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**THE LIVED EXPERIENCE OF THE NURSE EDUCATOR DURING CLINICAL
PRACTICUM. A PHENOMENOLOGICAL STUDY**

by

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ABSTRACT

Nursing research has centered on numerous aspects of clinical education, primarily from the student perspective. The purpose of this phenomenological study was to discover, explore and describe the perceptions of nurse educators regarding clinical teaching. By gaining an understanding of the meaning and practices, as perceived by clinical nurse educators, others involved in nursing education and practice may be sensitized to and have a greater awareness of the purpose of the nurse educator and what he or she brings to the students' educational experience. A written informed consent was obtained from five nurse educators from the Avalon region of Newfoundland and audio taped unstructured interviews were transcribed verbatim. Max vanManen's (1990) theoretical approach guided the research and revealed six themes: (1) The Nurse Educator as a Connection to Caring, (2) Being Human, (3) Learners and Know-how of Knowledge, (4) Seeking Validation. Alone in Becoming, (5) All Being, and (6) Guardian of Safety. The essence of the experience was becoming a nurse teacher.

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Finally, to my husband Jim, and our children, Samuel, Kaelyn and Thomas whose love and inspiration made it all worthwhile.

DEDICATION

**To my children, Samuel, Kaelyn and Thomas.
Mom is finished and you can have my autograph now.**

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CHAPTER ONE

Introduction and Statement of the Problem

Within the past twenty years a paradigm shift has occurred in nursing education that has emphasized higher education, professionalization and a theory to practice orientation (Rose, Beeby & Parker, 1995). Clinical education, a core element of nursing education, has been indisputably chronicled as the essential component within nursing curricula (Ferguson, 1996; Lee, 1996; Pugh, 1980; Reilly & Oermann, 1992). There has been irrefutable recognition given to its weight as a crucial component within professional nursing education and the assistance it has provided in shaping the identities of neophytes and their professional values, norms and attitudes of nursing (Benor & Levyof, 1997).

Clinical education, under the guidance of the nurse educator, has been depicted as a medium in which teacher, student and patient exist in a triad for the principal purpose of allowing the student to learn to be a clinician (Paterson, 1997). Guided by the nurse educator, the clinical practicum has allowed students to learn and develop problem solving skills, progress in their commitment to accountability and collaborate with other disciplines in the resolution of client problems (Paterson, 1997; Pugh, 1980; White & Ewan, 1991). Benner (1984) and Reilly and Oermann (1992) have portrayed clinical nursing education as the union of clinical environment and experiential learner where students step into the experience for the acquisition of knowledge.

Over the past three decades nursing scholars have explored many facets of nursing education. Innovative approaches in clinical teaching that have emphasised changes in curricular issues and instructional practices have dominated the nursing education literature (Diekelmann, 1990, 1993). While nursing research has focused on numerous aspects of education, only in recent years has the clinical experience been explored in any depth. Almost exclusive emphasis has been attached to the students' perception and little centered on the nurse educators' perspective and their experience with clinical teaching (White & Ewan, 1991). What has been a primary point, in nursing education research, has been the faculty-student relationship in the clinical setting and the caring practices of nurse educators, as perceived by nursing students (Bergmann, 1990; Hughes, 1992; Paterson & Crawford, 1994; Schaffer & Juarez, 1996). Research on the primary consumer of nursing education, the student, has contributed to the primary goal of improving nursing education but has not afforded the valuable contribution that nurse educators may also bring to such research (DeYoung, 1990). Benner (1984) and White and Ewan (1991) have strongly advocated for nursing research to concentrate on exposing the complexities and richness of clinical teaching. Such research, along with examination of the convoluted learning environment in which clinical teaching has existed, would offer value to nursing education and assist students in the application of tying nursing theory to their clinical practice.

Many scholars have identified the paucity of research from the nurse educators' perspective in the area of clinical teaching. The research that does exist has focused more

on assigned tasks of the clinical educators rather than on their experience and what they believe takes place in the realm of teaching in the clinical setting (Diekelmann, 1990; Paterson, 1997; Pugh, 1980).

The Investigator's Perspective

This study arose from the investigator's interest and in-depth awareness of the responsibilities, practices and role relationships which as a nurse educator one has to undertake while working with students in the clinical setting and the paucity of research on the nurse educator's perspective of the clinical practicum. The investigator had worked as a practicing critical care nurse and as a nurse educator in many areas of clinical practice. Clinical teaching had intrigued the investigator the most, as she had noted the many and varied responsibilities that had to be undertaken over the years, students' dependence for guidance and support and the intricacy of the clinical arena.

As those teaching experiences were explored several questions had come to light: When a nurse educator has entered into relationships with students and has guided them through their clinical education, how have nurse educators perceived those relationships? What have they believed to be the purpose, reason and insight into the meaning behind their role? What have they attempted to achieve? How have nurse educators contributed to the totality of the clinical experience? How have they seen the students benefiting from such a relationship? How have they passed on knowledge to students? The investigator wondered if such observations and feelings were the same for other nurse educators as

they told of their teaching practices. Such an insight, the reality as clinical nurse educators have perceived it, would contribute to existing nursing research. As Janice Morse (1992) had depicted, “I can’t imagine doing a phenomenological study without knowing something personally about the phenomenon I was interested in pursuing” (p.91).

Purpose of the Study

The purpose of this phenomenological study was to discover, explore and describe the perceptions of nurse educators as they encountered clinical teaching. If an understanding has been gained of the meaning and practices of clinical nurse educators , then others involved in nursing education may be sensitized to and have a greater awareness of the nurse educators’ role and what it brings to the students’ educational experience. As nurse educators have possessed a richer understanding of themselves then they “become more fully who they are” (vanManen, 1990, p.12). Thus the research question that was explored in this study was “what is the lived experience of the nurse educator during clinical practicum?”

The Limitations/Delimitations of the Study

Reflection on the lived experience, in phenomenology, is always retrospective, as it has already been lived through (vanManen, 1990). Some authors have suggested the recall of life events may be influenced by the participants’ feelings or their self-

perceptions at the time of asking (Ross & Buehler, 1994). A two to three week time frame was provided, before the interviews occurred, which permitted time for the participants to reflect on the phenomenon of interest (Sandleowski, 1999). Although the participants were very willing to participate, some were not as articulate in the descriptions of their experiences as others and those individuals therefore may have been influenced in their verbalizations by the investigator's encouragement to respond. Also as the investigator had already formed relationships with the individual participants, as colleagues, this may have prompted them to say what they thought the investigator would have preferred to hear.

A second limitation was the sampling process due to the investigator's limited monetary resources. The participants lived within a small urban region and all participants had received a portion of their education from the same post-secondary educational institution. Although the sample size and the homogenous nature of the group was appropriate, the lived experience of rural nurse educators or those with educational preparation from varied institutions may have altered the results (Sandelowski, 1995). Thirdly, the results of this study cannot be generalized to the general population of clinical nurse educators. Nonetheless, what the participants believed their self-perceptions and expectations were, how they formed relationships and were influenced by those around them and how they developed in their clinical roles have been noteworthy for other nurse educators who desire to discover their connection with clinical teaching and student learning.

Phenomenology implies that if the experience, significance and meaning of one's life has been well described it has represented a portion of that life-world (Sandelowski, 1986, 1998). A snapshot of the lived experience of the world of the clinical nurse educator and the notion that this study, through its descriptions, has contributed to the existing nursing literature has been notable (vanManen, 1990).

Finally, there was a varied range among the participants in their years of experiences. Having had experience being a clinical nurse educator for a longer period of time, their developmental maturity, problem solving strategies and experiential learning, may have influenced how they perceived their experiences. Another study of clinical nurse educators that investigates their experiences and perceptions may offer further meaning and depth to the lived experience of the clinical nurse educator.

Participants

Five nurse educators from the Avalon Peninsula of Newfoundland were selected by purposive sampling to describe what their experiences, as clinical nurse educators, were when with students during the clinical practicum.

Procedures

Unstructured audio taped interviews were conducted and transcribed verbatim. Data collection and description of themes was guided by vanManen's (1990) interpretive approach. Phenomenology, as a methodology for this research, was chosen because it

permitted the capturing of the deeper meaning of the lifeworld of clinical nurse educators as they reflected on their everyday experiences. Moreover the meanings that they attached to their lived experiences will serve to provide further knowledge development to clinical nursing education (Morse, 1992; Cohen & Omery, 1994; vanManen,1990).

CHAPTER TWO

Literature Review

A considerable amount of research has been conducted around clinical education and teaching in nursing education. Predominantly, the research has been from the students' perspective and has focused on the role expectations or behaviors that nurse educators should exhibit and the interpersonal relationships that develop between student and teacher in the clinical setting.

A general review of the literature was done and divided into three main sections. The first section concentrated on clinical teaching in nursing. The second section has addressed the roles that are assumed by the nurse educator while in the clinical setting and the third has explored the literature pertaining to the educator-student relationship. Lastly the research methods that have been used, pertaining to the clinical nurse educator, were discussed.

Clinical Teaching in Nursing

Carr (1983) and Smythe (1993) defined clinical teaching in nursing as a circumscribed period whereby teacher and student exist in a relationship, within a common environment. Here the teachers' primary purpose has been one of support, assistance, and guidance as they have influenced students' knowledge of nursing,

application of theory to practice and learning, and discovery from the clinical experience (Benner, 1984; Reilly & Oermann, 1992; White & Ewan, 1991).

The clinical setting, described as a highly unpredictable, intricate place where a variety of events transpire on a daily basis, has also been complicated with a number of political, emotional and social dimensions (Pugh, 1980). In this setting those dimensions, when exerted, have operated as constraints but also as facilitators for student learning (Packard & Polifroni, 1992; Tanner, 1994; White & Ewan, 1991). It has been suggested that this complexity of the clinical environment has impeded the unmasking of the richness of what clinical teaching has offered to nursing knowledge (Benner, 1984; White & Ewan, 1991).

Pugh (1980), a noteworthy researcher on clinical teaching, argued that although essential to nursing and integral to professional education, there is a need for a greater in-depth analysis of what clinical teaching means. While credence has been given to the numerous studies from the student perspective, Pugh maintained that research must give a better understanding of the perceptual world of the faculty, the meaning they attach to the clinical experience and the value they offer to nursing education. Diekelmann (1990, 1993) asserted reflection and research on the practice of clinical teaching in nursing will aid in the discovery of its' uniqueness and preserve its' value to the knowledge base of nursing .

One of the greatest stresses in nursing students' education has been that of the clinical experience. Its unpredictability, demands on students for accountability and

patient safety and the close alliance with professionals (clinical nurse educators) to whom they are answerable has been well documented in the nursing literature (Audet, 1995; Beck, 1993; Gallagher, 1992; Griffith & Baranauskas, 1983).

While the aim of nursing practice has been patient care, clinical teaching's focus has been educative. Although viewed by some as an academic discrimination, examined more closely the realities of practice compared with the idealistic responses of theory have posed great demands on the nurse educator in providing a valuable learning experience for students (Tanner, 1994; Packard & Polifroni, 1992; White & Ewan, 1991). Although there has been a paradigm shift to humanistic research in nursing, to benefit the student, there has been a dearth of scholarly studies focused on nurse educators' experiences and what these individuals have brought to clinical nursing education (Rose, et al. 1995).

The Clinical Nurse Educator Role(s)

The role(s) of the clinical nurse educator has proven to be one of the most adverse issues surrounding nursing education (Clifford, 1993; Crotty, 1993; Diekleman, 1990; 1993; Lee, 1996). Some researchers have argued that the primary purpose of the nurse educator has been the initiation of students into the profession of nursing. Descriptors such as professional role model and mentor have been used to depict the specific roles the clinical nurse educator has assumed (Betz, 1985; Wiseman, 1994). This has been particularly salient given that many researchers have found 'role' to be an elusive term,

one for which there has been no theoretical basis and about which much controversy has surfaced (Dieckleemann, 1990; Lee, 1996). Furthermore the roles of the nurse educator in relation to clinical teaching have often been confused and ambiguous (Clifford, 1996; Crotty, 1993).

The scholarly discussions on 'role' have predominantly focused around the term 'role model'. This term has been defined as one who is knowledgeable of and demonstrates appropriate behavior in their professional setting, thus allowing novice nurses to learn by example (Byrne, Kangas & Warren, 1996; Mercer, 1984). The term professional role model has been described as an individual skillful in developing interpersonal relationships, teacher, mentor, researcher, clinical liaison, counselor and evaluator (Betz, 1985; Orchard, 1994; Wiseman, 1994). Mercer (1984) and Vance (1982) have maintained these are roles within a broader, more intense role modeling form, that of mentorship. Indisputably multiple roles have been entered upon by the clinical teacher in nursing, that of nurse, counselor, teacher, advocate, facilitator, role model, and problem solver (Choudhry, 1992; Clifford, 1993; Crotty, 1993; Dieckleemann, 1990; Downey, 1993; Lee, 1996; Packard & Polifroni, 1992; Reilly & Oermann, 1992; White & Ewan, 1991). Ferguson (1996) and Reilly and Oermann (1992) have characterized the nurse educators' roles as possessing strong interpersonal abilities, skill in developing collegial relationships with students and clinical agencies, expertise in a specific area of clinical nursing and astuteness in the standards of professional practice. Orchard (1994) interpreted the clinical nurse educator role to be that of provider of safe patient care

through the assessment and supervision of nursing students. Orchard described five duties as essential to that role, including expectations of students' performance, student supervision, professional perception, testing of students' knowledge and withdrawal of students from the clinical situation or site when unsafe.

There has been a uniqueness associated with the nurse educator in which Kermode (1985) has made a clear distinction between the supervisor in teacher education and the clinical educator in nursing. In teacher education the supervisor has acted solely as an observer of the student-teacher. Dissimilarly, the clinical educator of nursing students has acted as both observer, for evaluation purposes, and participant in the clinical learning experience. Likewise Schuster, Fitzgerald, McCarthy and McDougal (1997) asserted assistance with patient procedures while evaluating the student has been common practice in clinical nursing education and as such has contributed to the uniqueness of that role.

An intimidating, constraining factor for the clinical educator has been the role of evaluator which the nurse educator has assumed as part of the student-teacher relationship (Smythe, 1993). During clinical teaching, when reasoned judgments about students' clinical competencies have been made, clinical nurse evaluators have drawn from self-critique of their own expertise and personal knowledge of nursing practice and education (Friedman & Menin, 1991; Girot, 1993; Paterson, 1997). Paterson and Groening (1996) contended the conscious and unconscious subjective responses of clinical faculty have impacted on the practices of the teacher/evaluator role. Hall and Stevens (1991), McBride

and Skau (1995) and Paterson (1994) have stressed self-critique of faculty responses, in particular to student learning, and state that where there has been deliberate, thoughtful, introspection this has enhanced the teacher-student relationship and ultimately the clinical evaluation process.

Conversely, Mahara (1999) has maintained the objective-subjective discourse on clinical evaluation and the dual teacher/evaluator role has promoted power differentials which have impoverished the teacher-student relationship. Faculty observation of students in unpredictable clinical environments coupled with the multiple roles of the clinical teacher has created a false teacher/evaluator dichotomy. Mahara suggested both are dependent on the other. Others have acknowledged this discourse but added this obscure dependency has had a tendency to surface more so for clinical faculty who had negative feelings about students or for faculty who have had to deal with student failure (Cohen, Blumberg, Ryan & Sullivan, 1993; Duke, 1996; Lankshear, 1990).

Many researchers have argued that faculty have not been educationally prepared to assume the clinical teaching role (Packard & Polifroni, 1992; White & Ewan, 1991). However it has also been acknowledged that many nurse educators have endured by being learners themselves as they become transformed into their roles over time (Diekelmann, 1990, 1993; White & Ewan, 1991). Infante (1985, 1986) and Karuhije (1986) have taken the position that clinical nurse educators, after a period of time, learn on the job and develop very good teaching skills. They also argued both undergraduate and graduate nursing programs have lacked courses that prepare individuals for the

clinical teacher role. Additionally, Infante and Karuhije reasoned nursing education has continued to adopt other discipline practices, that is, hiring individuals for their subject matter expertise and not their clinical teacher readiness. Although Infante's and Karuhije's words were dated they have continued to be reflective of many nursing education programs (Herrmann, 1997; Sellappah, Hussey, Blackmore & McMurray, 1998).

Equally, a shift to higher education coupled with nurse educators striving for academic excellence has inadvertently denounced the credibility of nursing education in the clinical setting and has cemented the belief that those who teach differ greatly from those who practice (Clifford, 1996; Glossip, Hoyles, Lees & Pollard, 1999). Hill (1990) viewed nurse educators as marginal people who sit on the periphery of the clinical unit as "those whose job it is to teach, to create, to heal are those who are viewed somehow as out of step with the real world" (p.18). Such thinking, Hill believed, has decreased the value of the nurse educators' presence and has discarded what they have offered to nursing.

Clinical nurse educators have characteristically brought their students to various units within clinical agencies at specified short intervals throughout each academic year. It has been suggested that this temporary placement within the permanent nursing staff system has caused conflict between nurse educator and nursing staff (Infante, 1985, 1986; Paterson, 1997). Infante (1986) and Paterson (1997) alleged nurse educators have been

visitors to the clinical area and although similarity was acknowledged as being nurses, they were non-members of the staff nurses' work-life.

Ohlen and Segesten (1998) have fortified the idea of clinical educators as temporary placements with the belief that as staff nurses are more task oriented it stands to reason that their attitudes may differ from the nurse educator who has an educative focus for students. Upton (1999) reasoned these differences have existed because practicing nurses have given little recognition to clinical educators' experience and expertise, as knowledge, while the contemporary opinion of research academics has undervalued the practicing nurses' autonomy. The pragmatic versus the ideal impression has been perpetuated in the literature and has severely diminished the truth, that both theory and practice can inform each other as experiential knowledge (Ohlen & Segesten, 1998; Upton, 1999). Yet the disproportionate value placed on the practical nursing skills and the intellectual abilities of academia has sustained the disparity between these two groups (Clifford, 1996; Dale, 1994; Hewison & Wildman, 1996; Ohlen & Segesten, 1998; Upton, 1999). Consequently the feeling perpetuated, of faculty struggle for role identity and clinical credibility, has succeeded and widened the academia and practice divide (Paterson, 1997; Packard & Polifroni, 1992).

The idea of the theory-practice divide has been brought further with Packard and Polifroni's (1992) and Paterson's (1997) notion of the clinical nurse educator 'fitting in' with the nursing staff. The clinical educators' acceptance or rejection by this group has weighed heavily on the close alliance in the working relationship of the clinical educator

with the nursing staff and has affected their socialization into the roles of the clinical educator. The views of Bradby (1990), Laing (1993) and Buckenham (1998) depicted socialization as an interactive learning process. The morals, knowledge, skills, attitudes and values of a group are blended into the individual who has joined. The content of the individual's role has been learned through the principle socializing agent, the clinical role model. Although faculty have been viewed as a distinct role model source for students, within this socialization process there has been little evidence to suggest as to how faculty 'fit' into the clinical setting as they socialize into their work roles (Packard & Poliforni, 1992).

