree in Education	3
Number of Years Practicing as a Clinical Teacher	
0 - 9 years	4
• 0-4 years	1
• 5-9 years	3
10 - 19 years	2
20 - 29 years	5
Number of Years Working as a Clinician Prior to Clinical Teaching	
1 - 6 years	7
7 - 12 years	2
13 - 18 years	1
19 + years	1
Current Type of Nursing Program Employed as a Clinical Teacher	
Diploma Nursing Program	3
Baccalaureate Nursing Program	5
Collaborative Baccalaureate Nursing Program	3
Specialty Nursing Program	0

Note. N = 11

Data Collection

To describe the process of attaining, demonstrating, and maintaining competence as a clinical teacher, data were collected from formal, semi-structured, audio-taped interviews with 11 participants. The goal of data collection was to gather empirical evidence that was accurate. Glaser and Strauss (1967) place more emphasis on the accuracy of data (i.e., quality) versus the kinds of evidence and the number of cases (i.e., quantity).

Interview

The structure and sequence of asking questions is an important dimension of the interview (Goetz & LeCompte, 1984). For this research study, the initial interview agenda (Appendix E) was semi-structured. The interview guide introduced the main themes of the interview to help participants' focus their thoughts regarding the process of attaining, demonstrating, and maintaining competence. The first interview with participants provided a basis for alternate and more directed interview questions for succeeding participants. The emerging categories and tentative conceptual framework provided structure for the second interview as participants were asked to clarify and validate data interpretations. Probing questions were also used to attain a deeper understanding of the participants' answers.

Ten participants were interviewed twice for confirmation and depth of information over the course of a 10-month period. An additional participant was interviewed once during the middle portion of the analysis process to further verify the dimensions of the categories. Each interview took approximately 60 to 90 minutes. Before each interview, participants were informed that a break could be taken. During the interview participants were also informed they could request to discontinue audio-taping at any time. To place participants at ease with the interview process, the researcher conducted interviews at locations selected by participants (e.g., home or work). An interviewer-administered demographic

questionnaire was completed at the end of the first interview (Appendix F) and confirmed during the second interview.

Research Notes

Research notes reflected the events of the interview as well as the personal aspects of the research process. Note taking is central to the research process since it marks the beginning of preliminary analysis and theoretical discovery (Spradley, 1979). The research notes for this study were organized as *think notes* and *memos*. The *think notes* were organized to include observations of (a) the events that transpired during the interview, (b) the general mood and tone of the interview, and (c) non-verbal communication of the participants. As well, think notes included personal impressions of the interview, descriptions of themes to further explore, and personal biases of the researcher (Spradley). The researcher recorded (i.e., hand written or audio-taped) most of the think notes immediately following each initial interview. Fewer think notes were recorded following the second interviews.

Ideas about the data, its interpretation, and the coded categories were elaborated upon in written or typed *memos* (Charmaz, 1983). *Memos* written by the researcher were a stepping stone between coding and writing the first draft of the analysis. Ideas, hypothesis, and conceptualizations regarding the coded categories (e.g., properties and consequences) were written as memos (Charmaz). These memos provided a basis for advancing the data from the empirical to the theoretical level of abstraction. This level of abstraction was necessary for the identification of the core category and the description of the basic social process reflected in the data (Glaser & Strauss, 1967). Thus, the conceptual pieces to the puzzle, if you will, became clearer to the researcher through having a "discussion" with herself through memo writing. Working conceptualizations of the framework depicting the process of becoming competent were also drafted in the form of memos.

Data Analysis

The goal of the data analysis is to create a vivid reconstruction of the phenomena being studied (Goetz & LeCompte, 1984). Since the objectives of this research were exploratory with an emphasis on theory development, constant comparative analysis was used. This method of analysis allowed the researcher to systematically *generate theory* by constantly comparing the data obtained through the interview process (Chenitz & Swanson, 1986; Glaser & Strauss, 1967). According to Glaser and Strauss there are four stages of analysis: (a) discovering the categories, (b) integrating the categories and their properties, (c) identifying the core category and delimiting the theory; and (d) refining and writing the theory. Since each stage of the analysis provided the basis for the next, the analysis required constant reflection and review of the data collected. In other words, the analysis was cyclical in nature and each phase was interconnected; several stages occurred at the same time. Theory that evolved using this method both subsumes and assumes verifications and accurate descriptions (Glaser & Strauss). When possible, every attempt was made by the researcher to permit the theory to emerge from the data.

Stage 1: Discovering the Categories

During the first stage, the researcher analyzed the interview data and research notes. As previously stated, data were collected from 11 participants. The interviews were transcribed verbatim, lines numbered, and hand coded. The researcher also listened to the audio-tapes a second time while alone to refresh her memory of the interview, correct transcription errors, and add intonations. The transcripts were read and each line or paragraph was deconstructed to identify a fact or an incident. These facts and incidents were underlined. Key words or phrases that represented and summarized the participants' thoughts were written either in the margin of the transcript or typed below participants'

comments¹. From the collection of facts and incidents a pattern of themes began to emerge. Codes were then developed to capture the meaning of the themes. The codes were a combination of the actual terms used by participants or terms constructed by the researcher. A working list of tentative codes was developed. The researcher then returned to the initial interviews to designate codes to each fact or incident. After the interviews were coded, the researcher documented a summary of the interview. This summary sought to capture an overview of the key themes discussed by each participant during the interview. This summary was beneficial as it became a source of quick reference for the researcher in comparing the similarities and differences among each participant's respective experience. To ensure accuracy of data collection, verify its interpretation, and control personal bias, the researcher's committee members read the data generated from a portion of the interviews. Furthermore, committee members validated conclusions made by the researcher .

Stage 2: Integrating the Categories and their Properties

Since the theory developed through constant comparative analysis, differing categories that emerged were compared with each other with the goal of reaching theoretical saturation. To facilitate theoretical saturation of the emerging categories, variability among participants was sought during the ongoing participant selection process. As data were compared, the working list of tentative codes developed in stage one were consolidated into a list of 29 codes (e.g., comfort level, confidence, and assessing the student). These codes represented important themes. The initial 29 codes were reorganized into 8 substantive categories (e.g., nursing practice, knowledge base, and evaluation process) that the researcher interpreted as pertaining to the same phenomena. The name selected for a category was more abstract than the concepts it represented. As data

¹ This means the researcher used a word processing program to type the code words/phrases into the actual transcript versus hand writing her comments. The code words/phrases were typed below the area that it referred to, key comments from participants were underlined.

collection and analysis proceeded, it became clear that some categories were defining characteristics, or *properties*, of other categories. Categorized data were compared to previous data and new incoming data. When the code did not fit in a given category, a new one was developed to represent the code. At the same time, similar properties were integrated into existing categories (Glaser & Strauss, 1967). To assist with the integration process, conjectures were tested, revised, or modified until all of the categories were linked together and relationships identified (Glaser & Strauss). The outcome of stage two was the identification of eight substantive categories linked together and arranged into a tentative conceptual framework that consisted of three phases.

Stage 3: Identifying the Core Category and Delimiting the Theory

The second interviews completed by the researcher became a means of testing the themes of both previous and new participants. Specifically, 10 participants were interviewed for a second time. In these interviews, participants were encouraged to elaborate upon and validate the themes identified in the tentative conceptual framework. As such, some participant quotes presented in the findings (Chapter III) were in response to reviewing the emerging framework. Terminology in some quotes may reflect the wording of the presented framework (e.g., phase one, phase two, and phase three). Nonetheless, this component of the analysis allowed the researcher to build and to modify the existing categories with the intent of formulating a theory from a smaller set of higher level concepts (Glaser & Strauss, 1967). In stage 3, the constant comparative method changed from comparing incident with incident to comparing the incident with the properties of the category. In other words, categories were moved to a higher level of abstraction. The eight substantive categories were refined and organized into nine major categories (e.g., dealing with anxieties, learning how to teach, and confronting learning issues). At this point, saturation of the major categories was achieved.

Since the nine major categories were established and linked, the next task was to reorganize the categories around a *core category*. The *core category*, also referred to as a major concept or core variable, was the category in which other categories fit and to which they all relate (Glaser & Strauss, 1967). Through reflective memo writing and dialoguing with committee members the relationship of the core category to each phase crystalized; the process as a whole began to emerge. All data related to the major categories were re-examined to saturate the categories and refine the conceptual framework. The researcher identified *developing self-confidence* as the core category. The three-phase process was reconstructed around the identified core category.

Stage 4: Refining and Writing the Theory

During the final stage of analysis, the researcher possessed coded data, a series of research notes, and a theory (Glaser & Strauss, 1967). The goal of this stage was to devise a theory consisting of a core category around which the other major categories fit (Chenitz & Swanson, 1986). The researcher's notes provided the content to support the preliminary conclusions about the main categories (Glaser & Strauss). After synthesizing and reorganizing the preliminary conclusions, the researcher devised a final conceptual framework of the central phenomena, namely the process of maturing as a competent clinical teacher. The core variable of this process was *developing self-confidence*. An additional review of the categories and of each participant's interview was conducted. A description of the *process of maturing as a competent clinical teacher* was identified and is presented in Chapter III.

Rigor

Grounded theory is a qualitative approach to exploring a social process and discovering theoretical explanations about a particular phenomenon (Glaser & Strauss, 1967). Qualitative methods, such as grounded theory, can not be evaluated against

conventional methods that are applicable to scientific criteria (Robinson & Thorne, 1988). Sandelowski (1986) suggests four criteria of rigor by which to evaluate qualitative research: credibility, fittingness, auditability, and confirmability. In this section, a discussion regarding each criterion addresses the concerns of rigor for this study.

Truth Value: Credibility

In qualitative research, *credibility* is similar to the conventional form of internal reliability. Credibility is the main criterion by which external reviews have confidence in the truth of the findings (Sandelowski, 1986). It attempts to measure the clarity and thoroughness of the description and interpretation of the phenomena under study (Beck, 1993). That is, can the researcher demonstrate that the study measures what is being studied as it is defined in the study (Beck; Sandelowski)?

To ensure credibility of this research, the systematic method of constant comparative analysis was used as a method for avoiding misinterpretation or inaccuracies of the data. Specifically, the researcher checked for denseness of the data and emerging categories by posing questions along each stage of the research process and constantly comparing incoming data with previously analyzed data. Throughout the entire analysis, the researcher maintained a certain level of skepticism about the emerging data and questioned herself about each set of data (e.g., what are the data descriptive of?, what category does this incident indicate?, and what is actually happening in the data?) (Glaser, 1978). Credibility was also established through *participant checking* and *peer debriefing*.

Participant checks involved completing a second interview with participants for the purpose of data clarification and validation of the emerging theory (Glaser & Strauss, 1967). *Peer debriefing* was ensured by having the researcher working collaboratively with the thesis committee members (e.g., sharing data, ongoing analyses, and emerging theory). The committee members posed key questions that guided and aided the researcher in

moving towards higher levels of abstraction. As stated previously, when members of the committee did not concur with the researcher's interpretations of the data, the inconsistencies were discussed until an agreement was reached. The activities involved in *peer debriefing* were important because it enabled the researcher to discover the processes underpinning the experiences of clinical teachers. Additional techniques used to ensure credibility were:

1. Documentation of descriptive think notes following each interview (e.g., setting, events, and behaviors of both the participants and the researcher).
2. Documentation of memos detailing the researcher's ideas, thoughts, hunches, and potential bias about conceptual notions and research methodology.
3. Audio-taped interviews were completed to obtain accurate and precise descriptions of the clinical teachers' experiences in attaining, demonstrating, and maintaining competence. After transcription, the researcher listened to the taped interviews once again to check for errors or omissions. Tone of voice and other non-verbal behaviors were also added to the transcripts at this time.

Applicability: Fittingness

Fittingness refers to how well the research findings "fit" into a context other than the one from which they were generated. In other words, how applicable and generalizable is the data outside the study situation (Beck, 1993; Sandelowski, 1986)? Thus, fittingness provides the foundation on which comparisons can be made. In grounded theory, both comparability and translatability can be used to contribute to the overall fittingness, or external validity, of any study (Glaser & Strauss, 1967). In fact, one of the goals of grounded theory is to establish generalizations regarding applicability, explanatory, and predicatory power (Glaser & Strauss).

Three strategies were used by the researcher to ensure fittingness of the data. First, the researcher described the characteristics of participants thereby assisting others to accurately transfer the findings to other similar groups. Second, the principles of theoretical sampling (Glaser & Strauss, 1967) were used to ensure that the findings were not only representative but also credible and applicable. According to Sandelowski (1986), another strategy for evaluating the credibility (truthfulness) of a study is if the audience views the findings as meaningful in terms of their experiences. Based on Sandelowski, the third strategy for evaluating the fittingness of the emerging theory occurred when the researcher presented the preliminary findings of this study at three conferences (e.g., international, national, and provincial). To elaborate, at a national conference for nurse educators, an oral presentation of clinical nursing teacher competence was given. It was readily apparent that the audience concurred with the process of becoming competent clinical teachers by the feedback received from the delegates. Then, at an international and provincial conference, preliminary findings were presented in poster format. During the viewing of the poster several external reviewers provided insightful and stimulating comments which assisted in the interpretations emerging from the data.

Consistency: Auditability

Reliability is typically thought of as being synonymous with auditability. It refers to the ability of another researcher, through replication, to arrive at similar, non-contradicting conclusions to those of the original researcher. Thus, another reader should be able to clearly follow the researcher's decision-making process as it pertains to the study under discussion. Since there can be no validity without reliability - and hence no credibility without auditability - the techniques used to establish credibility should be sufficient for demonstrating auditability (Sandelowski, 1986).

As previously discussed, the decision-making process for this study was guided by constant comparative analysis (Glaser & Strauss, 1967). The researcher maintained documentation on the entire research process by using transcribed interviews for each participant; code and category logs; think notes, memos, category booklets; and written drafts. As previously discussed, peer debriefing with committee members aided the researcher's decision-making abilities regarding the research process (e.g., interviewing techniques, coding of data, and interpreting the categories). Throughout the research process, the researcher sought the feedback of committee members regarding the clarification of categories, their properties, and the emerging conceptual framework.

Neutrality: Confirmability

The concept of confirmability is the criterion for neutrality or objectivity. Due to the subjective nature of qualitative research, confirmability refers to the findings themselves and not to the subjective or objective stance of the researcher. When auditability, credibility, and applicability are established confirmability is achieved (Sandelowski, 1986). Since the primary tools of any qualitative research, such as grounded theory, are the *sensory organs* of the researcher, one must strive for neutrality or objectivity. This was established by having the researcher, prior to the interviews, identify her beliefs concerning the competence of nurse educators in their role as clinical teachers. Furthermore, research notes (e.g., think notes and memos) were compiled throughout the research process. This provided a venue for the researcher to acknowledge and report any feelings, attitudes, or behaviors that may have influenced the research process. Finally, confirmability of the research findings was achieved by having the interpretations reviewed by two members of the thesis committee.

Ethical Considerations

In this study, the researcher used various strategies to protect the human rights of all participants. Ethical approval for this study was obtained from the Behavioral Sciences Screening Committee for Research Involving Human Subjects at the University of British Columbia. This study was developed by following the Canadian Nurses Association's (1994) guidelines for research and the International Council of Nurses (1996) ethical guidelines for nursing research. Each participant was required to sign an informed consent form which explained the nature of the study; the extent and duration of his or her participation; the interview process and how the interview information was to be used; and the anticipated benefits (Appendix D). Upon verbal request, each participant will receive a synopsis of the research findings.

Confidentiality was maintained by locking the transcribed interviews, notes, and audio tapes in a cabinet separate from consent forms and code lists. This material will be destroyed five years after the completion of the study. Moreover, to ensure confidentiality, additional measures were implemented, these include:

1. Identifying information was omitted from the interview transcripts, written reports, and verbal reports.
2. Only the researcher, the transcriber, and the thesis committee members were permitted access to the interview transcripts.
3. Transcribed interviews and notes located on the researcher's computer hard drive were protected by password access.
4. To ensure anonymity in the final report and subsequent presentation of the findings, the participants are referred to as a collective whole. In rare situations where the research is required to refer to an individual participant, a code number or pseudonym will be used.

Limitations of the Study

A limitation of this study was that participants who volunteered were more likely to have definite ideas and opinions about competence while those who are uncertain or indifferent may not. Since those volunteering were also more likely to be viewed as “competent” clinical teachers this may have reduced the number of participants who could speak to issues of incompetence. Furthermore, the volunteer nature of the participants limits the generalizability of the study to those that were interested and willing to participate. Also, those who refused to participate may have been disinterested in or had opposing beliefs about the research topic.

Conclusion

Grounded theory was used as the research methodology for investigating the *process of maturing as a competent clinical teacher*. Chapter II began with an overview of the theoretical foundations of grounded theory. The sample selection and criteria, the data collection procedure, and the stages of data analysis were outlined. A summary of the measures used to guarantee rigor were also identified by the researcher. The chapter concluded with ethical considerations and limitations of the study.

CHAPTER III: THE DISCOVERY

Introduction

The goal of this research study was to describe the process by which clinical nursing teachers attain, demonstrate, and maintain competence. As the investigation proceeded, it became apparent that participants went through a three-phase process as they matured into self-confident and competent clinical teachers. Further analysis exposed a core category of developing self-confidence that served to integrate and clarify variations in data from which further sub-categories emerged. The outcome of each of the three phases resulted in the building of various degrees of self-confidence and competence. The activities associated with "confidence building" in one phase were necessary for succeeding phases to occur.

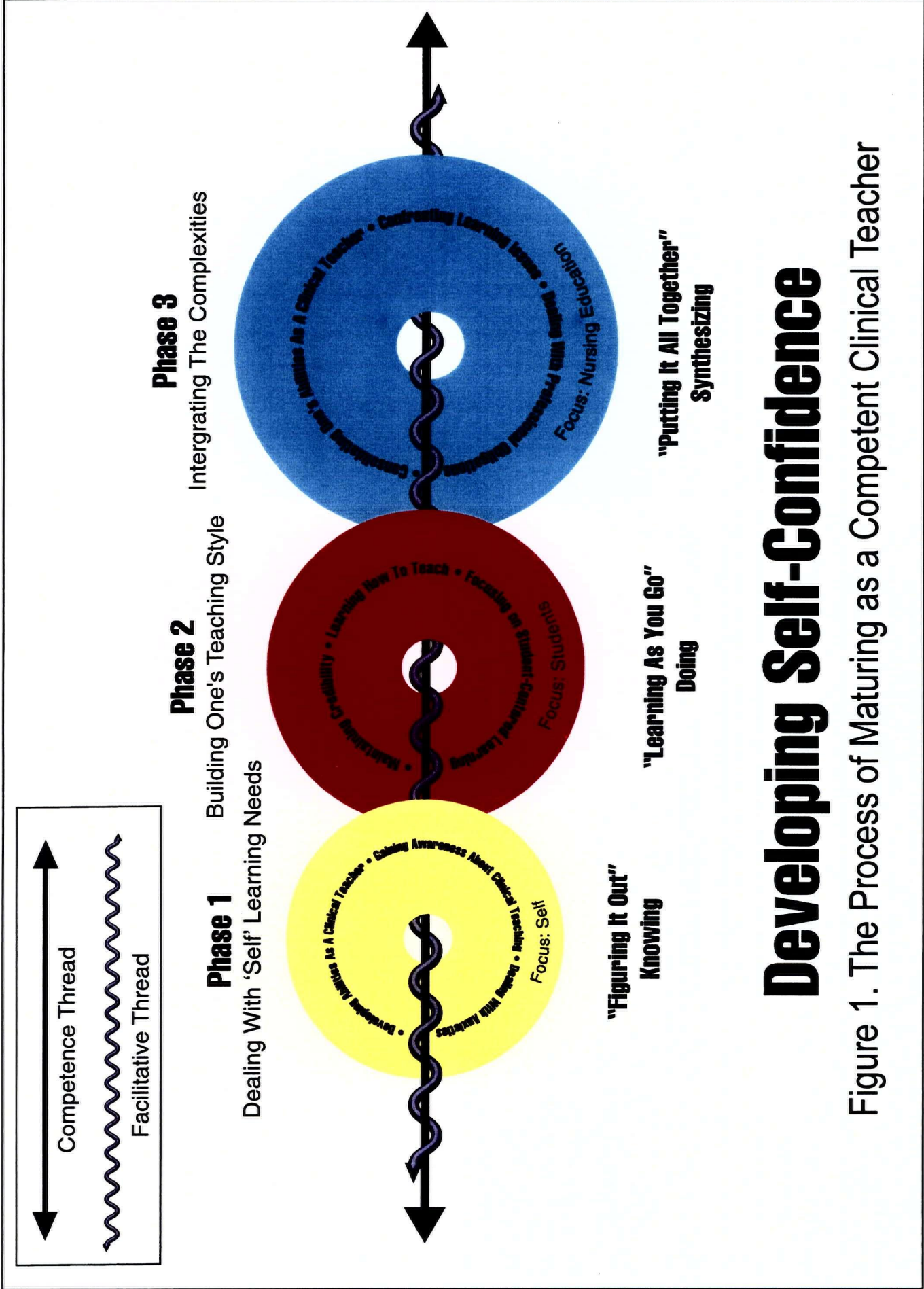
In this chapter, the outcomes of data analysis are presented. This chapter begins with a theoretical portrait of the three phases of maturing as a competent clinical teacher that evolved through grounded theory methodology. Next, a description of the core category is presented with a detailed review of the three phases to follow. Factors that facilitated the process will be addressed where their effect was most pronounced. Participants' experiences of incompetence will complete the chapter. Integrated throughout this chapter are verbatim quotations from participants. These quotes serve to illustrate and substantiate the researcher's interpretations of the process of maturing as a competent clinical teacher. Because all of the participants in the study were female, the clinical teachers will be referred to in this report using the feminine pronouns.

The Process of Maturing as a Competent Clinical Teacher: An Overview

Central to the participants' descriptions of their experience were the three phases through which they passed during the *process of maturing as a competent clinical teacher*. The three phases, as depicted in Figure 1, are: (a) dealing with "self" learning needs,

(b) building one's teaching style, and (c) integrating the complexities. Phases of this process, illustrated as independent circular shapes, evolved as opposed to concluding or commencing in an abrupt manner. Some outcomes of one phase became a prerequisite of the next phase. Thus, each phase became dependent on the previous one. Movement among the phases was multi-directional and multi-factorial. To best explain the process, each phase was depicted in a linear, distinct fashion; however, in actuality the phases were not mutually exclusive. Variations in the process will be discussed in a later portion of this chapter.

The first phase, *dealing with "self" learning needs*, was best described as a period of adjustment as participants dealt with the transitions or changes in their current position; for example, changing from working as clinicians to employment as clinical teachers. During this phase participants focused on themselves. They dedicated the majority of their time and energy to fulfilling their learning needs rather than those of the students. As a way of addressing their learning needs, participants employed three interrelated strategies: developing abilities as a clinical teacher, gaining awareness about clinical teaching, and dealing with anxieties. According to the participants, these strategies varied according to the context of each participant. At some point in phase one, the participants needed to address their own needs and anxieties before they could progress on to phase two; this condition was essential. Participants also needed to *figure out* what was expected of students in order to progress through the clinical course. The outcome of phase one was being able to know about and understand the clinical teacher role, an outcome that promoted higher degrees of *self-confidence*.



Developing Self-Confidence

Figure 1. The Process of Maturing as a Competent Clinical Teacher

Phase two, *building one's teaching style*, was primarily a time of trial and error. As clinical teachers become *self-confident* with the clinical teacher role, they ventured onward by challenging old assumptions, discovering new alternatives, and subsequently *building one's teaching style* (e.g., methods and philosophies). In this phase, participants focused on building a repertoire of teaching activities that fostered student learning. Participants used a combination of three interdependent strategies to develop their teaching style: maintaining credibility, learning how to teach, and focusing on student-centered learning. All participants, in one way or another, dedicated time towards critically appraising themselves. When reflection did not occur participants said they remained stagnant. The outcome of this phase was a variety of teaching methods which the participants had *self-confidence* in utilizing when a specific learning situation presented itself. *Self-confidence* in one's teaching ability was a requirement for moving to phase three. Two additional conditions needed to complete this progression were the commitment and the desire to advance the substantive area of clinical teaching.

The third phase focused on *integrating the complexities* of clinical teaching into their practice of educators. It was at this point that participants developed a greater appreciation and understanding of how to *consolidate their abilities as clinical teachers* within the *richness of the learning environment*. The focus of this phase was on directing energy towards the student but in a much broader context of the clinical teacher's *professional nursing obligations*. Participants who spoke of phase three had developed enough self-confidence and competence to *confront student learning issues*. The outcome of phase three led to a continual development of *self-confidence* and *competence* – there was no predetermined end. As new factors were introduced to participants who were experiencing phase three, they would mobilize various strategies to maintain and enhance their *self-*

confidence and consequently contribute to the *process of maturing as competent clinical teachers*.

