# A Critical Examination of Clinical Teaching in Undergraduate Nurse Education

by

Lisa Gaye McKenna

MEdSt GradDipHealthAdmin&InfoSys
BEdSt RN CertMid

Submitted in fulfilment of the requirements
for the degree of

Doctor of Philosophy

Deakin University

November 2004

# DEAKIN UNIVERSITY

## CANDIDATE DECLARATION

I certify that the thesis entitled

"A critical examination of clinical teaching in undergraduate nurse education"

submitted for the degree of

Doctor of Philosophy

is the result of my own work and that where reference is made to the work of others, due acknowledgment is given.

I also certify that any material in the thesis which has been accepted for a degree or diploma by any other university or institution is identified in the text.

Full Name.............................................…………………………………

(Please Print)

Signed .............................................................................………………

Date..............................................................................……………….

## ACKNOWLEDGEMENTS

This project could not have been completed without a number of people around me who provided encouragement, support and guidance. I heartily thank my supervisor Professor Sally Wellard for her unending direction, encouragement and patience. Without her expertise I would not have the rich methodological exposure and research insights that I have gained. I am also indebted to Associate Professor Kristen Heggen from the University of Oslo, Norway for her generous guidance, feedback and support during the data analysis and final stages of the thesis.

A great amount of thanks goes to my partner, Gerald and my wonderful children Hayley and Lachlan for their continued support. They allowed me space but provided an outlet for frustration, even providing encouragement and motivation when my enthusiasm waned and self doubts emerged.

My appreciation and thanks also go to the participants interviewed in the study. They openly shared their knowledge and experiences on which the study is built, and without whom the study would not have been possible. In addition, I would like to thank the Nurses Board of Victoria who provided access to documents that assisted in understanding historical aspects of clinical nurse education.

I would like to acknowledge the School of Nursing at Deakin University for providing financial support to assist with the conduct and completion of the study, along with my employer, Monash University who provided paid study leave at crucial points in the project that allowed me to reach project completion.

# TABLE OF CONTENTS

CANDIDATE DECLARATION i
ACKNOWLEDGEMENTS ii
SUMMARY vii

**CHAPTER 1: INTRODUCTION 1**

**1.1 Study overview 2**

**1.2 My personal positioning 4**

**1.3 Thesis construction 5**

**CHAPTER 2: CLINICAL EDUCATION IN NURSING 8**

**2.1 Background into clinical education 9**

**2.2 Theoretical models of clinical education 10**

**2.3 The theory-practice divide 12**

**2.4 Structure of clinical education 16**

**2.5 Models for the delivery of clinical education 17**
2.5.1 The nurse academic as clinical teacher 18
2.5.2 Sessional clinical teacher 19
2.5.3 Secondee/ Clinical Teaching Associate 20
2.5.4 Preceptor 22
2.5.5 Emerging models 26

**2.6 Discourses impacting on clinical education 28**
2.6.1 Workplace and Industrial discourses 29
2.6.2 Economic and resource implications 29
2.6.3 Competitive discourses 31
2.6.4 Discourses of collaboration 32
2.6.5 Discourses of globalisation 37

**2.7 Conclusion 38**

**CHAPTER 3: TEACHING AND LEARNING IN CLINICAL SETTINGS 40**

**3.1 Teaching in clinical settings 41**
3.1.1 The work of clinical teachers 42
3.1.2 Clinical teaching challenges 51
3.1.3 Clinical teaching effectiveness 53

**3.2 Learning in clinical settings 57**
3.2.1 Professional socialisation 58
3.2.2 The clinical learning environment 60
3.2.3 Challenge and confusion: Experiences of clinical learning 61
3.2.4 Stress in clinical learning 65

**3.3 Conclusion** 69

**CHAPTER 4: THEORETICAL CONSIDERATIONS** 70

**4.1 Philosophical foundations for the study** 71

**4.2 Foucauldian perspectives** 72
4.2.1 Discourse 73
4.2.2 Power-knowledge relations 76
4.2.3 Discipline 79
4.2.4 Subject 85
4.2.5 Multiplicity of Truths 86
4.2.6 Genealogy 87
4.2.7 Criticism of Foucault's work 89

**4.3 Conclusion** 92

**CHAPTER 5: METHODOLOGY** 94

**5.1 Overview of the study** 94

**5.2 Phases in the study** 96
Phase One: Genealogical (historical) inquiry 96
Phase Two: Exploring the contemporary context of clinical teaching 99