Some researchers have presented clinical teachers with both classroom and clinical responsibilities as better equipped to deal with the complexities of clinical teaching. Their awareness of curricular and practice issues and relevant and current nursing research has enhanced student learning and provided student/teacher cohesiveness in the clinical setting (Reilly & Oermann, 1992; White & Ewan, 1991). Faculty who have been conversant with current practice have improved their clinical credibility, their educator- nurse staff relationships and have provided expert clinical educator supervision to students (Choudhry, 1992; Paterson, 1997; Reilly & Oermann, 1992).

Wiseman (1994) and Ferguson (1996) have implied that role strain/conflict has played a significant factor in the clinical nurse educator's experience. It has been suggested that the maintenance of clinical credibility and expertise by nurse educators

will aid in bridging the gap between theory and practice. Moreover a qualitative inquiry into the concept of 'role' will yield a more comprehensive understanding of the perceptual world of the clinical educator (Chandler, 1991; Clifford, 1993, 1996; Crotty, 1993; Diekleman, 1990; Lee, 1996; Pugh, 1980).

The Student-Nurse Educator Relationship in the Clinical Setting

The way in which nurse educators have responded to their students in the clinical setting has proven to be crucial to student learning (Kirschling "et al"., 1995). The relationship between a nurse educator and student in the clinical setting has been described as a caring, nurturing encounter in which a demonstration of respect for and a genuine interest and confidence in the student by the nurse educator has prevailed (Miller, et al. 1990; Paterson & Crawford, 1994).

Reilly and Oermann (1992) believed clinical nurse educators that possessed positive effective behaviors of knowledge and clinical competency, teaching skill, and positive personal characteristics have promoted learning in the student. Some scholars have proposed an egalitarian relationship between nurse educator and student in which an equal partnership in the teaching learning process has existed and through open dialogue has enabled a sharing of ideas and life experiences (Downey, 1993; Plyes & Stern, 1983). Tanner (1990) posited such a relationship has given recognition to the expertise of the teacher, provided support and inspired the novice learner and as a result has encouraged a nurturing learning environment. From their comprehensive examination of clinical

teaching in nursing, White and Ewan (1991) clearly articulated the need for collegiality among student and teacher to foster mutual respect and reciprocity. They contended time and reflection on each learning experience as essential but believed collegiality has permitted personal development of both the student and teacher to occur.

Gastmans (1998), Reed (1996) and Taylor (1993, 1994) described the philosophical analysis of Hildegard Peplau's work on interpersonal relations as it related to the student-nurse educator relationship. These authors propounded an attitude of openness by the nurse educator, to the world of the student, provided a humanistic interpretative distinctiveness as central to the relationship and a professional-social meaning that has been distinctly connected. Collectively, Gastmans (1998), Reed (1996) and Taylor (1993, 1994) described the nurse educator as one who values the student as a whole person and supports, encourages, guides and respects him or her throughout their education. Additionally Reilly and Oermann (1992) have assumed a humanistic approach to nursing education and contend that the use of humor during clinical practicum has helped to confer the promotion of a stress free environment in the shared learning experience between teacher and student.

The claim that genuineness, mutual respect and trust has assisted in rapport building between nurse educator and student and trust have contributed to the promotion of learning in the clinical setting has been identified as a major thread in the nursing literature (DeYoung, 1990; Karns & Schwab, 1982; Reilly & Oermann, 1992). Genuineness, trust and respect for an individual along with empathetic understanding, as

the basis of any relationship has certainly been transferred to the student-educator encounter and has contributed to the humanism of nursing education (DeYoung, 1990; Karns & Schwab, 1982; Reilly & Oermann, 1992).

According to DeYoung (1990) empathetic listening has allowed nurse educators to understand the students' world, as students viewed it, has reaffirmed their acceptance of students as individuals and has ultimately enhanced students' self-esteem. Open, honest communication, in the student-teacher relationship, has contributed to a relaxed environment where student and faculty expectations are clearer where the nurse educator has been viewed as a role model for students. Role modeling has provided a foundation in which the student has incorporated the communication behaviors of the clinical educators into their patient relationships. DeYoung postulated nurse educators that possessed good interpersonal skills, were student oriented and comfortable in the teaching role provided better opportunities for student learning.

Nursing education in recent years has explored the value of caring as it relates to teacher student relationships and has been heavily influenced by Benner (1984), Bevis and Watson (1989), Leininger (1981) and Watson (1988). These theorists on caring have suggested caring experiences have been learned by students through the caring practices of faculty and the open dialogue that has existed within that relationship between teacher and student. As a philosophical approach in a profession that deals with health and healing caring, considered of primeval importance to the student-faculty relationship is the sense of caring about students in the clinical setting. Benner (1984), Bevis and

Watson (1989), Leininger (1981) and Watson (1988) conceded caring aids in facilitation of the teaching learning process, allows clinical educators to self-reflect on their own humanity and influences their connection to human caring. Canales (1994), Schaffer and Juarez (1996) and Tanner (1990) concurred with these statements. They added that teaching caring to students not only involved faculty caring for their students in the teaching/learning environment but also accentuated role-modeling behaviors of faculty that were emulated by students as they cared for their teachers and clients in the practice setting.

Caring has been considered to be an obscure, elusive phenomenon that has burdened the nursing literature in recent years (Lea & Watson, 1996). As human beings we experience and are aware of caring yet to experience its meaning caring must be practiced (Clarke & Wheeler, 1992). Remarkably some researchers have indicated that the nurse educator has emerged as the central and pivotal person in creating the caring environment for students in nursing education and is a crucial player as students see them implement caring practices with patients (Bergmann, 1990; Grams, Kosowski & Wilson (1997); Halldorsdottir, 1990).

Greene (1990) has postulated how the clinical nurse educator emits caring to students in the clinical setting and has attempted to explain it as:

Caring for those persons in the course of teaching is, in a certain respect, to lend them some of our lives. What we do is try to make accessible and learnable not merely the knacks, the rudiments, the tricks of the trade. We try to disclose the many ways there are of interpreting the experienced world. We try to create situations that will allow for the expression of a range of intelligence's, and we try

to provide opportunities for the release of imagination so that learners can strive for what lies beyond, what represents some meaningful possibility (p.39).

Nevertheless, research on caring in nursing education, what it is and how it is transmitted to students, remains opaque and what research that does exist has been mostly from the students' vantage point (Paterson & Crawford, 1994). There has been speculation that nurse educators have failed in communicating caring to their students yet the faculty perspectives of caring practices in the clinical setting has not been well studied (Grams, et al. 1997; Paterson & Crawford, 1994; Redmond & Sorrell, 1996). Much of the research pertaining to these elements has been qualitative in nature with phenomenology the main methodology (Halldorsdottir, 1990; Hanson & Smith, 1996; Kosowski, 1995; Simonson, 1996). These qualitative studies on nursing education have focused primarily on the student perspective in which caring interactions were described between faculty and students in either classroom or clinical settings or both. Descriptors used to explain the experiences of the caring interaction between student and faculty were that of attending, initiating, responding, connecting, affirming, motivating and empathizing. These studies revealed that a caring environment that supported humanism increased student self-esteem and motivation to learn. Essentially, all found that if faculty intentionally portrayed caring behaviors to their students in all interactions then this would result in meaningful human connections. Generally, each of the studies reviewed supported the need for a caring environment in which the nurse educator provided a non-

judgmental giving of self which the authors believed would assist in nurturing and valuing a caring humanistic environment for the student.

Research on the Clinical Nurse Educator

Clinical Teaching

Intrigued by the lack of congruency between faculty beliefs of important teaching behaviors and actual faculty behaviors implemented in the clinical setting, as reported by students, Pugh (1980) studied clinical teaching and adapted twenty teaching behaviors based on Fishbein-Ajzen's theory of reasoned action. This theory predicted volitional behavior and accounted for how individuals made decisions about carrying out certain behaviors. It is speculated that individuals executed specific behaviors if they had perceived that behavior as valued by those individuals who were important to them (Miller, Wikoff, & Hiatt, 1992). Pugh (1980) distributed questionnaires to both faculty and students and asked them to rank the twenty teaching behaviors on a seven-point scale, from one being minor to seven as essential. The results showed incongruency of faculty behaviors between intention and behaviors exhibited, as indicated by students. Pugh hypothesized that differing definitions between student and faculty, lack of opportunity in the clinical area for faculty to perform the behavior and difficulty in measuring complex, diverse behaviors as reasons for the apparent lack of congruence. To verify the students' reports Pugh observed, documented and described the behavior patterns of fifty faculty during a clinical day. Three distinct patterns of instruction were

identified: the instructor as (a) nurse, (b) teacher and (c) nurse teacher. Most of the faculty reported being comfortable in the latter role where both nurse and teacher behaviors were used. Role identification by faculty in this sample however, did not predict what role was indicated by their behavior. Pugh cautioned that for faculty who had provided the roles of practitioner and teacher in the clinical setting, time, opportunity and support were needed to improve and maintain those professional roles. Pugh also added a display of genuine intent on the part of the nurse educator who had enacted such roles was needed for the student to relate theory to practice.

Paterson (1997) examined clinical teaching from the perspective of nurse educators as temporary systems within a permanent structure. Six clinical teachers from four diploma and two university based programs in three Canadian urban hospitals participated in the ethnographic descriptive research. Data was collected through participant observation, structured and unstructured interviews, field notes, concept mapping and review of student documents. Paterson identified four consequences of being in a temporary system: territoriality, separateness, defensiveness and inter-group communication. Courting and negotiating were behaviors exhibited by the participants as they attempted to minimize those consequences.

The first consequence, territoriality, took the form of verbal and non-verbal feedback. Faculty reported in Paterson's (1997) study that staff had not provided necessary patient information and expected 'their' patient charts to be "given-up" by "our students" when requested. As part of this theme, Paterson described how the participants

learned to observe changes in the staff's behavior to anticipate or prevent conflict. The participants promoted semantic practices and used phrases such as "my students and your patients" and made visible property ownership. Faculty further described property ownership as intolerance towards students being used for service.

Separateness, the second theme, was described generally by faculty as little interaction with the nursing staff. The participants believed the staff perceived the nurse educators' jobs as "easy" and that it was "different from theirs". Additionally faculty reported the camaraderie with other clinical educators had given them support and encouragement within their jobs. These informal meetings provided comfort for the participants as they learned other nurse educators were having similar experiences and difficulties with nursing staff.

Defensiveness, the third theme, was evident with teachers who had not been familiar with the nursing staff or who lacked self-confidence in their role. However this theme was less apparent with experienced faculty who had had the same consistent yearly clinical unit assignments. The last theme, inter-group communication, was generally described as poor. The faculty reported that when the staff had given misinformation it required extra time to decipher patient data and added to the already heightened frustration levels of the participants. The faculty added that clarification to the nursing staff about student-patient assignment and student roles and responsibilities was needed daily even though such postings and descriptions of patient duties were clearly evident at each nursing station.

As a result of the consequences experienced by the participants, they learned to use courting and negotiating behaviors to avoid conflicts with the staff. For example, Paterson (1997) described three of the more experienced faculty had very carefully assessed and calculated potential risks before any issue was addressed with the staff. Paterson contended that the faculty had become sensitive to staff norms and had learned to anticipate student weaknesses before they had become problematic for the staff. Paterson also reported that faculty who remained on the same clinical unit year after year had been accepted by the staff as credible clinicians. Conversely, Paterson found alienation and loneliness still persisted, at times, for the two less experienced faculty as they perceived themselves as guests. These faculty avoided confrontations with staff choosing instead to discuss delicate issues with their students and treat them as learning experiences.

Paterson (1997) depicted the sixth participant as unique as this participant was a staff nurse on the same nursing unit where she had been assigned with students. This participant viewed the situation as advantageous as she was privy to the units' realities and unspoken rules and subsequently this had provided the best learning experiences for the students. Some consequences were reported, as the result of this position, namely staff expectations of additional nursing responsibilities unrelated to teaching. Most notable Paterson reported was the conflict this participant experienced differentiating between her staff role and her inexperience as a clinical teacher.

Paterson's research indicated educators who were consistently assigned to one clinical area formed a cohesive bond with the staff that benefited students' learning. Additional research that investigated how nursing staff evaluated clinical teachers and the use of faculty who both practice and teach on the same unit was encouraged. Paterson advocated more dialogue between education and practice to understand the consequences of temporary systems and the need for educators and practitioners to value each others' world.

McFayden (1991) contended clinical instructors have developed close relationships with students while in the clinical setting, played important roles in the students' learning, communicated nursing knowledge in facilitating theory to practice, and displayed genuine interest in students' and patients' care in a safe learning environment. In an exhaustive review of the literature McFadyen examined two areas that promoted the student-faculty relationship: the creation of a safe learning environment; and respect for students as people and learners. This literature complemented her study on the identification of instructor behaviors in the clinical setting. A questionnaire, with fifty-six behaviors associated with clinical teaching, was distributed to both faculty and students from a two-year associate degree program. The instrument used a five-point Likert scale to record responses divided into three sections: (a) important behaviors in clinical teaching, (b) frequency of use of behaviors and (c) effectiveness of use of behaviors.

Factor analysis of the data revealed three factors, with twenty-seven behaviors among those three: (a) educator function (the largest factor); (b) supporting individuality; and (c) applying theory to practice. McFayden reported faculty and students' responses differed in all three areas. In the section on important behaviors in clinical teaching, faculty perceived theory to practice and meeting educational needs of students as essential whereas the students reported the student-faculty relationship as higher. Frequency and effectiveness of use of the behaviors, the second and third sections respectively, indicated student perception differed from what faculty reported. Little correlation was seen between importance and the other two factors whereas a strong correlation existed between frequency of use and effective use of behaviors. McFayden suggested that further research was needed to identify important behaviors of faculty that are used most frequently and effectively in the clinical area, and how this relates to clinical teaching.

Grams et al. (1997) reported data from a two year interpretative phenomenological study of student and faculty caring groups showed three constitutive patterns and their relational themes: (a) creating a caring community; (b) experiencing the reciprocity of caring; and (c) being transformed. Creating a caring community, the first constitutive pattern, shaped the context of the groups and identified faculty behaviors as central to the caring interactions. The second pattern, experiencing the reciprocity of caring, described establishing the reciprocal relationship of caring that created an environment of trust, support and encouragement for the student participants. Being

transformed, the final constitutive pattern, revealed an overall changing of awareness of caring attitudes for all the participants in relation to their personal and professional lives. This study illustrated that a caring environment in nursing education served to empower the students, suggested the creation of egalitarian relationships and caring communities and enabled students to translate and transform their caring practices to their patients. For faculty members who participated in this research their roles evolved from “leader to member, friend and confidante” (p.15). The faculty-student relationship was viewed as equitable in power and mutually satisfying for both groups.

At Kent State University School of Nursing in 1994 a taskforce was struck to plan and implement a peer review-project as part of a National US peer review teaching initiative (Ludwick, Dieckman, Herdner, Dugan, & Roche, 1998). Although the primary intent of the national pilot project was classroom focused, across academic specialties, the nursing task force quickly realized that their focus would have to be on clinical teaching. Their decision was based on literature that emphasized the complexity of the clinical setting, inadequate preparation for the clinical educator, lack of recognition for expertise, isolation from peers and the time consuming nature of clinical teaching. Eighteen faculty members who supervised six to ten students in the medical/surgical clinical areas volunteered as participants for the study.

The two-year pilot project from 1995-1997 consisted of three phases: (a) planning; (b) orientation; and (c) feedback. A single peer reviewer with twenty-five years' experience in nursing education collected data through participant observation and

field notes. A final verbal report was given to each faculty member and used for personal reflection or summative reappointment. Three themes emerged from the peer reviewer's report on clinical teaching: (a) importance of reflective practice; (b) faculty development; and (c) a sense of community. Ludwick, et al. (1998) reported as the peer reviewer identified new potential clinical skills or explored and encouraged alternate teaching techniques with faculty, this was perceived by the sample populace as shared ideas and contributed to their professional growth and development. The peer reviewer reaffirmed, through dialogue, that the more experienced faculty made consistent appropriate clinical decisions while the novice teacher, although inconsistent, described increased confidence levels when appropriate decisions were made. Faculty also verbalized feeling connected when there were discussions among peers about clinical problems and potential solutions. The faculty reported such discussions replaced feelings of isolation and permitted safe disclosure of their clinical teaching practices for the purpose of peer-scrutiny. Although considered very time consuming clinical peer review was seen as a means by which scholarly clinical teaching could be documented. The authors suggested such a project promoted mentorship for new faculty through an environment of support and collegiality.

Roles of the Clinical Educator

Choudhry (1992), interested in the practice role of faculty and the vast recognition given to the integration of clinical teaching with practice, studied 291 faculty from both Canadian college and university programs and determined their perceptions of beginning

clinical faculty practice competencies. The competencies were generated from a larger study in which Choudhry looked at the multiple roles of faculty. Fifteen competencies in total were listed under 5 subgroups: (a) expert care provider, (b) interpersonal competence, (c) change agent, (d) researcher, and (e) educator. Using a five point likert scale, with five being the highest, faculty were asked to rate the fifteen competencies that a beginning nurse educator should possess. Both groups agreed all the rankings were important. However they differed in ranking four specific ones. Demonstration of specialized clinical expertise and the use of research based evidence to improve patient health was ranked higher by the University group.

The Community College respondents ranked the provision of theory based nursing practice and client advocacy as higher. Choudhry (1992) speculated such findings were justified as faculty who taught within colleges had been in more than one clinical area and, as a result, clinical specialty would be problematic. Both groups agreed that to teach nursing, competency in both teaching and practice was essential and that clinical competency could not be maintained through student supervision alone. The findings of this research articulated that 'beginning' faculty should possess advanced preparation, preferably at the Master's level. Choudhry argued that faculty who teach through their practice would demonstrate to students strong role-modeling of problem-solving abilities, effective interpersonal skills, critical clinical judgments and the facilitation of theory to practice but added educational support for faculty in this role is obligatory.

Packard and Polifroni (1992) explored the role perceptions and dilemmas of the clinical educator, specifically the meanings they attached to the student-teacher interaction, how they conveyed theory to students and the methods used to recognize and handle ambiguity in the practice of nursing. Twenty-six female and four male nurse educators who taught at the baccalaureate level, for at least two years, participated in this qualitative study.

Packard and Polifroni (1992) argued that understanding the intent of nurse teachers and the meaning of their work has been undervalued and as a teaching profession many nurse educators had not preserved their own practice. They described the role of the nurse educator as uncertain, where inter-role conflict was inevitable in the battle of balancing bureaucratic health structures with academia. The main accomplishment of clinical faculty they posited was to act as buffers against staff demands, protectors of patient safety and gatekeepers into professional academia. The difficulties encountered in the clinical educators' roles were numerous but safety, as an issue of protecting patients against student error, was the most communicated for this study. The sampled faculty described themselves as visitors within institutions, bidding for clinical credibility and giving constant reassurance to the nursing staff for the students' patient interventions.