In Figure 1, each circular shape is connected by two threads. One thread is depicted as a solid line. The other thread encircles the solid line and is graphically represented as a spiraling line. The thread illustrated as a solid line represents various degrees of competence – referred to as the *competence thread* – attained within each of the three phases. Movement along the *competence thread* (i.e., progression among the three-phased process of maturing as competent clinical teachers) was expedited by the presence of various facilitative factors that were identified by participants. Each facilitative factor was a component of the thread illustrated as a spiraling line. Collectively the facilitative factors were coined the *facilitative thread*. Each *facilitative factor* did not apply to all participants and the degree of applicability of the factors to each phase also varied. Participants reported various components of the *facilitative thread*: support, personality traits (e.g., attitude and reflective nature), continuing education, communication skills, relationships with clinical agencies, and teaching assignment. An analysis of these facilitative factors will be presented in a later portion of this chapter. Specifically, a report will be given to detail where the influence of the facilitative factors was most prominent.

The *competence thread* and *facilitative thread* have a interdependent relationship; the direction of movement along the *competence thread* was dependent on the presence of the *facilitative thread*. Although all *facilitative threads* are not necessary for competence to occur, some type of facilitative factor was required. For example, some participants said that progression from phase one to two would not have occurred when they did not have collegial support. Because having support lessened their anxieties about clinical teaching this was significant since a decrease in their anxiety levels allowed for the development of their *self-confidence* and *competence* as clinical teachers. Conversely, lack of support

hindered the process. In other words, participant progression through the phases was lengthened, stagnated, or regressed (e.g., incompetence).

As participants considered the applicability of the three phases to their own experiences, they perceived they possessed various degrees of competence as well as having some experiences of incompetence. Typically, participants categorized incompetence as either an *overall incompetence* or an *occasional incompetence*. At different times throughout each phase teachers are competent and incompetent in distinct ways. A synthesis of the participants' ideas of incompetence will be addressed in the final portion of this chapter.

The Core Category: Developing Self-Confidence

The core category underpinning the entire *process of maturing as a competent clinical teacher* is *developing self-confidence*. To foster the process, and thus progress from phase one to three, participants needed to develop a significant degree of *self-confidence*. The initiation of the "confidence building" process began with participants making a change, either self-initiated or as a result of external pressures (e.g., curriculum changes and reassignment of teaching responsibilities). A certain degree of *self-confidence* was required for participants to consciously make the decision to change in the focus of their nursing career. *Self-confidence* was increased further when the clinical teacher was successful in each phase.

The participants indicated that: (a) *self-confidence* was necessary for *competence* as clinical teachers and (b) at the end of each phase clinical teachers displayed different degrees of *self-confidence* and *competence*. In other words, the two concepts, *developing self-confidence* and *maturing as competent clinical teachers* had a reciprocal, interdependent relationship. When the participants viewed themselves as competent, *self-confidence* was enhanced because they realized their ability to be successful as clinical

teachers. Feelings of pride and respect heightened participants' *self-confidence*; the more *self-confidence* developed, the easier it was to engage in activities directed towards enhancing *competence*. The strongest reciprocal relationship between the *process of maturing as competent clinical teachers* and *self-confidence* appeared to be during phase one.

Guiding Frame of Reference

Throughout the *process of maturing as competent clinical teachers* the importance of managing a triad of relationships emerged (Figure 2). Participants in all phases used, in varying degrees, a frame of reference where the client's well-being was central to their competence as clinical teachers. Second to the client's well-being was the degree of student learning that occurred within a given clinical context.

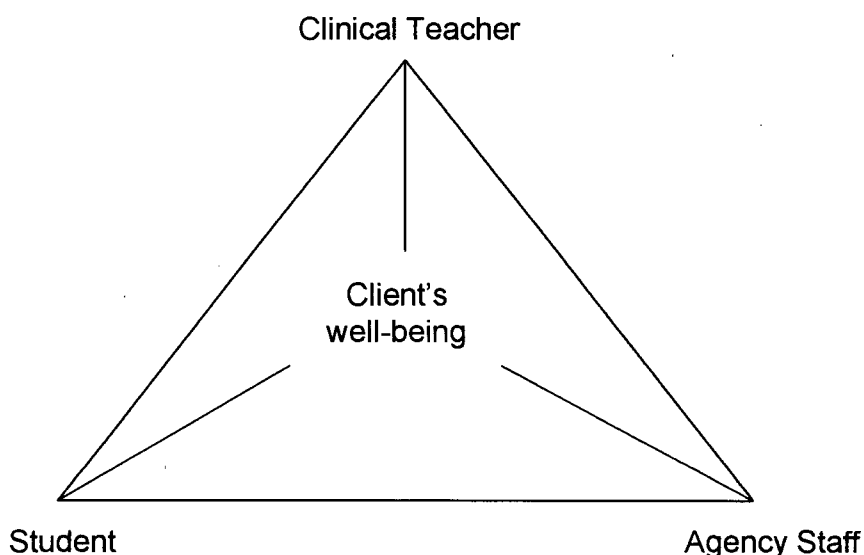


Figure 2. Triad of relationships managed by the clinical teacher.

This triad of relationships was an important frame of reference for clinical teachers dealing with every day teaching situations. As participants' *self-confidence* and *competence* in the clinical teaching role developed, they were better able to manage the triad of relationships. In phase one, for example, neophyte clinical teachers were most concerned for the safety of the client (i.e., what would happen if clients were harmed by students?). As

participants developed *self-confidence* and matured as *competent* clinical teachers they learned to let go and permit the student to learn. Thus, in phase two, the students' learning process gained equal attention in relation to the clients' well-being. In addition, contributing to the students' learning process were activities carried out by clinical teachers to maintain positive working relationships with the agency staff. Finally, in phase three, participants developed a degree of *self-confidence* and *competence* to manage complex situations that arose within the triad. In other words, all needs were met and energy was dedicated to each element of the triad as needed. This participant recalled her shift in thinking about the balance reached among the members of the triad, "In phase 1, I still was a bedside nurse, so my priority was the patient, the staff, the unit, the students. [Later], I moved into the idea of being a teacher, the students, on the unit with patients and staff". Other participants agreed with this clinical teacher. The participants came to see the students as only one variable within a larger context of clinical teaching where the needs of others (e.g., clients and agency staff) also needed to be managed. This dimension of clinical teaching, in addition to others revealed in this chapter, validated the complex nature of the *process of maturing as competent clinical teachers*.

In the following sections of this chapter, the three phases of the *process of maturing as competent clinical teachers* will be presented. The strategies and their consequences will also be described. The strategies used in the process of attaining competence were not necessarily exclusive to any one phase. For ease of reporting, three strategies are reported in phase one, three in phase two, and three in phase three. Moreover, the *process of maturing as a competent clinical teacher* will also be referred to as "the maturation process" and "the process of maturing".

Phase 1: Dealing With “Self” Learning Needs (Figuring It Out)

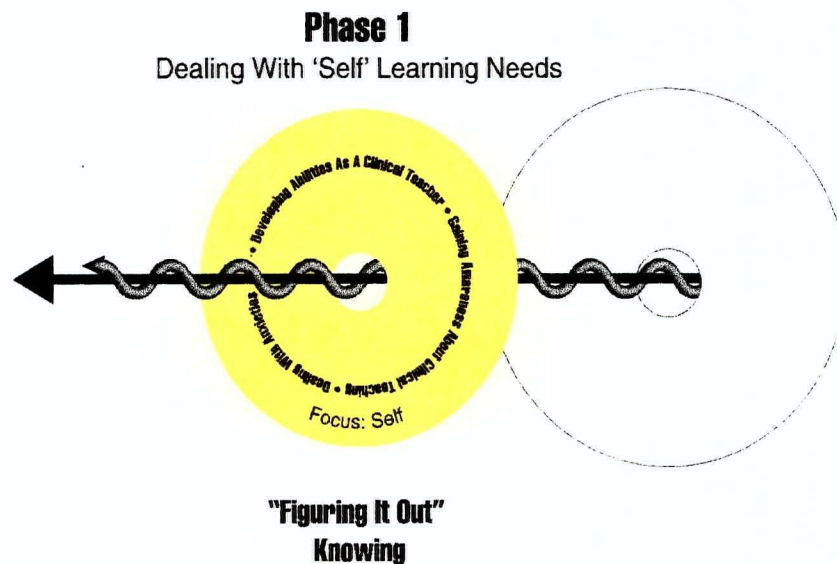


Figure 3. Phase one of the maturation process.

At some point in time, assuming a clinical teacher position was a new experience for the nursing clinicians who participated in this study. All participants stated that they needed time to adjust to the uncertainties that accompanied the transition to their teaching position. During phase one (Figure 3), many participants agreed their *self-confidence*, pertaining to their abilities as a teacher, was at its lowest point. Participants who lacked *self-confidence* in the new or adjusted teaching position went into what they referred to as “survival mode”. While experiencing the survival mode, participants coped by focusing their energy and attention primarily on *their personal learning needs* rather than those of their students. One neophyte clinical teacher recalled phase one, “It was all about me. And, the student success or failure or the program, I don’t recall it entering into it [sic]. Simply, how was I going to survive”. In addition, participants survived their new experience by relying primarily on their *self-confidence* as clinicians.

Participants' learning needs were individualistic in nature. Successful resolution of participants' own learning need(s) boosted their *self-confidence* as clinical teachers. Three strategies to address participants' learning needs included *developing abilities as a clinical teacher, gaining awareness about clinical teaching, and dealing with anxieties*. In phase one, support and repeated exposure to various teaching situations served as *facilitative threads*. To attain of certain degree of competence in phase one, the confidence building activities needed to occur before participants could shift their focus to students' learning. Building confidence became an outcome of phase one and a necessary condition for the occurrence of phase two. Another condition for the resolution of the first phase was participants need to *figure out* what was expected of students given the clinical course requirements.

Developing Abilities as a Clinical Teacher

Developing one's abilities as a clinical teacher required participants to acquire the knowledge, skills, attitudes, and judgements associated with clinical teaching. This strategy was used by all participants who had no previous experience as clinical teachers (also referred to as neophytes) or had their teaching assignment changed (e.g., clinical agency, level of student, or substantive practice area). The experiences of participants being reassigned to a new area of teaching will be discussed in a later portion of this chapter.

Participants dedicated a substantial amount of time towards building their expertise in the area of nursing practice where they were assigned to teach. Participants took a self-inventory to determine their learning needs. This critical evaluation included assessing their strengths and limitations regarding *nursing knowledge* – theoretical and practical – as it related to the clinical course and the level of student being taught. One participant's comments reflected the need that many other participants concurred with:

What I would try to do when I first started teaching was know all the nice to knows, need to knows and even the don't need to knows. And then it changed, probably I accessed the people I needed, I accessed the resources I needed.

Clinical teachers often expressed how it seemed like they were always trying to keep one step ahead of the students. In fact, some teachers became overwhelmed with the perception that they needed to know everything. For this participant, phase one meant that it was "getting past the point of knowing that it is okay to look up something when I need to".

Participants engaged in various activities to develop their *knowledge* and *self-confidence* in the substantive area by orientating to the clinical agency, engaging in nursing practice, reading textbooks and periodicals, attending workshops, reviewing the course syllabus, and conversing with other clinical teachers. Participants believed that the most significant factor that contributed to being a competent clinical teacher was having a solid grounding in the fundamentals of nursing practice. In phase one, clinical teachers relied on the fundamentals of *nursing knowledge* versus applying specific teaching and learning theory. The following two comments were typical of most participants' experiences "[In the beginning] I was certainly confident in my practice skills, and I knew my theory backwards and forwards". "I think probably at the beginning you rely... more that you are an expert nurse".

In addition to participants relying on the fundamentals of nursing knowledge, *dealing with their own learning needs* was also grounded in their experience in nursing practice. Nursing practice was identified as a prerequisite to becoming a self-confident and competent clinical teacher. Many participants clearly identified that a competent clinical teacher was someone who was, first and foremost, a competent clinician. To ensure clinical competence, teachers *engaged in nursing practice*.

Engaging in nursing practice occurred prior to or during the participants' clinical teaching activities. This activity was identified by participants as serving three purposes.

First, clinical competence allowed participants to build the *self-confidence* to succeed as clinical teachers. This belief was substantiated by the fact that nursing is a practice-based profession and as such, those who teach need to have a strong grounding in current clinical practice. Second, *engaging in nursing practice* allowed clinical teachers to access a frame of reference by which to create learning opportunities for students and evaluate student performances. Third, practice-based nursing activities contributed to participants' credibility as clinical teachers.

In summary, *identifying knowledge requirements* and *engaging in nursing practice* fulfilled participants' learning needs, built expertise and credibility, and promoted *self-confidence*. Some clinical teachers did not *develop self-confidence* until they learned more about clinical teaching. Learning about clinical teaching was another strategy used by all participants to make sense of what was required of them as clinical teachers.

Gaining Awareness about Clinical Teaching

Gaining awareness about clinical teaching was another strategy used in the first phase of *dealing with self learning needs*. Many participants began clinical teaching by emulating teaching behaviors they had observed as students. As participants continued teaching they gradually *figured out* the meaning of the clinical course. As this discovery was made, participants then determined the specific knowledge, skill, attitudes, and judgements required of them. As a neophyte clinical teacher, one participant recalled her experiences in gaining awareness:

One of the analogies I used for last semester was navigating a black hole because there is a structure of things but it's like there's nothing to find. So, your out there, you know your supposed to be teaching clinical skills, but, so okay what does that mean and how do you know what the student can do and can't do and how do you know what they've done and haven't done and so I just, it took a long time to be able to sort those things out.

During the period of gaining awareness about clinical teaching, some common areas of concern to participants were adjusting to the idiosyncrasies of the role, establishing student-teacher relationships, and evaluating students' performances.

Adjusting to the Idiosyncrasies of the Role. For many participants to be successful in phase one, they needed to go through the process of challenging preconceived views they held about clinical teaching. This process was achieved through questioning one's behaviors and the experience of actually teaching. During this process, participants spent a great deal of time (a) figuring things out by themselves, (b) paying attention to cues, and (c) pondering how their actions could be altered for subsequent teaching experiences.

Participants noted that as neophyte clinical teachers they regimented the students experiences in the clinical setting based on what *they thought* the student needed most: "I have a need that you [the students] do every single psychomotor skill on this unit". Clinical teachers went through a period of *figuring it out* to determine which clinical experiences the students needed to meet the required course objectives. One participant recalled dealing with this issue: "If they [students] are more involved with that patient and her baby in terms of supporting her breastfeeding should I haul her away to hang an IV medication... just for the experience?" Neophyte clinical teachers tried to do everything, be everywhere, and do all tasks. One participant said "I just stretched myself way too thin... and then my anxiety increased and their [the students] anxiety increased.... It wasn't a very good experience for any of us actually".

Establishing Student-Teacher Relationships. Part of the process of *figuring it out* was determining how to establish relationships with students. Most struggles associated with building relationships related to determining the nature of the student-teacher boundaries. This participant recalled her realization about this issue:

When I first started teaching, with one group of students, it was way too social. It was actually one of the nurses on the ward that said 'you know these are not your friends.' And I thought, oh ya right.... they were getting away with murder.

While the opinions on "boundary" issues varied among the participants, they did agree there was a need to base relationships on mutual respect and caring. Reaching tentative conclusions about the *student-teacher relationship* became a means of *gaining awareness about clinical teaching*. Additional issues associated with student-teacher boundaries were associated with incompetence. These concerns will be addressed in the latter portion of this chapter.

Evaluating Student Performance. Another component of *gaining awareness about clinical teaching* was becoming cognizant about *evaluation of student performance*. During the beginning of phase one, participants were uncertain about the "hows" and "whys" of evaluation. *Evaluation* was viewed as a task versus a process coinciding with learning. The participants' inability to evaluate students was primarily attributed to their lack of knowledge regarding the level of student and the outcomes expected of the particular clinical experience. All participants concurred with this clinical teacher's rendition of evaluating students:

Initially...you're kind of in a...fog...because you are evaluating and...you are not sure what you are seeing. You have a gut reaction that perhaps it is not what you should be seeing, but you are just not sure how to categorize that according to...an evaluation form.

In other words, the participants believed that as neophytes they did not know enough about evaluation and thus lacked the *self-confidence* to trust their judgment of the students' performances. Furthermore, participants expressed the need to develop insight into the level of student performance required during the clinical rotation. This step was crucial for the progression to phase two. Then in phase two, the clinical teachers could determine what was expected of the students for their progression through the clinical course. Another clinical teacher recalled her experience with evaluation as follows:

The bottom line that I am the person who decides whether or not this person passes or fails - it's a reality. So one of the big things that I know I really went through was how do I judge people who are in nursing? How do I judge that... behavior? Why do I judge that?, and how much do I understand where these judgments are coming from?

To deal with these uncertainties, participants required support from other experienced clinical teachers. This support served as reinforcement for their interpretations of student behaviors. Because of the unfamiliarity with evaluation, participants found dealing with borderline students to be problematic and anxiety provoking. In fact, a few participants recall avoiding these students as much as possible.

In sum, all clinical teachers implemented various activities to *gain an awareness of about clinical teaching* which led to the beginning of an appreciation for the complexities of clinical teaching (e.g., developing student-teacher relationships and evaluation).

Participants who understood the roles and responsibilities associated with clinical teaching experienced a sense of comfort and *self-confidence*. However, to develop the degree of *self-confidence* needed to progress to phase two, these clinical teachers need to move beyond *knowing about clinical teaching* and reconcile their *feelings of anxiety*. In fact, participants stated that unaddressed anxieties hampered their progression into phase two.

Dealing With Anxieties

All of the participants' narratives included detailed information about the *anxieties* they experienced and the strategies they used to deal with these stressors. The anxieties were most evident among participants who were adjusting (a) to the clinical teacher role or (b) to a new teaching assignment (i.e., course, level of student, agency, curriculum change, or substantive area of practice). Perceptions of these anxiety-producing stressors varied in both source and degree among the participants. Anxieties might also have been associated with phase two or three; however, the recollection of these anxieties, as recalled by participants, were predominant in phase one.

Participants who recalled being a neophyte clinical teacher attributed their *anxiety* to the lack of awareness about the scope of clinical teaching. Most of these anxieties could be classified as those relating to the environment, the teacher, and the student. As neophyte clinical teachers, many participants were anxious about not knowing how to teach. These feelings contributing to teaching anxieties were explained by one participant as "It was really difficult to come from being an expert nurse to being a novice teacher. It was like starting all over again". Other participants explained similar feelings. For example, they said "I [felt like I] needed to know everything and I ... didn't so I was really nervous"; "I [wanted] to do such a good job"; "It is really hard when you have 7 or 8 students...you feel like you are so responsible for them"; "I was absolutely terrified that the students would kill somebody, or cause a problem or make a mistake that would reflect badly on me or more importantly harm the patient"; "My anxiety arose from not knowing how to do it [teaching]"; "The other place that ... is anxiety producing is group dynamics and how to facilitate that conversation and having people feel comfortable and open and talking"; and "I didn't sleep before clinical ... wondering about what was going to happen and how could I manage it".

The sources of *anxiety* differed for participants, therefore, each employed various strategies to cope. One common strategy used by participants to minimize, and to eventually overcome, these anxieties was to ask questions. The participants questioned their own practice decisions, they asked questions of more experienced clinical teachers, and then asked questions of students. Other common strategies expressed by participants for dealing with anxieties included orientating to the clinical agency, establishing credibility, and learning to trust the students. Many participants were able to resolve their trust issues once they realized the students were capable of providing safe, competent care. This realization was often achieved by the end of phase one.

Orientating to the Clinical Agency. Participants agreed that spending time *orientating to the clinical agency*, prior to the arrival of the students, had several benefits. For many participants, orientating to the clinical agency was a means of identifying appropriate learning experiences for students and familiarizing themselves with the routines, rituals, and idiosyncrasies of agencies.

What you're learning when you go, there to go to the unit, ... is to find how they do things on that unit To know, on this ward, this is where they write, you know this is where they hide this, this is how they want you to organize your day, ... these are the rules. Just to actually get a bit of a grounding and the unwritten rules of the ward and getting to know the nurses on the unit a little bit and getting [to know] the routines.

A few teachers were initially unclear as to why teachers should make contact with the agency. This participant recalled her first experience as a clinical teacher, "I mean it was sort of like 'well you have to go make contact on the ward' and its like oh okay, so like what all are we supposed to be doing out there?". In retrospect, participants became aware of other benefits of orientating to the clinical agency: (a) being perceived as clinically competent and credible as clinicians; (b) identifying key personnel; and (c) building positive working relationships with agency staff. Although the exact length of time and nature of the activities associated with orientation varied among the participants the final outcome was greater *self-confidence* as clinical teachers.

Establishing Credibility. Participants also experienced the need to *establish credibility* – first, as a clinician and second, as a teacher. A fear of not being seen as credible was perceived as a hidden source of anxiety experienced by participants; however, it was essential to establishing professional working relationships with the agency staff (primarily other nurses). One participant summarized the importance of credibility, "They want to know can you [*sic*] practice ... it was establishing the fact that I am a practicing nurse and that I know how to nurse". Participants who sensed that the agency staff saw them as credible expressed a sense of comfort. This sense of comfort then heightened their

self-confidence and *competence* as clinical teachers. While *establishing credibility* was not viewed by all participants as an essential condition to growth as a clinical teacher, they did find that it gave them "one less thing to worry about". This realization was beneficial because it allowed the participants to focus their attention on their students' learning needs.

Summary

During the journey through phase one, clinical teachers implemented three strategies to *deal with their learning needs*. *Developing one's abilities as a clinical teacher* was as important as *gaining awareness about clinical teaching*. The data suggested that being competent as clinicians provided the foundation by which participants could then move towards understanding the roles and responsibilities associated with clinical teaching. Clinical teachers also developed a mental image of what was expected of them and students within a given clinical course. This development was a requirement necessary for the second phase. As participants became more knowledgeable of the clinical teacher role they experienced heightened *self-confidence* in their abilities as clinical teachers. This *self-confidence* was a necessary tool for helping new teachers deal with their anxieties. *Dealing with the anxieties* associated with clinical teaching (e.g., unfamiliar clinical area, credibility, and trust) was paramount to the attainment of *competence* as a teacher. Moreover, the threads facilitating the first phase of this process included collegial support and a consistent teaching assignment. In summary, clinical teachers described a process of developing enough *self-confidence* to enable them *to deal with their learning needs* and *advance to building their teaching style*. They continued through the *process of maturing as competent clinical teachers* by progressing to the second phase, *building one's teaching style*, which will be described next.

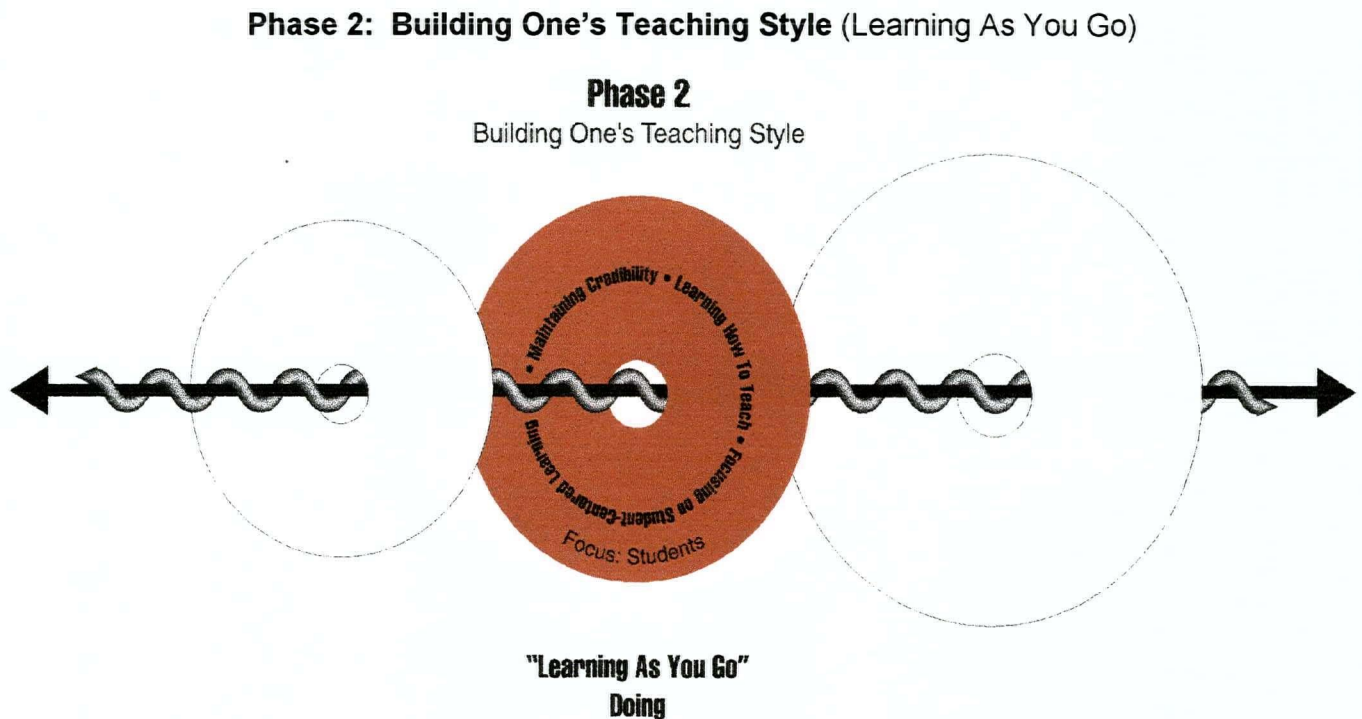


Figure 4. Phase two of the maturation process.

At the end of phase one, clinical teachers developed *self-confidence* in “knowing” about clinical teaching. This *self-confidence* was a necessary condition for *building one's teaching style*; that is, for “doing” clinical teaching (Figure 4). The most significant component of this phase was the metamorphosis that participants went through to develop their teaching style. This transition was assisted by three strategies: *maintaining credibility*; *learning how to teach*; and *focusing on student-centered learning*. According to the participants, a prerequisite to implementing the three strategies was the awareness about what was expected of students to progress in the clinical course.

All participants used three strategies to build a repertoire of teaching methods to promote student learning and indirectly ensure client safety. Thus, the driving force for participants became the students' needs – with the assumption that the clients' needs were also being met. One participant explained the difference between phase one and phase two as, “Phase one is most likely about you, your movement away from ... bedside nursing to a

different type of role, your competency Phase two is about being interested in ... students and wanting their success”.

The three strategies that participants used in phase two enabled clinical teachers to develop their teaching style. This resulted in an increase in the clinical teachers' *self-confidence*. An enhanced *self-confidence* then promoted an environment for the continuation of the *process of maturing as a competent clinical teacher*. As well, having support and engaging in reflective thinking were *facilitative threads* that affected both the core category of developing *self-confidence*, and the characteristic of *competence* as clinical teachers. An additional requirement for progression to phase three was a sense of commitment and dedication to advance the substantive area of clinical teaching.

Maintaining Credibility

Since the primary focus of phase two was the students, participants dedicated only a limited amount of time to *maintaining the credibility* they established for themselves in phase one. Participants used the same techniques in phase two to maintain credibility; they continuously orientated themselves with the clinical agency, developed positive working relationships, and demonstrated their abilities as clinicians. The participants' believed that student learning was hampered when they did not maintain their clinical competence and credibility. Thus, *maintaining credibility* became a foundation for establishing a context in which the students' learning could occur. Being seen as credible also became a mechanism used by participants to foster camaraderie and develop respectful working relationships with the agency staff.

These relationships with the staff are vital for me for many reasons. One is the acceptance of the students, but also because ... [of] my situation ..., I had ten students on four wards, okay, so they were on two floors, but four wards.... So I couldn't be everywhere and ... you know when you don't really know these students what do you do? ... So that building of the relationships with the staff was vital because they were the people who were there, they became my eyes and ears and my hands.

The primary outcome of *maintaining credibility* was that it allowed participants to focus their energy on individualizing students' learning, achieving the course objectives for the clinical rotation, and ensuring quality client care. *Maintaining credibility* also provided the foundation for achieving the other two strategies: *learning how to teach* and *focusing on student-centered learning*.

Participants discussed how *maintaining credibility* (e.g., theoretical knowledge and nursing practice) helped to create an environment to support student learning. This clinical teacher discussed the importance of nursing practice in this manner:

You don't need to know every frigging policy ... or things like that, that's part of the on the job learning curve. But, if you don't know how to do an assessment and you don't know the population base, then how do you teach your student? I don't think teachers need to be experts in the, totally in the subject matter, but I think that they have to have some foundational knowledge in order to teach.

Participants engaged in a wide variety of activities to maintain credibility. Some of these activities were reading journals, attending conferences, assisting with laboratory teaching, and engaging in nursing practice either in a clinical agency where participants were teaching students or elsewhere. These activities resulted in participants' abilities to keep current with nursing practice and teacher practice. Continuing to *engage in nursing practice* as a means of maintaining clinical competence was seen as the most important component of *maintaining credibility*.

Maintaining credibility not only contributed to participants' abilities as clinicians (i.e., clinical competence) but also facilitated their ability to *learn how to teach*. Stated another way, maintaining credibility allowed clinical teachers to (a) define expectations of students, (b) facilitate instructor organization, (c) modify teaching strategies (e.g., role modeling), (d) select clients, (e) create learning opportunities for students, and (f) build and maintain existing working relationships with agency staff (e.g., public relations). Thus, the purpose of *maintaining credibility*, as identified by participants, was much broader than in phase one.

Credibility became a means by which participants developed *self-confidence* in their nursing practice and clinical teaching. Being perceived as *credible* and *self-confident* helped clinical teachers to *develop their teaching style* and facilitate student learning.

Learning How To Teach

The second strategy, *learning how to teach*, was interrelated with the third strategy of *focusing on student-centered learning*. In order for participants to develop their own teaching style they also needed to determine the essential components of clinical teaching (e.g., understanding the student, facilitating student learning, giving feedback, and evaluating students). Thus, the second strategy referred to the activities used by participants to learn how to teach while the third strategy identified the activities that clinical teachers used to promote student-centered learning. These strategies occurred simultaneously.

Learning to teach was primarily concerned with challenging old assumptions and discovering new alternatives. Neophyte clinical teachers began teaching by emulating behaviors of clinical teachers they had as students. Participants in phase one also spent a great deal of time observing and questioning other clinical teachers. With successful completion of phase one, participants developed enough *self-confidence* to venture towards the challenges of the second phase – to implement, test, revise, and refine their own methods of teaching.

Through the process of trial and error, participants adopted a series of approaches *to learn how to teach*; these included: evaluation and feedback (e.g., self, colleagues, students, and formal performance appraisals), reflection (e.g., introspection and review), observation (e.g., other clinical teachers and student responses), discussion (e.g., with a supportive mentor or role model), education (e.g., undergraduate and graduate studies in

nursing), and examination of the research literature. One common link among these approaches was the necessity of participants to engage in some method of critical self-appraisal. Regardless of the means of appraising (e.g., self-evaluation, reflection, or dialoging with others), participants needed to evaluate their abilities as clinical teachers.

I think it is thinking about my experience, reflecting on my experience and learning from that, whatever that experience might be. It might be being on the ward with students looking after the patients or it could be reading something ... You can't learn from your experience ... unless you think about it and relate it to your past and your future.

When "self-appraisal" did not occur, participants did not further develop their teaching style nor did they advance to the next degree of *competence* as clinical teachers. Collegial support during the appraisal period served to be beneficial in providing an environment to augment participants' *self-confidence*. Continuing education was another facilitative thread mentioned by some participants as a means of learning how to teach.

Participants also expressed *time* as an essential component of *learning how to teach*. *Time* simply referred to the period of time necessary for personal growth to occur. *Time* also allowed for repeated exposure to a breadth of clinical teaching experiences. One participant identified how time influenced her awareness, "When you first start teaching you think you know more than you do and it is not until you get experience you realize [what] you don't really know". Not only did participants need to have exposure to various situations but they also needed to encounter successful outcomes. Experiencing successful outcomes was critical because it was another means for developing *self-confidence*.

In addition to the importance of time in developing self-confidence, the data also revealed the participants' ability to have insight into and be willing to change their behavior (i.e., reflection). This insight and willingness helped participants to continue learning from their experiences and adjust their teaching styles according to changing circumstances and variables. Participants then began to develop a sense of which particular teaching strategy

worked best for a given situation. This participant provided a vivid recollection of this process:

Time is a really big factor ... you get the exposure that you need. You run into situations more often than once. You have an opportunity to see how you deal with them and you have a chance to look at an evaluation of that to see whether that was a good outcome or a not so good outcome and whether you need to improve on, change [sic] that the next time. So that, once you have some experiences with it, it makes it a lot easier and that comes with time.

Although several participants in the first phase considered their behaviors to be somewhat inappropriate, it was not until the second phase that participants felt *self-confident* enough to address the need for change and enact on suitable methods for change.

I have always reflected, but I have not always acted on that reflection and I guess that is based on your level of...feeling comfortable with yourself. Yeah...when I first started teaching...I wouldn't act on it because I felt I had to know everything.... Now I don't feel I have to know everything and...there is no way I can know everything and so I...will go back and re-visit that [event].

Focusing on Student-Centered Learning

Dealing with the components of the *students' learning process* coincided with the previous strategy *learning to teach*. Although the *learning process* was a concern with other phases, it seemed to be a predominant theme in phase two. One clinical teacher summarized her shift in thinking while teaching students on a labor and delivery unit:

I think before I was interested ... in getting the students deliveries [sic], thinking that was what they would need. What I have come to realize now is...about the process of learning and applying what you can learn in one situation. So, more the principles of learning and [how] to move it to another situation.

Because participants had dealt with their anxieties and uncertainties associated with phase one, they were better equipped to focus on *student learning processes* in phase two.

Participants emphasized four components of the *learning process*: understanding the student, facilitating student learning, giving feedback, and evaluating students. With repeated exposure to the components of the learning process, participants enhanced their abilities as clinical teachers (i.e., knowledge, skill, attitude, and judgement). Second,

exposure positively affected their *self-confidence*. Third, as the participants' *self-confidence* increased so did their *competence*. Being competent clinical teachers in phase two resulted in increased student learning, client safety, and fulfillment of the clinical teacher role. Focusing on student learning involved knowing the student, facilitating student learning, giving feedback, and evaluating students.

Knowing the Student. To successfully develop student-teacher relationships participants identified the need to shift their perspectives and attitudes towards students. Participants in phase one confronted issues relating to student-teacher boundaries. Participants in phase two further refined these boundaries; however, they also needed to *understand the student* from the student's perspective. Participants in phase two realized that students are individuals who have unique learning needs, styles, and interests. This participant recalled her thoughts on why teachers need to understand students:

At level two ... they [students] need to understand why they are doing things and take it a bit slower. They need to learn to do a good job with the hands on stuff, but I think they could take more time to make sure they know why they are doing what they are doing I think maybe I value the "understanding". I know that the students have taught me over the years a better notion at where they are at and how I think how they need to move to become a competent practitioner. I think I used to make some assumptions about how quickly they could pick things up and how simple things are when they are not simple at all.

Many participants found when they understood the students they were better able to *facilitate the students' learning*. Participants enlisted several types of activities to gain an understanding of students (e.g., pre-clinical interviews, informal meetings with the student, observation of behaviors, and retrospection). At the end of the second phase, some participants viewed the learner first, as an individual first and second, as a student. Other participants did not experience this realization until phase three. As a new clinical teacher, this participant was unsure how to manage students. She discussed how her abilities changed as her competence increased:

Well the way I would go into a situation, I would spend some time discussing the situation with the student. Then I would review, reflect on that once I finished and I would think to myself, "oh, boy, I didn't handle those points or I didn't handle that situation very well," and part of it was ... I did not feel very competent in my abilities to handle students but I had to start somewhere to learn about them. And now when I go into a situation ... I feel more competent So it changed from being unsure about myself and moving into [feeling] competent.

As the degree of *self-confidence* and *competence* increased so too did participants' abilities to understand individual students. One factor that facilitated the understanding of students was longer clinical rotations for a given clinical course. In other words, during longer clinical rotations, participants' gained more time to *understand students* and build student-teacher relationships.

To further develop an *understanding of students*, participants talked about how *trust* and *tolerance* of students was necessary. For example, when clinical teachers did not convey some degree of *trust* in students' abilities they also did not provide students with adequate opportunities to become independent practitioners. Simply put, participants needed to "let go" and trust students in order to facilitate learning. Furthermore, clinical teachers needed to become *tolerant* of various student behaviors. In phase one, participants stated they often overreacted to certain student behaviors. This teacher explained, "I remember reaming out a student simply because she kept saying 'okay'." Another participant found herself reacting to students negatively because she did not like some of them, "I would interact with them on ... an annoyed level, we would find a place where we disagreed and then I was as sad as they were at times ... that was silly but I think that was part of my growth and development". Being patient and identifying with the students' perspectives (i.e., empathetic) became a virtue necessary for knowing individual students and a co-condition for *facilitating student learning*.

Facilitating Student Learning. As participants became more experienced with the intricacies of clinical teaching, they struck a balance between the students' needs and the application of the principles of teaching and learning. Because clinical teachers had *self-confidence* in their nursing practice (i.e., clinical competence) this allowed them time to build a repertoire of teaching methods which would facilitate learning in a given context (e.g., level of student). This participant recalled how her ability to facilitate student learning had changed:

As a novice, just not being aware of the type of clinical experiences that I could hook the students into I was ... wanting to make sure they understood the right answer about ... the specific thing I was asking them. Whereas now I am more interested in not only the answer but also how their thought process goes. So I think it is a whole maturation that has occurred more in my ability to bring it out of them than their ability to do it.

Matching one's teaching style with the students' needs and course requirements became an effective means of presenting students with a variety of relevant learning opportunities.

Participants identified various teaching strategies used in the second phase to *facilitate student learning*. Two examples of these strategies are *patterning information* and *role modeling*. A common teaching strategy discussed among several participants was the ability to *pattern information* in such a way that it was useful, understandable, and memorable to students. This was accomplished by breaking learning tasks into manageable pieces or smaller parts. The ability to simplify tasks into smaller steps was viewed by many participants as a strategy used by experienced and competent clinical teachers. This clinical teacher spoke about how she simplified tasks for students during their first clinical experience:

I particularly break it down in deciding how much to give them in terms of their assignment I ... selected the patients very carefully so that I know they can all communicate So it is broken down so that they only have to talk and meet the patient for the first time. And then the next time it is the hygienic care, it is the mouth care, the bath, the bed So, I break down what they are doing by only giving them so much and by doing very careful patient selection ... [it] requires a lot of judgement and experience on the part of the teacher.

Another strategy used by all clinical teachers was *role modeling*. Clinical teachers modeled appropriate professional nursing behaviors to students. The teachers' intent was to encourage professional nursing behaviors among the students. While clinical teachers in phase one may have used *role modeling*, it became a more purposeful behavior in phase two and three. In phase two, participants primarily focused on yet another component of the learning process, which included student evaluation (i.e., summative and formative).

Giving Feedback. The data revealed that participants lacking *self-confidence* in their abilities as clinical teachers had a tendency to be either uncomfortable in giving or incapable of providing constructive feedback to students. Participants who were uncomfortable with providing feedback were more prone to focusing solely on either negative or positive behaviors. Participants postulated that this inability to provide feedback was primarily due to their lack of *self-confidence* regarding their knowledge about how and when to give feedback. This participant explained how her abilities to give feedback changed:

I went so much on my own background and training. I gave a lot more negative feedback and not enough positive, not intentionally, but ... it's much easier to see where somebody goes wrong than to sit down and say okay what did they really do that was really good or positive. So, as I went on I had to learn to be more positive and to focus on the things that were really important rather than what they [the students] weren't doing.

It was also difficult for clinical teachers to ascertain when the students needed feedback. This was further complicated particularly when participants were unsure about what was expected of the students. Thus, the precursor to offering feedback was identifying the level of clinical expectations to be achieved and then conveying these expectations to students in a clear fashion at the beginning of the semester. Participants found having strong communication skills to be an essential component in developing their abilities to offer constructive feedback and thus assist and support student learning. Therefore, as

participants developed professional *self-confidence*, their abilities to provide constructive feedback improved.

Usually by phase two, if not earlier, participants had enough *self-confidence* to provide constructive feedback. Participants often followed one method for giving feedback to all students. As the participants' *self-confidence* and *competence* grew, the clinical teachers began to individualize their feedback methods to meet the needs of individual students. For example, this clinical teacher commented on what she had learned over the years in terms of giving feedback, "It is better just to give it, say it right out and get it out on the table and then work with it there. I try to be a bit careful about when I give it and how I give it, but I am always clear". A larger component of giving feedback was evaluating students in the context of achieving the course objectives.

Evaluating Students. Through trial and error, participants developed a greater sense of understanding about "how to" interpret student performance. As clinical teachers developed their abilities as evaluators, they reported being knowledgeable of and proficient with the process. Participants also identified that through their lived experiences they encountered repeated exposure to a breadth of students. From these experiences they developed a mental image of acceptable student expectations given the course requirements and the level of the student group. They became *self-confident* in trusting their judgement for identifying, interpreting, and diagnosing student behaviors. This was something participants in phase one struggled with.

It seems when I first began teaching I thought they [students] were all just great and I was doing a great job and it wasn't until I was in it longer that I realized that I was really lacking in this whole evaluative thing. I was seeing what I wanted to see rather than truly looking at them [students] with ... a more critical eye ... I was ... rubber stamping them all ... unless it was very blatant I would pick it up [their lack of skill], but I let lots go by for sure.

Initially some participants reported being rule-bound by carefully following the evaluation guidelines as determined by the program. With experience, teachers developed

ways of relying on various sources of evidence to evaluate students (e.g., assessment tools, formative evaluations at the end of each clinical day, and discussions). A common theme for participants was their ability to eventually internalize the course objectives. When this internalization occurred, evaluation became second nature to the participants. This further substantiated and reinforced their intuitive abilities to evaluate their respective students.

Initial intuitive reactions experienced in phase one were now enacted upon in phase two. Clinical teachers were *self-confident* and *competent* enough to trust their interpretations and tentative conclusions about the students' behaviors and clinical abilities. One participant talked about her experience with intuitive feelings:

You move into another phase where you know what you are seeing and you are able to pinpoint it ... Then, I think you move into another phase where you ... have a gut feeling that they will be able to do it [pass the course]. Most of that is based on your ... intuition or your gut feeling as to what you see that student do and what you feel that their potential is.

Participants in phase two listened to their "gut reactions" and substantiated these feelings with ongoing observations and evaluative data. After developing *self-confidence* in evaluating "typical" student behaviors, participants stated that they began to initiate the development of their abilities in dealing with borderline students.

Summary

Implementing a combination of three strategies – *maintaining credibility*, *learning how to teach*, and *focusing on student-centered learning* – allowed participants to *develop their teaching style*. The first strategy, *maintaining credibility*, provided a foundation for which participants *learn how to teach*. In *learning how to teach*, a requirement of the participants was having the insight and willingness to critically appraise their own abilities. Self-evaluation and time to experience a breadth of student learning situations allowed clinical teachers to *learn how to teach* and further *develop self-confidence*. The third

strategy, *focusing on student-centered learning* required participants to develop a greater appreciation for students as individuals with unique needs and challenges. Intertwined in the three strategies were a series of activities that directly resulted in the building of relationships with students, agency staff, and other colleagues. For some participants, the building of relationships contributed to the development of their overall teaching style.

Through the implementation of the three strategies – combined with time, support, communication skills, and personality traits (e.g., willingness to learn and ability to reflect) – participants developed a repertoire of teaching abilities (e.g., knowledge, skill, attitude, and judgement) which combined to *develop their teaching style*. Subsequently, the *development of one's teaching style* resulted in higher degrees of *self-confidence* in participants' abilities as clinical teachers. This cyclical process between *developing a teaching style* and increasing self-confidence was necessary for clinical teachers to proceed with the *process of maturing as competent clinical teachers*. *Integrating the complexities* of the clinical teacher role became phase three of the maturation process.

Phase 3: Integrating the Complexities (Putting It All Together)

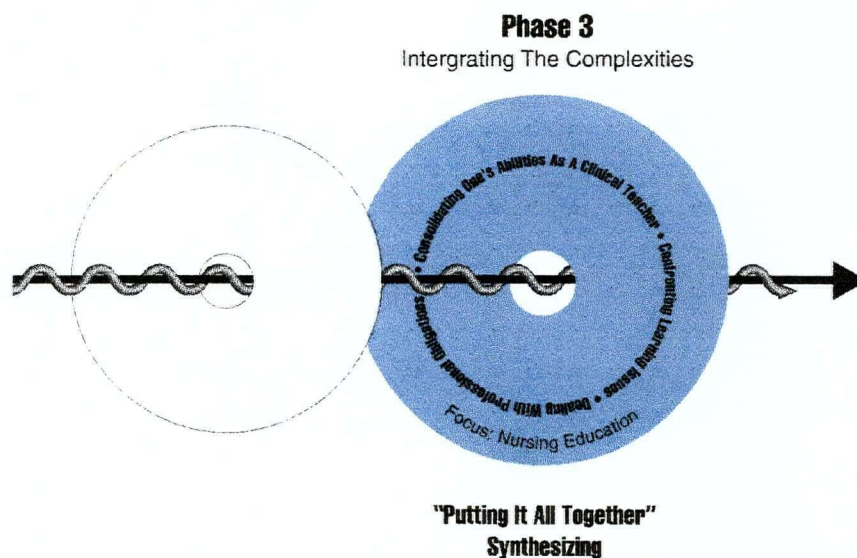


Figure 5. Phase three of the maturation process.

At the end of phase two, participants developed *self-confidence* and *competence* in “doing” clinical teaching. This provided a foundation for *synthesizing* the intricacies of clinical teaching. Participants in phase three perceived *competence* as a continual evolution of one’s “self” . Part of this evolution was the participants’ abilities to crystallize their conceptualization of clinical teaching in a broader context (i.e., bigger picture).

I know what the big picture is. I know what I want, what my end goal is and that is to have the best student and client experience possible. You know, that the student gets their best experience as well as the client has the best safe, psychological care they can and if I need to confront [sic] or I need to do the PR [sic] in order to get it Then, I think that is seeing the big picture as opposed to going for gratification for yourself in that you’re the clinical teacher and you’re seen as being very competent Then, you have to look at what is the better good for all.

A necessity for participants in phase three (Figure 5) was having this clear focus on the bigger picture of clinical teaching. Participants facing the challenges of phase three described themselves as clinical teachers with a spirit of inquiry, a willingness to change and take risks, and a commitment to clinical teaching. Armed with these capacities, participants dedicated time and energy to integrating the foundational components of clinical teaching in complex learning situations (e.g., variations in learning situations and learning styles, confrontational issues, and failing students). This integration of the participants’ clinical teaching abilities was directed towards the greatest good for all – the students, the client, the clinical agency, and the substantive area of clinical teaching. Factors that facilitated integration were identified as institutional support, effective communication skills, and involvement with additional curricular activities (e.g., curriculum development).

While all participants could identify with and speak about the first two phases of this process, fewer articulated the properties of phase three. Consequently, two themes emerged. First, participants identified that strategies developed previously (e.g., dealing with anxieties, sustaining credibility, and maintaining clinical competence) were an obvious

and ongoing part of phase three. Second, the final phase included three additional strategies: *consolidating one's abilities as a clinical teacher, confronting learning issues, and dealing with professional obligations*. For example, in order to facilitate student learning and preserve *self-confidence*, participants were cognizant of the need to sustain their credibility in the clinical agency. However, the amount of time and energy consumed by this strategy was, in comparison to phase one and two, less dominant in phase three.

No longer are the routines or the idiosyncrasies of the unit a challenge to my feeling of competence because I know that I know this area, have theoretical knowledge that is current and extensive. Students know that, the nurses know, ... and the head nurse knows me, not just as a clinical teacher but in a broader context.

This awareness, therefore, allowed clinical teachers to spend a greater amount of time focusing on the bigger picture of clinical teaching.

As the complexity of phase three increased so too did participants' inability to view the development of their competence as a linear event. As previously stated, strategies used in previous phases became interwoven components of the third phase. Participants describing the process of maturing considered an endless list of strategies to be used in clinical teaching. Consequently, the boundaries between phase two and three were not as distinct as the division between phases one and two or phase one and three. The outcome of phase three was a strong degree of *self-confidence* and *competence* as a clinical teacher. Because participants viewed the development of competence as a process, attainment of phase three was not an arrival at competence. Rather, phase three signaled continual maturation of the participants' abilities as clinical teachers. That is, participants continued to engage in lifelong learning activities that were directed toward maintenance of their *competence*. In addition, the context in which participants taught was never static. Thus, clinical teachers needed to develop *self-confidence* and *competence* to accompany the ongoing changes experienced in phase three.

Consolidating One's Abilities as a Clinical Teacher

Just as the participants' expertise as clinicians set the foundation for phase two, the *building of one's teaching style* became the foundation for phase three. The participants believed that a lack of a solid grounding in who they were as teachers (e.g., style, perspectives, philosophies) limited, if not prevented, their progression to phase three. In phase three participants used the three strategies identified in phase two; however, the strategies evolved to have more meaning attached to them. This interconnectedness between phases allowed participants *to consolidate their abilities as clinical teachers* so they could individualize students' learning.

It doesn't mean that you are so rigid that you take away the individuality and I think that [individualizing] is the real mark of an expert teacher. When we talk about the student that is an excellent ... above average student and the good student and the student that will struggle ... [to] achieve minimal level of competence, you know within that there are lots and lots of ways to individualize the students [learning].... I think that in the case of excellent teachers they keep in mind the reason why the course outline and the [ends in] views ... is because they should have meaning for the end product.

Participants identified that a *facilitative thread of consolidating one's abilities as a clinical teacher* was having varied experiences with diverse student populations. The outcome of this strategy was a continual development of the arsenal of teaching strategies that contributed to participants' teaching style. In addition, as participants developed *self-confidence* in their teaching abilities, they were assertive enough to *confront learning issues*. These two strategies had a complementary relationship. An increase in *self-confidence* with participants' teaching style affirmed their *self-confidence* to confront learning issues.