Packard and Polifroni (1992) maintained as clinical educators availed of "teachable moments" it required them to expeditiously ascertain student readiness for the experience, ensure patient safety was foremost, provide specific direction, guidance and support throughout the moment, and observe and evaluate as the episode unfolded.

Packard and Polifroni also reported faculty considered themselves as nurses and relied heavily on prior coping strategies they had used in practice when faced with complex clinical/student situations. They concluded that faculty struggle for role identity and clinical credibility warranted further research.

Glossip, et al. (1999) explored, through action research, the benefits of nurse teachers returning to clinical practice. Action research was used as it implied close cooperation between the participants and the researcher was “rooted in the experience of the people it seeks to understand” (p.395). Data was collected from reflective journals, semi-structured interviews and focus groups and content analysis was used to interpret the data. The findings were presented in four categories: (a) expectations of self and others; (b) entering someone else’s world; (c) more awareness of student’s needs; and (d) teaching theory and practicing nursing. Essentially in the first two categories the nurse educators viewed themselves as de-skilled, unaccepted by the nursing staff and reported unrealistic expectations placed on them by that same group. The nurse educators described their experiences as time-consuming events in which they offered explanation of their purpose, reinforced their expertise or developed educator-staff relationships on the clinical units. The final two categories discussed how the nurse educators recognized the importance of safe clinical working environments for students, being good mentors and being recognized as a part of the team. The authors acknowledged this study as small scaled but believed it had offered insight and benefit in having nurse educators with students who also worked alongside nursing staff as practitioners. They also concurred a

supportive network of peers with similar experiences was essential to benefit nurse educators who return to clinical practice.

Brown's (1999) report on the evaluation of a twelve-year mentorship program for faculty at the University of North Carolina indicated that their program had a positive impact on both the professional and personal development of novice faculty. Forty-four faculty served as mentors for forty-seven new faculty members in their first year of employment with pairing based on mutual interests. A feedback questionnaire from both groups reported the program as beneficial but believed an established school philosophy of mentorship, support from administration and yearly evaluative reports were needed to complement such a program and ensure success.

Nahas (1998) studied forty-eight undergraduate students from Australia using Colaizzi's phenomenological method that explored their lived experience of humor as used by clinical educators. The themes revealed were: (a) being human where teachers shared their stories and admitted their limitations; (b) creating a positive clinical environment which turned stressful experiences into memorable laughing moments and allowed release of student tension; (c) connecting with students decreased social distance between student and educator and displayed mutual respect of humor; (d) facilitating learning allowed laughing at ones mistakes and made work easier; and (e) respecting the personal nature of humor allowed for reflection on awareness of cultural taboos of humor. Nahas posited, when used appropriately, humor improved the student-teacher relationship but cautioned users to be vigilant to the cultural variances of students.

Wiseman (1994) identified important role modeling behaviors of clinical nurse faculty and used Bandura's social learning theory as the theoretical framework to support the findings. Wiseman asked students and faculty to rate the importance of twenty-eight role model behaviors/characteristics of nurse educators. Both junior and senior nursing students perceived the clinical faculty as role models and all students perceived themselves to practice these behaviors. However both student groups reported inconsistencies in the rewards they received from faculty for attempting to emulate those same role-modeling behaviors. Wiseman found a need to explore further the concept of role modeling in the clinical setting from the perspective of student, faculty and staff nurse. This study concluded that the problems inherent to the clinical educator's role(s) were attributed to the capricious status of nursing and the growing gap between practice and academia.

The Lived Experience of the Clinical Nurse Educator

Duke's (1996) phenomenological study explored the lived experiences of four sessional clinical teachers with student clinical evaluation. Four themes emerged from the data: (a) oppressed group behavior; (b) self-esteem; (c) role conflict; and (d) moral caring. Duke attributed the first two themes to the lack of confidence the participants had in the role of clinical educator and insecurities felt about teaching, particularly related to assuring student success and the oppression of women in general. As all the participants had come from an apprenticeship, dominated style of diploma nursing education, Duke

based her assumptions on previous literature on oppression and gender stereotypes of women. As the data was explored Duke found the participants attributed student difficulties to be related to their own personal inadequacies in their new role as teacher. She found that, although the participants relied on their “gut feelings”, when a student performed poorly, their overall responses to problematic situations was in the students’ favor. This incongruity between thought and action Duke believed was related to their novice role and the lessening of their intuition.

The final two themes, role conflict and moral caring, were related to the participants’ moral dilemma of deciding between the protection of the patient and the students’ rights. The participants had expressed anger, frustration and disappointment in the students when patient care was compromised. All participants readily acknowledged the personal lives of their students and how this impacted on student performance but the ‘motherly role’ they took on, as Duke (1996) described, caused inner conflict for the participants when the evaluator role surfaced. Although the participants had the ability to readily identify the student problem, they experienced personal dilemmas between moral commitment to the student and ethical responsibility to the patient. Despite the difficulties experienced by the participants in evaluating the students, in this study, all students passed their clinical courses. Duke asserted the relationship that had developed between teacher and student had constrained the participants’ ability to objectively evaluate the situations. Their reliance on the supervisory techniques of planning and directing, a practitioner role, had been utilized instead of the evaluator role needed as a

clinical teacher. Duke gave attention to the clinical teachers valuing and ability to readily acknowledge psychomotor efficiencies in the students but associated this behavior with the participants' legacy of educational preparation. Duke's study affirmed the stress faculty sometimes experienced with role conflict especially where patient safety was an issue and recommended more educational support for those individuals who choose to teach students clinical nursing as warranted.

Ferguson's (1996) phenomenological research study explored nurse educators' perspectives during clinical practicum. Four clinical educators with pre-registration Bachelor of Nursing students, from four different nursing schools in Southeast Australia participated in this study. Ferguson's data revealed five themes: (a) being human; (b) having standards; (c) developing own teaching style; (d) learn as you go; and (e) not belonging. Although the first three themes were supported by the literature, Ferguson found the last two to be attributed to the lack of educational preparation and role requirements of the participants. The findings of this study suggested further research was needed that explored educational support for clinical educators in terms of maximizing their effectiveness in their respective roles, and the link this may have to student learning.

Summary

Reputedly clinical nurse educators have immense obligation and perhaps power for molding the students' professional practice beliefs. There has been a dearth of published research addressing the nurse educators' perception of clinical teaching and

learning and what this knowledge brings to the education of nursing students.

Introspectively and through planned discourse nurse educators must discover their purpose within the clinical environment, their influence and effect on those around them and how they ultimately influence student learning.

Despite the abundance of qualitative literature pertaining to clinical nursing education, almost exclusively the student perspective has been the focus. It is hoped the phenomenological approach used in this study to explore the meanings of nurse educators and what they bring to the clinical educational experience may contribute in-depth information to those involved in clinical education in nursing.

CHAPTER THREE

The Research Method

This chapter consists of two main sections. The first section presents phenomenology as a methodological approach. The second section describes the methods of participant selection, data collection, data analysis, methodological rigor and ethical considerations.

Research Design

Phenomenology was the qualitative research approach chosen for this study. Phenomenology “in a philosophical sense, refers to a particular way of approaching the world” (Parse, 1996, p.12). Phenomenological research, rooted in the German philosophical tradition of Husserl and Heidegger and developed later in France by Satre and Merleau-Ponty has been intrigued with the life-world (Cohen, 1987; Reeder, 1987). vanManen (1990) described phenomenology as a means to understand a phenomena by maintaining a view of the whole while encouraging an attentive awareness to details and trivia of everyday life. As a philosophical theory, phenomenology has acknowledged that all human existence is meaningful and as a research method has sought to explore and describe a phenomena as it is consciously experienced (Anderson, 1989; Beck, 1994; Lauterbach, 1993; Parse, 1996; Spiegeberg, 1982; vanManen, 1990). vanManen (1990) stated “we are not reflexively conscious of our intentional relation to the world” (p.182),

consciousness is short-lived and can only be described retrospectively, that is as a phenomenological reflection.

Phenomenology, a human science, has been used to study individuals within their context and connection to their lived experiences to gain insightful portrayals and meanings of their worlds (Beck, 1994; Oiler Boyd, 1993; vanManen, 1990).

Fundamentally the aim of phenomenological inquiry has been to gain a deeper understanding of the human experience and its meaning of everyday life, through descriptions of the life-world as it is lived by the participants (Anderson, 1989; Oiler Boyd, 1993; vanManen, 1990).

Phenomenology as a research method has become increasingly useful to nurse researchers who have chosen to focus on human behavior and the human experience and has been valued for its discovery and meaning of being human (Beck, 1992, 1993, 1994; Dieklemann, 1990; Morse 1992; Sandelowski, 1986, 1998; vanManen, 1990). Considered to be parallel with nursing, phenomenology has valued the personal whole and the meaning those individuals have given to lived experience (Gastmans, 1998; Munhall, 1994). Nursing, which has a human holistic interpretative character, has sought meaning to everyday living and new ways of being in the world (Gastmans, 1998; Munhall, 1994; Taylor, 1994). Conceptually, phenomenology has provided a closer fit with the clinical nursing setting and hence has provided the investigator with an understanding of the deeper meaning or significance of the human experience through the participants'

reflections of being a clinical nurse educator (Beck, 1993, 1994; Munhall, 1994; vanManen, 1990).

The methodology as outlined by vanManen (1990) was the approach used in this research design. VanManen (1990) believed that phenomenology, ultimately, explicated personal meanings to understand the experience in the experience that has led to the knowledge of the whole, a deeper fuller understanding and meaningfulness of life and humanness. The motive of the investigator, for having chosen such a design, was its descriptive, interpretative qualities that concentrated on the participants' subjective experiences, their thoughts, feelings and perceptions, of being a nurse educator in the clinical setting. To accomplish this, the investigator observed, explored and described the nurse educator's lived experience of clinical practicum, as the individuals perceived it to be. The investigator remained true to the narratives of the nurse educators' experiences, looked at the parts and gained understanding and then returned to the whole for new perspectives and insights (Lauterbach, 1993; vanManen, 1990). In harmony with the phenomenological approach the technique of bracketing was used by the investigator to suspend any prejudiced notions and assumptions (vanManen, 1990). The investigator prejudged that being a nurse educator in the clinical setting was difficult and that clinical nurse educators were influenced by other professionals who were around them. These assumptions and notions were made candid and then held in dormancy by the investigator which allowed new perspectives to surface, as if the phenomena had been viewed for the first time (Beck, 1994; Bousfield, 1997; Rose, et al. 1995; Sandelowski, 1998).

Research Methods

Participant Selection

A purposive sample of five nurse educators participated in this study.

Purposive sampling was utilized as it has been a common method of sampling in phenomenological research and has aided researchers to maximize and discover a variety of patterns by increasing the range of events, incidents and experiences of data collected (Byrne, et al. 1996; Sandelowski, 1986, 1998, 1999). Accordingly the investigator selected participants who had intimate knowledge of the phenomenon under study, who were articulate, had a range of nursing education experiences, and who had at least five years of full-time work experience as a nurse educator with nursing students in the clinical setting.

A letter (Appendix C) was sent to each of the Directors of Nursing and Acting Directors of Nursing at the five Nursing Schools in the metropolis of St. John's. The five schools were: Center for Nursing Studies; General Hospital School of Nursing; Memorial University School of Nursing; Salvation Army Grace General Hospital School of Nursing; and St. Clare's Mercy Hospital School of Nursing. At the time of this study one Director was the senior administrator for two Schools of Nursing. A list of all full time faculty who had been currently employed for at least five years within each school was requested from each Director. Upon receipt of the lists, a letter (Appendix D) was sent to forty-two nurse educators requesting their participation in this research study.

The investigator maintained a time log, and eighteen nurse educators responded in their willingness to participate. The first five individuals who responded were selected. Five participants were selected as this constituted an appropriate number for a phenomenological study (Sandelowski, 1995, 1998). Also it was anticipated that the size of the sample would permit a variety of experiences, while not being overwhelming considering the large volume of narrative data for analysis that would be obtained (Munhall & Oiler, 1993; Sandelowski, 1995, 1998). One of the original respondents withdrew because of time constraints and work commitments. In sequence from the time log, the next nurse educator was contacted by phone and the first individual who verbally affirmed their inclusion in the study was selected.

Data Collection

The nurse educators who had agreed to participate in the study contacted the investigator by phone and /or electronic mail. The initial contact by the proposed participants permitted a time for the investigator to explain the research study, confidentiality and anonymity provisions, procedures of data collection, time commitment, and their right to withdraw from the study at any time. Once the nurse educators agreed to become involved, a convenient time for the first interview was selected. The lapsed time between the initial phone contact and scheduled interview was approximately two to three weeks. Sandelowski (1999) suggested allowing time for the participants to reflect on the event enables them to be retrospective and enhances their

narratives, thereby inciting minimal intrusion from the researcher. The interviews were conducted at a place and time convenient for the participants. Each preferred a private area in their work place for the taped interviews. Prior to data collection, each participant again was apprised of the purpose of the study, the method of data collection, confidentiality provisions and the right to withdraw from the study at any time. An informed consent (Appendix A) was obtained, signed and a copy provided to each participant. With the informed consent signed each participant was asked to respond to the following statement “ Can you tell me what it is like to be a nurse educator in the clinical setting? ”

Data was collected using audio taped unstructured interviews with each interview lasting approximately eighty to one hundred and fifty minutes in length. As the study progressed the unstructured interviews became conversations and participants co-researchers as both the participants and investigator entered into a “process of coming to know” (Sandelowski, 1998, p.468). Trust had been established very early in the conversational process as the prior professional contacts between the participants and investigator enabled the trusting relationships. The interview process was used as a means to remain close to the experience, as lived, explore the whole experience to the fullest and allow the participants and the investigator to reflect on the phenomena of interest (Bousfield, 1997; vanManen, 1990). The communicative techniques of silence, clarification and reflection of thought were used by the investigator and assisted in the conversational process. The participants were encouraged, when necessary, with open-

ended questions, clarification and active listening to expand in their dialogue. These styles were used to facilitate the descriptions of the participants' thoughts and feelings of being a nurse educator in the clinical setting. Such communicative techniques also assisted them in creating their own sense of reality and enhanced the investigator's comprehension of the participants' dialogue (Bousfield, 1997).

Data was collected until there was redundancy of descriptions in the phenomena of interest. Conversations gradually diminished into several pauses and or silence which implied "silenced by the stillness of reflection" (vanManen, 1990, p.99). Each audio taped conversation was transcribed verbatim by the investigator. Clarification was needed from four of the participants so second interviews were scheduled, that lasted twenty to thirty minutes in length, and a fuller description of the experience was obtained.

Data Analysis

In the execution of this research study data collection and analysis were guided by vanManen's (1990) interpretative approach. The investigator undertook a communication among the following six research activities: (a) identified a phenomenon which had seriously interested the investigator - the nature of the lived experience of being a nurse educator in the clinical setting; (b) investigated experience as it is lived, rather than as it was conceptualized - the investigator actively explored the experiential descriptions of the lived experience of the participants rather than having relied on one's personal conceptualization of the event; (c) reflected on the essential themes which characterized

the phenomenon under study; (d) described the phenomenon through the art of writing and rewriting; (e) maintained a strong and oriented relation to the phenomenon; and (f) balanced the research context by considering parts and whole (p.30-31).

In the data analysis the investigator transcribed, verbatim, each audio taped interview. The written text was transcribed into a typed format whereby a sense of each conversation was gained. The tapes were then replayed as each typed transcript was read to ensure all data was present. The investigator immersed in the data, read and reread the transcripts and engaged in a process of reflection. The approach of deep reflection coupled with the participants' narratives assisted the investigator in understanding the significance of their experiences. These approaches, along with the prolonged engagement with the participants, aided in the identification of themes (Sandelowski, 1998; vanManen, 1990).

Thematic description according to vanManen (1990) is "the process of recovering the themes or themes that are embodied and dramatized in the evolving meanings and imagery of the work" (p.78). To uncover and isolate themes about the phenomenon of nurse educators experiences in the clinical setting vanManen's selective or highlighting approach and the detailed or line by line approach was used. Themes served as focal points around which phenomenological interpretation occurred and these approaches enabled the investigator to reconnect the themes to the whole (vanManen, 1990). This approach allowed a balancing of the research context by considering parts and whole, a "looking back at the contextual givens and how each of the parts needs to contribute

toward the total” (vanManen, 1990, p.34). The themes were written and rewritten in consultation with two thesis supervisors. This collaboration allowed for support of the investigator’s thoughts, on what each participant had said, and provided a time to sanction or approve the essence.

All participants were given a copy of their transcript and reviewed and made deletions of text where applicable. Two of the participants were asked to read the themes and essence to determine if the descriptions reflected their original experiences. Both participants agreed the text had offered a true reflection of their experiences.

Methodological Rigor

Credibility in qualitative research has been viewed by vanManen (1990) as the ‘validating circle of inquiry’ where the reader has acknowledged and recognized experiences “that they have had or could have had” through the researchers description and interpretation of the lived experience (p.27). Beck (1992, 1993, 1994), Oiler (1982) and Sandelowski (1986, 1995, 1998) suggested that credibility measures how strong and real the descriptions of the phenomenon are. The methodological rigor proposed by Sandelowski’s (1986) and adapted by Beck (1993) that of, credibility, applicability, consistency and confirmability, has been used in this research study.

Credibility.

Sandelowski (1986, 1998) has interpreted truth value or credibility to lie within the discovery of the experience of its participants, their human phenomena as they have lived and experienced it. In this study, the five clinical nurse educators were the experts and most trustworthy sources of wisdom and insight into the experience of clinical teaching.

The investigator undertook several activities so that credibility of findings was assured. Oiler (1982) has argued that it is impossible to be totally free from bias but it can be controlled through bracketing, a process where the investigator has put aside their attitude on the phenomena of interest. Prior to each conversation the investigator attempted to bracket experiential knowledge, perceive the experience anew and describe accurately the reality of the nurse educators' perceptions. Bracketing personal knowledge from professional experience assisted the investigator to view, experience and understand the phenomena as if for the first time (Beck, 1992, 1993, 1994; Oiler, 1982; Sandelowski, 1986, 1998). The investigator's personal perspectives were recorded before and during data collection through journal writing. This process, throughout the study, enabled the investigator to reflect on personal feelings, maintain a heightened awareness of the phenomena of interest, record insights gained and reflect on reflections (vanManen, 1990). This attentiveness to self-questioning of assumptions allowed the investigator to gain new understandings of the lived experience of the nurse educator and thereby limited potential bias (Cohen & Omery, 1994; Oiler, 1982).