The strategy of consolidation primarily related to the participants having several realizations about teaching and learning. This realization was coined the "aha experience". The "aha experience" was categorized as the (a) perspective of learning (e.g., student and teacher) as a process rather than a product, (b) richness of the learning environment,

(c) management of relationships, and (d) importance of knowing the student. Through the process of *putting it all together*, participants conceptualized various concepts in a new way. Approaches used to consolidate one's clinical teaching abilities paralleled those identified in phase two as a means of learning how to teach (e.g., evaluation, reflection, discussion, education, and examination of the research literature).

Learning as a Process. The basic principles of teaching and learning developed by participants in phase two became the basis of refining their teaching methods to facilitate student learning. There was an "aha experience" where participants' realized that learning was viewed as a process rather than a product. One participant explained how she matured:

When I first went into teaching, ... because I had been at the bedside so much, ... I tended to want to get in there and do things I almost had to ... sit on my hands ... or, your know zip my mouth because I wanted to impart that knowledge. Now, I tend to stand back and if I think that ... the patient is going to get into any jeopardy or anything I will sort of step in So, I found that I ... over the years you learn to step back more and watch and give them feedback after, if it is not putting the patient in jeopardy.

Similar to experiences in phase two, participants realized that they needed to give up control over the student for learning to occur. Participants in phase three had a heightened sense of what were appropriate expectations of students in a given clinical course. These realizations facilitated participants' *self-confidence* in selecting learning experiences (i.e., clients and client situations) for students.

In phase three, client selection became an integral component of the learning process. Although participants in preceding phases were also concerned with client selection, the essence of this task became more apparent in phase three. Participants considered an array of variables when selecting clients for the students. These variables included: individual student abilities and interests, client characteristics, course

requirements, agency opportunities, and clinical teacher abilities. This participant described the variables she considered when selecting clients for senior nursing students:

I am looking at numbers of individuals they care for, acuity of individuals, perhaps organization as in a variety of kinds of individuals and then I want to make sure that over the course of a rotation that they have adequate numbers of patients and numbers of skills and so on. I try to make sure if people look at what I have done that I have, as much as possible, ... really had an opportunity to maximize their learning given what is available and they have all been treated equally.

This quotation reflects the thoughts of many participants. In fact, many participants agreed client selection involved a balance between the course objectives, the level of students, and the students' needs while at the same time ensuring the well-being of the clients.

For many participants, fostering learning also involved assisting students with "thinking" skills. Assisting students with their thinking skills was one way that participants fostered the learning process. For example, more attention was allocated to discussing client issues with students to help develop skills for higher levels of thinking (e.g., problem-solving and critical thinking). In addition to the development of higher levels of thinking, a few participants in phase three had adequate *self-confidence* to role model and encourage students to challenge the boundaries of nursing practice. Success in these activities further contributed to development of the participants' *self-confidence*.

The context of *learning as a process* also applied to clinical teachers. Participants realized that the *process of maturing as competent clinical teachers* required lifelong learning. One participant discussed her revelation on lifelong learning: "One [component] is the integration as you describe it and the other is the lifelong learning about the different teaching strategies, different environment We are never finished learning how to teach". The ability to engage in lifelong learning allowed for further development of *self-confidence* and the continuation of the *process of maturing as competent clinical teachers*. Activities of lifelong learning encompassed both changes in nursing practice and nursing education. A

complementary relationship between nursing practice and teacher expertise evolved from the data.

Richness of the Learning Environment. In addition to the realizations associated with the *learning process*, participants experiencing phase three also developed a greater understanding of the *richness of the learning environment* and the factors impinging on the environment (e.g., client demographics, changes in the clinical agency, changes to health services, and political influences). These two concepts were closely related in that the environment was a means to facilitate learning. This participant elaborated on this point:

As an expert teacher, you have knowledge of the concepts and the principles that you are trying to get across to the students in a very broad way. You are not orientating to unit X, you want them to be able to identify those themes, or those concepts or those [ends in] views and to transfer them across the health care perspective in a variety of different units and agencies I try to look at and use a variety of tools to help them assess what they need to know and help me to determine whether I am giving them the kinds of experience that will broaden their skills and abilities by the time they leave.

Participants with a broad perspective of clinical teaching utilized and encouraged multiple sources of learning in the clinical setting. The clinical teacher was no longer seen as the primary source of knowledge. As well, participants realized that some learning occurred regardless of the events planned by the teacher and that each student took something different away from each learning situation.

Knowing the Student. Another property of *consolidating one's ability as a clinical teacher was knowing the student*. The outcome of knowing the student was to facilitate the learning process by displaying empathy towards students. In addition to empathy, the ability to be considerate of and compassionate towards individual students (e.g., cultural, learning disability, and personal issues). While a similar strategy was used in phase two it was further refined in phase three. One outcome of *knowing the students* was the development of caring relationships between students and teachers. These relationships were based on mutual respect and trust. Demonstrating caring attitudes towards students also

encompassed the notion that the students' needs and interests changed with each clinical course.

As a means of *putting everything together*, participants tried to develop a sense of who the students were as individuals. To accomplish this goal, participants concentrated on the subtle cues given by each student (e.g., overwhelmed with a clinical assignment, learning difficulties, and cultural needs). This participant shared her thoughts about students: "I think I was more concerned [in the beginning]... about finding, you know, making sure the students got the ... technical kinds of things and now I am much more interested actually in students as individuals". Participants who were empathetic to students as individuals were more likely to have insight into the students' performances and behavior.

I think it's easier for me to see where the students are coming from because it is so overwhelming and they are so vulnerable and it is very traumatic So I try to tailor my teaching to their individual, where they are and where they are coming from.

In addition to the strategies used in the second phase to *understand the student*, participants in phase three engaged in both formal and informal activities. Some clinical teachers conducted formal *preclinical interviews* to develop a sense of who the students were on a professional level. Thus, participants thought they were better able to individualize instruction based on the personalities of each student in the larger context of the course requirements and agency opportunities. This participant recollects the purpose of preclinical interviews as follows:

One thing we do in preclinical interview is find out the mode of learning that students have - her learning style. I am interested also in some of their other real life experiences, like what type of job did they have before they came into nursing and what did they do during the summer. That tells me a lot about their maturity, the amount of work they do with the public, their completion skills, their resourcefulness, their industry and their self-esteem, ... there is a whole lot of other facts and also I like to know that, I just like to get to know them as a person and I think they probably appreciate that, too.

Additional methods of getting to know students included informal activities such as *working alongside students* and *informal discussions*. These activities also helped to build

professional student-teacher relationships and role model various aspects of nursing practice.

Confronting Learning Issues

The strategy of *confronting learning issues* emerged subtly at first. Many participants described difficult issues that they encountered. These issues were often ignored in phase one but confronted in phase three. In phase one, participants were not prepared with enough information about their role and therefore, they lacked the *self-confidence* to deal with learning issues. In phase two, participants may have identified learning issues; however, they did not always have the self-confidence to effectively deal with them. Although a few participants in phase two may of had the self-confidence to confront some learning issues, discussions of participants' abilities to deal with such issues was prominent in phase three. Participants in phase three, developed enough *self-confidence* in their abilities as *competent* clinical teachers to directly express their opinions. This strategy evolved into a more assertive stance depending on the participants' experience and *self-confidence* as a clinical teacher. This participant recalled her "aha experience":

I remember specifically when my "aha" came around it was a really bad clinical situation and after I spent about 3 hours doing PR stuff around, it was something the students ... were blamed [for] ... I remember thinking so this is what clinical teaching ... is all about ... just the feeling you have competence and confidence to go after it as opposed to before where I might have skirted the issue and I felt myself incompetent in those situations.

When dealing with a range of issues, participants considered what would be in the best interests of the student, the client, the agency staff, and the nursing profession. *Confronting learning issues* required participants to advocate for all students and to fairly evaluate borderline (or failing) students. Successful resolution of confrontational issues boosted participants' *self-confidence*. The participants' felt more *self-confidence* for dealing with conflict when they used assertive communication techniques with others (e.g., agency staff, students, and other clinical teachers). Participants involved with classroom teaching

and curriculum development stated that effective communication skills broadened their perspective of clinical teaching within the larger context of nursing education.

Advocating for Students. Central to participants' experiences with learning issues between students and other persons (e.g., clinical agency staff, clinical teachers, and clients) was the need to advocate for students. In many instances, the participants became the students' voice. Participants implemented various strategies for the purpose of becoming stronger advocates for students. For example, some clinical teachers dedicated time towards establishing new and maintaining existing positive working relationships with the agency staff. The participants viewed these relationships as essential when advocating for a broad spectrum of student learning experiences. This participant recalled advocating for students:

The other thing about the difficult situations is ... if you go back to the [example of] having the students in report. If you can speak to the unit manager ... and relate why it is important that the students to get that experience. If you can relate it to the reality of being a nurse, most times they hear you and then and then together you can problem solve effectively. I have done that with medications, I have done that with meeting rooms, I think we have all had experiences where ... it is just easier not to have them [students] there because it is just too many people and too much chaos, but that is not going to meet the objectives that we need to meet. So how can we work around this? What can we do? What protocol can we put in place? What communication needs to occur? ... So if you are a credible nurse ... and a credible teacher you can usually facilitate that in an environment.

Included in this participant's description of advocating for students was her goal to facilitate learning. Her rendition of advocating for students also outlines the importance of establishing and maintaining positive working relationships with agency staff with the intent of gaining the power to advocate for a broad spectrum of student learning experiences.

If you ... know that you are being ... given credit for what you know by the staff and they have some regard for you, then ... it's ... much easier to advocate for the students. I feel like I am a much better advocate for the students then I was in the past.

Participants in phase three reported a higher degree of *self-confidence* and *competence* in their abilities as clinical teachers. To them, this meant they were better able to advocate for students.

Evaluating Borderline Students. In addition to advocating for students, participants in phase three believed they had an obligation to deal with borderline students. This participant elaborated on her professional obligation:

I think there is student advocacy, I think that is so important, and yet at what point do you draw a line in the and say "I'm sorry this is not the right place for you at the right time. This is what support we can offer you to withdraw with dignity, but this is not a safe place for you to be".

By the end of phase two, participants had a handle on the "know how" of evaluating student performances. Furthermore, the participants believed that positive experiences in evaluating students heightened their development of *self-confidence* with the evaluation process. The difference for participants phase two and phase three was a further refinement of the evaluation process in phase three. Participants in phase three also believed that they had become more skilled with the evaluation process, particularly with decision-making and teacher judgement.

I can look much wider than ... in Phase 2. I see why this can't be ... taken lightly. I can look at the whole and their [students] functioning ... I can pull from my arsenal of my strategies and try them out to see if ... there is anything that would make a difference. I have less in my arsenal in the center [phase 2]. I may still make suggestions, but I have to struggle more with it and in this case, I mean it is still going to be a struggle, but the decision is clearer.

As well, participants revealed that they were much more capable of immediately assessing students as borderline. This participant revealed her focus about evaluating borderline students:

To diagnose it fairly quickly and to help the student have some insight into what that problem is Because ... I can tell them what the problem is ... but if they don't see it ... they are going to say, well I'll just "jump the hoops" for her.

Thus, participants dealing with borderline students placed more emphasis on assisting students to gain insight about their behavior (e.g., unsafe performance or inappropriate behaviors). As participants gained more experience for dealing with borderline students, they also gained more *self-confidence* in their skills for the “due process” of evaluation (e.g., identifying and delineating areas of concern, developing learning contract, and documenting observations) and for dealing with the appeal process. It was interesting to note that once clinical teachers informed students of borderline performance, participants’ focused more on gathering evidence to support their assessment than on the process of learning. To facilitate the evaluation process, participants also used advanced communication skills to assist students in gaining insight into their borderline performance.

Participants in phase three continued to build their repertoire of teaching methods for giving feedback, evaluating students, and generating remedial learning activities. Furthermore, participants had a greater intuitive sense of identifying whether students had the potential to succeed. As with phase two, intuition was one of many sources of evaluating students’ performances. An increased *self-confidence* in dealing with borderline students was often accompanied with a greater understanding of the institutional conditions influencing participants’ decisions to fail or not fail students. Participants also believed that their ability to assign failing grades to students was facilitated by having a supportive institutional environment (e.g., Chairperson or Dean).

Dealing with Professional Obligations

The second strategy, *confronting learning issues*, was interconnected to the third strategy, *dealing with professional obligations*. In order to effectively *confront learning issues*, participants also needed to have a greater sense of their obligations to the nursing profession. Thus, the third strategy of *professional obligations* provided a frame of reference by which participants identified the need to *confront learning issues*. The strategy of *dealing*

with professional obligations occurred through a variety of activities carried out by participants. The most common examples were (a) role modeling the profession to students, (b) role modeling clinical teaching, (c) supporting other clinical teachers, (d) failing students when necessary, and (e) maintaining clinical competence. Most participants' obligations to the nursing professional stemmed from their desire to ensure safe and competent client care. This participant summarized her professional obligations as a clinical teacher:

You have above average knowledge, you work in research, you are an innovator, you always trying to grow, you have clinical expertise, but it is not at the level of an expert nurse, there are trade offs here because you can't be doing both.

On the other hand, although participants had a professional obligation to clients, their role as clinical teachers also included capitalizing on a wide range of learning experiences for students within the larger context of the course requirements. Participants in phase three clearly recognized that clinical experiences contribute to nursing education. Clinical practice was valued for the richness and diversity it added to the educational experience.

Participants believed they had an ethical and moral obligation to themselves, the students, the clients, and the nursing profession to make an ongoing commitment to maintain their clinical competence. In other words, participants expressed a conscious need to maintain their standards of nursing practice. Participants experiencing phase three also demonstrated a tremendous sense of commitment to their students and to their own lifelong learning needs. This participant elaborated on her sense of commitment:

It is the part of you that makes you go to the library when you would rather be going for coffee. It is that part of you that wants you to make sure that you give the best you can to your students ... in the end that is where ... you feel like you have done a really good job. And I think that's ... passion, passion making.

This participant talked about time she dedicated to maintaining her nursing expertise: "It is important enough for me to do that ... I have two months off during the summer and I devote a month to working and a month off ... It is just too important to me not to do it".

In working with colleagues that were either new to clinical teaching or that were less experienced, participants believed that they had an obligation to support these and other clinical teachers. Some participants mentioned that clinical teachers in phase three would take on mentoring responsibilities. Often participants in phase three became sources of support (e.g., mentor, role model, and collegial support) to other clinical teachers experiencing a variety of phases.

Summary

The *self-confidence* developed in phases one and two allowed participants to progress to phase three. In phase three, participants were *integrating the complexities* of the clinical teaching role. Three intersecting, related strategies were used in the *process of maturing as a competent clinical teacher*. Strategies from phases one and two were a presumed part of phase three along with the three other strategies being: *consolidating one's abilities as a clinical teacher, confronting learning issue, and dealing with professional obligations*. As participants integrated these three strategies they experienced an "aha experience". During these experiences participants came to view their role in a different light. Upon entering clinical teaching, participants conceived clinical teaching as "simple". However, upon further examination of their competence as clinical teachers, they realized the complexity of clinical teaching. That is, the participants realized the necessity of integrating the complexities of clinical teaching into their daily activities as clinical teachers. The integration of the clinical teaching role was facilitated by the amount of institutional support, the utilization of advanced communication skills, and the involvement with additional curricular activities.

Germane to phase three was the recognition that clinical teaching competence development did not simply end at phase three. Even though participants had attained a high degree of *self-confidence* and *competence* by this phase, participants continued with

the maturation process as new contextual variables were introduced to their role. As new variables were introduced, participants mobilized a series of strategies to maintain and strengthen their *competence*. Hence, the maturational process of competence was both evolutionary and cyclical in nature.

Facilitative Threads

The process of clinical teacher maturation as depicted in Figure 1 (page 46), indicates that the three phases are joined together by two threads. The straight line, or *competence thread*, is surrounded by a spiraling line which is referred to as the *facilitative thread*. Movement along the *competence thread* (i.e., movement through the process of maturing to be competent clinical teachers) was determined by the presence or absence of the *facilitative thread*. Although only one *facilitative thread* is represented in the diagram, there are several facilitative factors that combined to constitute the *facilitative thread*.

The facilitative factors were any internal or external stimuli that, when present, prompted the occurrence of a phase or strategy within the *process of maturing as competent clinical teachers*. Not all facilitative factors applied to each phase or strategy. In addition, each respective participant experienced a variety of factors depending on their individual needs. In some instances the facilitative factors were as important as the strategies corresponding to each phase. The following discussion provides examples of common facilitative factors identified by participants; the examples include: support, familiarity with clinical agencies, stable teaching assignments, knowledge and education related to teaching and learning, personal qualities, communication abilities, and curricular involvement.

Support

Some form of *support* was required by participants to facilitate the transition among the three phases. Both the amount and type of support varied among the participants.

Types of support ranged from collegial group support (e.g., team meetings) to individual support (e.g., role models or mentors). Regardless of the type of support needed, additional requirements that needed to be met for the support to be effective were that the support provider(s) needed to be able to (a) relate to teaching; (b) share experiences both positive and negative; (c) listen; and (d) guide, support, and advise. In addition, support was more effective if it was provided in a safe environment. The various examples of support identified by participants included being orientated by their predecessors and being provided psychological support to deal with such matters as negative student-teacher experiences. One invaluable type of support identified by participants was some form of collegial support (e.g., mentor or role model). Collegial support was viewed as important because it contributed to the self-appraisal and reflection process required to accurately assess the participants' teaching abilities. In phase three, it was beneficial for clinical teachers facing difficult work situations (e.g., a student appealing a failing grade) to have institutional support. An additional source of support in all phases was that provided by the clinical agencies (e.g., cooperative agency staff). The support of these agencies demonstrated their commitment to the students' learning.

Familiarity with the Clinical Agencies

Being familiar with a clinical agency was also reported to promote the participants' *self-confidence* and *competence* in the clinical teacher role. For example, participants who were educated in hospital-based programs and then later taught in the same program and clinical agency expressed fewer feelings of anxiety and higher degrees of *self-confidence*. Analogously, participants who described the most *self-confidence* in their abilities as clinical teachers were those who had advanced education in a specialty area of nursing and then taught in this area in an agency where they had previously practiced. In both examples, participants were familiar with the clinical agency. This familiarity included having

successfully established professional relationships and demonstrated credibility. This point is significant since this familiarity further facilitated the development of *self-confidence* and *competence*.

Stable Teaching Assignments

Participants who described the most *competence* in their teaching abilities were those who had (a) a consistent teaching assignment (e.g., same level of student, same clinical agency, or same clinical course), (b) been assigned to teach a “familiar” substantive area of nursing practice, and (c) longer clinical rotations with students. Several participants concurred with this participant’s thoughts on the benefits of being assigned to one clinical agency for an extended period of time:

I think one of the key things is being in the clinical environment for a long time period ... because once you established yourself as a teacher in that setting and build a rapport with the staff ... and physicians the better our skills are because we are comfortable and the more learning there is for the student because the staff then reach out to the student.

Having a stable teaching environment allowed participants to focus more of their energies towards students versus themselves. Furthermore, participants having consistency in their teaching assignments experienced a sense of comfort. This participant expressed her thoughts regarding the importance of being familiar with the environment, “I think you gain confidence in a variety of ways, one is by experience, familiarity with the area, familiar with the context and the content of what your teaching and the environment you’re working in”. Thus, a comfortable environment encouraged further development of *self-confidence* and *credibility* – both factors contributed to the *process of maturing as competent clinical teachers*. Conversely, an unfamiliar environment delayed the maturation process of competence. This was not to say that clinical teachers should not be reassigned to other clinical courses. Rather participants in the first and second phases needed consistency in their teaching environment while participants in the third phase were more able to cope

competently with a reassignment of course. Participants in the third phase were more adaptable because they had developed their teaching style to a point where they had the *self-confidence* and *competence* to handle the uncertainties associated with changes to their teaching assignment.

Knowledge and Education

Participants who possessed theoretical knowledge in teaching and learning theory also reported fewer anxieties and more *self-confidence*. These participants believed that they progressed to phase two at a swifter pace because they did not have as many extraneous variables to deal with (in comparison to neophyte clinical teachers with no previous knowledge related to teaching and learning) when reassigned. Consequently, these participants were able to direct more energy towards developing their teaching style versus dealing with their learning needs. In addition, continuing education in any phases provided important opportunities for enhancing the participants' knowledge base and providing an environment for reflection. In phase three, continuing education became an integral part of the participants' commitment to lifelong learning.

Personal Qualities

The data also revealed that participants viewed some personal qualities as helpful for progression through the maturation process. Specifically, facilitative personal characteristics were cited as individuals with an outgoing personality, a sense of humor, a willingness to learn and to change, a personal desire to succeed, an ability to gain insight into their behaviors, a natural ability to reflect, an ability to challenge oneself, an attitude of commitment, and a spirit of inquiry. Participants who displayed these qualities believed they experienced a less traumatic journey in developing *competence*, particularly in both phase two and phase three. For example, this participant described how it was necessary for her to be willing to change:

[In the] second phase I would still be working on my teaching ... it would be hard for me to ... let go of my tried and true methods ... After all these years it is maybe easier for me to let go in some ways And to be competent yes, we do need to be willing to make change.

Many teachers discussed the quest for knowledge as being an important component of the process of maturing. This quest protected participants from complacency. According to one participant, complacency was detrimental to achieving higher degrees of competence:

Some times they [students] do test [you] and I think that for me I look at it as a way to increase my competence ... having [that] quest for knowledge. And it makes it much easier for me because I like that challenge so I can be the best that I can be But ... they are making me develop more as a teacher and that is one thing that I have always felt is that I can always learn more [about] A couple of times in my teaching in clinical I was quite complacent and I really got pulled up by my socks, not intentionally, by a student ... I realized that I had become complacent about things and I needed to get some joy back in my teaching and delve a little deeper in my competence so that I could make it more exciting for them [students].

Participants displaying the aforementioned personal qualities identified greater feelings of *self-confidence* and *competence* as clinical teachers.

Ability to Communicate

Although participants' communicative abilities were facilitative in all phases, their recollection of the importance of effective communication was emphasized in phase three. In other words, participants may have indirectly alluded to the use of their communication skills during the *process of maturing as competent clinical teachers*. However, in phase three the participants clearly recognized the significance of effective communication on all aspects of the maturation process. Specifically, the use of therapeutic communication techniques was discussed in the context of the triad of relationships (Figure 2, page 50). Sound communication skills were needed to build strong student-teacher relationships.

It really is important. You have to be able to communicate really diplomatically with the personnel that you're working with and of course with your students. You have to ... communicate your concerns to them [students] without putting them down.

In developing one's teaching style, effective communication techniques were tested as participants experimented with ways to articulate their expectations, provide feedback, and

cultivate student insight. This clinical teacher summarized her thoughts on competence and student-teacher communication:

I think ...it is absolutely vital, probably [in] two...or three ways. One, you have to be able to communicate clearly what ... you expect of students and you need to be consistent ... If you're saying one thing then what you do follows that through. I think you need to be consistent in the kind of feedback that you give students and the kind of support you give them, so there's the verbals and there's also the non-verbals and there's how you handle stressful situations There may appear to be less structure [to communication] ... but the purpose is clear.

As participants progressed through the three-phased process they developed further *self-confidence* and *competence* in their abilities to communicate effectively with students.

Curricular Involvement

Some participants in phase three mentioned that it was easier to *integrate the complexities* of their teaching role when they were either currently or previously involved with curriculum activities (e.g., curriculum development and classroom teaching). Being involved in such activities broadened participants' perspectives of nursing education, of which clinical teaching was a sub-component. At the same time, teaching in the classroom or laboratory setting reduced the theory-practice gap common to nursing education. Participants had more *self-confidence* in their abilities to integrate the theoretical content into the clinical setting. Being familiar with the theoretical content facilitated the development of their abilities as clinical teachers and thus the maturation process.

Summary

Participants identified seven external and internal environmental factors that facilitated the three phase of the *process of maturing as competent clinical teachers*. These factors commonly provided comfort to participants in the clinical teacher role. Furthermore, higher degrees of comfort fostered the development of the participants' *self-confidence* and *competence*. On the other hand, while the facilitative factors could account for some of the variations in the maturation process, additional forces appeared to influence the process.

Variations in the Process of Maturing as a Competent Clinical Teacher

The previous portion of this chapter presented a sketch of the three-phased maturation process. Although the process was presented in a linear context, in essence it was influenced by an endless number of variables. As new variables were added to the clinical teaching context, the phases and strategies unique to the maturation process unfolded in a unique and complex fashion. Typically, clinical teachers experiencing the process for the first time did so in a similar manner; that is, all experienced the three-phased process. However, at other points in time variations in the process occurred as a result of changes brought about by external forces (e.g., delegated by supervisor and imposed curriculum or program changes). In many of these situations, participants were faced with changes to their teaching assignment (e.g., a different clinical course, level of student, clinical agency, or substantive area of nursing practice). Regardless of the specific change, participants were placed in situations unfamiliar to them. In many instances, teachers could experience these variations in any phase. Then, as a general rule, participants would regress to a previous phase. After experiencing a change, the participants needed some time to focus on themselves before they could focus on their students. The most common variations in the maturation process were experienced during phase two and three.

In every phase, one of the main changes discussed by participants was reassignment to a new clinical agency. Moving to a different clinical agency was often accompanied with teaching a new clinical course and a different level of student. When participants were in phase two (i.e., developing one's teaching style) when this change was superimposed on their teaching, they reported a regression to phase one. These participants recalled their anxieties being related to issues of clinical competence and unfamiliarity with the context. For example, this participant recalled moving around at least two or three times a year. She said, "I would be at a new agency, didn't know the people,

didn't know ... the kinds of patients ... and I didn't know the students, so everything was unknown."

It was common for participants re-experiencing the uncertainties of phase one to cope by relying on their *self-confidence* and *competence* in their teaching abilities. In some instances they also relied on their abilities as clinicians. Thus, a complementary relationship was established between their teaching abilities and their clinical abilities.

Common to all participants re-experiencing phase one was their ability to adjust to the situation in a more manageable way. Participants were familiar with the difficulties associated with phase one. Therefore, they were able to more quickly mobilize the necessary strategies to deal with their learning needs. This participant shared her experience with changing to a new clinical agency: "It seems to go much faster and the anxiety isn't as much When I think ... back, I ... ended up knowing that I was ... a teacher, therefore I ... knew that I had the skills that I needed ... to learn about the area". This participant's experience paralleled others who were reassigned to teach in a new area:

I would have to orient myself to the new environment, both the physical and the psychological environment, but I would have a better idea of what cues to attend to, to move to the second [sic] and then adjust my teaching style based on the environment and the students.

To continue to progress forward in the maturation process participants mobilized previous strategies that had been beneficial in the past. Consequently, participants' *self-confidence* returned more quickly which then expedited the process of moving on into phase two.

To summarize, the data revealed that a disruption of participants' stable teaching environment resulted in some degree of regression in the participants' *self-confidence* and *competence*. Participants needed time to reapply coping strategies for various phases. The type of strategies used was dependent on the context and participants' self needs. In many instances where there was some type of change to the participants' teaching assignment, they needed time to become familiar with teaching in the new context, establish credibility,

and deal with anxieties. Successful resolution of the participants' learning needs boosted their *self-confidence* and *competence* as clinical teachers. This adjustment period allowed for their progression to subsequent phases. The pace at which participants progressed through the phases during a second exposure was faster in comparison to the first time they experienced this process.

Incompetence

During the three-phased process of developing competence, participants possessed various degrees of *competence* as well as having some experiences of *incompetence*. Participants described two types of *incompetence*: (a) *occasional incompetence* and (b) *overall incompetence*. Participants described *occasional incompetence* as a situation that happened irregularly or infrequently. Many examples of *occasional incompetence* were commonly related to participants' abilities to perform specific clinical skills. *Overall incompetence* was descriptive of a clinical teachers overall abilities, or lack of. The outcome of both types of competence varied in severity.

Common to both types of incompetence were clinical teachers' inability to meet the conditions and outcomes of particular phases. There were also common situations or events the precipitated incompetence. Some participants commented that when they were reassigned to a new area of clinical teaching (e.g., clinical course, level of student, substantive area of nursing practice, and clinical agency) they were more likely to encounter some form of incompetence. In these instances, participants were lacking in their capacities to be *competent* in carrying out a required activity. As well, participants who did not have a supportive environment were threatened by low levels of *self-confidence* which led to further *incompetence*. In contrast, participants who had a stable teaching assignment but experienced incompetence did so due to a lack of motivation and insight. Thus, *occasional*

competence was more often a result of external influences whereas *overall incompetence* was a result of internal influences.

One primary difference between *occasional* and *overall incompetence* was that the latter referred to clinical teachers who demonstrated a consistent pattern of unacceptable behavior(s). This clinical teacher elaborated on the determination of incompetence:

There are levels of ... incompetence in a way that I would feel strongly enough to make a report to a supervisor about and I have done this. And then there are reports of incompetence where it is a, maybe a singular incident that is uncharacteristic of the person or a knowledge deficit that they are working on or maybe something they are doing. So I guess maybe the attitude around their, whatever they are doing, is really important too in their incompetence.

As revealed by this participant, the second most common determinant of incompetence was the attitude held by clinical teachers. When incompetent clinical teachers demonstrated a desire, motivation, and willingness to change they were deemed worthy (by others) to receive a second chance to improve their performance. Thus, a clinical teacher's incompetence was tolerated or even forgiven when he or she had a positive attitude towards learning from his or her mistakes. A main factor influencing clinical teachers' abilities to overcome incompetence was described by participants as reflection.

Occasional Incompetence

Occasional incompetence was described by participants as situations where very specific types of knowledge, skill, attitude, or judgement were required in a given situation. Participants dealing with an unfamiliar situation experienced feelings of uncertainty and nervousness. This participant elaborated on her feelings accompanying occasional incompetence:

Well I certainly have been in situations where I didn't have a clinical background and I had to rely a lot on the staff and that was very uncomfortable You're just ... sort of nervous about, is there something I am missing here that I should know that I don't know, that's that lack of ease and lack of familiarity.

Most participants described situations where they experienced *occasional incompetence* as those instances where skills or knowledge were infrequently used and rarely seen (e.g., glucometer in labor and delivery, IV pumps, infant resuscitation, and enema administration). This clinical teacher recalled her experiences of occasional incompetence while assisting a student insert a nasogastric tube:

I hadn't done that for years ... and I ... [was] reviewing the procedure and then taking all of the stuff in and then trying to do it and it was really difficult ... Thinking is there something I am missing here or am I doing this right or am I hurting this person ... I felt like I wasn't competent, I ... wasn't confident in my competence You don't have that degree of comfort that assures you that at least you think you're competent ... I think they are times when you think your competent and maybe your not.

In the experiences of *occasional incompetence*, participants did not have the clinical background or *self-confidence* to act in a competent manner. Participants that experienced this type of incompetence either realized their incompetence at the time of their actions or in hindsight when they reflected on their actions. A common element of reported *occasional incompetence* was that it was related to a single incident that was uncharacteristic of participants' overall performances.

Overall Incompetence

Overall incompetence was described as a state when a clinical teacher lacked most of the conditions and outcomes necessary for the progression through the three-phase maturation process. In many instances there was some type of imbalance in their abilities as clinical teachers. In addition, their behaviors were at extreme ends of a continuum (e.g., either lackadaisical or tough). Participants found it difficult to address *overall incompetence* because their experiences were based mainly on third party observations. Participants' views about *overall incompetence* were grouped into four main categories: (a) lackadaisical or tough beyond reasonable expectations, (b) focusing on personal needs, (c) non-professional student-teacher relationships, and (d) not keeping current with nursing

practice. Although some participants did elaborate on the meaning of each category, few personal experiences of feeling or being *overall incompetent* were revealed.

Summary

Clinical teachers describing incompetence characterized the phenomena as either being an *occasional* or an *overall*, broader type of incompetence. Incompetence was brought about by either external or internal circumstances. For example, a change in teaching assignment is an external influence while a lack of motivation is an internal influence. Participants who experienced *occasional incompetence* had insight into the factor(s) that led to the incompetent situation. Consequently, they mobilized a number of strategies to overcome their deficiency. On the other hand, clinical teachers that met the criteria as being incompetent in a broader manner seemed to lack both the motivation and the insight to overcome their deficient abilities (e.g., tough or lackadaisical attitudes and unprofessional student-teacher relationships). Persons characterized as being *overall incompetent* did not have the capacities to fulfill the clinical teacher role, to conduct student evaluations, to build professional relationships, to facilitate learning, or to understand the students. Hypothetically, this inability to progress through the process of maturing could be accompanied by low degrees of *self-confidence*. Consequently, as the lack of *self-confidence* and *competence* intensified, the incompetent clinical teachers would conceivably stagnate or regress towards phase one.

Conclusion

In this chapter, the study findings of 11 clinical teachers' experiences of competence were presented. The analysis of their experiences was conceptualized as a three-phased *process of maturing as competent clinical teachers*. Although the maturation process was viewed, to some extent, as unique to each individual, many common findings emerged from the participants' discussions of their competence. These findings contributed to an

increased understanding of the overall three-phase process of becoming competent, the central focus and strategies common to each phase, and the factors that facilitate progression. These findings and their implications for nursing education and future nursing research will be discussed in the following chapter.

CHAPTER IV: DISCUSSION OF THE FINDINGS

This research set out to explore the process of attaining, demonstrating, and maintaining competence as described by clinical teachers. Chapter III presented the outcomes produced by grounded theory data analysis. In this chapter, select findings of the data analysis will be discussed in relation to the literature. Although issues and concepts relevant to competence have been acknowledged in the nursing literature, no empirical evidence has been published which explores the phenomena of competence in the context of clinical teaching. Consequently, the following discussion will rely on research and anecdotal literature from various disciplines and interrelated topics. The conclusions that emerged from the analysis of the interview data will serve to organize a discussion of the findings: developing self-confidence, the process of maturing as a competent clinical teacher, strategies specific to the phases of the maturation process, facilitative factors, and incompetence. Also, throughout the chapter, reference will be made to the defining attributes, antecedents, and consequences of competence as introduced in Chapter I.

Developing Self-Confidence

*“As you get more comfortable as a clinical teacher
you feel more comfortable and competent inside of yourself”*

Participant

The core category that emerged from the data analysis was self-confidence. This core category depicts the basic social process by which participants develop a degree of self-confidence necessary for the progression among the phases. It was rewarding to observe how the core category, as depicted by participants, captured the meanings of their actions and interactions with others, and accounted for the variations within their behavior patterns. Also, it was fascinating to discover that at the end of each phase participants described different degrees of self-confidence and competence. It appears likely then that self-confidence is an antecedent to competence and that competence is a state-of-being

which exists as an evolving process. The significance of these findings will be discussed in this section.

Self-Confidence and Other Related Concepts

The participants described self-confidence as a feeling of self-reliance and a firm belief in their personal powers. In a review of the CINAHL and Psychinfo databases, various authors have identified relationships among self-confidence and hardiness, self-efficacy, self-esteem, self-worth, mastery, locus of control, and a sense of coherence. Regardless of the term utilized, these concepts contain a common element. That is, each concept is "associated with a sense of self derived from direct encounters with and mastery of elements in the environment" (Fidler, 1981, p. 568). To be competent, individuals need to develop a sense of inner confidence that they can succeed. Bandura (1977) refers to this confidence in one's ability to be successful as self-efficacy. Self-efficacy is a sense of controlling one's own destiny.

In this study, participants who were the most self-confident felt a greater sense of control over their environment. For example, in phase one, the development of the participants' sense of self is attributed to dealing with their own learning needs. At the end of this phase, participants developed adequate self-confidence to believe in themselves. In other words, participants believed they could be successful as clinical teachers. In each phase, the consequences of gaining the self-assurance needed to succeed is positive reinforcement for developing more self-confidence. Eventually high self-confidence leads to competence. An increase in self-confidence and a greater sense of control resulted in movement through the three-phased process.

In listening to participants' experiences, it was interesting to determine how their self-confidence and perceived sense of control contributed to their maturation as competent clinical teachers. Second, it was fascinating to learn that teachers who had greater

perceptions of self-worth and self-confidence became stronger advocates for students. Third, those participants who were self-confident, had well-developed teaching styles, and who had a number of years of teaching experience were not particularly concerned with the perceptions of others. Nagelsmith (1995) concludes in her literature review that "...with increased levels of competence comes a corresponding increasing sense of self-worth and empowerment" (p. 247). Since self-worth and self-efficacy are components of self-esteem, individuals with a higher sense of self-esteem are more apt to succeed (i.e., become competent). In this study, participants concluded that with self-confidence came a sense of self-direction, meaningfulness, and a sense of control that guided their thoughts and actions for maturing as competent clinical teachers. In sum, both the concepts of self-efficacy and self-worth are valuable for explaining the variances in self-confidence. Furthermore, these findings substantiate a claim made in Chapter I: self-efficacy and self-confidence are antecedents to competence.

Self-Confidence and Competence

It was significant to discover that in phase one participants' believed one of the most significant factors contributing to being competent clinical teachers was having a solid grounding in the fundamentals of nursing practice. This grounding brought them a sense of comfort. Participants who perceived themselves to be competent as clinicians had a basic degree of self-confidence necessary to progress through the three-phased maturation process. Crandall (1993) found that outstanding clinical teachers display "confidence in their clinical competence and are comfortable with their roles as mentor and teacher" (p. 89). Empirical evidence by Mozingo, Thomas, & Brooks (1995) reports that students who perceive themselves to be clinically competent reported higher levels of self-confidence. Conversely, Gillespie (1997) identifies that the clinical teachers' self-confidence both as teachers and as clinicians is a significant factor in competently meeting the students'

learning needs. Clinical teachers who lack self-confidence were limited in what they could offer students in their clinical learning experiences. This finding suggests teachers with less self-confidence are less competent in their abilities as clinical teachers (Gillespie).

Therefore, it is reasonable to suggest that a teacher's ability and self-confidence, as a clinician and as a teacher, has a strong influence on clinical teacher competence. In other words, not every competent clinician is a competent clinical teacher. Rather, competent nursing practice is an antecedent to becoming a competent clinical teacher.

Ironically, participants having more experience as clinicians (e.g., greater than 10 years) appeared to have more difficulty adjusting to the clinical teacher role. It is interesting to note that quantitative research by O'Shea (1982) reports a positive correlation between years of nursing practice and the amount of role strain when adjusting to the clinical teacher role (e.g., increased years of nursing practice results in increased amounts of role strain). O'Shea believes that clinical teachers with many years of nursing practice may experience more role strain because they self-impose their expectations for client care on students. These expectations make it more difficult for these teachers to let go and trust the students to care for clients. Similarly, some participants of the present study reported difficulty in learning to permit the students to function independently; however, the findings were not correlated to the years of nursing practice held by participants.

Based on the findings of the present study and other literature, clinical teachers with experience in nursing practice have more self-confidence in their abilities as clinical teachers. Similarly, participants having background knowledge and experience with teaching reported higher degrees of self-confidence, comfort, and competence in the clinical teaching role. In surveying health educators, Jacobs and Wylie (1995) conclude that those with no background in health education showed significantly less self-confidence and competence in their teaching ability than those with some background in health education.

Qualitative research by O'Shea (1982) concludes that teachers with less teaching experience report increased amounts of role strain. Based on these findings, one could conclude that a variety of past experiences (e.g., clinical and teaching) enhances feelings of self-confidence.

Summary

While little empirically-based research explores the direct nature of the relationship between self-confidence and clinical teacher competence, these findings confirm and add to other findings that a reciprocal and interdependent relationship exists between these two concepts. This inner assurance, or self-confidence, has value because it promotes a sense of being able to influence and master the environment of clinical teaching. When participants' sense of competence and self-worth was strong, they were able to perceive themselves as being able to cope and mature as competent clinical teachers. The participants with stronger self-confidence also expressed higher degrees of clinical teacher competence. Consequently, I suggest that developing self-confidence is an antecedent to becoming competent clinical teachers. Concepts such as self-worth, self-efficacy, and locus of control are interrelated with self-confidence and are therefore antecedents to competence. Further quantitative studies are necessary to determine the exact relationship between these concepts.

The Process of Maturing as a Competent Clinical Teacher

This study revealed the existence of a three-phased, evolving process that clinical teachers' experience within a given situation and context. Due to a paucity of literature specific to the *process of maturing as a competent clinical nursing teacher* comparisons will be made between the overall process described in this thesis and three areas of the literature: (a) the process of adjusting to clinical teaching, (b) the experience of teaching, and (c) the development of a supervisory role. Specific strategies used within the

three-phased process will be discussed after this section.

One of the most noteworthy findings regarding the overall maturation process was that the participants experienced varying degrees of anxiety. At first, I was unsure of the cause of these variations. Upon further exploration, the participants revealed their varying degrees of anxiety were related to their (a) self-confidence, (b) previous experiences in teaching and nursing practice, and (c) abilities to adjust to their new role. Participants who were adjusting to their new role as clinical teacher described a transitional period of uncertainty. To better understand this transitional period, I reviewed the literature on models of adjustment. Two models of adjustment related to the experiences of the clinical teachers in this study; they were the Brooke Model of Adjustment (Bentz & Ellis, 1991; Brooke, 1989) and the Community College of Philadelphia Model of Adjustment (Bentz & Ellis, 1991). Both models provided information relevant to understanding the feelings many clinical teachers' experienced as they moved through the process of maturing as competent clinical teachers.

As previously stated, participants new to clinical teaching often experienced feelings of anxiety and uncertainty. Furthermore, some participants expressed feeling a sense of loss when dealing with the transition from being an expert clinician to novice teacher. The two models of adjustment define this feeling of loss as a "transitional" feeling (Bentz & Ellis, 1991; Brooke, 1989). This feeling results from a loss of expertise (e.g., changing areas of nursing practice from familiar to unfamiliar) and a loss of relationships from the former familiar clinical setting. With a loss of the expert nursing role, clinical teachers often experience feelings of frustration, anger, and resistance (Bentz & Ellis, 1991). Hess (1986) found that psychotherapists who assume the additional role of supervising students also experience a transitional period. For supervisors, two factors that influence their adjustment to their role change were high expectations and lack of preparation for the role (e.g., education and practice related to the theoretical basis of supervision). As previously stated,

those having background preparation in education were better equipped to cope with the adjustment period. In addition, according to Bentz and Ellis, factors that facilitate faculty recovery from a loss of self-confidence are support and orientation to the clinical agency. Participants in this study also identified with the need for support and clinical orientation; however, taking time to deal with their self learning needs was viewed as a requirement to developing their teaching style.

It is also interesting to note that participants teaching in a familiar area of nursing practice recalled a less traumatic transitional period. That is, they experienced fewer feelings of anxiety, higher degrees of self-confidence, and stronger perceptions of competence. These participants also progressed faster to phase two. Quantitative research by O'Shea (1982) concludes that teachers with less teaching experience report increased amounts of role strain when they are familiar with the substantive area. Additional research in nursing education has studied role transitions and nursing students. For instance, Mozingo et al. (1995) reveals that competency levels of students are affected by factors such as self-esteem, level of anxiety, and clinical and technical skill. In dealing with the transition from school to a work setting, Kramer (as cited in Mozingo et al.) found that many graduates with low self-esteem also felt inadequate. Other research on nursing student performance found that high levels of anxiety were also associated with low self-esteem (Mozingo et al.). In these cases, anxiety is shown to negatively effect the development of self-confidence and its components (e.g., self-esteem). One could assume that these findings also apply to clinical teachers. In extreme cases, anxiety may hinder the continuation in the process of maturing as a competent clinical teacher.

In sum, empirical data from this study serves to support and strengthen the ideas proposed by Bentz and Ellis (1991) and vice versa. Specifically, the first phase of dealing with self learning needs was described as a period of adjustment. During this time,

participants dealt with the transitions or changes of adopting the clinical teacher role. Models of adaptation (Brooke, 1989; Bentz & Ellis) primarily resemble phase one of the process of maturing as competent clinical teachers. The models are helpful for explaining the variations some teachers may encounter during the process. For example, teachers may experience variations in their feelings while progressing through the maturation process. Anxiety and tension, and plateaus of comfort and a sense of empowerment are common feelings. This finding is common to the identified defining attribute of competence in Chapter I. Moreover, the findings from this study substantiated the claim that a defining attribute of competence is that it is an evolving process of continual development. Second, this evolution is influenced by clinical teachers' abilities to deal with their surroundings.

While reviewing literature related to the overall maturational process a relevant study by Ferguson (1996) was discovered. Ferguson's findings of the lived experience of a clinical teacher revealed a similarity to phase two's subtitle, *learning as you go*. Ferguson's version of *learning as you go* documented the experiences of clinical teachers and how they evolved to achieve a firm grounding in their clinical teacher roles. Similar to Ferguson, this study viewed *learning as you go* as a necessary component of the second phase of building one's teaching style. While Ferguson's study describes characteristics similar to those in phase two, the specifics of these findings lacked depth and breadth. First, Ferguson focused primarily on the experiences of clinical teachers rather than their competence. Second, little was written to support the participants' descriptions of the events of phase three of the maturation process. In sum, the combined evidence from this study and Ferguson's study suggests that becoming competent is a process embedded in a deeper sense of being and is existential in nature.

The most relevant piece of literature relating to the topic of this thesis was written by Hess (1986). Hess's model of supervisor development is comprised of three stages: Stage

A – Beginning; Stage B – Exploration; and Stage C – Confirmation of Supervisor Identity. This model incorporates existing knowledge from the literature with anecdotal comments from Hess's observations of supervisors of students in the field of psychotherapy and counselling. While the empirical basis for Hess's work is not parallel to that found in this study, several commonalities exist between the stages of supervisor development and the process of maturing as competent clinical teachers. Of significance are the similarities between beginning supervisors and neophyte clinical teachers (e.g., dealing with role change, emulating other teacher or supervisor behaviors they observed as students, and difficulties with student evaluation). As well, both supervisors and clinical teachers experience a phase where they shift their attention from their own learning needs to those of their students. Accompanying this shift in focus is the development of their teaching and supervisory abilities. Hess noted that the development of supervisory abilities included learning how to evaluate and tolerate students. In this study, it was revealed that developing trust and tolerance of students was necessary for gaining an understanding of students. Absent from the literature are other discussions related to the development of tolerance.

Two other similarities between this study and Hess's study are the wording of descriptive phrases. First, while Hess's (1986) model uses terminology that reflects the *stages of maturation for student supervisors*, this study referred to the process of competence as the *process of maturing*. Second, in Hess's final stage of supervisory development and this study's third phase of the maturation process, supervisors and teachers respectively implement strategies directed towards the *consolidation of their identity*. Furthermore, the model development completed by Hess was the only source of literature found to parallel the findings in phase three of this study's maturation process. Additional similarities between these two studies are (a) the supervisors' willingness to confront evaluation issues such as inadequate student behavior, (b) the inclusion of the

students' evaluations as an ongoing component of the learning process, and (c) the focus of supervision on the students' learning agenda.

To conclude, Hess's (1986) work is important to the findings of this study because it confirms the existence of a process for the development of one's abilities as a clinical teacher. Specifically, these findings support the experiences of phase three of the maturation process. Although Hess did not discuss competence or self-confidence directly, the combined findings of this study and Hess's work substantiated my claim that competence is an evolving process of continual development.

Summary

The overall process of maturing as competent clinical teachers bears a strong resemblance to the models of adjustment by Brooke (1989) and by Bentz and Ellis (1991), the model of supervisory development by Hess (1986), and the lived experiences of clinical teaching by Ferguson (1996). These similarities indicate that smaller components of the process of maturing as competent clinical teachers are available in the current literature; however, this study is the only source to provide empirical evidence to describe the overall three-phased process. More specifically, previous research relates more to the first and second phase of the maturation process and less to that of phase three. It is my contention, however, that clinical teacher competence can be achieved by attending to all three phases of the maturation process.

Strategies Specific to the Phases of the Maturation Process

Since there has been little nursing research about the overall process of clinical teacher competence, the literature was classified according to three specific strategies: establishing and maintaining credibility, learning how to teach through reflection, and knowing the student. By comparing and contrasting the existing literature on these strategies important agreements were found in the data; however, there were also key

points of divergence to be considered.

Establishing and Maintaining Credibility

*We judge ourselves by what we
Feel capable of doing,
While others judge us by what
we have already done.*

Henry Wadsworth Longfellow

As participants spoke with vigor about their experiences as competent clinical teachers, outcomes of competence were revealed. These outcomes included success, promotion opportunities, and credibility. As Longfellow suggests, most external judgments of competence focus on the perceived abilities of clinical teachers and are based on their accomplishments. The same was true for the participants of this study who believed they were judged on their abilities first, as a clinician and second, as a teacher. Regardless of others' perceptions about their credibility, participants stated that establishing and maintaining credibility refers not only to being up to date with current nursing practice, but also to being familiar with current teaching practice. This finding is incongruent with the current nursing literature which equates clinical teacher credibility with the ability to perform solely as a clinician (Cave, 1994; Fawcett & McQueen, 1994; Goorapah, 1997). A literature review by Fawcett and McQueen (1994) reveals that the term clinical credibility is descriptive of keeping up to date with both theory and hands-on nursing practice. Crotty (1993) holds similar beliefs about the importance of updating theoretical knowledge and basic skills to retain clinical credibility. Moreover, the nursing literature seeks to determine the amount and type of nursing practice necessary for clinical teachers. For example, to claim credibility, Green (as cited by Fawcett & McQueen) believes clinical teachers should

spend a specified amount of time in nursing practice². The rationale behind these perspectives is that being clinically up to date will ensure that the theory taught in the classroom reflects what is being performed in practice; thus remaining current is thought to lessen the theory-practice gap. In this study, credibility is more than the fulfillment of practicing for a number of years as a clinical nurse. Rather, it is maintaining a blend of expertise as a clinician, a teacher, and an academic; all of these roles are necessary to uphold professional credibility.

The outcomes of being perceived as credible affected the respective teachers, the agency staff, and the students. Participants who believed the agency staff perceived them as credible felt a sense of comfort. This comfort heightened their self-confidence and competence as clinical teachers. Being seen as credible became also a "tool" used by participants to foster camaraderie and develop respectful working relationships with the agency staff. According to Kramer et al. (1986), clinical teachers who engage in nursing practice are perceived as being credible. With this established credibility, teachers receive more positive reinforcement from agency staff than non-practicing colleagues (Kramer et al.). Moreover, teachers perceived as credible by students tend to develop a greater connection with students (Kramer et al.; Gillespie, 1997). Thus, being perceived as credible by both agency staff and students had professional implications on how clinical teachers demonstrate and maintain their competence.