The process of bracketing, or freedom of bias, was aided by a manner of rigorous reflection known as phenomenological reduction, whereby original awareness was neither confirmed or denied (Beck, 1994; Sandelowski, 1986, 1998). Bracketing and reduction allowed the investigator to set aside one's natural attitude toward the world and enabled the description of the lived experience and the meaning of the experience for the participants to emerge. Beck (1992, 1993), Cohen and Omery (1994) and vanManen (1990) contended that the researcher's heightened original awareness of a lived experience was essential to phenomenological research, and reduction, as a technique, was used in phases or degrees. A peeling away of the layers of meaning of the interpreted experience, over time, allowed the perceived world to emerge, and as such was seen by the investigator in a richer, deeper, manner (Beck, 1992, 1993; Cohen & Omery, 1994; vanManen, 1990). Moreover the investigator's concentrated use of the communicative techniques of silence, open-ended questions and active listening contributed to the conversational process and promoted the investigator's unobtrusive presence (Oiler, 1982). This, along with the decision for multiple interviews, confirmed the truth value of the human phenomena of its participants, as they had lived and experienced it (Sandelowski, 1986, 1998; vanManen, 1990).

The investigator returned the thematic descriptions and the essence to two of the participants to ensure the lived experience of the nurse educator during clinical practicum, had been captured. Both educators agreed that it was a true representation of their

experiences. This “member check” suggested by several researchers has been at the center of participatory approaches of investigation and as such ensured credibility of findings (Beck, 1992, 1993, 1994; Cohen & Omery, 1994; Sandelowski, 1995, 1998, 1999).

Applicability.

Applicability in qualitative inquiry has been related to generalizability in quantitative research (Sandelowski, 1986). Field and Morse (1985) have argued that generalizability in qualitative inquiry has never been the aim but instead one has to “elicit meaning in a given situation at a particular period of time” (p.22). Sandelowski (1986) has suggested if the findings of the research study are a true representation of the participants’ experiences then they have ‘fit’ the data from which they were derived. The descriptive interpretations of the findings along with numerous illustrations of the participants’ own voices, in this study, contributed to the applicability of the data.

Consistency.

Sandelowski (1986) referred to consistency as the decision or audit trail. Consistency has been described as a means whereby another researcher, using the same data as that of the investigator, arrived at similar conclusions. The investigator achieved the ‘audit trail’ through the presentation of thick, rich slices of original quotes, the privacy and confidentiality that was assured each participant for the interview and the

transcription of data by the investigator alone. If the reader can follow the 'decision rail' and clearly follow all decisions from beginning to end, as outlined by the investigator, then consistency is said to have been achieved (Sandelowski, 1986). Collectively these methods increased the consistency of the data (Beck, 1992; Sandelowski, 1986,1998).

Confirmability.

Confirmability, as described by Sandelowski (1986), is the neutrality of the findings and has been achieved when credibility, applicability and consistency have been established in the research study. At each phase of data analysis participatory dialogue between the investigator and several individuals, who were experienced in qualitative research methodologies, aided in the distinguishing of the themes according to vanManen's (1990) selective or highlighting and line-by-line approaches. This collaboration provided a time that determined likeness of thought, offered insights, new perceptions and time for the investigator to ponder additional questions. This process brought out hidden messages and allowed a deeper meaning from the data to be gained (Sandelowski, 1986, 1998). Peer examination and frequent consultation also assisted in strengthening the confirmability of findings (Beck, 1992, 1993).

The participants who were all nurse educators in the clinical setting and who were articulate in their descriptions enhanced this research. The audio tapes with their abundant original quotes from the participants provided rich detailed information for this

study and contributed to the confirmability of the data (Beck, 1992, 1993, 1994; Sandelowski, 1986).

Additionally, experiential understanding of the phenomena in this study, for the investigator, was gained through personal experiences interacting with the clinical nurse educators, professional clinical experiences, and consulting phenomenological and professional literature, for the process of reflection. In totality this permitted for the investigator richer meaning into the lived experiences of the nurse educators during clinical practicum (Cohen & Omery, 1994; vanManen, 1990).

Ethical Considerations

Prior to commencement of this study, permission was granted from The Ethics Committee, Faculty of Education, Memorial University of Newfoundland. As the participants were known, by the nature of their work and professional relationships to many nurse educators and administrators in the field of nursing, anonymity and confidentiality of participants was strictly protected by the investigator alone. When approval had been granted from The Ethics Committee, the Directors from each School of Nursing in St. John's were contacted (Appendix C) and requested to offer the names of the nurse educators within their institutions that met the criteria for inclusion. Participant selection has been previously discussed in this chapter.

Each participant was informed that the use of personal names or pseudonyms would not be used on the transcriptions to decrease the risk of identification.

Additionally, they were informed the investigator had sole access to the personal data that had been placed in a locked drawer at the investigator's residence. The participants were also informed that all tapes and any identifiable information; consent forms, demographic sheets (Appendix B) and transcripts would be shredded upon completion of the study. The investigator assured the participants that their experiences would be described in a manner whereby identification of the information source would be impossible. The transcripts were shared with the participants and time provided for the deletion of revealing information and to ensure that anonymity had existed. One participant's description of a clinical incident with a student had readily identified her and that portion of her transcript was deleted.

Participants were informed that the information provided from the study may enhance and benefit nursing education and research but the study itself would not guarantee personal benefit. There were no perceived physical risks while participating in this study and it had been planned for the investigator to stop the interview had the participants wished to do so. Throughout the conversations, the nurse educators had found themselves raising their own awareness as they reflected on their experiences but none had become upset as they expressed their personal feelings.

Summary

This chapter has presented phenomenology as the methodological approach used in this study. The methods of participant selection, data collection, data analysis, methodological rigor and ethical considerations have also been addressed.

vanManen (1990) has strengthened the purpose of experiential understanding of phenomenological research for the investigator to mean:

The point of phenomenological research is to ‘borrow’ other people’s experiences in order to better be able to come to an understanding of the deeper meaning or significance of an aspect of human experience in the context of the whole of human experience (p. 62).

CHAPTER FOUR

Findings

This chapter is divided into three sections. A description of the participants is offered in section one. Section two provides the description of themes that emerged from the data and section three addresses the relationship among themes and the essence of the experience of being a clinical nurse educator.

Description of the Participants

The investigator's aim was the provision of a generic, anonymous description of the five participants who participated in this study. The participants, all women, ranged in age from early thirties to mid fifties. Four had received their initial nursing education through diploma programs supplemented by university degrees, while the fifth had attained her education through a generic baccalaureate program. All had received their undergraduate preparation within the same institution and, at the time of this study, all were at varying stages of graduate and post-graduate preparation in the fields of education and/or nursing. All the participants had both classroom and clinical teaching experience, which collectively, had ranged from nine to fifteen years while four of the participants had taught in both diploma and generic baccalaureate programs. Their clinical expertise, predominantly, was in medicine and surgery but also included community, maternal/child and mental health nursing. All participants were married and

four of the participants had children. Additionally, their years of experience as practicing nurses ranged from two to twenty three years respectively.

Description of Themes

The themes that emerged from the data and reflected the experience of being a nurse educator in the clinical setting were: 1. The Nurse Educator as a Connection to Caring; 2. Being Human; 3. Learners and Know-how of Knowledge; 4. Seeking Validation. Alone in Becoming; 5. All Being; and 6. Guardian of Safety.

Theme One: The Nurse Educator as a Connection to Caring

Caring was a prominent theme throughout all the transcripts. The word caring has been translated from the old English word “caru” and defined as one who possesses a fondness, a liking for, or one who feels an interest in or concern for another (Woolf, 1975, p.168).

All participants described caring as a means of understanding the other, primarily the student, and the reality of their situation. Routinely they used conversation as a method to understand the histories and varied backgrounds of each student, and described such dialogue as a means whereby the self-respect and dignity of the student could be maintained. In their personal descriptions of how they, as educators, perceived themselves words such as, support, personal recognition, understanding, respect, and feeling comfortable were consistently expressed.

As one participant described how she cared for the students she said:

I try to be very supportive and understanding of them. Not only in their professional situations but their personal as well, if they choose to confide in me. I want them to feel comfort when I say how are things going? How are you doing? I want them to feel comfortable enough to answer.

All participants believed when they showed support to students it helped them, as educators, to acknowledge and understand how their own emotions, feelings and stress levels impacted on the students' clinical performance and also heightened their awareness to sensitive issues in their students' lives. Such experiences they believed not only aided in learning about themselves as caring individuals but their verbalizations of their caring practices implied a direct link with their students which, for them, had great relevance both personally and professionally.

All study participants hoped that students would view them "as helping" in the students' educational endeavors. Self-assurance that every student felt 'at ease and was happy' in the clinical arena was considered more than just an expression of interest on the part of the participants; it was a personal desire. Several participants related the use of various techniques to help the students feel more comfortable with them, such as humor, sharing of self, giving a hug, offering feedback, listening, or story telling.

I often tell stories and use humor not only to help the student relax but also it helps to make them comfortable. So I have incorporated this into my teaching in the clinical area, when appropriate.

Sometimes I just like to have a conference where we go over and sit down and we tell each other about our day and relax and perhaps have a little bit of a chuckle

regarding some of the lighter things that have happened that day. I think that it is extremely important to make them feel at ease.

The extent of caring, for some educators, meant “being in-tune” with those students who experienced a myriad of emotions to sensitive issues in the clinical setting such as a patient’s death, seeing a traumatic emergency or for those students who had a stressful clinical day. One participant often paralleled the way she felt about her students to that of a patient population. That is to say, as a practicing nurse she had been exposed to numerous situations where patients expressed extremes of anxiety and fear of the unknown. This required her to respond, as a nurse, with sensitivity, professionalism, humanity and friendliness, in the broadest sense. Now, as a nurse educator in dealing with students’ anxieties and emotions, she extended that same patient approach and in-depth awareness to the students’ situations to “help them just get through it”.

I find they are really under a lot of stress and in some cases things are tumbling around them. I’m trying to be so sensitive to that and recognize that there is a lot of stress in their lives and there is a lot of work that they have to do. So I’m trying to stay professional but also realizing that I have to be a little bit of a friend to them because I’m human and we are a caring profession, we are nurses.

Two of the participants related their own personal experiences with student life as they viewed the students’ world. They felt this prior exposure provided an advantage of not only learning from their own mistakes but also gave a personal declaration to their “human side” as they shared stories with students. They claimed this sharing helped to displace the hierarchical barrier that “teacher knows all” and provided for them an empathetic lens from which to view the students’ world.

I let them know that I've gone through it in my own education and I understand and empathize with them.

Over the years I have found that when I self-disclose about mistakes I have made, it makes the students feel better, comfortable. It helps them to realize I'm in this position not because I'm some super nurse or anything like that but that it's experience and I've learned from that experience.

One participant suggested that putting herself in the place of the student enriched the experience for her. She believed it allowed the student to see the depth of feeling, the sincerity and respect that, as an educator, she had felt for her. In one regard it affirmed a personal shaping from both an emotional and logical basis as to what her clinical teaching sometimes meant. Caring for the student was more than just a behavior but a connection between educator and student, a bond, a value, that was seen as intimate and implied a personal transcendence into who she was as a person and as a professional.

I try to get the trivial nature of things sometimes to come through while still respecting how they feel. I remember one time a student was drawing up a med and in her nervousness she dropped the vial of morphine. She was absolutely devastated and began to cry and I tried to make light of the situation and say it was no big deal and we'll draw up another one, but at the same time not to make her feel silly for how she felt.

For another participant the most challenging part of being in clinical with her students was when difficult situations arose. The inner turmoil that she experienced between anger and the attempt to understand a student's inappropriate action was troublesome. She relied often on intuition to know when a student 'didn't belong in nursing' but she had to look at the person and could not ignore their inner being. A gentle, careful approach was considered to protect and preserve the student's self-worth,

the person as an individual, but she also had to be an encourager and a realist. Somehow, as an educator, she had to get the student to self discover the negative behavior, the lack of preparation and how it had impacted on the patient situation so that the “student would learn from it” and make a personal choice, hopefully the right one. Coming to the realization that her words changed the career choice of someone’s life was arduous but the words were truthful.

Sometimes it can be a great impact on the student that what they did could have killed someone and inside my stomach is in a knot and my feeling is that they do not have what it takes. How I approach that is very important to me. That’s a very real thing for me and I try to save their soul. I’d rather do anything else than fail a student but yet it has to be done.

In their conversations and encounters with the students, the participants strongly voiced their use of respectful deportment with them. They were keenly aware of the students’ fragile self-image and wanted to understand the students’ point of view and show respect for their feelings. The participants expressed such phrases as, “being cared for; caring about them; care how they are progressing and we are a caring profession”, which strongly vindicated the intense belief, for them, that caring was inherent to nursing, inherent in the sense that each participant, in giving an immediate response to the students, preserved the students’ dignity and aided in assisting them to see positive attributes and goals in their choices. Equally, those phrases assisted the participants to find personal meaning and growth for themselves, in the experience of caring about another.

I always try with students to give them a pat on the back and say you've really had a good day today, I really appreciated what you did and it's very important for me as the nurse educator to say that to the students and give them recognition.

It's so important in how I handle them, my response to them especially in first year where they are so impressionable.

I get their viewpoint and if it is a legitimate reason it's okay. Like a student was up all night with a sick child and the student is stressed out and they didn't get to do their research then I support that student and give them time to prepare and go do it.

I really want to know how they are doing, are they relaxed with me, are they feeling okay?

As they displayed a caring approach to the students, two nurse educators believed it was their "mothering abilities" they had used with their own children that had helped them with students who experienced both personal and academic problems in the clinical setting. They described protecting the students' vulnerability and fostering the students' knowledge and sense of self-worth as their main aims. As a means of nurturing the students, these participants believed in offering several approaches. They described such methods as giving hugs, allowing them to voice their uncertainty, sharing their experiences privately, being present and encouraging the students. The participants believed the nurturing offered the students a sense of sanctuary that interconnected educators and students.

I hate it when students cry. I hate it. I don't like to see anyone cry and I immediately give them a hug, just like I would hug my child. I try to portray to them that I'm here to help you and don't feel that you can't ask me any questions.

I think as a parent I've put a lot of work into teaching my children and I think it flows over into my clinical teaching. I let the students think for themselves and show them dignity and respect for their choices.

All participants acknowledged the students as “their group, my students or my clinical group”, a recognition of students not as possessions but as a group of individuals with whom they had a personal journey, with whom they had taken an interest in and developed a kinship with while they nurtured their education. Likewise all of the participants believed they were much more than just an educator in the clinical setting but a human being offering guidance and support to another individual whom was learning. Moreover, all agreed caring was the most powerful agent as they recognized their own abilities and became perceptive to students' needs.

“Being human” they believed, enabled them to take the caring experience to a very personal level, one human being helping another, as they explored the private side of the students they met, their lives, families and marriages. They felt their personal disclosures helped make for a closer union between student and educator, where each got to know the other. The nature of the clinical setting involved the participants being with groups of students for an extended period of time, sometimes three to five days a week for four to twelve weeks in duration. In such situations students and educators worked together in many and varied patient encounters, sometimes in close quarters where physical touching between student and teacher in the delivery of clinical procedures was required. Four participants expressed “getting to know the students and for them to know me” as vital to this unique relationship.

I have to accept that coming to the clinical area the students come with all kinds of baggage and problems of their own. It may be something personal or they have difficulty with learning.

I make an effort to get to know each one, a little bit about them, where they are from, if they have any children, family, are they married or single. It's important for me to get to know them and I tell them about myself, I see nothing wrong with that. We're all different.

I can't think that the student is only here to learn and they have to cope with their outside life separate and that I don't have anything to do with that. I cannot look at them or the situation like that.

Theme Two: Being Human

An exploration of the relationships which the participants had in the clinical setting allowed the second theme to be revealed, being human. A desire by the participants to be seen as human by their students was paramount and all other aspects of their characters seemed to be less crucial. The word human was translated from the middle English word "humain" to mean one who is compassionate, sympathetic and considerate for others (Woolf, 1975, p.556). The participants interacted on a daily basis with numerous individuals namely students, nurses, physicians, occupational and physiotherapists, and supervisors, all of whom had diverse backgrounds, personalities and characteristics. It was the kinship of student and nurse educator and nurse educator and colleague that were discussed the most. To a lesser extent the participants discussed the relationships they had with the nursing staff and other professionals on their respective clinical units.

They described the former relationships as positive, ones built on mutual respect and trust. Mutual respect, equality, giving time to listen, and being non-judgmental were expressed as a means that fostered these positive relationships. Moreover, all the participants saw the student- nurse educator relationship on a professional level with a certain degree of friendliness that allowed for both teaching and evaluation to occur. Some believed this respectful distance permitted positive interaction, rapport building and openness while others saw the relationships as enriched experiences where they learned to appreciate the lives of the students and valued their diversity. As they learned about the lives of their students they learned more about themselves.

Over time, as the participants became more comfortable in their roles, they found themselves being less judgmental and more supportive to the students' situations. The ultimate goal for all the participants was to foster the belief that theirs' would be the type of relationship where trust between student and teacher was paramount. As a result they revealed more of their personal side so the students saw who they were as individuals. Three of the participants hoped their student-teacher relationships were reciprocal in nature. They described their relationships as an empowered force where open dialogue between student and teacher contributed to the personal emotional growth of each participant.

I think it is important that I let them know I'm learning from them as well. So if they come up with an idea I kind of make a big deal about it and redirect the group to say just listen to what Jane is saying and I never heard of that before or that's a really good point.

I try to show interest in their learning and then I think that spurs them on to realize that everyone has a contribution to make.

I learn some new thing everyday from them and about me and I think it makes our relationships better in the end.

All participants used self-disclosure to the students. They believed cohesiveness seemed to emerge between them when feelings were discussed and when stories and failures were shared. Self-disclosure that revealed their own vulnerabilities helped to create a nursing bond between them where they were seen as having had experienced similar life events. Here they believed, through the sharing of personal stories, their students viewed them as both a leader and as a member of the group.

Being with them in the clinical area I get them to discuss problems that they may have. Then in conference I'll usually get them to relax by me telling them clinical stories. It decreases their anxiety.

I think students should always feel free to come and talk with me about what is going on. I really think I show openness for it. I started to develop that awhile ago.

I think sort of actively listening to them and cueing into their needs is important for me as their instructor, it's not always easy but for me it is important for them and their learning.

Relationships with my students are a very real part of this job. I certainly want to have a good professional relationship so that if a student does something wrong they know they can come to me and tell me about it.

I would always like to think that they could come and talk to me about anything.

Two of the participants believed that admitting their own limitations and mistakes, and a belief that they did not possess all the right answers encouraged a trusting, open relationship with their students. Sharing their inadequacies and exposing their vulnerable side influenced positive impressions of what the students thought of them as nurses and as educators.

I find the relationships that I have with my students are something that I value. Even if during their rotation I did something wrong I admit to it and how I approach that situation reflects what they think of me.

So I say no I didn't know that or I must use that the next time I'm speaking with the next group of students.

All participants agreed the element of time was a major factor that influenced rapport building. Over time they saw how they had impacted and affected the students' lives. That is to say, the longer amount of time they had spent with the students, getting to know them and vice versa, contributed greatly to the caliber of their relationship. There were some situations where personalities had come into play that either impeded the relationship or had given rise to instantaneous rapport. The participants attributed this to human nature and that "everyone does not always get along". They agreed having gotten to know the students personally, having known something about them had made it more interesting and aided that natural tendency to listen more attentively to them.