In this study, clinical teachers engaged in various activities throughout the three phases that allow them to gain credibility as clinical teachers. An indirect consequence of

² In the nursing literature this is often referred to as faculty practice or clinical practice. A dichotomy of the meaning of the term faculty practice exists. The definition of faculty practice can range from moonlighting or working per diem over and above the faculty/clinical teacher role to joint employment as a clinical teacher combined with regularly scheduled nursing practice (e.g., direct client care or clinical nurse specialist role) at a clinical agency (Kramer et al., 1986). Kramer et al., states that teaching students in the clinical setting is not faculty practice because the central focus of the clinical teacher's time is on the students rather than performing direct client care.

credibility was a sense of power and greater self-assurance. Similarly, Kramer et al. (1986) believes that clinical teachers who are perceived as credible have a degree of social power within the system; that is, they are perceived as having sound judgment and as being effective change agents. Participants in this study stated that social power allowed them to be better able to advocate for a broad range of student learning experiences. In short, with credibility, clinical teachers gain more power and a sense of prestige, which in turn promotes an environment supportive of student learning.

From a professional and personal point of view, maintaining and improving clinical and teaching skills leads to affirmation of one's professional credibility as a clinical teacher. I believe that credibility is more than being up to date with current nursing practices. Because of the dual role of the clinical teacher as a clinician and as a teacher, it is reasonable to conclude that clinical teachers have a professional obligation to keep abreast of the changes in nursing practice *and* teaching practice. Unequivocally, perceived credibility positively affects the teachers personally; it also affects the agency staff and students. Clinical teachers in this study establish credibility through competence and feel a sense of satisfaction from perceiving themselves as competent. While credibility was initially regarded as a consequence of competence (Chapter I), activities inherent to the strategy of establishing and maintaining credibility may also be a means for attaining, demonstrating, and maintaining competence. Thus, credibility may be a defining attribute of competence.

Learning how to Teach Through Reflection

Most of the nursing literature presents evidence for "how to" teach rather than addressing the process of determining what and how clinical teachers learn to teach. As the success of phase one is predicated on clinical teachers' foundations in nursing practice, the ability to reflect on one's teaching allows for the development of one's teaching style. To develop one's teaching style, clinical teachers in phase two needed to engage in some

method of critically appraising themselves; this self-assessment led to further skill and competence development. Thus, the cognitive flexibility to reflect on unchallenged assumptions about teaching is one way in which clinical teachers learn how to teach. Although several authors have written about the models of reflection and the use of reflection with students, the nursing literature does not discuss how reflection contributes to the process of becoming a competent clinical teacher. In this section, the importance of reflection in the context of competence is explored.

Initially, neophyte clinical teachers begin teaching by emulating behaviors they viewed as students. Participants scrutinized their experiences as students to determine what behaviors they liked and disliked of their teachers. These likes and dislikes formed the framework for their teaching behaviors in phase one of the maturation process. In phase two, participants challenged old assumptions and discovered new alternatives by implementing, testing, revising, and refining their methods of teaching. The activities described by the participants parallel Schon's (1987) concepts of knowing-in-action, reflection-in-action, and reflection-on-action.

Knowing-in-action refers to tacit knowledge that clinicians bring to a given situation (Schon, 1989). In this study, clinical teachers with previous teaching experience or those who had received education in teaching practices reported a smoother transition to the clinical teaching role. Less time was spent focusing on the "self" learning needs and teachers were better able to progress to the second phase of developing their teaching style. Clinical teachers also noted the importance of knowledge in the fundamentals of nursing practice.

Reflection-in-action includes the activities used by clinical teachers who reflect upon what they are doing and who convey knowledge through their actions (Schon, 1987). This type of reflection is often described as a type of knowing that can not be explained with

words. When using this type of reflection, clinicians think about how to modify a given a situation without interrupting what they are doing at the time (i.e., on the spot experimentation) (Schon). Some participants in this study talked about the use of their intuitive actions, which were derived from years of experience, as a means for modifying a given situation while it was occurring. This type of intuitive knowledge was commonly used when participants talked about evaluating students' performance.

Participants in this study also described behaviors known as *reflection-on-action*, that is, recalling what has been previously done to see how knowing-in-action contributed to the unexpected outcome (Schon, 1987). This type of reflection encourages a critical appraisal and the restructuring of thoughts to change the future actions of clinical teachers. For instance, in phase two, a necessary element for developing one's teaching style was the use of some method of critically appraising oneself (e.g., self-evaluation, reflection, or dialoging). When "self-appraisal" did not occur, participants did not develop their teaching style nor did they advance to the next degree of competence as clinical teachers. Scanlan and Chernomas (1997) suggest that reflection allows teachers, through conversing with the self, to evaluate their teaching. Through such reflective practices teachers are presumed to gain a better understanding of their teaching abilities. Furthermore, this insight is believed to facilitate further development of professional expertise (Scanlan & Chernomas). Saylor (1990) proposes that reflection is necessary for self-evaluation and that self-evaluation is necessary for competence. These findings are consistent with Toliver's (1988) beliefs that inductive reasoning skills such as reflection promote clinical competence. Similarly, Maynard (1996) reports that experience and education play an important role in competence development. Participants in this study claimed that education contributed to the process of competence because it creates an environment for challenging existing assumptions about their clinical teaching practices.

In conclusion, nursing practice is not enough to ensure competence as clinical teachers. Competence of clinical teachers in this study was dependent upon a cognitive process of awareness and critical analysis that ends in development. A result of this cognitive process is learning in the form of affective, cognitive, and/or behavioral changes. That is, clinical teachers learn how to teach. With ongoing development in one's abilities to teach, clinical teachers progress in the process of maturing as clinical teachers. At the same time, these findings support the claim that the actual ability to learn and to gain meaning from one's experiences (e.g., critical thinking, problem-solving, and reflection) is a defining attribute of competence. Reflective thinking is necessary for the attaining and maintaining of competence.

Knowing the Student

Another strategy found in phases two and three of the maturation process was a clinical teacher's ability to know the student. In this study, knowing the student encompassed the process of seeking to understand and know the student outside of their immediate role as a learner. Knowing the student also implies seeking to understand the student's perspective and acknowledging the student as a valued and unique individual. It was interesting to note that the participants' views on knowing the student were similar to those expressed in the literature. The literature, however, uses the terminology of *knowing the patient* in nursing practice (Benner, 1984; Radwin, 1996; Tanner, Benner, Chesla, & Gordon, 1993). Since knowing the student is a relatively new concept, particular attention was directed towards the literature on knowing the patient.

Radwin's (1996) review of the research literature found that knowing the patient embodies two components: nurse's understanding of his or her clients and the individualization of client interventions. Additional phenomenological research by Tanner et al. (1993) indicates two similar yet distinct categories of knowing the patient: in-depth

knowledge of the patient's patterns of responses and knowing the patient as a person. Both notions represented some of the participants' accounts of the concept of knowing the student. In many instances, participants first needed to build their theoretical knowledge of teaching and learning as a means for better understanding their students. This finding supports the notion that theoretical knowledge forms the foundation of the tacit knowledge characteristic of competent clinical teachers (Tanner et al.). Knowledge gained from experience also contributes to how clinical teachers come to know their students.

In this study, knowing the student as a person was one way in which clinical teachers became more involved with and concerned for students' learning. This familiarity allows the teacher to complete student evaluations by viewing the learner as a unique and distinct individual. Participants who understood the students in their clinical groups were able to assume a type of advocacy which reflected empathy and caring. The actions described by participants of this study are congruent with some of Paterson and Crawford's (1994) indicators of caring faculty. Specifically, Paterson and Crawford refer to faculty who know students as individuals, listen to students, and act as advocates. This suggests a relationship between being caring and being competent. Paterson and Crawford also explain how "few ontological definitions refer to teacher competence as an aspect of caring" (p. 165).

Research by Gillespie (1997) also concluded that teacher competence is inclusive of the teacher's ability to recognize and respond to his or her students' learning needs. The factors that influenced a teacher's ability to respond to student needs are knowing the student and the teacher's abilities, skills, and confidence as an educator and a clinician. In addition, Gillespie reports mutual knowing between students and teachers is necessary for the formation of a student-teacher connection. Students who experience a connection with clinical nursing teachers perceived themselves to be known as whole persons. Gillespie

defined knowing the students as including teacher recognition of students as a person (e.g., lives outside of school), a learner (has individual learning needs), and a nurse (e.g., has knowledge and contributes to patient care) (Gillespie). Knowing is currently associated with building a caring student-teacher relationship. This type of relationship has been shown to affect student learning. It is also a strategy inherent to the process of maturing as a competent clinical teacher (e.g., phase two and three). This study demonstrated that clinical teachers who achieved a higher degree of self-confidence and competence did so because they engaged in activities of knowing the student.

Previous research and anecdotal literature on knowing reinforces the importance of the student-teacher relationships in the context of clinical teaching. New to the nursing literature is the clinical teachers' use of knowing the student as a strategy for developing their teaching style and integrating the complexities of the clinical teaching role. In short, knowing the student is inherent to the maturation process, the demonstration of competence, and may even be a defining attribute of competence. Teachers who are not able to engage in caring relationships with their students may demonstrate a lack of competence. Without understanding students as individuals, it is difficult to individualize the learning process and focus on student-centered learning.

Summary

Three strategies common to the process of maturing as competent clinical teachers have been discussed in detail: establishing and maintaining credibility; learning how to teach through reflection; and knowing the student. Existing literature is congruent with the findings of this study; all agree that nursing practice contributes to clinical credibility. However, the participants in this study differed by identifying that clinical teachers need to keep abreast of changes and trends in nursing education. At the same time, being perceived as credible influences the means by which clinical teachers attain, demonstrate,

and maintain their competence. New to the literature are discussions regarding how clinical teachers learn to teach. The existing literature and findings from this study support the premise that ongoing reflection and a spirit of inquiry is crucial for the development of a clinician's abilities and clinical teacher competence. Another component of the process of maturing is the teacher's ability to know and understand the student. Findings from this study correspond to studies on knowing the patient. Previous research by Paterson and Crawford (1994) and Gillespie (1997) acknowledges the significance of knowing the student as an element of caring behaviors of clinical teachers and for the development of student-teacher relationships. New to the nursing literature is the notion of knowing the student as a defining attribute of competence.

Facilitative Factors

The facilitative threads comprise factors that directly or indirectly influence the process of maturing as a competent clinical teacher vis-a-vis the development of self-confidence. Some of the predominant external or internal factors influencing competence are: support, consistency in the teaching assignment, and clinical background. The salient features of these factors will be reviewed. Overall, the presence or absence of these factors can either facilitate or hinder a clinical teacher's ability to attain, demonstrate, and maintain competence.

Support

Participants' expressed that some form of support was necessary to facilitate the transition throughout the process of maturing as competent clinical teachers. One significant finding of this study was that some neophyte clinical teachers spent a great deal of time and energy trying to figure out their clinical teacher role. A few participants expressed frustration and resentment when discussing this issue; support was not given to them in their new role. Colleagues who lacked empathy (e.g., forgot what it was like to be a new teacher) and

professional caring (e.g., non-supportive) left new clinical teachers to figure things out for themselves. This often resulted in the new teachers becoming isolated from others. While clinical teachers do need to figure out some elements on their own, it is important to support neophyte clinical teachers in a way that may expedite their progression to phase two.

The significance of support in this study was revealed in the consequences experienced by the participants. Participants receiving support felt empowered; furthermore, feeling empowered helped to develop their self-confidence and their drive to control their development as competent clinical teachers. Langford, Bowsher, Maloney, and Lillis (1997) identified some of the consequences of social support as personal competence, perceived control, positive affect, sense of stability, recognition of self-worth, and decreased anxiety. At the same time, Mozingo et al. (1995) reveals the most salient factors that influence perceived competence are anxiety and social support. These findings are significant since anxiety is negatively correlated to competence while social support is positively correlated. It is reasonable to conclude that positive forms of support for clinical teachers are a factor that facilitates the process of maturing; however, support is not a consistent requirement of competence.

Consistent Teaching Assignment

One unexpected finding of this study was that competence of clinical teachers was dependent on external factors beyond individual control and is, to some degree, contextually determined. Lack of control of external factors brought about feelings of vulnerability. Jameton (1984) reports that in a setting with support, clinical teachers may be very competent. In a context where clinical teachers are continually being reassigned without appropriate support, a lack of competence may result. The participants of this study agreed with Jameton's findings. In addition, a previous discussion of the literature substantiates the claim that consistency in the teaching environment is necessary for self-

confidence and competence. Specific to this study, participants' perceptions of self-confidence and levels of anxiety also varied with the match between their teaching assignment and their clinical background (e.g., generalist versus specialist). White (as cited in Schwammle, 1996) suggests personal motivation and interest prompts the desire to explore a substantive area of nursing. Fidler (1981) proposes that competence in an area is more readily achieved when the topic has greater meaning to the individual (e.g., intrinsic gratification, personal pleasure, and satisfaction). Thus, being motivated, interested in, and familiar with an area of concern facilitates the development of self-confidence and minimizes anxiety.

Bentz and Ellis (1991) recommend that during a clinical teacher's initial period of adjustment he or she should remain on one unit. Familiarity with an area is important because clinical teachers (including expert teachers) who are outside of their comfort zone can temporarily behave as novices (Bentz and Ellis). This research also reflects the participants' thoughts on being re-assigned to new clinical agencies. That is, clinical teachers experiencing the first and second phases need consistency in their teaching environment. Once clinical teachers develop their teaching style and enhance their self-confidence they are better equipped to handle the uncertainties associated with changes to their teaching assignment. Bentz and Ellis's research on the two models of adjustment provide new insight into the variations in comfort experienced by mature clinical teachers reassigned to an unfamiliar clinical area. This finding is significant because it is important to recognize there are differing degrees of competence which are dependent upon the teachers' abilities as nurses and teachers. Bentz and Ellis also found that clinical teachers in unfamiliar areas utilized new practice patterns which also resulted in new teaching strategies. Furthermore, these new patterns of teaching and nursing often led to

the development of collaborative partnerships among faculty, agency staff, and students (Bentz & Ellis).

Based on the findings of several authors, matching clinical teachers' teaching assignments to their clinical background has some influence on their self-confidence (Fidler, 1981; Schwammle, 1996; Wood, 1987). In this study, when participants are matched with an area of familiarity less time is spent focusing on their self learning needs and more time developing their teaching style. Participants' abilities to deal with changes in their teaching assignments were enhanced by support. The participants' nursing background (e.g., generalist or specialist focus) also influenced their abilities to adjust. This will be elaborated upon in the following section.

Clinical Background

While the issue of nursing practice has already been discussed in the context of credibility, at this time I will discuss this study's findings on the amount of clinical expertise required of teachers in the clinical setting. Specifically, the debate of "how much" and "what type" of nursing practice is necessary to be competent as clinical teachers has not been determined. Participants in this study revealed two differing perspectives; one from a generalist and the other is from a specialist perspective.

The participants' abilities to cope with changes in their teaching assignment were related to their nursing background as either a generalist or a specialist. Participants with a generalist background believed their breadth of past experiences contributed to increasing degrees of *self-confidence* and *competence* when coping with a variety of clinical courses and clinical agencies. Participants with a specialist background believed their qualifications also increased their *self-confidence* and *competence* when teaching in their specialty area. However, participants with a specialist background identified a decrease in their *self-confidence* and *competence* when reassigned to a different substantive area.

Both perspectives have merit. The data reveal that, for study participants, the importance lay not in whether they are a generalist or a specialist but in the participants' perceptions of their abilities as clinicians and teachers. Participants with either type of background went through a process of reviewing their past experiences and mobilizing their abilities to cope in a new teaching assignment. Thus, it is the participants' perceptions of self that affects the degree of *self-confidence* they have teaching in a new area and not their nursing background. Generalists typically work in a variety of clinical settings. Generalists identify that they may be limited in their abilities in certain substantive areas; however, they manage by capitalizing on the strength of their teaching abilities. Specialists, on the other hand, benefit from their expert knowledge base to maximize the learning opportunities available to students.

Another important finding is that most participants believed that it is an unrealistic expectation to be both an "expert nurse" and "expert teacher". A few participants, who were specialists in their substantive area, thought they met the standards of being both an expert nurse and expert teacher. Regardless of the specific nature of nursing practice, all participants agreed due to the practice-based nature of nursing, clinical teachers needed to maintain their competence as clinicians to demonstrate competence as clinical teachers. It is reasonable to conclude that the answer does not lie in "how much" or "what type" but rather to what degree does each clinical teacher perceive the need for a maintaining a certain degree of expertise in their nurse practice to fulfill their role obligations.

Summary

Various factors in their presence, or absence, may either facilitate or hinder the maturation process. Undoubtedly, the presence of support is a positive factor that promotes the process of attaining, demonstrating, and maintaining competence. At the same time, having consistency in one's teaching assignment is beneficial for attaining and maintaining

a certain degree of competence. Clinical background adds a new dimension to the construct of competence. In Chapter I, an individual's expertise in nursing practice was identified as an antecedent to competence. The findings of this study supported this claim; however, clinical teachers also need to perceive themselves as capable clinicians (e.g., generalist or specialist). This perception contributed to the attainment of competence and facilitated the maturation process.

Incompetence

*"You get the four kinds of people.
The group who are competent who hate teaching and don't come back;
the group who are competent who stay;
then you get the group that are incompetent that hate it and leave...
then you still get the group that are incompetent and stay because they don't
have the insight to realize they are incompetent"*

Participant

Inferiority, unpreparedness, and unskillfulness are all subentries to the word incompetence (Nagelsmith, 1995). According to Mobily (1992) and Poteet (1987), incompetence is often attributed to a lack of requisite skill, knowledge, or the ability to enact the assumed role. The findings of this study are parallel to the findings of Mobily and Poteet. For some participants, incompetence stemmed from an inability to perform certain behaviors. These behaviors were most often clinically based. For others, incompetence was a result of a lack of commitment and a lack of job satisfaction. All of the participants in this study have experienced feelings of incompetence at some time in their career. This finding is not reflective of the current nursing literature where the concept of incompetence in the context of clinical teaching is rarely acknowledged. Three sources of literature useful for understanding incompetence are administrative incompetence (Poteet), understanding competence in nursing students (Giot, 1993), and uncaring behaviors of nursing faculty (Hanson & Smith, 1996).

It is interesting to note participants' varied responses to the word incompetence. Some participants were comfortable using the word to readily identify examples while other participants thought that the word was too harsh because it evoked a negative and hopeless connotation. Participants who viewed the word in a negative manner tended to have more difficulties in articulating examples of incompetence. There was also some reluctance in labeling someone as incompetent or for reprimanding teachers for isolated mistakes. This reluctance was justified by claiming that mistakes do happen. Participants in this study did not view others as incompetent when they learned from their mistakes, displayed a willingness to improve, and demonstrated insight into their behavior.

The importance of having insight is supported by Girot (1993) who reports that incompetent student behaviors result from a lack of insight into their behaviors. Forgiving others for their mistakes, as described above, is indicative of the participants' cultural concept of responsibility. This feeling of responsibility tends to focus more on the goodness of one's intentions rather than one's ability to carry them out perfectly (Jameton, 1984). In this study, it was common to forgive mistakes unless they were seen as a continuous pattern of unacceptable behavior. Thus, the attribute determining incompetence is whether there is a consistent pattern of unacceptable behavior by a clinical teacher. Poteet (1987) and Huettl (1996) support the belief that behavioral patterns displayed over time are indicative of a persistent deficiency or lack of competence. Furthermore, Huettl states that the degree of seriousness of a single mistake also certifies incompetence. In other words, the seriousness of the actual or potential outcome of a single event may constitute incompetence (e.g., degree of harm to the client). Only one participant mentioned the seriousness of an event as a determining factor of clinical teacher incompetence.

Another theme common to the participants' discussions of incompetence was that it was described as a product or end. For example, competence was discussed as a

developmental process while overall incompetence was described as a personal attribute or an outcome. Moreover, all instances of overall incompetence related to personal or internal factors whereas situational or external factors were influences contributing to occasional incompetence. Participants' views on occasional incompetence implied that when a clinical teacher is maturing as a competent clinical teacher they can also experience incompetence.

Occasional Incompetence

In most instances, participants who experienced occasional incompetence stated they were deficient in an area of knowledge or skill due to some unexpected external circumstance (e.g., change in teaching assignment or unexpected event in the clinical setting). Wood's (1987) description of clinical teacher accountability alludes to the effects of mismatching clinical placements for clinical teachers. However, the extent of these situational influences on clinical teacher competence has not been examined in the literature. Nonetheless, it is reasonable to infer from this study that external factors are significant contributors to some incidents of incompetence.

The examples of incompetence given by participants related to clinical teachers' abilities as clinicians and, in some instances, their abilities as teachers. Mobily's (1992) review of the literature indicates that some clinical teachers may lack adequate formal preparation in the strategies of teaching; this may contribute to their lack of competence. As well, clinical teachers who are expert clinicians discover that competence in the practice of nursing (i.e., clinical competence) does not ensure competence in the clinical teaching of nursing (Mobily). On the other hand, some may believe that only the appearance of competence is needed to survive within the institutional system. Participants in this study who experienced occasional incompetence were committed to mobilizing the necessary resources to overcome this deficiency. Furthermore, participants were committed to maintaining a degree of competence that was adequate for meeting students' needs and

ensuring client well-being. Overall, most participants had a genuine desire to demonstrate legitimate competence and not merely the illusion of competence.

Overall Incompetence

New to the literature are four descriptions of overall incompetence: (a) lackadaisical or tough beyond reasonable expectations, (b) focusing on personal needs, (c) non-professional student-teacher relationships, and (d) not keeping current with nursing practice. Some elements of overall incompetence were similar to Poteet's (1987) descriptions of the five characteristics of incompetent administrative behaviors: uncommitted, absent, arrogant, fearful, and indecisive. In this study, a lack of commitment was described by participants as reflecting incompetence. The participants also defined teachers who were too lackadaisical or too tough or who did not keep current in their nursing practice as being incompetent. These teachers were seen to be uncommitted to their clinical teaching role. For example, they often abdicated their responsibilities to others and lacked accountability for their actions. Hanson and Smith's (1996) descriptions of uncaring behaviors (e.g., unavailable, hurried, condescending, disrespectful, rigid, defensive, and uninterested) of clinical teachers also correspond to participants' descriptions of incompetent clinical teachers. By applying these findings to the context of the participants' discussions on incompetence, clinical teachers who are uncaring would likely be seen to lack competence in the clinical teacher role.

Summary

The findings of this study supported the existence of incompetence in clinical teaching. Overall incompetence was described as an outcome (i.e., end product) whereas occasional incompetence was a part of the situational and dynamic nature of the process of maturing as competent clinical teachers. These findings prompt the question: Can incompetence and competence exist simultaneously? The participants' discussions suggest

these two phenomena can co-exist. This study reveals that deficits in clinical teachers' abilities as clinicians are not the only contributors to incompetence. Defining attributes such as inadequate teaching abilities and a clinical teacher's lack of ethical conduct within the student-teacher relationships are also significant. Further issues of concern are the antecedents to incompetence. For instance, what are the effects of support, situational factors (e.g., changes to teaching assignment, stability in the clinical areas, and involvement in curricular activities), and personal qualities on incompetence?

Conclusion

In this chapter, 11 clinical teachers' descriptions of the process of maturing as competent clinical teachers were presented. The identified process and strategies were discussed in relation to the current literature. There are many findings in this study that did not exist in or were contrary to the literature on competence. Other findings served to support various aspects of the literatures' conceptualization of competence. Some of the existing literature offered insights into clinical teacher competence that were not revealed in these findings.

New to the substantive area of clinical teaching was empirical evidence from this study that clinical teachers become competent by experiencing a three-phased process. This process includes elements from various models of adjustment and supervisory development. There was evidence to substantiate the claim that self-confidence is an antecedent to competence. Confusion in the literature exists, however, regarding the nature and scope of self-confidence and competence relative to other concepts such as self-worth, self-efficacy, and locus of control. Nonetheless, many of the antecedents to competence are intrinsically related to personal feelings of confidence, worth, and control. Furthermore, this study indicates that support for clinical teachers is a factor facilitating the maturation process. At the same time, management of extrinsic factors such as consistent teacher

assignments and previous experiences are attributes to the process of maturing as competent clinical teachers. The premise that teacher competence is situation specific and context bound is also supported as a defining attribute.

By completing each phase of the maturation process clinical teachers attain a certain degree of competence. With continued use of various strategies, clinical teachers maintain their competence. One of the most common ways of demonstrating competence was through various teaching activities and interactions with student. This study's findings suggest that a clinical teacher's abilities and his or her competence, or lack thereof, can have an influence on the learning process. These findings have implications for nursing practice, research, education, and administration. A summary of this study, the conclusions, and the implications of the major findings will be discussed in detail in the following chapter.

CHAPTER V: SUMMARY, CONCLUSIONS, AND IMPLICATIONS

Summary of the Study

The purpose of this study was to describe the process, or processes, by which clinical nursing teachers attain, demonstrate, and maintain competence. Indirectly, this research was aimed towards uncovering the factors and situations that either facilitate or hinder the process of becoming competent.

Background

In recent years there have been numerous changes in nursing education and the health system. These changes have promoted uncertainties which have, no doubt, contributed to an increased focus on determining the competence of those who teach in clinical settings. For example, these changes have resulted in an increase in the complexity of the role and responsibilities of clinical teachers. Consequently, administrators of post-secondary institutions and supervisors of clinical agencies want to be assured that students are being accompanied to the clinical setting by teachers who demonstrate competence. Furthermore, present-day students tend to be more vocal about wanting to receive quality education. While the scope and nature of clinical teaching has been studied in the past, research related to the process of attaining, demonstrating, and maintaining competence in clinical teaching is limited.

Literature Review

A review of the literature from education, nursing, psychology, and other health related disciplines revealed numerous attributes, antecedents, consequences, and empirical referents related to competence. Nearly all definitions found in the literature placed the responsibility for competence on the individual teachers. Teachers are expected to do something to be competent. Although most authors conceptualized competence as an action outcome or personal attribute, some studies recognized that competence evolves

and is influenced by various situations and contexts. Based on a review of the academic literature, a tentative definition of competence was developed:

Competence is the actual, or potential, state of and ability to integrate and apply a blend of attributes identified in the cognitive, psychomotor, and affective domains through an evolving process. This process requires an individual to gain meaning from his or her experiences. Motivation, interest, energy, and commitment are required to help an individual deal with the internal and external factors that influence his or her state-of-being competent. Furthermore, competence is not a constant state. Rather, feelings fluctuate between anxiety and tension, comfort, and a sense of empowerment.

Since concepts provide the building blocks from which theories can be built, the results of this concept analysis directed the remainder of this research study.

Methodology

A grounded theory design was chosen for this study because of its goals. The goals of grounded theory include (a) discovering theoretical concepts about phenomena and (b) exploring basic social processes derived from empirical evidence. The grounded theory orientation was best suited to answer the research question: What is/are the process, or processes, described by nurse educators for attaining, demonstrating, and maintaining competence in their role as clinical teacher?

Eleven clinical nursing teachers from three nursing programs in the Lower Mainland of British Columbia were interviewed. Ten of the eleven participants were interviewed a second time. All interviews were audio-taped and transcribed verbatim. Since the objectives of this research were exploratory, the researcher used a method of constant comparative analysis designed by Glaser and Strauss (1967) to: (a) discover the categories, (b) integrate the categories and their properties, (c) identify the core category and delimit the theory; and (d) refine and write the theory. This method of analysis allowed the researcher to systematically generate theory by constantly comparing the data obtained during the interview process. In an analysis of the interview results, common themes were found to comprise the process of maturing as a competent clinical teacher.

The Process of Maturing as a Competent Clinical Teacher

The participants' descriptions of their maturation as competent clinical teachers were complex and varied. Central to the participants' descriptions of their experiences were the three phases through which they all passed during the *process of maturing as competent clinical teachers*. Chapter III presented the *process of maturing as competent clinical teachers*. This process was comprised of three phases characterized by key strategies, outcomes, conditions, and facilitative factors. The participants experienced the three phases in their own unique ways. For example, each participant progressed through the maturation process at a different pace. Furthermore, as circumstances continued to change, the clinical teachers continued experiencing the process. Thus, movement among the phases was multi-factorial and multi-directional with no predetermined end.

Although the participants' circumstances varied, the core variable of *developing self-confidence* connected the participants' experiences and explained the variance in their movement through the process. A degree of *self-confidence* was required to enact strategies and to move from phase to phase. Outcomes of one phase became conditions for the next phase. As participants progressed through the three-phased process they simultaneously developed more *self-confidence* and *competence*. In other words, as clinical teachers developed *self-confidence* in their abilities their *self-confidence* and competence developed further.

The first phase, *dealing with "self" learning needs*, was best described as a period of adjustment. During this phase participants dealt with the transitions or changes in their current position. For example, changing from practicing as clinicians to working as clinical teachers. During this phase participants focused primarily on themselves. They dedicated the majority of their time and energy to fulfilling their learning needs rather than those of the students. To address their learning needs, participants employed three interrelated

strategies: developing abilities as a clinical teacher, gaining awareness about clinical teaching, and dealing with anxieties. According to the participants, these strategies varied according to the context of each participant. At some point in phase one, the participants needed to address their own needs and anxieties before they could progress from phase one to phase two; this condition was essential. Participants also needed to *figure out* what was expected of students in order to progress through the clinical course. The outcome of phase one was being able to know about and understand the clinical teacher role. This outcome promoted higher degrees of *self-confidence* as clinical teachers became more comfortable in their teaching role.

Phase two, *building one's teaching style*, was primarily a time of trial and error. As clinical teachers became *self-confident* with the clinical teacher role, they progressed onward by challenging old assumptions, discovering new alternatives, and *building one's teaching style* (e.g., methods and philosophies). In this phase, participants focused on building a repertoire of teaching activities that fostered student learning. Participants used a combination of three interdependent strategies to develop their teaching style: maintaining credibility, learning how to teach, and focusing on student-centered learning. All participants dedicated time towards critically appraising themselves. When this reflection did not occur participants said they remained stagnant. The outcome of this phase was the acquisition of a variety of teaching methods. Furthermore, the participants felt *self-confident* when utilizing these methods in relevant learning situations. *Self-confidence* in one's teaching ability was a requirement for moving from phase two to phase three. Two additional conditions were needed to complete this progression: the commitment and the desire to advance the substantive area of clinical teaching.

The third phase focused on *integrating the complexities* of clinical teaching into the practice of educators. During this phase participants developed a greater appreciation for

and understanding of how to *consolidate their abilities as clinical teachers* within the *richness of the learning environment*. The focus of this phase was on directing energy towards the student, but in a much broader context of the clinical teacher's *professional nursing obligations*. Participants who spoke of phase three had developed enough self-confidence and competence to *confront student learning issues*. The outcome of phase three was a continual development of *self-confidence* and *competence* – there was no predetermined end. As new factors were introduced to participants experiencing phase three, they would mobilize various strategies to maintain and enhance their *self-confidence*. These strategies contributed to their *process of maturing as competent clinical teachers*.

Facilitative threads consisted of various factors that influenced the process of maturing as competent clinical teachers. Factors common to most participants included: support; familiarity with the clinical agency; stability of teaching assignment; congruency between teaching assignments and the clinical teacher's substantive area of nursing practice; continuing education related to teaching and learning; personality traits; communication abilities; and involvement with additional curricular activities. The facilitative threads affected the maturation process in varying degrees for each individual participant; however, all participants experienced the influence of facilitative threads to some degree.

During the three-phased process participants experienced *occasional incompetence*. This type of incompetence usually resulted from external influences or circumstances for which participants were unprepared. When the participants lacked preparation, they did not have the capacity to be *self-confident* or *competent* in completing the specific activity. Clinical teachers who demonstrated a consistent pattern of unacceptable behavior(s) experienced *overall incompetence*. Common descriptions of an incompetent clinical teacher included persons who did not have the capacities to fulfill the clinical teacher role. Both

types of incompetence indicate limited progression through the maturation process. Furthermore, this lack of progression was often accompanied by low degrees of *self-confidence*.

Summary of the Major Findings

The results of this study delineated the process by which participants matured as competent clinical teachers. Based on the study findings, the following conclusions can be made about clinical teaching in nursing.

1. Becoming a competent clinical teacher is an ongoing maturational process comprised of three phases: (a) dealing with "self" learning needs, (b) building one's teaching style, and (c) integrating the complexities. While each clinical nursing teachers' progression is unique, all teachers experience elements of the three-phased process. During each phase the clinical teachers utilize various strategies. Competence development includes elements of education and nursing practice. Progression through the process is influenced by clinical teachers' desire to succeed and their respective commitments to teaching.
2. Developing self-confidence is both a condition and an outcome of progressing through the process of maturing as competent clinical teachers. Self-confidence increases during the three-phased process as competence builds. Development of self-confidence is also influenced by internal and external factors.
3. The process of maturing as competent clinical teachers is based on several conditions: clinical teachers may or may not experience each phase, the process is ongoing, movement is multi-directional and multi-factorial, and completion of each phase leads to the development of self-confidence and a degree of competence which is necessary to begin the next phase.

4. Clinical teachers who experience the maturation process encounter fluctuating feelings of anxiety and tension as well as plateaus of comfort and a sense of empowerment.
5. During the first phase of the maturation process, neophyte clinical teachers rely on their abilities as clinicians. Once the period of adjustment is complete, competent clinicians should not be assumed to be competent clinical teachers. Rather, the development of the teacher's competence is continual and is based on his or her cognitive ability to learn and gain meaning from his or her experiences. Gaining meaning from experiences is achieved through critical thinking, problem-solving, or reflection. These are the primary ways in which clinical teachers develop their teaching style. To learn and grow teachers must also have an attitude of inquiry, a willingness to improve, an ability to gain insight, and a commitment to lifelong learning.
6. Competence as a maturation process is situation specific and context bound. A variety of factors (e.g., internal and external) affect the course and outcome of the process. These factors include: support, nursing practice, familiarity with clinical agencies, stable teaching assignment, knowledge and education related to teaching and learning, personal qualities, communication abilities, and curricular involvement. In addition, others must perceive the teacher to be credible.
7. Clinical nurse teachers experience incidences of competence as well as incompetence. In many instances the word incompetence carries a pessimistic connotation. Incompetence among clinical nurse teachers is either occasional or overall. Occasional incompetence is conceptualized as a minor mistake lacking severe outcomes while overall incompetence has significant repercussions. Clinical nurse teachers who are "overall incompetent" lack commitment, lack accountability, and

demonstrate uncaring behaviors. While instances of incompetence are observed they are rarely taken seriously from an administrative standpoint.

8. These findings prompt the question: Do incompetence and competence exist simultaneously as suggested by the participants' discussions of occasional incompetence? This study reveals that deficits in clinical teachers' abilities as clinicians are not the only factor attributed to incompetence. Defining attributes such as inadequate teaching abilities and the clinical teachers' ethical conduct in student-teacher relationships are also significant.
9. During the maturation process, clinical teachers use a variety of complex and dynamic strategies for establishing and maintaining credibility. Strategies include remaining current with both nursing and teaching practices. Credibility is important since it affects teachers, students, agency staff, and clients. Credibility can not be established solely by practicing for a number of years as a clinician. Rather, credibility is established and maintained by demonstrating a combination of expertise as a clinician, a teacher, and an academic; these are necessary to uphold professional credibility.
10. The abilities of competent clinical teachers do have some affect on the learning environment. Furthermore, this may have some influence on student learning.
11. In most instances, clinical teaching is an enjoyable and liberating experience. Clinical teachers derive a sense of satisfaction from watching their students learn and contribute to nursing practice.

Implications for Nursing

The findings of this study have implications for clinical teachers, administrators of post-secondary educational institutions, and educators of clinical teachers. Included in this discussion will be suggestions for future research.

Clinical Teaching Practice

According to the participants' descriptions, competence is embedded in a deeper sense of being and is existential in nature. While it is challenging to objectively evaluate this state-of-being, this view of competence becomes more possible with a realization that clinical teachers are continually developing their competence. Participants revealed that within each phase they implemented several strategies to attain, demonstrate, and maintain competence. Several elements of the three-phase process have implications for clinical teacher practice.

The most significant implication of this study is that attaining, demonstrating, and maintaining competence is not the sole responsibility of the clinical teacher. In fact, competence is a diverse and complex process influenced by internal personal, structural, situational, and contextual variables. However, despite the variables beyond clinical teachers' control, educators must assume responsibility for helping to ensure their professional competence. First, clinical teachers need to be cognizant of the overall process of maturation to fulfill their role obligations. Second, clinical teachers need to be aware of the aforementioned factors that may influence this process. An awareness of this process, and the variables which may affect it, is crucial because it may lead to changes in the strategies used in each phase. These changes are also significant since, as clinical teachers use these strategies, they learn how to better adapt to their environments and how to maintain or enhance their degrees of competence. Third, clinical teachers realize that competence is not a final destination; once competence is attained, ongoing effort is required to maintain and enhance one's abilities. In other words, educators need to understand that the development of their teacher competence is an ongoing work in progress.

Gaining an understanding of the maturation process will not only assist with attaining, demonstrating, and maintaining competence, but will likely provide a sense of comfort to some clinical teachers. For example, clinical teachers often experience a period of adjustment when they begin their teaching role. During this time they need to identify and confront their own learning needs. Teachers also need to acknowledge to themselves that they do not know everything about their new position. Taking the time to deal with their own learning needs is essential for the development of their respective teaching styles, self-confidence, and competence. In addition, familiarity with the process of maturing could help to normalize the feelings of uncertainty, vulnerability, and anxiety clinical teachers commonly experience.

Clinical teachers in this study believe it is unrealistic to expect them to be both an expert nurse and an expert teacher. All participants also agreed that to be competent clinical teachers they need to maintain their competence as clinicians. Therefore, according to these views, practicing clinical teachers should not focus on the number of hours performing nursing practice or the type of nursing practice. Rather, it is more appropriate to focus on the teacher's identified need and then implement strategies for improving his or her abilities as a clinical teacher. For example, a clinical teacher must take responsibility to overcome any deficiencies he or she may have in a specific area(s) of practice. Overcoming deficiencies may be achieved through individual efforts or by attending a professional development seminar.

To date, the nursing literature has explored the impact of the clinical teachers' actions relative to the teachers themselves and the students' learning. The literature does not conclusively specify the exact influence of clinical teacher behaviors on student outcomes. However, this study does indicate various situational and contextual variables that alter how educators teach and how students learn. In light of this finding, clinical

teachers need to consider how their competence affects student learning. A further influence of teacher competence on students is the clinical teacher's ability to role model. Many participants stated that they initially learned how to teach by imitating the same behaviors they observed as students. It is important for clinical teachers to realize that in this role they are not only modeling nursing practice, but also teaching behaviors. Clinical teachers also need to consider the effects of their actions on the clinical agency and their staff, the educational institution, the professional regulatory and licensing bodies, the clients, and their colleagues.

This study's findings suggest that one of the consequences of higher degrees of clinical teacher competence is varying degrees of power, authority, and respect. A clinical teacher who is viewed as an expert teacher (i.e., credible) will receive a higher level of respect from their colleagues and students and will consequently have more power in the learning environment. Therefore, it is important for clinical teachers to be aware that others' perceptions of their competence can have varying consequences for both student and teachers. For example, clinical teachers must correctly use their power and authority to benefit their students. Based on these findings, clinical teachers need to be aware of the necessity to engage in various activities to establish and maintain their credibility both as teachers and as nurses. This credibility is essential for progression through the process of becoming a competent clinical teacher and the facilitating of student learning.

This study suggests that three strategies help clinical teachers develop their teaching style and competence. First, the findings support the claim that nursing practice does contribute to teacher competence. For example, clinical teachers who perceive themselves to be competent as either generalist or specialist clinicians have the self-confidence necessary to progress through the process of maturing as competent clinical teachers. Specifically, nursing practice is a prerequisite to becoming a competent clinical

teacher. Individuals attain competence in the first phase of the maturation process by relying on their abilities as clinicians to help them through the adjustment phase. Second, education and experience as a teacher facilitates competence as a clinical nursing teacher. This is knowledge is important for nurses interested in pursuing a clinical teacher role and those currently teaching.

Despite these two findings, however, it is important to note that neither nursing practice nor teaching practice are adequate for ensuring competence as a clinical teacher. Teachers must also have the cognitive flexibility to engage in reflective thinking. Reflective thinking is the third, and most important, strategy for developing clinical teacher competence. Often this type of reflective examination allows clinical teachers to improve their teaching abilities and enhance competence. Thus, it is the responsibility of the individual to continue refining reflective thinking skills through his or her ongoing practice. Through reflective thinking clinical teachers gain meaning from their experiences which, in turn, help them to learn how to teach and develop competence. This notwithstanding, it is important to note that competence is more than an individual responsibility. I believe that administration also plays an important role in influencing the process of maturing as competent clinical teachers.

Administration

The findings of this study are important for the preparation of neophyte clinical teachers and the ongoing development for current faculty members. Various external factors, which administration can influence, play an important role in the development and maintenance of clinical teacher competence. It is clear that faculty new to the clinical teaching role require support (e.g., institutional and collegial) to minimize their anxiety and maximize their self-confidence. Administration can assist by establishing various resources (e.g., forms of professional caring) to support the development of self-confidence and

competence. For example, establishing orientation programs and ongoing professional development programs can promote personal development, including the identification of personal learning needs. Administration could also encourage experienced clinical teachers to assume a supportive mentoring role for new teachers. To summarize, this study discusses the importance of helping clinical teachers feel supported. Clinical teachers receiving support feel empowered. This sense of empowerment helps to develop the clinical teachers' self-confidence. In turn, increases in self-confidence could help clinical teachers to feel more motivated to assume an active role in determining the course of their development as competent clinical teachers.

This study also revealed that the context of clinical teaching influences clinical teachers' abilities to display competence. This finding indicates that unstable teaching assignments (e.g., reassignment, staff turnover, and part-time clinical teachers) do impact the self-confidence and competence of clinical teachers. This impact may be reduced by modifying such things as hiring practices and workload decisions. Contrary to the current trends of hiring clinical teachers on a contractual, short-time basis, I believe that it would be beneficial for administrators of undergraduate nursing programs to hire faculty on a full-time basis to teach in both clinical and classroom settings. The benefits of such hiring practices are two-fold. First, having faculty teach in both settings would (a) better prepare faculty for clinical and classroom teaching, (b) reduce the theory-practice gap, and (c) enhance the credibility of classroom teachers since others would view them as being competent in both the classroom and the clinical setting. In short, these changes would reduce the incidences of unfamiliarity clinical teachers have with the learning that occurs in the classroom setting and vice versa. Second, I believe that long-term positions benefits the educational institution because teachers have the opportunity to mature as competent clinical teachers.

Research suggests teachers would benefit from involvement in the decision-making process for such things as matching clinical teachers to clinical agency placements. This would include sharing decisions to identify the substantive area and type of agency in which specific teachers are most suited to being placed. This shared decision-making has been shown to increase faculty members' feelings of control, self-worth, and empowerment. Furthermore, clinical teachers who are motivated and interested in their teaching assignments are more likely to experience a degree of competence required to continue the maturation process.

Another recommendation for improving competence is ensuring consistency in clinical teachers' assignment. Neophyte clinical teachers should be assigned to areas with which they are most familiar and competent. Changes to teaching assignments should be kept to a minimum or at least avoided until neophyte clinical teachers are established in their new role. More experienced clinical teachers are usually more adept at coping with changes; however, continual changes in substantive areas can also negatively effect their self-confidence and competence. Overall, the decisions made by administration have significant influences on the competence of clinical teachers and their progression through the three-phased maturation process.

While competence is associated with success and promotion, incompetence creates work for others and imposes risks for the students, the clients, and the integrity of the nursing program (Jameton, 1984). For students, incompetence may hinder their learning. For clients, incompetence may hinder their well-being. Clinical teachers must be professionally accountable to ensure that quality education and client care is provided. The negative connotations often associated with incompetence make it less likely that instances will be reported. As a result, incompetent individuals are not likely to receive the assistance they need for professional development. The question not answered in this study was: How

long would clinical teachers observe the incompetent behavior of others before taking action (e.g., confronting the individual or reporting their observations to their administrator)? In most instances, incompetence is viewed as a personal responsibility. However, I believe that administration must assume some responsibility for dealing with issues of incompetence. Next, administration must review the various factors which may be contributing to a teacher's lack of competence (e.g., improper teaching assignment and frequent reassignment, a lack of time to orientate to clinical agencies, or a lack of credit for clinical teaching contributions). Finally, administrators must consider the means by which clinical teachers are to be evaluated.

The methods utilized by administration for evaluating clinical teachers may also be influenced by the findings of this study. First, competence as a maturation process was described by participants as a state-of-being. While there are inherent difficulties in evaluating an individual's state-of-being at any point in time for a given situation and context, it is important to address this dimension in the evaluation process. Second, included in the evaluation of clinical teachers should be aspects of the maturational process. Third, consideration must be given to aspects of both teacher competence and nursing competence. Other questions that this study prompts is: Who should evaluate the clinical teachers' competence? Should the evaluator(s) be a nursing colleague, a teaching colleague, an administrator, or another individual? The findings of this study suggest that some incompetent clinical teachers do not have insight into their inadequate behaviors. Consequently, it is important for administrators to consider multiple evaluators to complete clinical teachers' evaluation. I believe using a panel of evaluators (e.g., students, colleagues, and administrators) will be beneficial since each type of evaluator will contribute to the evaluation process in differing ways.

Many administrators base hiring decisions on the assumption that competent nurses will be competent clinical teachers; however, the findings of this study may relate to the hiring practices of educational institutions. For example, as previously stated, clinical teachers do not learn how to teach solely from nursing practice. Clinical teachers learn how to teach by accessing a combination of knowledge and experience from nursing, teaching, and learning situations. Clinical teachers also learn to teach by using reflection; that is, their cognitive flexibility to gain meaning and insight from experiences.

Education for Clinical Teachers

The clinical teaching role places two differing demands on nursing faculty: (a) competence in nursing and (b) competence in teaching. Clinical teachers that have knowledge in and experience with teaching reported higher degrees of self-confidence, comfort, and competence in their clinical teaching role. Therefore, the findings of this study have direct implications for preparing nurses for a clinical teaching role.

Evidence to suggest the need to better prepare faculty for the clinical teaching role was first introduced by Infante in 1975 and restated by Karuhije in 1986. Despite these appeals, little has been done to better prepare new clinical teachers. In some provinces, content related to teaching either does not exist in graduate curricula or is being removed from masters programs. I believe this has severe implications for the competence of clinical teachers responsible for teaching the next generation of nurses. Clinical teachers unprepared for the clinical teaching role may affect the quality of education students receive. Because of the demand for quality preparation of baccalaureate nurses, graduate nursing programs (e.g., masters and doctorate) need to offer courses relevant to clinical teaching.

To ensure that professional practice is guided by theory, graduate nursing curricula for future clinical teachers should focus on both teaching and learning. The findings of this

study clearly indicate that those interested in clinical teaching also need to be knowledgeable about the process of maturing as competent clinical teachers. For example, graduate education in nursing should focus on the (a) knowledge and skills required for understanding students (e.g., student counselling, student evaluation, and negotiating a supportive learning environment), (b) various strategies used to develop one's teaching style, (c) educational theory applicable to the practice of clinical teaching, and (d) factors that facilitate or hinder teacher competence. Furthermore, graduate programs could offer opportunities for helping clinical teachers develop reflective thinking skills.

Research

Various researchers have studied the substantive area of clinical teaching. Empirical evidence from this study identifies a need for additional research into the basic social process of maturing as a competent clinical teacher. While the multi-dimensional nature of clinical teaching makes it difficult to explicate the process of competence in a straightforward manner, replication of this study with a larger and more diverse group (e.g., cultural and male perspectives) may reveal either a variation or a consistency with these findings. Additional research in the following areas would enhance the current knowledge on the maturation process:

1. Empirically-based research exploring the direct relationship between self-confidence and clinical teacher competence. This research should include an examination of the proposition that self-confidence is an antecedent to clinical teaching.
2. Examination of the relationship between self-efficacy and competence.
3. Research to more clearly describe the process of enacting the clinical teaching role (i.e., performance) in relation to the process of competence.
4. Advanced levels of cognitive thinking have been linked to the maturation process.

Empirical evidence substantiating the link between critical thinking and clinical teacher

competence is necessary. Also, further research is needed to confirm the relationship between reflection and learning how to teach, and reflection and clinical teacher competence.

5. Examination of methods for evaluating competence from various perspectives (e.g., self, administrators, students, and colleagues).
6. Research to further explicate the situational and contextual nature of competence.
7. Due to increasing levels of client acuity in the clinical setting, clinical teachers are challenged to continually demonstrate credibility and competence. Research is needed to explore the importance of expertise as both clinicians and teachers and how this expertise contributes to credibility.
8. Exploration of the phenomena of incompetence, including, an examination of the defining attributes, antecedents, and consequences of incompetence.
9. Research into the differences between occasional and overall incompetence.

Conclusion

This study has explored the process by which clinical teachers attain, demonstrate, and maintain competence. Through the experiences of 11 clinical teachers the process of maturing as a competent clinical teacher was revealed. The findings illuminate the complex, unique nature of clinical teacher competence and the attributes, antecedents, and consequences of competence. The study's findings also provide direction for nursing education, practice, administration, and research. Ultimately, the researcher hopes that the questions raised and suggestions proposed in these findings will prompt other researchers to study the phenomena of competence in the context of clinical nurse teaching.