In their descriptions of the relationships they had with their students, all participants readily recognized those students who were committed, interested and eager to meet the clinical challenges. Two participants had verbalized it was those individuals

who were indecisive, aggressive or insincere that had given way to them experiencing internal conflicts. Although the participants acknowledged that their personal and professional perspectives may have been challenged from time to time by such students they had conceded that “liking someone did make the job a lot easier”.

I guess I take a liking to some more than others and maybe unconsciously I give them more smiles and let them see the more personal side of me.

I find sometimes when the student is not prepared, they don't care, I have internal discomfort in that relationship. I guess because their personality reflects their lack of interest.

When the rapport was well established one participant found the use of humor effective and enhanced the social context of the student-teacher relationship but stressed it was used with caution as not everyone saw the appropriateness of it.

Sometimes humor just helps them to relax if I make things light. They then see me as a person then. But some get offended and so over the years I've learned to be sensitive to that.

One educator felt her relationships which she had developed with students was described as a tenderness, a gentleness and an understanding that was embedded in her. She felt it extended beyond the passing on of mere knowledge to another but into a personal frame of reference that allowed her to be truly who she was.

You know they become a part of me after a time. I want them to succeed so I guide them and help them to become that nurse.

Integral to the clinical experience for the students, some educators described their provision of a comfortable learning environment that they believed influenced the

student-faculty relationship the most. A controlled environment that allowed the students to feel at ease was very difficult due to the unpredictable nature of the clinical setting.

The participants insisted the presence of a comfortable environment was important so the students could make that connection between theory and practice.

In the clinical setting I want them to be comfortable and comfortable with me and that I've made it a nice environment to learn is important for them. You can't learn when your upset.

I've seen students frightened and very scared and how can they learn like that?

They have to know what they are supposed to know and I'm there to help them fit the theory in. So in the clinical area they see me as their link and they are not trying to hide under the bed (laughing) when they see me coming up the hall.

I want them to feel and say I'm glad you're here and I have this question to ask. This is what I did, I'm not sure if it's right but this is how I did it. It really starts from the minute that I meet them.

Another relationship that was identified as important was the reciprocal partnerships formed with other clinical faculty. In particular, these relationships were described as positive affirmations where mutual support was primary. Shared experiences, whether personal or related to work-life, were viewed as very consequential and such experiences had provided opportunities whereby faculty related to one another as they purposely verbalized emotions. The bond that existed between colleagues developed quickly and easily and sometimes went beyond description. One participant viewed it as a sisterhood where one cried in the midst of chaos and words were not immediately necessary to explicate the situation, just a comforting "yes I understand" helped to reaffirm ones capability for the job. These close friendships for her made the

unbearable days bearable in knowing that a friend, a colleague was near with words of encouragement. Some participants described their relationships with other clinical faculty as a strong support system that helped them to “enjoy their jobs”. Such a system allowed looking at student situations or issues from many perspectives, provided emotional support or provided time to argue as well as encourage the other. This relationship was described by the participants as a collective strength that gave it unique personal meaning. There was comfort in knowing there was someone close by who they called on for help. For all participants, as they reflected, this relationship stretched the margins of colleague to that of confidante.

My colleagues are very important to me and I’ve earned their friendship and they have earned mine.

I feel I can go and speak to them (colleague) confidentially and ask their advice.

I think, the people I work with, my colleagues, there is no question for me that they have an influence on my attitude and how I am when I go to work. For me it has been very positive.

I often go to colleagues if say I’m on surgery and go to another floor and ask their advice and they help me to think it through carefully.

I value the work and support that my colleagues share with me everyday.

The participants accepted that relationships also extended to other professionals such as the nursing staff in the clinical areas. The primary intent of forming a rapport with this professional group, they all conceded, was for the benefit of the students. Developing this relationship was characterized as arduous and a time consuming event but imperative. The daily face to face interaction with the staff was essential, not only for

patient information, but it provided a means whereby the participants could learn about the staff's varying personalities. They used this knowledge, and approached 'things' with the staff on a personal level, and used the staff-educator relationship to their advantage. When the participants encountered the staff, they used what information they had about them and buffered and protected students when necessary. They acknowledged the greatest importance of such a relationship with the nursing staff was so that students and future students would receive good clinical experiences. All participants fully acknowledged when conflict had arisen between them and the nursing staff it had major repercussions for the students' learning. The participants perceived themselves mainly as public relations people, within this relationship, and tried to make that link between the staff nurses' world and their own. All participants felt that over time these relationships had taken on a more personal nature and made their clinical rotations that much more enjoyable. As they spoke of their relationships with staff nurses two nurse educators expressed:

You know, as an instructor, it is important for me to have good relationships with the staff nurses. When they say we're looking forward to seeing the students coming back then it is a real positive reinforcement and feedback for me.

You have to have a good rapport with the staff nurses because we're coming back year after year and for the most part I have had a good rapport with them all. I have to be nice some days when I don't want to be (laughing) but that is what relationships are about.

Theme Three: Learners and Know-how of Knowledge

The third theme, learners and know-how of knowledge, reflected the nurse educators' beliefs that they had learned a great deal over the course of their respective careers. Knowledge, from the middle English word "knowlechen", has been translated to mean one who gains familiarity with something through association and experience (Woolf, 1975, p. 639). All participants had concurred they had received no formal preparation in their baccalaureate education into the teaching role of the nurse educator, especially for the clinical setting. Three participants revealed how they "inherited" or "fell into" the clinical nurse educator role.

I was a nurse, a staff nurse, I had no background or education in University, of how to teach nursing students clinical.

One day I was a staff nurse looking after sick people and the next day I was a teacher with my degree. I had a lot of knowledge about being a nurse but I didn't have a lot of knowledge about being a clinical educator.

You know you're just put there and this is it, now teach.

They had recounted how they learned theories of education and teaching and learning strategies for the classroom but had received little guidance for clinical teaching. Once faced with the challenges of students and patient situations in the clinical setting, it was the knowledge of "What would I do as a nurse in this situation?" that came through. They had learned a great deal from their years of experience as staff nurses and what they

did know about practice they knew very well. One participant recounted the importance of her diploma in education that had helped her adjust to her new role.

I think about my experiences from when I became a diploma nurse and I draw from them all the time when faced with clinical/student problems.

Likewise, most participants had drawn from their varied backgrounds and brought that with them as clinical educators. They admitted, however, that they had adopted a “learn as you go” philosophy so they could bring meaning to the total clinical experience for the students. Although they relied on their nursing practice knowledge, they had recognized very early on, as clinical educators, little teaching had occurred. Initially they often told students what had to be done next in relation to patient care. Two of the participants expressed what they viewed as important when they first started into this role.

First coming from a practice background I was oriented as to what to do next and it was very important to me that the students knew all the skills.

I had been in practice so long myself in a med-surg setting and I had learned, you know over the years basically, how to carry out my day.

They acknowledged their inexperience in the role of clinical educator was reflected in their own interactions with staff and had ultimately affected the students’ learning. It was their own anxiety levels, rigidity and the belief they had to know everything as clinical teachers, that contributed to their sometimes defensive and/or assertive behaviors with those same people. When the truth was revealed that they had not possessed all the knowledgeable answers, their stress and anxiety levels heightened

and resulted in their defensive responses. Five of the educators reflected on how these feelings affected their roles in the clinical settings.

When I first started teaching in the clinical area, everything was done by the book. Certainly if I had a particular conference planned the conference went as scheduled and if the students didn't get over till 3:15 then I guess they had to stay till four o'clock because I was the one who said how we must do things.

I know initially I would sit down with the student in the clinical setting but I would be totally focused and say this is what I see and this is what the problem is and this is what you need to do about it without letting them speak.

In my earlier days of teaching I didn't take the time to talk with the students because I think my anxiety was so great at the time that I needed someone to sit down and talk with me (laughing). You think you're having a bad day listen to mine.

When I first started out I was so confused and lacking self-control because I had to know everything for myself, or at least I thought I did. I was not comfortable with myself. Who was I supposed to be?

I was well, we have to do one, two, three, four, and five and nothing else gets done until then. It was my way of controlling things.

For one participant her emphasis with the students had to be on work with little exchange for social professional dialogue. The idea of being viewed by her students as anything other than "hard" was not readily cherished by her as she admitted she never was really in-tune, initially, with how the students were feeling because she had not perceived that to be a part of her role. So when she had asked a clinical question and had received blank stares from the students she became more militant in her responses to them.

It was difficult not having any confidence in myself. So I didn't care really how the students were feeling because I was too concerned about how I was feeling (laughs).

As a clinical educator she believed her focus was to ensure that all the care for every patient was completed without any consideration given to the students' learning needs. The bedbaths, vital signs and dressings had to be completed and charted accurately, that was the focus for her. Clearly she had understood the expectations of what was to be done for each patient but somehow she had been unable to make the link with how the students learned from the experience. She described a total loss of control and a mental fatigue as she tried to determine if she was doing a good job. As she continued with her thoughts she said sheer panic ensued if her organized day went awry.

I think I felt I had to do everything and cover everything and make sure everything was done right without giving any consideration to the student and the anxiety they were having, let alone the anxiety I was having.

When they first became clinical educators the participants held the belief that sometimes it was as though they had endured being put on 'viewing blocks' where every thought and wrinkle was exposed for all to see. If there was any evidence that suggested they lacked knowledge, it served to fuel their inner turmoil that they really had nothing of educational value to offer. For many of the participants, it seemed for a period of time that there always had to be a protective cloak, a shroud so "the teacher who may not know" could not be unveiled. However unrealistic as a novice educator, they acknowledged they had the self-perception that not knowing "how to be" echoed

internally “have to be”. The inherent fear that they had not known the answers had caused them to look at themselves as failures. One participant said she made herself believe she had been infused at some point with a wealth of knowledge after having received the title of clinical nurse educator.

I had to know all the answers. I had to know all the questions. I couldn't say, well I don't know about that? I wouldn't let myself do it.

For another participant all the facts had to be shared with the students even when they had not held the capacity to understand them. As an educator she had the knowledge about every patient and expected the students to recall the same information. As a result, in her earlier years, those unrealistic expectations and her lack of “not being able to see the bigger picture” had impacted on those students around her and resulted in her being labeled as strict, cruel and unkind. These perceptions, which she admitted for the time may have been true, were acquired from a false self-belief of who she thought she was supposed to have been. She described it as an imprisoned sense of reality. Her perception of not knowing every question and answer was unacceptable, after all it was what she viewed a nurse teacher to be, a perfectionist. She described hours and hours of study and preparation on the nights prior to clinical, researching every assigned patient's condition. She was compelled to know every problem, treatment, medical condition, and every nursing consideration.

I had my clipboard where I knew every detail about each patient and if the students left something out I would say oh but what about this?

She admitted, although an intimidating tactic this had not been her intent. This participant believed, at the time, she had to know absolutely everything because she was the teacher. Another participant claimed, periodically as an educator, she doubted her own knowledge and often questioned her ability to make credible clinical judgments.

I don't know I think I felt the students would be better off with someone else than with me. I remember if I had to fail someone, I lost sleep. I kept asking myself was I being objective enough? Do I not like this student? Did they say something to turn me off?

As time passed, however, they realized the message they had sent to their students was wrong and in fact, by their own behavior, perpetuated to the students a perfectionist image. As they verbalized their thoughts, they allowed themselves to eventually realize they had not been the total source of knowledge, nor was it required. Letting go of the regimented structure of doing "everything by the book" lessened their anxiety and gave way to shared discussions with the students. As the participants' comfort level increased within themselves, they noticed a considerable change in the students' levels of stress, it had decreased. Before, they had not allowed the time to consider how the students were feeling, it was not in the schedule.

As they tried to understand their roles, all participants accredited the support and expert advice they had received from their colleagues as invaluable. As educators most had not wanted their colleagues to perceive them as unknowledgeable. All participants described their situations as stepping into the experience until some level of comfort within themselves as clinical educators had been achieved. They held the belief that they

were the educated experts in a field that had insisted a sound knowledge base was essential, so to seek out the expertise of other educators who answered their clinical problems would have been viewed as incompetence. As their self-image improved and confidence increased it had become much easier for them to ask for that expert opinion. Four participants considered that, as time had passed, they felt liberated from knowing everything and realized they had become learners as well. They expressed their thoughts as they described how they sought advice to clinical problems or concerns.

I kept thinking did I do the right thing? Do I really know what I am doing? Now I am very comfortable in asking another instructor.

Now it is nice to know what the other instructors are doing but before I was afraid to ask them. Now I'll use their advice.

I get an objective viewpoint and I not only developed confidence in my own ability but also in asking for someone else's perspective.

I don't think I was willing to talk with my co-workers and to continuously seek input from other people because I thought I should know the stuff.

At some point all had commented they had achieved a level of comfort in 'not knowing' and once acknowledged there had been a "great ease to the job". Without hesitation it became acceptable for them to admit to both the nursing staff and students that the information was new, they had learned themselves from the experience or that they needed guidance from the nursing staff with new or unfamiliar procedures. As they expressed their lack of knowledge to the staff nurses and asked for their advice and expertise the participants acknowledged what was most apparent was this had eased

tensions between them. As they exposed their vulnerabilities they shared their relief at being viewed as learners as well.

Now if I don't know something usually the student and I will go look it up.

I have no problem now going to the staff and say hey I've never seen this before. Can you help me?

Upon reflection, "getting the staff nurse out of her system" was a means by which this nurse educator succeeded and clarified what was expected of her during clinical. Moreover, this process had helped to increase her ability to understand different student approaches to particular clinical situations. Although she had not denied how her practice had helped her with clinical decisions she realized that after some time it was necessary to "let the staff nurse go" and allowed the educator to emanate. When clinical problems arose with students, the staff nurse in her recognized the need for immediate documentation about the change in the "fresh post-op patient" but it was the clinical educator that had recognized why the anxious student was overwhelmed with the sudden responsibility and neglected to document. "Letting the staff nurse go" was a struggle, she admitted, as sometimes she fought to control her reactions to situations. She related how this internal struggle had enhanced her confidence and self-perception that she had possessed valuable knowledge that enabled her to pass on that experience and knowledge to others.

When I see something that they have done wrong sometimes I take a deep breath and enter the room, go back outside (laughs) and take another deep breath (laughs) and go back in and try to get the student to discover where they went wrong. It is hard.

Experiential learning, mentorship and continuing education, either through formal graduate and post-graduate programs or professional development in-servicing, was cited as processes that aided the nurse educators in their clinical teaching. Four participants considered experiential learning as the greatest contributory medium and one to which they attributed an increased confidence in doing their jobs.

My continuing education for me, the courses, seminars and workshops I attended throughout my career did help.

What I had learned in some of my graduate courses with learning theories helped, then I was able to test that out in the clinical area with the students.

One of the things, as a result of in-servicing on how to approach clinical problems, is how I handle situations with students. I think it is in a much more effective manner.

The longer I've been in the clinical area the greater my ability to handle the more difficult situations.

Additionally the participants saw their ability to assist students in applying classroom theory to patient care situations as essential to teaching students in the clinical environment. Again, it was their previous knowledge as a practitioner that they relied on when faced with clinical problems, but over the years this had blended with their knowledge as educators.

Theme Four: Seeking Validation. Alone in Becoming.

The fourth theme was seeking validation, alone in becoming. Validation has been translated from the middle Latin word “validus” and means approval or acceptance (Woolf, 1975, p.1292). Becoming a nurse educator, for all participants, was a challenge. Having achieved their undergraduate degrees in nursing, their main intent at some point, was to become involved in nursing education. Initially when they became clinical nurse educators they saw themselves taking on new responsibilities and roles but what they hadn’t anticipated were the many conflicts they encountered with the nursing staff. Along with the title of nurse educator had come isolation. Although not alone in the physical sense, many felt alone in their situations as some experienced being the sole educator on a particular unit and in some instances an institution. Their presence on any given clinical unit commanded loneliness as they constantly defended who they were or what they were doing. Two participants reflected on their feelings of isolation and being abandoned by their nursing peers.

I would overhear them (staff) saying well who is she? What can she do?

I remember an I/V was blocked and I went to get the nurse on the floor and later two of the nurses were talking saying that I could teach it in the classroom but I couldn’t deal with it here.

In their earlier years, as educators, all were cognizant that the nursing staff had continuously observed their actions and judgments. Although some agreed their thoughts about it might have escalated to the point of paranoia, the daily dissections by the staff

nurses was an ever-looming presence. All participants admitted they had tried to understand their lack of acceptance by the staff nurses and acknowledged that the historical roots and power struggle between theory and practice had always been somewhat strained. What complicated the picture further was, as nurse educators in the clinical setting, they were only seen on the floors for specified periods of time throughout any given school year. As verbalized by several participants, this pattern served to aggravate the situation and alienated further the staff world from theirs.

I feel as though I'm continuously being tested or I'm being watched. I have to be careful how I handle situations with the students.

I get the feeling that the staff see me, as well, you're the teacher you know it all and go do it with them (students).

A large part of the time I was defending the school or myself.

I know they were watching me and listening to what I was telling the students.

If clinical was to be more tolerable, the participants sought reasons as to why the division between themselves and the nursing staff existed. Some situations were easier to understand especially when, as educators, they had been asked to attend to students in a clinical area for which they were unfamiliar. Their lack of experience and expertise had been very apparent for the nursing staff to witness. One participant expressed how she felt as a novice in the clinical setting.

They (staff) were not comfortable with me being there because they had no confidence in what I was doing. I didn't have any confidence in me either. It was so new.

When conflicts arose between the participants and the nursing staff, some educators pondered if their presence was somehow misconstrued as threatening. Others commented that they perceived a strain had existed between them and the staff nurses primarily because the staff lacked understanding as to what constituted their (educators) job realities. The participants postulated there was a general misunderstanding about the hours of preparation and incorporation of learning opportunities they, as educators, provided for their students on any given clinical day. All participants knew, as a rule, all that preparation went unnoticed by the staff, as they were busy with their own responsibilities.

If the students don't get help from me at a first year level, and then they ask the staff, then the staff are saying what am I doing up there with them (students)?

Some areas have been very receptive while other areas have not and I don't know if they (staff) think I'm somehow stepping onto their turf.

I'm not looking for approval all the time but I'm sensitive to it.

I think the staff perceived me as having an easy job. They compare what they do to me, what they see me do which is only perhaps half of everything. I think it is how well prepared I am as an educator in the clinical setting that comes through that makes it look so easy, maybe.

I've had conflicts with the staff nurses and they'd say things to me like how come you don't have this done yet? You'd never be able to do this if we weren't here to help you out and show you the way to do it.

The struggle for acceptance persisted and for a long time they received the constant reminder from the staff that "we don't do things like that around here". The educators soon discovered that, to be welcome in the clinical area, they must conform to

unit rituals. Thus compelled to prove themselves, they utilized student-patient situations that revealed their knowledge base. Furthermore they believed as they displayed their ability to make sound clinical judgments, this portrayed to the nursing staff that they were indeed capable of competent patient care. The participants demonstrated and adopted an open communication with the staff to narrow the gap between what was perceived and what was the actual reality. They had come to know the unit routine and assisted whenever time allowed.

I pitched in and helped out making beds and helped with the unit workload and talked to the staff.

I started to get used to the routine and I knew what needed to be done.

I find I'll make a point of explaining why the students have to leave the floor for conference and when they'll be back instead of just leaving.

The big thing for me was how quickly I would integrate with the staff on the unit so they would accept me as a member.

The establishment of their credibility as clinical educators was another aspect of their job that they had not anticipated. Their professional nursing peers, the nursing staff, held the power to accept or reject them. One participant reflected on her earlier experiences as one who had been viewed by the nursing staff as "that one who comes late and leaves early". She had known there was little consideration or recognition given to the hours of research and preparation for the nine assigned students' workloads she had prepared to ensure the clinical days had indeed gone smoothly. She recalled how some nurses had commented that her job was mundane. She viewed it to be otherwise.

All they see is the bed baths and if that is all they had to do how much easier their jobs would be. But it's what I do during the bath with my first year student that they don't see. So they don't understand really what it is that I do.

To confirm her capabilities as a practitioner and as an educator one participant found she had more conversations with the students about their head to toe assessments, alternate comfort measures or communication styles in front of the nursing staff, when appropriate. For others this style of communication sometimes was not an option as they felt it would have complicated their situations further. For example, one participant remembered for some time the staff on her unit thought her day ended at two-thirty, however her reality was far from their perceptions. Often her days extended beyond eight hours and entailed hour-long clinical conferences, the correction of nine nursing care plans, and troubled conversations with students about incompetent care. In her earlier experiences she always felt a need to defend her actions to the staff but agreed that such a strategy had not helped in developing relationships with them. As time went on and her confidence in her own abilities increased her responses were less guarded.

I had to learn to let it go and not let it bother me. I took comfort in knowing what I was doing was right.

One participant felt she established credibility with the nursing staff through her students. Her particular situation warranted explanation as she was only a voice and face to many of the hospital personnel, as she checked on her fourteen students and floated in and out from unit to unit, all over the hospital.

If they perceive the students as positive then they usually see me in the same way.

Another described herself as the unknown entity. She felt herself a stranger as she graduated from one school of nursing, her students came from another, and neither school was affiliated with the agency they had been assigned to.

But I find moving back into this particular hospital where nobody knows me and every year it's a struggle. Because this course only runs once a year and I sort of always have this little hurdle to jump over in the beginning.

This situation created tension with the staff as she recalled their reception was divided between peculiar glances and hesitant responses. This participant's previous experience as a clinical educator in a hospital from which she had graduated was all she had known and it had been very positive. There her presence was never in question as she received total acceptance by those who knew her. Upon reflection she realized she had asked too much of the nurses in the newer agency, to accept her with open arms on their unit and make independent clinical decisions with "their patients" was unrealistic.

We work as a team in nursing and coming into that particular team I sort of can't come in off the street and say well here I am, tell me things, trust me. It doesn't work that way.

Another participant decided to work on developing a richer, deeper rapport with the staff so they would come to know her both personally and professionally. There were daily interactions with the staff asking their advice about patient assignments, how they were doing with their degree or how their children were. She conceded this approach revealed who she was as a person and as a nurse and helped ultimately in their acceptance of her.

They didn't know me or how I worked, that whole idea of trust in the relationship had not had a chance to develop and that takes a long time.

Another participant described seeking approval as an enduring presence. Earlier experiences were unpleasant where it seemed that the staff discredited any and all of her responses.

I am an educator in the area of practicing nurses and that is a bit uncomfortable at times. I never feel totally accepted. I can see through the way some people interact with me that you're from the school and you don't know the real story kind of thing.

Always having existed on the periphery, she was an outsider and the situation had become more complex when certain roles had to be assumed. Such an encounter occurred when both she and her senior students took on the roles of charge nurse or team leader. Such a learning experience required one of the nurses on the unit to step aside for the day as instructor and student assumed the responsibilities. The nurse in charge was a position where the other team members gave respect for one's knowledge and leadership abilities. They (staff, student and educator) then had to work together to ensure all aspects of care for a number of patients was completed. To portray to the students this aspect of her responsibility and that they were a valued member of the team was indeed ironic. At the time, she believed, all were unattainable.

Sometimes when I'm on the unit I see it more from the staff they don't trust me. They may come and say what did you do about this? Or has this been put in the computer yet? Or have you sent the patient to the OR yet? They check up on me to see if I've done things with the students and that is not a pleasant kind of thing.

Her turbulent conflicts with the nursing staff over the years had eventually subsided, gave way to more peaceful episodes, and her defensive responses eventually were replaced with polite professional distance.

I take a deep breath sometimes and I don't respond to the things that they say about the school and about educators. I don't get involved. I keep my distance.

When the days went well, all procedures completed and all assigned care given the participants felt at ease because this meant there were less demands on them from the staff, and there was less emphasis on their knowledge or their capabilities. Nevertheless, when procedures were missed or inappropriately performed by students, their knowledge of teaching methods was questioned. They confessed it was exhausting at times trying to juggle the students' learning needs and trying to keep the staff happy. However they knew that how the staff received them directly affected the students' acceptance as well. The participants made the students and their acceptance as educators on the unit priority.

I know if they like me, the students will have a better time.

If things go well and we have a good rotation then we will be welcomed back year after year.

My approach that I take in the clinical areas is important so the staff are more accepting of the students.

At times there had been great doubt that the participants' acceptance would be accomplished. However, approval eventually came though the path had taken various forms. Some participants had achieved staff approval when they were visibly seen

participating in the workload of the unit. For others, it was interacting with the patients or displaying a genuine interest in the personal lives of the staff.

I find out what their background is. What are their interests? I get to know them as a person in an area where I can just sit down and talk with them and develop friendships.

If a patient is in pain or incontinent, I'm in with the student and then when the staff see that then I become more on the same level with them. It gives me a kind of approval with them because I'm doing things like them but I'm doing it from a different perspective.

The staff would see me interact with them (patients), how I interacted, things that I said, questions that I asked them or questions they would ask me and that made me be seen in a different light I guess.

The participants believed their greatest accomplishment in achieving acceptance and approval from the staff was developed when they had sought the knowledge and guidance of the nursing staff on clinical problems. Some admitted they sought the staff's expertise even when they had already known the answers. One participant communicated to the staff that their presence was reassuring and that their guidance and expertise aided her as an educator but their knowledge and participation also contributed to the students' education.

I'd ask them about things, professional issues or current information on some aspect of patient care.

Additionally all participants found if their clinical assignments remained the same year after year, staying on a particular unit provided stability for them. Likewise the participants' presence on the unit allowed them to become valued members of the team

and helped build relationships with the staff as they were sought for their knowledge and expert opinion.

Theme Five: All Being

The fifth theme was all being. Being, from the old English word “beon” when translated means the totality of existing things (Woolf, 1975, p. 101). In the descriptions of the roles participants had assumed most emphasis was given to those they held whilst associated with their students. There were many responsibilities that were assumed, as a clinical educator, that of educator and facilitator, evaluator, counselor, mentor and mediator. The participants used the term educator synonymously with facilitator and all clearly believed inherent in the educator role was that of evaluator. The participants believed both occurred simultaneously as they guided students through their clinical education. As teachers, they provided instruction with procedures for the students to acquire skills and assisted their learning through the offer of examples and problem solving techniques. As an evaluator, they assured whether each student upheld the standards of practice. This responsibility was not taken lightly but with considerable allegiance in mind as they viewed their purpose as demonstrating fairness and effectiveness in the students’ evaluation. The participants upheld the belief that their main intent of such a dual role was to have had provided opportunities for learning so the students would leave with more knowledge but also ensured students’ knowledge was satisfactory for practice.

As facilitators of learning, the participants were confident in their vast knowledge as clinicians which they believed enabled the students to look at situations more critically.

I have to be knowledgeable about many things as I discuss patient problems with them (students).

I draw from my nursing experiences all the time.

I integrate the skills into their learning but as the educator I facilitate.

I may have questions to discuss so I try to prompt them and encourage them to think in a certain way until they go, oh yes I never thought about that.

Colloquy complemented this aspect of their role. A verbal exchange between student and educator every morning shaped the students' plans of care, priorities of the day and their organizational abilities. Generally these conversations had given the participants a sense of each student's comprehension level relative to the assigned patients' care.

So I pose the questions but they have to reason it out.

I help them think through the assessment and how they can both physically and mentally assess that person.

I work on a surgical unit so my students are in their final year and they have to have done a thorough respiratory and GI assessment prior to me seeing them. Then, I expect them to take that data and use it effectively.

Are they able to zone in on the patients' care and needs and organize their thoughts? That's the kind of things I look for.

My first round I try to go to every single student in every single room so they can give me their initial assessment.

As the participants used these dialogues between student and educator, they promptly determined whom they had to enlighten or spend more time with. Their comments:

I need to know.

I have to see.

I have to make sure.

They have to tell me how.

I must get an idea of what they know.

suggested an urgency so a snapshot of each student's capabilities as well as limitations was procured. Although the ideal was to have assessed all students prior to their delivery of any patient care, the participants confessed this rarely occurred because of unforeseen clinical events or circumstances. These events had come in the form of bandages askew, intravenous lines infiltrated or changed patient status but whatever the delay it prevented them from getting, at times, a clear portrayal of each student's inclinations. In the ideal world, they admitted, every student would have been accurately assessed prior to their responsibilities commencing, but in actuality this usually had not been the case. What had occurred were instances that obligated the participants to select specific students with recognized weaknesses. The craft of student selection was something that they had perfected over the years and relied on it heavily to filter out the anxious or unprepared student. They admitted they grouped the students into categories of "weak and strong" but such labels allowed a special approach by the participants, chiefly to the weak. As

two participants spoke they described the approach as a one on one, not to isolate or treat those students differently but a time that provided extra opportunities for learning.

They're the ones I focus on the most, the ones I spend the most time with and the ones I ask the most questions of.

I keep the weaker student informed of their progress so everything is up front because we're working together towards the same goals.

Two other participants considered that, while such an approach had allowed a fair chance for the "weaker" student, it had also resulted in inequality for the others.

Sometimes the decisions they had made where their expertise had been given to just one student had not always sat well with them. One participant felt an injustice had often been served to the other members of the student group who were seen as more independent and capable.

I may plan to stay with her for fifteen minutes but forty-five minutes later I'm still in there guiding her through it.

While the second participant believed the more capable student had required and had the right to the educator's expertise, she also confessed the reliance on the stronger student to be independent and reliable had helped her attend to other responsibilities. The stronger students with their dependable, self-motivated nature, had made the clinical situation more pleasurable and manageable for her. Moreover, as another participant stated, in the end it was always the student who had not been prepared that had warranted closer watchfulness and assessment of their actions.

The weaker students are the real challenge. I have to get the facts clear, what the weaknesses are and then I meet with them immediately.

The more difficult aspect of “the weaker students” had come when stories of student and educator had not coincided. Approaching such a situation with diplomacy, calmness and objectiveness was seen as a challenge but an approach that was warranted. It also allowed those “weaker” students the opportunity to identify the problem and grow from the experience. As one educator expressed, the intent of the objective approach was toward the students’ identification of the problem and impression of the situation so they learned more from the exposure to error.

I’m trying to evaluate them and discuss it to the point that they themselves realize the ramifications but I don’t want to make such an impact that it’s going to negatively affect them for the rest of their lives.

The close attention that was given to early recognition of problems, one on one guidance, support and the offer of ongoing feedback to students who were experiencing difficult clinical situations gave, as one participant described, a sense of self-satisfaction as an evaluator in knowing “everything possible was done”. However as an individual she had a certain degree of self-doubt as to the decisions made, especially if clinical failure had been the outcome for the student. Two participants said that first and foremost fairness had always been the inference so that every benefit possible was assured each student in their clinical education.

I go through a process when I’m questioning myself and if I get all the right answers and it supports my opinion then I know I did what’s best.

I don't enjoy failing students but I know I can recognize the problem early on.

As one participant examined how she dealt with the weaker student, she expressed the questions she often asked of herself.

Am I treating them any differently? Have I done anything different with him or her? Did I give them harder patients than the others?

This participant assured herself that there was no bias intent and that hopefully the student had seen the honesty and fairness in such an approach. Furthermore she believed that fairness was required if mutual trust had been formed between her and the students. Other participants, however, believed they trusted their students when questions were answered and all assigned responsibilities and procedures completed. The participants confessed they then responded to the students with loyalty, belief in their abilities or increased their level of responsibility and protected them against conflict from other health personnel. However that trust in the student was not always reliable. Some educators had found it had been burdensome, especially when the student had proven their capabilities and was given independence but had failed to follow through with competent care. Two participants expressed that the evaluator in them was never quieted.

Once I educate them about the siderail and they learn from it I expect them to uphold that. But if the siderail is left down again for the second or the third time I have to write that down. They are being inconsistent with care.

If I get a student who says they have finished their complete bed bath and I know it is impossible in the time frame she allotted then I start to feel very uncomfortable.

A role less cherished was that of counselor. Although the participants had dealt with student issues, after years of experience they recognized more readily those situations they considered as “out of their league”. They acknowledged clinical rotations increased students’ anxiety, stress and personal circumstances so the participants listened to the problems, guided and supported the students in their decisions, and assisted them in identifying alternative choices.

Oh several students who I can think of now were ready to quit and pack their bags to leave so I’d call them over to listen to them to see if I could be of any help.

You know she was going to leave because she had failed the exam so I just talked with her to help her think things through.

Although the participants felt equipped to help the students re-priorize their patient care or provide alternatives for their study habits, most felt less readied to offer advice for personal issues. Instead they encouraged them to seek professional help but continued to be a presence of support as the crisis evolved. The participants recognized when they had become involved with personal issues it consumed them and took away valuable time and the benefit of the learning experience for other students. One participant stressed there had to be clear distinctions and boundaries within this role and emphasized the whole group’s learning and not just the problems of one individual.

I listen to them but often refer them to a counselor or some other professional.

One participant described herself as a mentor or role model. As a mentor she guided the students and helped them focus their thoughts about nursing or framed it for them and brought some meaning to their career.

I had one student who worked with troubled adolescents and she had a lot of experience behind her already in this area. She bounced ideas off me and we talked and I encouraged her to keep it on track.

Likewise some participants viewed themselves as role models for the students. As such, they had often made a point of being seen interacting with physicians, staff nurses and patients and hoped the students witnessed and developed the practice of those same behaviors. What they had portrayed to the students was most meaningful because the students had seen many things as they worked on the floors, with some things not so positive. However as role models they hoped the students would come to them for guidance when situations arose that were less than proper. One participant felt although she had little control over what the students saw in the clinical setting, she hoped her words had influenced them enough to perceive the events accurately and prudently.

Not that I'm the most perfect nurse in the world but in this job I'm expected to be a role model and it's part of what I do for them (students).

The participants acknowledged the importance of professionalism in the clinical area. Likewise they felt their responses to other health professionals in relation to unprofessionalism was not always well received and had caused conflicts among them and the nursing staff.

I experienced a situation when the students witnessed an R.N. giving a patient a bed bath without the curtain drawn so I discussed the ethical privacy issue with her.

If I know a patient is at risk I've talked to the nursing staff about it and sometimes I've had to go to the supervisor because I believed the patient would have been at further risk. For a while I was the glass ivory tower person.

Patient advocacy was considered of primary importance and as educators they all emphasized this role. Whether they had assured that students gave competent quality patient care or that other health professionals upheld the standards of nursing practice, one participant saw this as inherent in her job. She viewed it as a positive role- modeling behavior for others to emulate.

I had a male student who came to me because a patient wasn't receiving the proper treatment for his medical condition. So together we had to treat that very sensitively and approach the nursing staff and medical resident with it and the result was the student was correct and the patient received the appropriate treatment.

Some participants described themselves as mediators between the students and the nursing staff. Situations where complaints about students were received with little documented evidence to support the accusations were most troublesome. Such conflicts necessitated detective work, a sorting through the data, careful attention to personalities and "all sides of the story", so an outcome that was just and fair had occurred. Sometimes it had been apparent that a power struggle between student/staff personalities had existed or there had been a misinterpretation of what the student had been allowed to do. Whatever the cause some participants found themselves easing tensions, securing calmness and clarifying responsibilities. As educators, they felt they had to be careful and

remained objective because decisions made may have influenced how future groups of students would be treated. The participants realized when the outcome had been in favor of the student, penalties often ensued and students may not be welcomed back or future rotations would be made unpleasant.

Yes this is a first year student and yes they know this but no they cannot do it without me and here is the reason why.

I often make a point of observing the student in that particular problem area to then draw my own conclusion.

That whole situation sometimes leaves me helpless because I want to support the student but I have to get all the facts first from everyone.

Theme Six: Guardian of Safety

The sixth and final theme was guardian of safety. The word 'guardian' has been translated from French origin to mean keeper, or protector (Woolf, 1975, p.509). The participants described the values and attitudes they had held in relation to safe clinical practice. As clinical nurse educators, they dealt with human beings who required various aspects of care. In this capacity they had to be reassured that each student under their guidance possessed a sound knowledge base and sufficient judgment when faced with clinical decisions. Foremost the participants required that the students act in a prompt prudent manner in clinical situations, however they had also realized each student was at varying levels of preparation. The participants fully acknowledged and accepted student errors in communication while they developed their therapeutic patient relationships.

They understood this would eventually transpire with time and experience. Although obligated to provide the best learning experiences available for students, this was outweighed by the participants' belief that patient protection was primary against incompetent caregivers. It was the breaches of safety by the students that had caused stress and anxiety to deepen within each educator.

The participants labelled this protection of patients as professional accountability. They described it as a duty to protect individual patients as they maintained and upheld the standards of nursing practice or stopped unsafe nursing actions while they worked with their students. Clinical assignments, therefore, were carefully orchestrated so the student nurses' capabilities matched that of patient acuity. For example, one participant believed a student who exhibited several areas of weakness in maintaining sterile technique would have not been assigned to a patient who required multiple procedures where their protection against infection was principal. The participants watched and evaluated their students for both the accepted performances as well as any inadvertent harm that had taken place.

I don't think I'm as concerned as much about how the students say things as long as they are safe, if that makes sense. To me in nursing safety is the bottom line.

When I come to a safety issue, for example a patient who is on seizure precautions and my student who was in her last year left the siderail down, that is totally unacceptable. That represents not thinking someone who cannot think in a way that is conducive to being a professional nurse.

If it comes to safety issues then I just see red. There are no excuses, I don't care if you're tired, I don't care if you're sick, if you're sick get off the floor.

When something serious happens I get a chill up my spine and I get sick to my stomach.

If there is a problem in the persons' (students') way of thinking and they don't understand the importance of keeping the patient safe then they shouldn't be here.