References

- Bandura, A. (1977). Social learning theory. Englewood Cliffs, NJ: Prentice-Hall.
- Barnes, N.L., Duldt, B.W., & Green, P.L. (1994). Perspectives of faculty practice and clinical competence. Nurse Educator, 19(3), 13-17.
- Beck, C.T. (1993). Qualitative research: The evaluation of its credibility, fittingness, and auditability. Western Journal of Nursing Research, 15(2), 263-266.
- Benner, P. (1984). From novice to expert. Menlo Park, CA: Addison-Wesley Publishing.
- Benor, D.E., & Levinyof, I. (1997). The development of students' perceptions of effective teaching: The ideal, best, and poorest clinical teacher in nursing. Journal of Nursing Education, 36(5), 206-211.
- Bentz, P., & Ellis, J.R. (1991). The challenge to faculty. In V. Walters (Ed.), Teaching Gerontology (pp. 25-34). New York: National League for Nursing.
- Bergman, K., & Gaitskill, T. (1990). Faculty and student perceptions of effective clinical teachers: An extension study. Journal of Professional Nursing, 6(1), 33-44.
- Bevis, E.O., & Watson, J. (1989). Toward a caring curriculum: A new pedagogy for nursing. New York: National League for Nursing.
- Brooke, V. (1989). How elders adjust. Geriatric Nursing, 10(2), 66-68.
- Brookfield, S. (1987). Developing critical thinkers: Challenging adults to explore alternative ways of thinking and acting. San Francisco: Jossey-Bass Publishers.
- Brown, S.T. (1981). Faculty and student perceptions of effective clinical teachers. Journal of Nursing Education, 20(9), 4-15.
- Brunke, L. (1997). Nurses review ways to demonstrate competence. Nursing BC, 29(1), 22-23.
- Burrows, E. (1989). Clinical practice: An approach to the assessment of clinical competencies. British Journal of Occupational Therapy, 52(6), 222-226.
- Butler, F.C. (1978). The concept of competence: An operational definition. Educational Technology, 7(1), 7-18.
- Campbell, I.E., Larrivee, L.L., Field, P.A., Day, R.A., & Reutter, L. (1994). Learning to nurse in the clinical setting. Journal of Advanced Nursing, 20, 1125-1131.
- Canadian Nurses Association. (1993). Blueprint for the criterion-referenced nurse registration/licensure examination. Ottawa, ON: Canadian Nurses Association.

Canadian Nurses Association. (1994). Ethical guidelines for nurses in research involving human participants (2nd ed.). Ottawa, ON: Author.

Cave, I. (1994). Nurse teachers in higher education - without clinical competence, do they have a future? Nurse Education Today, 14(5), 394-399.

Charmaz, K. (1983). The grounded theory method: An explication and interpretation. In R.M. Emerson (Ed.), Contemporary field research (pp. 109-126). Prospect Heights, IL: Waveland.

Chenitz W.C., & Swanson, J.M. (1986). From practice to grounded theory. Don Mills: Addison-Wesley Publishing.

Choudhry, U.K. (1992). New nurse faculty: Core competencies for role development. Journal of Nursing Education, 31(6), 265-272.

Choudhry, U.K. (1992a). Faculty practice competencies: Nurse educators' perceptions. The Canadian Journal of Nursing Research, 24(3), 5-17.

Cohen, J.A. (1993). Caring perspectives in nursing education: liberation, transformation and meaning. Journal of Advanced Nursing, 13, 621-626.

Covey, S.R. (1995). The seven habits of highly effective people (Workshop Guide, Version 2.0). USA: Covey Leadership Centre.

Cox, K. (1988). What is included in clinical competence? The Medical Journal of Australia, 148(1), 25-27.

Crandall, S. (1993). How expert clinical educators teach what they know. Journal of Continuing Education in the Health Professions, 13, 85-98.

Crotty, M. (1993). The emerging role of the British nurse teaching in Project 2000 programmes. Journal of Advanced Nursing, 18, 150-157.

Crotty, M., & Butterworth, T. (1992). The emerging role of the nurse teacher in Project 2000 programmes in England: A literature review. Journal of Advanced Nursing, 17, 1377-1387.

Davis, D.C., Dearman, C., Schwab, C., & Kitchens, E. (1992). Competencies of novice nurse educators. Journal of Nursing Education, 31(4), 159-164.

Fawcett, T.N., & McQueen, A. (1994). Clinical credibility and the role of the nurse teacher. Nurse Education Today, 14(4), 264-271.

Ferguson, D.S. (1996). The lived experience of clinical educators. Journal of Advanced Nursing, 23, 835-841.

Fidler, G.S. (1981). From crafts to competence. American Journal of Occupational Therapy, 35, 567-573.

Fong, C.M., & McCauley, G.T. (1993). Measuring the nursing, teaching, and interpersonal effectiveness of clinical instructors. Journal of Nursing Education, 32(7), 325-328.

Ford, J.S., & Profetto-McGrath, J. (1994). A model for critical thinking within the context of curriculum as praxis. Journal of Nursing Education, 33(8), 341-344.

Ford, M.E. (1985). The concept of competence: Themes and variations. In H.A. Marlowe and R.B. Weinberg (Eds.), Competence development: Theory and practice in special populations (pp. 3-15). Springfield, IL: Charles C. Thomas Publisher.

Gallagher, J.J. (1994). Teaching and learning: New models. Annual Review of Psychology, 45, 171-95.

Gatz, M., Barbarin, O., Tyler, F., Mitchell, R., Moran, J., Wirzbicki, P., Crawford, J., & Engelman, A. (1982). Enhancement of individual and community competence: The older adult as community worker. Annual Journal of Community Psychology, 10(3), 291-303.

Gee, K. (1995). Competency through being: The enemy within? British Journal of Nursing, 4(11), 637-640.

Gillespie, C.M. (1997). The essence of student-teacher connection in the student-teacher relationship in clinical nursing education. Unpublished Master's thesis, University of British Columbia, Vancouver, British Columbia, Canada.

Girof, E.A. (1993). Assessment of competence in clinical practice: A phenomenological approach. Journal of Advanced Nursing, 18, 114-119.

Glaser, B.C. (1978). Emergence vs forcing: Basics of grounded theory analysis. Mill Valley, CA: Sociology Press.

Glaser, B.G., & Strauss, A.L. (1967). The discovery of grounded theory: Strategies for qualitative research. New York: Aldine Publishing.

Goetz, J.P., & LeCompte, M.D. (1984). Ethnography and qualitative design in educational research. Toronto, ON: Academic Press, Inc.

Goorapah, D. (1997). Clinical competence/clinical credibility. Nurse Education Today, 17, 297-302.

Hanson, L.E., & Smith, M.J. (1996). Nursing students' perspectives: Experiences of caring and not-so-caring interactions with faculty. Journal of Nursing Education, 35(3), 105-112.

Halldorsdottir, S. (1997). Implications of the caring/competence dichotomy. In S.E. Thorne & V.E. Hayes (Eds.), Nursing Praxis: Knowledge and Action (pp. 105-124). London: Sage Publications.

Harwood, C., & Olson, J. (1988). Peer evaluation: A component of faculty performance appraisal. Journal of Nursing Education, 27(8), 377-379.

Hess, A.K. (1986). Growth in supervision: Stages of supervisee and supervisor development. Clinical Supervisor, 41(1-2), 51-67.

Huettl, L. (1996). Accountability. Nevada RNformation, 5(4), 10.

Infante, M.S. (1975). The clinical laboratory in nursing education. New York: John Wiley & Sons.

International Council of Nurses. (1996). Ethical guidelines for nursing research. Geneva, Switzerland: International Council of Nurses.

Jacobs, W.J., & Wylie, W.E. (1995). Who teaches health education in Texas secondary schools? Journal of School Health, 65(9), 365-368.

Jameton, A. (1984). Competence: Nurses have an obligation to be competent. In A. Jameton (Ed.), Nursing Practice: The Ethical Issues (pp. 80-88). Englewood Cliffs, NJ: Prentice-Hall.

Johnson, D.E. (1966). Competence in practice: Technical and professional. Nursing Outlook, 14(10), 30-33.

Karuhije, H.F. (1986). Educational preparation for clinical teaching: Perceptions of the nurse educator. Journal of Nursing Education, 25(4), 137-144.

Karuhije, H.F. (1997). Classroom and clinical teaching in nursing: Delineating differences. Nursing Forum, 32(2), 5-12.

Kelly, E., & Young, A. (1996). Models of nursing education for the twenty-first century. In K.R. Stevens (Ed.), Review of research in nursing education (Vol. 7) (pp. 1-39). New York: National League for Nursing Press.

Kirkpatrick, M.K. (1992). The ABCs of maintaining clinical competence. Nurse Educator, 17(3), 5-6.

Knox, J.E., & Mogan, J. (1985). Important clinical teacher behaviors as perceived by university nursing faculty, students, and graduates. Journal of Advanced Nursing, 10, 25-30.

Kolb, D. (1984). Experiential learning theory. Englewood Cliffs, NJ: Prentice-Hall.

Kramer, M., Polifroni, C., & Orgonek, N. (1986). Effects of faculty practice on student learning outcomes. Journal of Professional Nursing, Sept-Oct, 289-298.

Krichbaum, K. (1994). Clinical teaching effectiveness described in relation to learning outcomes of baccalaureate nursing students. Journal of Nursing Education, 33(7), 306-316.

Langford, C.P., Bowsher, J., Maloney, J.P., Lillis, P.P. (1997). Social support: A conceptual analysis. Journal of Advanced Nursing, 25, 95-100.

- Lee, D.T.F. (1996). The clinical role of the nurse teacher: A review of the dispute. Journal of Advanced Nursing, 23, 1127-1134.
- Maynard, C.A. (1996). Relationship of critical thinking ability to professional nursing competence. Journal of Nursing Education, 35(1), 12-18.
- Marcinek, M.A. (1993). The curriculum revolution: Transforming barriers to education for Registered Nurses. Nurse Educator, 18(4), 13-16.
- Maynard, C.A. (1996). Relationship of critical thinking ability to professional nursing competence. Journal of Nursing Education, 35(1), 12-18.
- McCabe, B.W. (1985). The improvement of instruction in the clinical area: A challenge waiting to be met. Journal of Nursing Education, 24, 255-257.
- Milligan, F. (1998). Defining and assessing competence: The distraction of outcomes and the importance of educational process. Nurse Education Today, 18, 273-280.
- Mobily, P.R. (1992). Role strain. In L.B. Welch (Ed.), Perspectives on faculty roles in nursing education (pp. 1-12). New York: Praeger.
- Mogan, J., & Knox, J.E. (1987). Characteristics of "best" and "worst" clinical teachers as perceived by university nursing faculty and students. Journal of Advanced Nursing, 12, 331-337.
- Morgan, S.A. (1991). Teaching activities of clinical instructors during the direct client care period: A qualitative investigation. Journal of Advanced Nursing, 16, 1238-1246.
- Mozingo, J., Thomas, S., & Brooks, E. (1995). Factors associated with perceived competency levels of graduate seniors in a baccalaureate nursing program. Journal of Nursing Education, 34(3), 115-122.
- Myrick, F. (1991). The plight of clinical teaching in baccalaureate nursing education. Journal of Nursing Education, 30(1), 44-46.
- Nagelsmith, L. (1995). Competence: An evolving concept. The Journal of Continuing Education in Nursing, 26(6), 245-248.
- Nehring, V. (1990). Nursing clinical teacher effectiveness inventory: A replication of the characteristics of "best" and "worst" clinical teachers as perceived by nursing faculty and students. Journal of Advanced Nursing, 15, 934-940.
- Neufeld, V.R. (1985). Implications for education. In V.R. Neufeld & G.R. Norman (Eds.), Assessing clinical competence (pp. 297-310). New York: Springer Publishing.
- Oermann, M.H. (1996). Research on teaching in the clinical setting. In K.R. Stevens (Ed.), Review of Research in Nursing Education (Vol. 7) (pp. 91-126). New York: NLN Press.

Oldmeadow, L. (1996). Developing clinical competence: A mastery pathway. Australian Journal of Physiotherapy, 42(1), 37-44.

O'Shea, H.S. (1982). Role orientation and role strain of clinical nurse faculty in baccalaureate program. Nursing Research, 31(5), 306-310.

Paterson, B., & Crawford, M. (1994). Caring in nursing education: An analysis. Journal of Advanced Nursing, 19, 164-173.

Paterson, B. (1997). Nursing 580: Teaching in clinical nursing. Unpublished Course Materials. University of British Columbia at Vancouver, BC.

Poteet, G.W. (1987). Recognizing and responding to administrative incompetence. Nursing Management, 18(1), 43-46.

Radwin, L.E. (1996). 'Knowing the patient': A review of research on an emerging concept. Journal of Advanced Nursing, 23, 1142-1146.

Registered Nurses Association of British Columbia [RNABC]. (1990). Nursing competencies and skills required of the new graduate. Vancouver, BC: Author

RNABC. (1992). Standards for nursing practice in British Columbia. Vancouver, BC: Author.

RNABC. (1996). Continuing competence: A discussion paper. Vancouver, BC: Author.

Reeve, M.M. (1994). Development of an instrument to measure effectiveness of clinical instructors. Journal of Nursing Education, 33(1), 15-20.

Roach, M.S. (1984). Caring: The human mode of being, implications for nursing. Toronto, ON: University of Toronto.

Robertson, M.H.B., & Boyle, J.S. (1984). Ethnography: Contribution to nursing research. Journal of Advanced Nursing, 9, 43-49.

Robinson, C.A., & Thome, S.E. (1988). Dilemmas of ethics and validity in qualitative nursing research. The Canadian Journal of Nursing Research, 20(1), 65-76.

Salvatori, P. (1996). Clinical competence: A review of the health care literature with a focus on occupational therapy. Canadian Journal of Occupational Therapy, 63(4), 260-271.

Sandelowski, M. (1986). The problem of rigor in qualitative research. Advances in Nursing Science, 8(3), 27-37.

Saylor, C.R. (1990). Reflection and professional education: Art, science, and competency. Nurse Educator, 15(2), 8-11.

Scanlan, J.M., & Chernomas, W.M. (1997). Developing the reflective teacher. Journal of Advanced Nursing, 25, 1138-1143.

Scheetz, L.J. (1989). Baccalaureate nursing student preceptorship programs and the development of clinical competence. Journal of Nursing Education, 28(1), 29-35.

Schwammle, D. (1996). Occupational competence explored. Canadian Journal of Occupational Therapy, 63(5), 323-330.

Schon, D. (1987). Educating the reflective practitioner. San Francisco: Jossey-Bass.

Sieh, S., & Bell, S.K. (1994). Perceptions of effective clinical teachers in associate degree programs. Journal of Nursing Education, 33(9), 389-394.

Slunt, E.T. (1993). Caring: A meaning of competence. In J. Simmons (Ed.), Celebrating 40 Years of Associate Degree Nursing Education (pp. 37-46). New York: National League for Nursing Press.

Spradley, J.P. (1979). The ethnographic interview. Toronto, ON: Holt, Rinehart and Winston.

Strauss, A., & Corbin, J. (1990). Basics of qualitative research: Grounded theory procedures and techniques. Newbury Park, CA: Sage Publications.

Tanner, C.A., Benner, P., Chelsa, C., & Gordon, D.R. (1993). The phenomenology of knowing the patient. Image: Journal of Nursing Scholarship, 25(4), 273-280.

Toliver, J.C. (1988). Inductive reasoning: Critical thinking skills for clinical competence. Clinical Nurse Specialist, 2(4), 174-179.

Van Ort, S.R. (1983). Developing a system for documenting teaching effectiveness. Journal of Nursing Education, 22(8), 324-328.

Walker, L.O., & Avant, K.C. (1995). Strategies for theory construction in nursing (3rd ed.). Norwalk, CT: Appleton & Lange.

Ward-Griffin, C., & Brown, B. (1992). Evaluation of teaching: A review of the literature. Journal of Advanced Nursing, 17, 1408-1414.

Watson, S.J. (1991). An analysis of the concept of experience. Journal of Advanced Nursing, 16, 1117-1121.

Weitzel, M. (1996). Evaluation of clinical competency of clinical nursing faculty. Journal of Nursing Education, 35(2), 51-53.

Wellard, S.J., Rolls, C., & Ferguson, D.S. (1995). Evaluating clinical educators: An employer's perspective. Journal of Advanced Nursing, 21, 737-742.

While, A.E. (1994). Competence versus performance: Which is more important? Journal of Advanced Nursing, 20, 525-531.

White, B. (1994). Competence to consent. Washington, D.C.: Georgetown University Press.

Whitman, N.I. (1990). Clinical colleagues as a source of data for faculty evaluation. Western Journal of Nursing Research, 12(5), 644-658.

Wiedenbach, E. (1969). Meeting the realities in clinical teaching. New York: Springer Publishing.

Wills, M.E. (1997). Link teacher behaviors: Student nurses' perceptions. Nurse Education Today, 17, 232-246.

Wong, J., & Wong, S. (1987). Towards effective clinical teaching in nursing. Journal of Advanced Nursing, 12, 505-513.

Wood, V. (1987). The nursing instructor and clinical teaching. International Nursing Review, 34(5), 120-125.

Yonge, O. (1986). Nurse educators' perception of clinical competence. Alberta Association of Registered Nurses (AARN) Newsletter, Jan, 23-25.

Zimmerman, L., & Waltman, N. (1986). Effective clinical behaviors of faculty: A review of the literature. Nurse Educator, 11(1), 31-34.

Appendix A

Domains of Competence

1. *Cognitive Domain*

- comprehension and application of nursing knowledge (e.g., theoretical, personal, and practical)
- comprehension and application of teaching-learning knowledge (e.g., principles of adult learning and the learning process)
- utilization of critical thinking which includes the ability to problem-solve and make clinical and teacher judgments

2. *Affective Domain*

- interpersonal skills
- critical reflection of one's personal characteristics
- attitudes (e.g., enjoys nursing), values, and beliefs
- professional behaviors (e.g., role model, responsible for actions, caring, ethical, genuine interest in student learning, and lifelong learner)

3. *Psychomotor Domain*

- clinical skills
- teaching skills
- expert learner skills
- physical and motor skills

Appendix C Letter of Invitation

Dear Clinical Teacher:

My name is Angela Wolff. As my thesis project at the University of British Columbia, Master of Science in Nursing Program, I am conducting a research project to learn more about nurse educators' perspective of competence in their role as a clinical teacher. I am inviting you to participate in this project (September, 1997 until March, 1998).

The results of this study may provide nurse educators with a clear understanding of competence in their role as clinical teacher. With your input it is hoped that alternate ways of clinical teacher evaluation will be formulated. This study will prove to be beneficial to contributing to changes in nursing education.

If you agree to take part in this study, I will interview you twice to explore your viewpoint of clinical teacher competence. Each tape-recorded interview will take about 1 hour of your time, and will be conducted at a location of your choice. The taped interview will be transcribed, with the omission of identifying information. After the first interview has been analyzed, the researcher will arrange for a second taped interview to clarify and verify the issues identified and described in the first interview. The total time required for each participant is estimated to two hours. Demographic data will also be collected to assist the researcher in analysis and description of the sample for this study.

Your participation is strictly voluntary. You may withdraw from the study at any time without jeopardizing your position as a clinical teacher. Participation in this study will not have any effect on faculty performance evaluations. There will be no cost to you as a result of taking part in this study. Thank-you in advance for your assistance is furthering research in nursing education. If you would like to participate in this study or if you would like further information, I can be reached by email at awolff@unixg.ubc.ca, XXX-XXXX (work), collect at (403)XXX-XXXX (home), and XXX-XXXX (fax); or you may contact my thesis chairperson, Carol Jillings at XXX-XXXX.

Sincerely,

Angela Wolff, BScN, RN
MSN (student)

Appendix D Informed Consent

Attaining, Demonstrating, and Maintaining Competence:
The perspective of Nurse Educators in the role as clinical teacher

Researcher: Angela Wolff, BScN, RN
Master of Science in Nursing Student
School of Nursing
University of British Columbia
Vancouver, BC
Phone: XXX-XXXX (home)

Supervisor: Dr. Carol Jillings
Associate Professor
School of Nursing
University of British Columbia
Vancouver, BC
Phone: XXX-XXXX

As my thesis project at the University of British Columbia, Master of Science in Nursing Program, I am conducting a research project to learn more about nurse educator's perspective of competence in their role as a clinical teacher. I am inviting you to participate in this project.

The results of this study may provide nurse educators with a clear understanding of competence in their role as clinical teacher. With your input it is hoped that alternate ways of clinical teacher evaluation will be formulated. This study will prove to be beneficial to contributing to changes in nursing education.

If you agree to take part in this study, I will interview you twice to explore your viewpoint of clinical teacher competence. Each tape-recorded interview will take about 1 hour of your time, and will be conducted at a location of your choice. The taped interview will be transcribed, with the omission of identifying information. After the first interview has been analyzed, the researcher will arrange for a second taped interview to clarify and verify the issues identified and described in the first interview. The total time required for each participant is estimated to two hours. Demographic data will also be collected to assist the researcher in analysis and description of the sample for this study.

Our conversations will be kept confidential as I will assign a code number to each participant, no names will be used on tape or in transcriptions of the interview. A list of the names and code names will be kept locked in a secure place. All tapes, transcriptions, and notes will be kept in a locked cabinet, separate from consent forms or code lists, for five years after the completion of the study. Typed notes and transcriptions will be kept under password on my computer hard drive. Consent forms will also be kept for five years. Only myself and my thesis committee will have access to the data collected during the interviews. Data may be used for another study in the future, if the researcher receives approval from the appropriate ethics review committee. When the study is finished and upon request, a written summary of the results can be sent to you.

Appendix D (continued)

The information and findings of this study may be published or presented at conferences, but your name or any material that may identify you will not be used. If you have questions or concerns about this study at any time, you can call the researcher or supervisor at the numbers above.

Your participation is strictly voluntary. You may withdraw from the study at any time without jeopardizing your position as a clinical teacher. Participation in this study will not have any effect on faculty performance evaluations. There will be no cost to you as a result of taking part in this study. Thank-you in advance for your assistance is furthering research in nursing education.

If you have any questions or concerns, I can be reached at XXX-XXXX (home); or you may contact my thesis chairperson, Carol Jillings at XXX-XXXX. If you have any concerns about your treatment or rights as a research subject you may contact the Director of Research Services at the University of British Columbia, Dr. Richard Spratley at 822-8598.

Consent

The reason for this study is to explore nurse educator's perspectives of competence in their role of clinical teaching.

I, the undersigned, have read the participant information letter and consent to participate in two taped-recorded interviews conducted by Angela Wolff. Any questions have been answered to my satisfaction. In addition, I know that I may contact the persons named above if I have further questions either now or in the future. I understand that my name will be kept confidential. I understand that participation in research is voluntary and I am free to withdraw from the study at any time. In addition, I understand that my signature indicates that I have received a copy of the consent form.

This is to certify that I _____ (print name) have read and understood this consent, the research study has been explained, and all my questions have been answered. I hereby agree to participate as a volunteer in the above named project.

(Participant Signature)

(Date)

(Signature of a Witness)

(Date)

(1 copy to subject, 1 copy to researcher)

Appendix E

Sample Interview Questions

Attaining Competence

- What experiences have you had as a clinical teacher that have enhanced or hindered your competence?
- Who or what contributes to your competence?
- What did you do to become competent?

Demonstrating and Maintaining competence

- Tell me about a time (an experience) when you were competent as a clinical teacher.
- Tell me about a time (an experience) when you (or a colleague) was incompetent (compare with competent).

Demonstrating Competence

- How would you describe a clinical teacher that is competent? Could you tell me more about.....
- How would you describe a clinical teacher that is incompetent? Could you give me an example...

Types of Competence

- Do you see a difference between teacher competence? Nursing competence?
- How does your competence in teaching relate to your competence as a nurse?

Evaluating Competence

- Is competence more of a concern for licensing body, self, or students?
- Who do you think should evaluate competence of a clinical teacher (e.g., self, students, peer, administration)?
- How did you decide you were competent to become a clinical teacher?

Appendix F Demographic Form

1. Gender:

_____ Female
_____ Male

2. Level of education upon initial R.N. registration:

_____ Diploma in nursing
_____ Baccalaureate Degree in nursing
_____ Other (specify) _____
_____ Year of graduation _____

3. Level of education to date:

_____ Baccalaureate Degree in nursing
_____ Master's Degree in nursing
_____ Doctorate in nursing
_____ Degree (specify) _____
_____ Other (specify, includes certificate programs) _____
_____ Year of graduation _____

4. Total number of years of clinical teaching experience _____
Years Months

5. Total number of years of experience as a Registered Nurse (before the commencement of clinical teaching):

_____ Years
_____ Months

6. Program type currently teaching in:

_____ Diploma Nursing Program (length of program) _____
_____ Baccalaureate Nursing Program
_____ Collaborative Baccalaureate Nursing Program (specify if program offers first 2 ½ years or entire 4 years) _____
_____ Specialty Nursing Program (specify length) _____
_____ Total number of years spent teaching clinical in the above program _____

Appendix F (continued)

7. Type of program taught in the past:

- _____ Diploma Nursing Program (length of program) _____
_____ Baccalaureate Nursing Program
_____ Collaborative Baccalaureate Nursing Program (specify if program offers first 2 ½
years or entire 4 years) _____
_____ Specialty Nursing Program (specify length) _____
_____ Total number of years spent teaching clinical in the above program

8. Specify past and current clinical settings in which you taught as a clinical teacher:

9. Level of student taught. Indicate the length of time you taught at this level.

Year 1 _____

Year 2 _____

Year 3 _____

Year 4 _____

Other (specify) _____