Another aspect of ensuring patient safety was "knowing everything about the patient". The participants in a variety of ways described this but most often it involved data they had gathered on the assigned students' patients. Typically, the participants arrived in the clinical area the day before and sought appropriate patients for their eight to ten students. This had entailed reading charts thoroughly, speaking with the nursing staff in relation to "anything new and what would be planned for tomorrow", and lastly reviewing the medication and nursing kardexes for additional patient information. The participants stressed, especially on a medical unit, medications alone for sixteen to twenty potential patients often consisted of reviewing fifty to seventy medications. This had not included those medications that the patients could receive at irregular intervals for unanticipated events such as chest pain or unpredictable high blood pressure. Three participants relayed that data gathering was a very time consuming task. Nevertheless it was essential if they were to have a sense of where each patient was in his or her current plan of treatment, what the students would be responsible for and how, as educators, they would "tie it all together" for the students.

I always read the patients' charts thoroughly myself to know the history.

Well I've looked at their kardexes and charts and their general type of care but I don't know the real story until I go in the patients' room.

Then I go to the staff to get their input as to how Mr. Smith likes his particular dressing to be done or what time will someone else be going to the OR.

So the participants were assured that they were fully prepared for the day's events, they started very early on the assigned clinical day, usually an hour before the students arrived. During that time they had painstakingly reviewed progress notes, medication kardexes for changes and then completed a head to toe assessment on each assigned patient which established a foundation from where their day may begin. One participant shared her thoughts about preparation for clinical and described that, as she proceeded with precision from student to student, she then determined if the initial clinical findings of each student matched her own.

I would observe them interacting with their patients, a quick assessment of how they connected with them. Then I would call the student outside the room to describe to me the patient's condition, not formally but what do they perceive the nursing care to be? The patient's needs for the day and how they would go about it safely?

Two participants said, although their preparation provided some comfort, they knew there would be many unknowns that would surface throughout the shift and cause a rippling effect to the most organized of days.

I mean I get report from the staff but it's not until I'm there with the student in the patient's room that I get a sense of what's really happening.

Now I'm making a round on ten patients and go in and check on dressings, I/V's, hickman catheters and hopefully get to all of them before the day begins.

Other participants expressed that there were many unpredictable incidents that arose which created some degree of upheaval in the proposed plan for that day. It was the unanticipated unknowns such as disconnected intravenous lines, skewed dressings, refused care, allergic reactions or episodes of chest pain that made their organized days increasingly stressed. Ultimately this meant that visits to students were rushed, took on a hectic pace and were ineffective as they tried to ascertain if the student had comprehended what they had said. The participants described those days as having left them with a very uneasy mind, frustrated in the fact that they had little success in what they taught.

Sometimes I have very limited time with the students other than running in and saying are you okay? Well I got to go. But it's the running from room to room, you do this I/M, dressing, you do this.

All I do sometimes is procedures. I spent no quality time with the students.

Two participants related how the hectic pace of teaching made them realize if patient care was left undone it was their responsibility alone and they then had to rectify those situations. The participants believed that they had let the patients down and had not succeeded in organizing the day sufficiently enough to ensure the students had completed all assigned care. The participants recognized that while all their students may have not given the same level of care, it had been their responsibility to ensure that the students completed that care. As two participants talked they expressed their concerns about this level of responsibility.

I always feel that when I leave the floor if the job has not been done well then I feel responsible and I will stay behind and go to that patient and make sure even little things like their unit is tidy before I leave the floor.

I let the staff know what we are going to do and they organize their day around us so if something doesn't get done then I take the blame for it.

A major part of the clinical experience was to observe the student and, if necessary, intervene on the patient's behalf. The participants specified this as guardianship that was a constant, never-ending, alertness for them. For one participant it extended beyond the clinical shift into her personal life. As she arrived home the emotional wariness of the long day remained with her as she felt she "never really left clinical behind". There was a trepidation that procedures may have been left undone, patient care incomplete or an omission of medication that she had overlooked. It required her to allot a time frame each clinical night where she anticipated calls from the nurse in charge who requested clarification or resolution on a student problem. This vigilance persisted until 'clinical time' had fully lapsed, which for her was two twelve-hour shifts a week. This meant the constant mindfulness to patient safety had not subsided until she was ready "to let it go". Although all consuming, she believed "this time" had helped her resolve responsibilities and finally abandon her wary thoughts until the next clinical day when the cycle resumed.

It is so much a part of me and there is so much responsibility. Those patients are relying on me so I have to make sure my students care for them completely. It is who I am as a nurse.

The participants assured the students received appropriate and meaningful learning experiences but never at the expense of the patients. Over the years all educators had recognized a need to organize their assignments with diligence so that some students received challenging experiences while others were granted their turn in time. Most hazardous they felt were the obstacles of high student numbers in the clinical setting. As a result they believed sometimes their presence had revealed a physical and emotional division among the students. They described physically being with one student while they performed procedures or care while mentally “wondering where the others were and what they had been up too”. The increased student numbers in the clinical area caused great worry and frustration for the participants.

Sometimes they had felt the physical/mental division among students was a piecemeal approach, at times, to clinical education. As educators they felt they only sensed “bits and pieces” of what their students had actually done and they had not gotten a clear picture of the students’ understanding, clinical reasoning or ability. Numbers and the hindrance of insufficient time played havoc with the participants’ personal values of what clinical education implied. The increased number of students in any one clinical area had impeded their primary intent of the practicum to draw upon their expertise and knowledge to foster student learning. In addition, increased students meant increased patient data to be retrieved and retained by the participants. All educators related that this was a very challenging area but one which they had perfected over the years out of necessity.

Eight or nine students is too many, six is great and seven you can work with but once it goes over seven there is one student that I don't get to see all day.

Most of my work is in final year so my students are providing total patient care and I often have a large number of students in the clinical area. That means I won't be seeing each student for long periods of time.

I mean I am here to ensure patient safety and that the patients receive the care they need. It is a tremendous responsibility. Still after years of clinical teaching I still find I have so many students to look after that I would much rather a small group ratio.

I get too many students there's no doubt in my mind about that. But sometimes hours pass by and I don't see them and in those hours that pass by I'm worried about them. Worried are things going well? Worried are the patients safe?

When I think I'm responsible for eight to ten students and each one has one to two patients that's sixteen to twenty patients I'm responsible for, along with the students, that is twenty-four to thirty people. It's unrealistic. Each team leader in the unit has two to three professionals working with her and I have my students and patients distributed in three units. So not only do I have people all over the floor I have three different teams to report too. I tell you I feel as though I should have roller skates on sometimes (laughs).

Because of increased student numbers one participant expressed great disdain with the endless race against time, especially when situations demanded her individual attention. She believed the time that had to be given to one student's safety violation proved to be an injustice to the remaining number of students on the floor. She expressed valuable time not only had been taken from the other students learning but the incident often left her drained of any further emotional energy.

If I spend time with a student who has had a medication error the other nine are left to fend for themselves. Besides that the student is upset, the patient's upset, the team leader is upset, I am and the doctor gets involved. So it adds to my stress and the other nine students don't get the attention they should.

Four of the participants had reflected on their own practices and considered their personal commitment and responsibility to the patients had failed somehow when the students had not upheld duties of care. The student, the participants considered, to be an individual, a middle person between themselves and the patient. When they assumed that care for the patient through the student they had found it was a burdensome task. The participants had known their knowledge and expertise guided the students' care but their watchfulness also had to ensure that no ill harm to the patients occurred. Even when students assumed independently more of the patient care, mentally at times there was an inability for the participants to let their supervision go as they continued to fear that some harm may result. Acts of negligence by a student ultimately lay with the participants and, as a member of a profession where patient advocacy was uppermost, students' incompetence had been awarded zero tolerance. As nurse educators they were responsible to guide and evaluate their students but as a nurse they had to protect and ensure the patients received their entitled care. Some participants expressed their thoughts of feeling engulfed by this dual responsibility.

If the patient didn't receive their pain med and the student didn't tell me then at some point I should have been there and assessed the patient to know she needed the med and then tell the student she should have been aware of this. That's the kind of responsibility I assume.

I think I'm there to teach and the final outcome is the patient so I guess the responsibility of the student reflects me and if they are not doing the care then I do take that personally.

When I get the call from the supervisor telling me that my first year student forgot to unclamp the foley catheter and now the patient is in severe pain and trauma, it's

me who did this. I forgot to unclamp it. It's almost like there was no student there because the student looks to me for everything to be perfect.

I was somehow ineffective in getting the message across to the students so they provided ineffective patient care. It is my fault.

One participant believed that, when students were assigned patients, she had essentially promised the patients that they were not at a greater risk for infection or unsafe care because they had a student. This participant reflected on her responsibility and felt it was her presence and diligence that guaranteed patient safety.

So I would stay with them until I thought they knew what they were doing and I would go over my list to make sure they had not forgotten anything and I knew the patient was safe with them. Then I would go on to the next student.

But this participant admitted there had to come a time when she had to trust the students and hoped that all she had taught in the way of safe patient care had prevailed.

But I have to try and see it in them. The students that I have, have to be able to provide safe, responsible care to their patients.

Situations of dishonesty were cautiously approached. One participant strongly believed integrity to nursing was regarded as an essential element of the profession and there was little tolerance for those students who lacked such a characteristic. If warranted, a desire to fail such a student was deemed an appropriate and justified course of action. For this participant a personal anguish ensued when a student had performed poorly with patient care and attempted to correct errors through deceit. The end result for the student usually had been clinical failure, however more importantly she felt she had somehow

failed the patient and “let him down”. In this situation she felt her job to attend to the students’ learning was secondary to what she expected of herself as a nurse and the care the patient was supposed to have received. She had to give herself time for forgiveness and approval to let herself think about it, what had occurred, what didn’t occur, and what she could have done better.

I knew she (student) didn’t do the assessment and yet she charted that she did. She didn’t have the time to do it. I know that. But she stood in front of me and lied about having it (assessment) done. We don’t need people like that in nursing.

For other participants the issue of dishonesty had given them a general uneasiness about letting those “types” of students have any contact with patients who were so vulnerable and dependent on others for care. It caused them to internally question, observe and wonder if having such a person (student) care for the patient compromised the patients’ safety. These situations caused their vigilance to increase.

When I do find the student in something dishonest I approach that very carefully. I approach it and this is only after many years of experience, but to get the student to reveal what she has done and then I discuss my findings and even then sometimes they (students) still lie.

If I can’t trust them to be safe it is upsetting for me. I have to say this is my deepest emotion but I don’t want them there with me. Sometimes I feel that way.

You know a student who tries to cover their tracks, it’s an upsetting feeling. You know they are lying and yet sometimes I can’t prove it.

Summary of the Relationship Among Themes

All themes were integral and interrelated and interwoven and dependent on the other, so to consider them separately was difficult and challenging. Additionally some participants experienced certain aspects of a theme more intensely than the others had. The following discussion and exploration of the themes, as they related to each other, provided a phenomenological description of what clinical practicum meant to the lived experience of the nurse educator.

The participants' stories revealed shared understandings and personal beliefs about their lived experiences of clinical teaching. For all caring was immutable, always present in them in some form and displayed in a variety of ways. It extended beyond the participants and was reflected in their relationships with the students, nursing staff, other nurse educators and patients. However it was the students whom the participants spoke of the most and to what end they approached that student-educator relationship was of principal importance. The participants felt the uniqueness of this relationship allowed them to enter the world of the student in a significant way. They saw their students as individuals with feelings and emotions, individuals whom they guided and supported throughout their clinical education. The participants believed their approaches to the student-educator relationship had allowed the hierarchical lines of teacher and student to abate. As clinical educators they maintained their professionalism yet also expressed their

desire to have been viewed as individuals who related the human aspects of life with their students' learning.

As the participants reflected on their relationships with students they accepted, by the nature of their responsibilities, that it also had encircled the nursing staff. The relationships formed with this group were less agreeable as the participants' stories resonated with their need for acceptance and approval from that group. The participants initially felt abandoned by the nursing staff and attempted to reason why such tensions existed. They proposed it had been the 'theory practice gap' which preceded them but, whatever the cause, the participants persisted in their search for validation and to prove themselves credible in the eyes of their professional colleagues.

As educators they clearly understood how to be a nurse; their own practices had taught them very well and they had drawn from those experiences regularly. They equally recognized the momentous responsibility of taking individuals and molding them into professional nurses. Consequently, to varying degrees they experienced trepidation over what they were required to know as they questioned their self-portrayal as clinical educators to those around them. Over time, self-confidence in their knowledge and clinical practices succeeded in shaping them as individuals and as clinical educators. The participants had acknowledged that they had learned a great deal over the course of their respective careers but had learned the most from their clinical experiences with students. Equally they had been urged forward by other clinical educators as all participants shared stories and realized and accepted they had expertise as well as knowledge yet to learn.

As clinical educators there had been many demands placed on them and many roles to be assumed that were often ambiguous, ill defined and obscure. As they had become confident in their abilities and learned to accept themselves as knowledgeable experts this eventually allowed adaptation to those new roles. Most notable for the participants was the dual role of teacher and evaluator. While they taught their students they also questioned if what was taught had been effective as the participants determined whether students had learned or whether experiences provided had been beneficial. Although they pondered this often it had never been at the expense of the patient. A responsibility to the students was required however a preserved loyalty to the patient as guardian of their care prevailed. The unpredictability of clinical always kept the participants vigilant. Their obligation had been to the student to teach them to be nurses but their guardianship ensured the patients' safety. This reminded them of their responsibilities as nurses and as educators and was continuous and never quieted.

In totality the experiences in the clinical setting for the participants were constant reminders that all they had learned as practicing nurses and what they had yet to learn as clinical educators was incorporated and molded into the clinical teacher.

The Essence

The phenomenological descriptions of the meanings and significance of the thematic statements helped the investigator to move closer to the essence of the

experience. The investigator explored the experience of what it meant to be a nurse educator during clinical practicum and moved closer to understanding its fundamental meaning. As the themes were described nurse and teacher fused and the essence emerged and was revealed as becoming a nurse-teacher.

Phenomenology has asked the question what makes the phenomenon what it is, “what makes it possible and without which it could not be what it is” (vanManen, 1990, p.10). If the clinical practicum were any other the experience would not have had the same meaning for the participants. The investigator has not assumed by this that all other clinical educators and their clinical experiences in other professions are the same but the effect that teaching clinical nursing education has on these nurse educators has sculpted who they have become in a distinct way.

The word ‘becoming’ implies to grow and emerge with new characteristics and from which there is no end. Metaphorically speaking, becoming a nurse teacher has been likened to that of a prism. A prism, in and of itself, has clear distinctions and boundaries that have helped to define its simplicity yet also has revealed its complexity, many parts within the one whole. Its lines are precise and distinguished, one part from another, however with the illumination of light a looking through and beyond the lines of distinction has been released. The light has helped to unite the whole and blended the light patterns so complicated definiteness becomes one. For that reason the clinical nurse educator has been compared to that of a prism. On the surface of this person there has been distinction of roles, clearly defined responsibilities, a caring person who was

knowledgeable, who was a professional, a nurse, a teacher, a learner. As those lines dissolved the distinctions fused and made the divisions less penetrable and definite and revealed a oneness, a oneness that extended beyond and never ended - an individual who is a becoming a nurse-teacher.

Summary

This chapter has given a description of the participants in this study and has provided the description of themes that emerged from the data. The relationship among themes and the essence of the experience of being a clinical nurse educator was also presented. The participants' rich accounts of their experiences in the clinical setting while teaching has contributed to the nursing literature and does offer value to nursing education, practice and research.

CHAPTER FIVE

Discussion

The aim of this research was to discover, explore and describe the meaning and significance of the lived experience of the nurse educator during clinical practicum. This chapter provides the identified themes and the investigator's descriptive findings as they relate to the reviewed literature. The implications for nursing education, practice and research have also been explored. Finally, the summative statements of this study are addressed.

Discussion of Findings as they Relate to the Literature

Numerous researchers have examined different aspects of nursing education. However, the majority of the literature has been associated with topics that pertained to curricular issues. Inasmuch, some authors have investigated the nurse educator but their research has been predominantly associated with the students' vantagepoint. A major thread in the nursing literature has been the student-nurse educator relationship and its caring connection to the promotion of student learning in the clinical setting (DeYoung, 1990; Karns & Schwab, 1982; Reilly & Oermann, 1992). Generally researchers supported the need for a caring environment where nurse educators provided a non-judgemental giving of self that assisted in valuing a humanistic environment for students (Halldorsdottir, 1990; Hanson & Smith, 1996; Kosowski, 1995; Simonson, 1996) yet the

faculty perspectives of caring practices in the clinical setting has not been well studied (Grams, et al. 1997; Paterson & Crawford, 1994; Redmond & Sorrell, 1996).

Clinical teaching in nursing has offered support and guidance to students' knowledge but has also contributed to their high stress levels (Beck, 1993; Benner, 1984; Griffith & Baranauskas, 1983; Reilly & Oermann, 1992; White & Ewan, 1991). Integral to professional education some researchers have argued for a greater in-depth analysis of what clinical teaching means, the role of the clinical educator, the perceptual world of clinical faculty and its' value to the knowledge base of nursing (Diekelmann, 1990; Pugh, 1980). Although some researchers have contended the primary purpose of the nurse educator has been the initiation of students into the profession of nursing the roles associated with clinical nurse educators have been confused and ambiguous (Clifford, 1993; Crotty, 1993; Diekleman, 1990).

Other researchers have argued that faculty have not been educationally prepared to assume the clinical teaching role (Packard & Polifroni, 1992; White & Ewan, 1991). Such an assumption has inadvertently denounced the credibility of nursing education in the clinical setting and cemented the belief that clinical educators are marginal, temporary people within permanent structures (Clifford, 1996; Glossip, et al. 1999; Hill, 1990; Ohlen & Segesten (1998). Inasmuch, role strain/conflict has played a significant factor in the clinical educator's experience (Ferguson, 1996; Wiseman, 1994). Hence there has been a dearth of literature that has addressed the nurse educator's perspective and what they have offered to nursing education. The anecdotal literature has been replete with the need for

support for nurse educators as they discover their role requirements and what research that has existed illustrated the need for further research from the educator's perspective (Byrne, et al. 1996; Dieckmann, 1990; Friedman & Menin, 1991; Girot, 1991; Lee, 1996; Smythe, 1993).

The descriptions by these women as they reflected on their lived experiences, its meaning and significance, supplied valuable narratives for the investigator and formed the basis for the intertwined themes. The experience of being a nurse educator in the clinical setting, in this study, meant many things to the participants: The Nurse Educator as a Connection to Caring; Being Human; Learners and Know-how of Knowledge; Seeking Validation. Alone in Becoming; All Being; and Guardian of Safety. As individuals they experienced the intensity of clinical teaching. Distinctly and collectively they uncovered the complexities of the clinical nurse educator, as they perceived it to be.

The first two themes, **the nurse educator as a connection to caring and being human**, generally implied that the participants guided and assisted the students throughout their educational experiences "at all costs". The nature of the participants' approaches differed somewhat, individually, but all believed they had impacted on their students' lives in some significant way. An attitude of respect, caring, support, valuing, guiding and concern for the student's general well being were the chronicles expressed by the participants in their everyday encounters with their clinical groups. The behaviors of the participants, as they expressed evidence of support and nurturing for their students, were incorporated in their stories.

The participants valued the emotional development of the students and saw this as a key concern as they entered into their worlds. They viewed attentive listening, fostering self-esteem, encouraging and motivating, using humor and revealing personal stories of their own failures and accomplishments as practicing nurse educators, as a means of connection and caring for their students. The main foundation of their actions was based on the participants' belief that reciprocal relationships existed between student and educator. Equally the participants' urged that such behaviors had promoted a comfortable learning environment. The findings of this study are validated by those of Ferguson (1996), Grams, et al. (1997), McFayden (1991), and Nahas (1998) that clinical educators developed close bonds with students and created egalitarian relationships.

Likewise the studies of Halldorsdottir (1990), Simonson (1996), Kosowski (1995), and Hanson and Smith (1996) illustrated the common thread that caring was essential to the student-teacher relationship. Although these studies were identified as student focused the research findings can be applied to the participants' descriptions in this study. The extent of caring for the students by the participants in this study meant the nurse educators were sensitive to the students' needs, became empathic to their world and responded to their sometimes fragile self-image with expressions of sincerity and respect that connected teacher and student.

The nurse educators in this study assumed that the caring relationships they developed with their students, over time, were influenced by many factors. Circumstances such as faculty and student personalities, how their students interacted with them, what

the participants thought of each student and how each participant changed personally as a result of the relationships formed were evident. The participants protected the students' vulnerability, allowed the students to voice their uncertainties and shared in their private struggles. This permitted "the caring" to become very personal, one human being helping another. As the participants gained personal experience with their students and developed student-teacher bonds they believed this had transformed them both personally and professionally.

A distinct factor in the first two themes was also the faculty-faculty relationships formed. The participants learned from their more experienced colleagues and encountered camaraderie and common teaching experiences. The informal relationships developed within this group offered the participants collegial support, mentorship, faculty growth and connection in the clinical setting. The promotion of formal faculty relationships to encourage mentorship and support also has been suggested by Brown (1999) and Ludwick, et al. (1998). In this study the faculty-faculty relationships were informal. This may have been related to the friendly culture of the Newfoundland region or the small faculty numbers that existed within the schools where the participants were employed. Hence the smaller number of faculty the more likely each participant would develop informal relationships.

Despite the participants' practical experience and advanced educational preparation all believed they lacked sufficient knowledge for the role of clinical educator. This was congruent with the beliefs of Infante (1985, 1986), Hermann (1997) and

Sellappah, et al. (1998) and the lack of educational preparation at the Masters level to assume clinical teaching roles.

In the third theme **learners and know-how of knowledge** the participants interpreted themselves as “unknowledgeable”, learning by trial and error and adopting a learn as you go philosophy. Initially the ‘strangeness of their new situation’ of being a clinical educator and the unpredictability of clinical caused anxiety. Subsequently the participants learned to adapt to the ‘upheavals in the day’, and strategizing and problem-solving their way through patient-student events. The ability to adapt, however, had not occurred overnight and was fostered through experiential learning. Their knowledge as nurses and their present experiences as clinical educators provided the greatest contributory medium to their learning. The more time spent in the clinical area with the students provided an avenue whereby the participants perfected their problem solving skills and increased their confidence to teach as they provided competent patient care. Although they met with many obstacles, difficulties and stress along the way, all expressed their commitment to the students’ education and goals and the provision of meaningful learning experiences. The wisdom of gained knowledge and knowledge then in turn shared with students was an empowering force as this had given the participants the greatest satisfaction to their work. Experiential learning as a primary medium to enhance a person’s knowledge base was illustrated and strengthened by Ferguson’s (1996) and Packard and Polifroni’s (1992) research findings.

The participants acknowledged their inexperience as clinical educators was reflected in their defensive responses to staff and students and equally with the unrealistic expectations they had sometimes placed on the students' learning. The participants described themselves as regimented, task oriented, intimidating perfectionists with little time for social professional dialogue. As there has been little research into the educator's perspective on clinical teaching, the investigator cannot account for the participants' personal responses associated with their lack of knowledge. It may be suggested these were natural responses to defend their professional image or that becoming a clinical educator involves an intricate developmental process as Dieckmann (1990) has suggested. Yet the developmental process which an educator may go through, while they are perfecting their teaching style, has not been explored in any depth.

Seeking validation. Alone in becoming, the fourth theme was reflected in the participants' narratives of 'not belonging' or 'not being accepted' on the clinical units by the nursing staff. The participants expressed power struggles with the staff and pondered if their presence had been perceived as threatening. The participants' expertise and experience was in question as they believed the nursing staff generally misunderstood what constituted the participants' job realities. The nurse educators' stories of their encounters with the nursing staff were so illustrative of how they believed the staff saw them, as worthlessly docile. Individually the participants moved from passive acceptance of the staff responses to questioning and critiquing arguments and professional assumptions that had been made. Described as an adversarial relationship, the participants

noted how the nursing staff had known when they were unfamiliar with unit routines, viewed them as occasional visitors to the area and were valued not for their knowledge, initially, but for their contributory benefit to unit routines. Yet, the participants acknowledged that the nursing staff themselves largely determined when they would be allowed to join in unit activities. Ultimately this alienating and exclusionary process deprived the participants from becoming part of 'the team'. Serendipitously crucial to their acceptance was the proof of their clinical credibility to that same group.

Equally important in this theme the participants described their own means of validating their presence and decreasing their feelings of abandonment by forming alliances with other nurse educators who had similar experiences. In the participants' struggle for credibility and acceptance they promoted open communication with the staff, utilized student-patient situations that revealed their knowledge and familiarized themselves with unit routines. Although various extremes of tension with the nursing staff were experienced by all participants, some more severe than others, respectful distances were always maintained. Most significant in "being accepted" was when the clinical educators showed personal interest in the staff's lives, sought them for their expertise and remained assigned to the same clinical unit yearly. Collectively this provided stability in their staff nurse-educator relationships, improved experiences for students and sealed their credibility with their nursing peers. This was consistent with Infante's (1985, 1986) and Packard and Polifroni's (1992) views of nurse educators as

visitors in the clinical setting and Bradby's (1990), Buckenham's (1998) and Laing's (1993) ideas of role socialization.

The findings of this study are also congruent with that of Paterson's (1997) findings of faculty being viewed as temporary systems. Additionally the findings of this theme have contributed to the literature on the theory-practice divide posited by Glossip, et al. (1999), Hewison and Wildman (1996), Hill (1990), Ohlen and Segesten (1998), and Upton (1999). These authors have argued if staff nurses and clinical educators maintained dialogue and shared perspectives of each other's world it would improve their relationships, enhance student learning and narrow the theory-practice divide.

As the clinical nurse educators in this study described themselves in the fifth theme, **all being**, providing educational experiences for students necessitated many role variations. Primarily the participants believed their own behaviors, attitudes and values about nursing influenced and guided students as they cared for their patients. The participants envisioned themselves as a combination of teacher, mentor, counselor, role model and evaluator. This was consistent with the literature of Betz (1985), Byrne, et al. (1996), Mercer (1984), Orchard (1994), Reilly and Oermann (1992), Vance (1982), White and Ewan (1991), and Wiseman (1994) in the identification of nurse educator roles.

Of the many roles the participants assumed evaluator was most worrisome. The concern of fairness to each student in his or her clinical education was foremost. However fairness became increasingly difficult when student to teacher ratios grew. The

consequence of student numbers and its impact on patient safety, the quality of the learning experiences provided and the increasing level of responsibility and accountability was arduous. The level of supervision the participants provided to the students was related to patient acuity and student ability, there had to be a match. Equally the addition of one to two students with marginal abilities in a clinical group created significant worry over safety issues. Duke (1996), Packard and Polifroni (1992) and Paterson (1997) reported similar findings. Generally all participants had sought answers to what was “expected of them” or “their purpose” in their role as clinical educator. The ambiguity felt around role expectations and role clarification was consistent with the findings of Choudhry (1992), Duke (1996), Packard and Polifroni (1992), Paterson (1997), and Pugh (1980) and supported by the anecdotal literature of Clifford (1996) and Lee (1996).

The sixth theme **guardian of safety** was an assumed responsibility as nurses but not specific to nursing education; it was analogous to their responsibility to their patients. The guardianship was an extension of their professional self and what was expected of them as a nurse and as a professional who cared for the public. Keeping vigilant of student behavior and action, because of moral and ethical responsibilities to the patient, was a permanent attentiveness that all experienced. In dealing with patients’ lives the participants had to be assured that their students possessed sound knowledge and sufficient judgment in caring for those individuals. It was evident the participants had difficulty disentangling ethical and moral allegiance to the patients from the educative

responsibilities to their students. Nevertheless the unpredictable nature of clinical, increased student numbers and student safety violations created a hectic pace for the participants and played chaos with their personal values of what clinical education implied, to provide their expertise so the students could learn from the experience. Similarly the ambiguity between patient and student rights and clinical nurse educators valuing safe clinical environments was consistent with the reported findings of Duke (1996), Glossip, et al. (1999) and Packard and Polifroni (1992). Additionally the participants had expressed an uneasiness with the student being the “middle person” in the educator-student-patient triad. However, the clinical educator in this triad has not been addressed in the literature to any extent.

Implications for Nursing Education, Practice and Research

Indisputable recognition has been given to clinical nurse educators as principle partners within students’ education. Yet the results of this study revealed that role expectations and role clarification of the clinical nurse educator has continued to be an ambiguous issue for these participants. Consequently these nurse educators have realized their opaque presence, within clinical nursing curricular structures, has contributed to the sometimes contradictory perceptions of their role by other health professionals. As nurse educators continue to develop within their roles they must use their own experiences as well as the experiences of other nurse educators to examine the meaning of their professional connection and relevance of their roles. Dialogue between nurse educators

must exist to expand the broader views of where these individuals belong within health care organizations. Discussions between nurse educators and staff nurses, in particular, will give recognition to the expertise and credible knowledge of both groups. As nurse educators' experience their work environments curricular issues that speak specifically to the socialization process within nursing should be addressed within clinical education. Curricular issues at the baccalaureate level should reflect discourse on the student-faculty and faculty-staff nurse relationships and its impact on student clinical education and learning within those relationships. Understanding the relationships that form between nurse educator and student and nurse educator and other professionals has implications for areas of the curriculum that speak specifically to leadership and management roles within nursing practice. Such emphasis will also enhance faculty and staff nurses and student and staff nurse relationships. Additionally the provision of in-servicing strategies for clinical evaluation of students, for those staff nurses who have chosen to practice in the preceptorship role, would be of benefit. At the Masters level, curricula should particularly address the role of the clinical educator in nursing education and strategies for clinical teaching.

The results of this study may not have direct implications for nursing practice but in understanding the purposes of the clinical nurse educator and how they experience their world will ultimately impart better care to patients. Understanding the practices of nurse educators while they teach students in the clinical setting, their connection and role within the health care team, will improve student-educator, educator-nursing staff and

student-nursing staff relationships, enhance communication between these groups and ultimately increase positive patient care and patient outcomes.

The meaning of clinical teaching for nurse educators can be supported through continued research based evidence both quantitatively and qualitatively. Subsequent research in the following areas would offer contributory knowledge to the field of nursing education:

1. Exploring the professional identity of the nurse educator.
2. A comparative study between the professional identity of clinical nurse educators and the professional identities of other teaching professionals such as social work, medicine and physiotherapy.
3. The influence of peer review in clinical teaching.
4. How do nurse educators teach in a practiced based discipline?
5. The development of clinical teaching models for scholarly practice.
6. How does continuity of yearly clinical assignments of faculty affect their teaching practices?
7. How do nurse educators define their conceptualization of clinical teaching?
8. What is the developmental process of becoming a nurse teacher?
9. Continued research into nursing practice and education perspectives on the theory-practice gap.
10. Exploring alternative models of clinical teaching that speak specifically to faculty who teach clinical and develop their own clinical practice.

11. The patient/teacher/student triad -how is safety measured with patient care?
12. How the clinical nurse educator 'fits' as a member of the health care team and their influence on that work environment.
13. What are the role expectations and perceptions of clinical faculty- from the faculty, staff and student perspectives?
14. What is the lived experience of male clinical nurse educators?

Conclusion

Phenomenological research, as an appropriate methodology for this study has offered an understanding to the human experience of being a clinical nurse educator. Lauterbach (1993), Sandelowski (1986, 1998) and vanManen (1990) suggested that phenomenology for researchers has offered harmony among the phenomenon under study, the research process, the self-interpretive human experience and the ability to comprehend it. The purpose of this study was to discover, explore and describe the lived experience of the nurse educator during clinical practicum. Data was gathered through unstructured audio taped interviews with five clinical nurse educators from the Avalon region of Newfoundland. Using the phenomenological method of vanManen (1990) six thematic descriptions were revealed: 1. the Nurse Educator as a Connection to Caring, 2. Being Human, 3. Learners and Know-how of Knowledge, 4. Seeking Validation. Alone in Becoming, 5. All Being, and 6. Guardian of Safety. The essence of the experience for this study had come to mean becoming a nurse teacher.

Clinical teaching, a highly unpredictable place where moments to teach are seized and the ability of the educator to be flexible, adaptable, skillful and amiable in such an erratic environment has been undeniable. The complex relations that have developed between the individual nurse educator, clinical teaching and its complexity and the role demands placed on the clinical nurse educator have been replete. Clinical nurse educators must attend to promoting their self-value and self-competence in clinical teaching and continue to facilitate and support faculty connectedness as they learn their place within nursing education.

The contribution and understandings of this research study and its findings have been supported and validated by current literature. Further exploration into the lived experience of the nurse educator would illuminate perspectives on clinical teaching and further the knowledge base of nursing education. As a novice investigator it has been fully acknowledged that this study has been “one phenomenological description, one interpretation, and no single interpretation of human experience will ever exhaust the possibility of yet another complementary, or even potentially richer or deeper description” of being a nurse educator during clinical practicum (vanManen, 1990, p.31).

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APPENDIX A

Consent Form Faculty of Education Memorial University of Newfoundland St. John's, Newfoundland

Consent to Participate in Educational Research

Title: The Lived Experience of the Nurse Educator during Clinical Practicum: A Phenomenological study.

Investigator: Wanda Emberley- Burke R.N., B.N.
Phone: 579-9047

Thesis Supervisor: Marilyn Thompson (709-737-4627)

You have been asked to participate in a research study. Participation in this study is entirely voluntary and you may decide to withdraw from the study at any time without prejudice or refrain from revealing any experience that you choose to omit.

Confidentiality of all information concerning participants will be maintained by the investigator by ensuring all tapes and transcripts are under lock and will be only accessible to the investigator. Specific quoting from the transcripts will be shared with the thesis supervisor but the investigator will uphold anonymity of each participant. All data will be erased and shredded upon completion of the study.

The investigator will be available during the study at all times should you have any problems or questions about the study.

Purpose of the study: The purpose of this study is to explore and describe the perceptions of nurse educators regarding their roles during the clinical experience. By gaining an understanding of the meaning and practices, as perceived by nurse educators of their interaction with nursing students in the clinical settings, others in nursing education, may be sensitized to and have a greater awareness of the nurse educator's role and what this brings to the students' educational experience.

Description of procedures: You are asked to participate in one to two audio-taped interviews, conducted at a place of your choosing. The interview will be approximately 1-2 hours in length. A second interview maybe scheduled if clarification is needed and will be of shorter duration. You will be informed at the beginning of the

interview that the investigator is interested in obtaining your thoughts, feelings and any other relevant information you feel is helpful in describing the experience of being a nurse educator during clinical guidance of nursing students. You will be asked to read the investigator's copy of your interview to confirm that the description of your thoughts and feelings is adequate. Interviews should be completed within a three month period.

Foreseeable Risks, Discomforts and Inconveniences: There are no foreseeable physical risks as a result of this study, however some may find it difficult to discuss private and personal emotions. If this happens, you may terminate the interview at any time or request the interview to be rescheduled.

This study meets the ethical guidelines of the Faculty of Education of Memorial University of Newfoundland. Should you have any questions about this research or the investigator, there are resources which you may contact: The office of Graduate Studies, Faculty of Education; Dr. L. Phillips, Associate Dean of Graduate Studies, Faculty of Education, Memorial University of Newfoundland.

I _____, the undersigned, agree to participate in the research study described. I fully understand what is involved in this study and any questions I had have been answered. I realize that participation is voluntary and that there is no guarantee that I will benefit from my involvement. I acknowledge that a copy of this form has been offered to me.

Signature of participant: _____

Date: _____

Signature of witness: _____

Date: _____

I _____, the undersigned, agree to be audio-taped during this interview as a part of this research study.

Signature of participant: _____

Date: _____

Signature of witness: _____

Date: _____

To be signed by the investigator: To the best of my ability I have fully explained to the participants the nature of this research study. I have invited questions and provided answers. I believe that the participant fully understands the implications and voluntary nature of the study.

Signature of investigator: _____

Date: _____

APPENDIX B

Demographic Profile

Name of Participant: _____

Address: _____

Phone: _____

Age: _____

School of Nursing: _____

Level of program teaching: _____

Area of clinical responsibility: _____

Number of years practiced in nursing: _____

APPENDIX C

Letter to Director of Nursing

Dear _____,

I am currently a part-time student in the Graduate Program: Post Secondary Education, Memorial University of Newfoundland. As a partial requirement for the degree of Master of Education I have to conduct a research study. This study will be under the guidance of Marilyn Thompson. This is a qualitative research study using phenomenological methodologies. The purpose of this study is to describe the experiences nurse educators have during clinical guidance. The ultimate purpose of this study is to contribute to the nursing knowledge base of nursing education and improve the educational experiences for students.

This letter is to request a list of the names of those nurse educators currently employed full time in your agency and who have had a minimum of five years experience with nursing students in the clinical setting. The research will not be conducted during work hours and will not interfere with your faculty member's employment responsibilities at any time, nor will it require the release of any student documents.

If you have any questions regarding this study do not hesitate to contact me at any time. I will be contacting you shortly for your response.

Yours Sincerely,

Wanda Emberley-Burke R.N., B.N.
(Phone: 737-3640/579-9047)

APPENDIX D

Letter to Nurse Educator

Dear _____,

I am currently a part-time student in the Graduate Program: Post Secondary Education, Memorial University of Newfoundland. As a partial requirement for the degree of Master of Education I have to conduct a research study. This study will be under the guidance of Marilyn Thompson who has experience in research and nursing education.

I am seeking individuals who would be willing to participate in a qualitative research study using phenomenological methodologies. The purpose of this study is to describe the experiences nurse educators have with their students during clinical guidance. The ultimate purpose of this study is to contribute to the knowledge base of nursing education and improve the educational experiences for students. Data collection will consist of one to two taped interviews lasting approximately sixty to ninety minutes in length. Anonymity and confidentiality will be assured at all times. I hope that you give my request a favorable response. I can be contacted at the following numbers (home 579-9047/ work 7373640) if you agree to participate or should you have any questions regarding this study.

Yours sincerely,

Wanda Emberley-Burke R.N., B.N.