**5.3 Criteria for inclusion and recruitment of participants** 100

**5.4 Ethical considerations of the study** 103

**5.5 Data collection – Semi-Structured Interviews** 104

**5.6 Data analysis** 105

**5.7 Discourse analysis** 106

**5.8 Issues of validity** 108
5.8.1 Representing participants 111
5.8.2 Drawing conclusions 113
5.8.3 Representing the chosen paradigm 115
5.8.4 Reflexivity 116

**5.9 Conclusion** 117

**CHAPTER 6: CHANGING TIMES IN AUSTRALIAN NURSE EDUCATION** 118

**6.1 Academic voices** 119

**6.2 Hospital-based nurse training** 121
6.2.1 The dominance of medical discourses in nurse training 122
6.2.2 Being an employee 124

**6.3 Moving towards tertiary based nurse preparation** 128

**6.4 Entering new territories** 132

**6.5 Tertiary-based nurse education** **134**
6.5.1 Moving into academia 135
6.5.2 The emergence of pedagogical discourses 139
6.5.3 Wards as contexts for struggle 141
6.5.4 Evolution of clinical teaching models 143

**6.6 Conclusion** **147**

**CHAPTER 7: THE PARTICIPANTS** **148**

**CHAPTER 8: SOCIO-POLITICAL CONSTRUCTIONS OF CLINICAL TEACHING** **157**

**8.1 Educational discourses and impact of academic curricula** **158**
8.1.1 Use of clinical learning objectives 158
8.1.2 Assessing clinical performance 162
8.1.3 “Topping up” 164

**8.2 Teaching from “personal curricula”** **166**
8.2.1 Adding a clinical skills dimension 168
8.2.2 Using experience 170
8.2.3 Applying assumptions 171
8.2.4 Illness-centredness 175

**8.3 Management and institutional discourses** **177**
8.3.1 Discipline in the ward 177
8.3.2 Human resource issues 180
8.3.3 Coordinating loyalties 186

**8.4 Conclusion** **188**

**CHAPTER 9: IT’S A JUGGLING ACT!** **190**

**9.1 Seeking balance and equity** **190**
9.1.1 Discourses of equality 191

**9.2 Educational versus nursing discourses** **198**
9.2.1 Not enough time! 200
9.2.2 Time and Expectation setting 206

**9.3 Balancing workload demands** **208**
9.3.1 Trading time 209
9.3.2 Not being on autopilot 212

**9.5 Conclusion** **217**

**CHAPTER 10: BUILDING RELATIONSHIPS** **219**

**10.1 Maternal-child relationships** **219**
10.1.1 Nurturing and protecting 220
10.1.2 Supporting and guiding 224
10.1.3 Laying down the rules 228

**10.2 Clinical teacher-university relationships** **232**
10.2.1 Visibility 234
10.2.2 Disciplining clinical teaching 236

**10.3 Relations with clinicians** **241**
10.3.1 Familiarity 241
10.3.2 Workloads and reciprocity 244

**10.4 Relationships with patients** **247**
10.4.1 The patient as ‘docile body’ 247

**10.5 Conclusion** **252**

**CHAPTER 11: REFLECTING ON COMPLEXITIES** **253**

**11.1 Curricular confrontations** **254**

**11.2 Theory-practice relationship** **258**

**11.3 Clinical teaching work** **261**

**11.4 Locating a place for this study** **266**
11.4.1 Limitations of this study 266
11.4.2 Opportunities for further research 268

**11.5 Conclusion** **270**

**CHAPTER 12: CONCLUSION** **271**

**REFERENCES** **278**

**APPENDIX 1: PUBLICATIONS AND PRESENTATIONS ARISING OUT OF THE STUDY** **304**

**APPENDIX 2: PLAIN LANGUAGE STATEMENTS** **305**

## SUMMARY

Clinical education is an integral part of undergraduate nurse education. Whilst extensive research has explored roles of clinical teachers and clinical teaching, largely through perceptions of their effectiveness, little is known from clinical teachers about how they perceive their work, factors that shape their work, and what clinical teachers themselves shape. It is the development of clinical teaching both from historical and current perspectives that formed the basis for this unique study which adds new understandings to existing knowledge around this important area of nurse education.

This study was undertaken in two phases. The limited, first phase involved an exploration of the evolution of clinical teaching models prior to, and following, the transfer of nurse education into the tertiary education sector in Victoria, Australia. Data were collected through interviews with individuals who were involved in nurse education around the time of the transfer, as well as sourced from an array of documentary sources. The analysis provided a foundational understanding of the evolution of clinical teaching models developed which informed the second and larger phase of this study. In phase two, nine clinical teachers were interviewed about their clinical teaching work to explore the discourses impacting on that work. Participants included clinical teachers from the three predominant models of clinical teaching in current Victorian practice.

Foucault's ideas on discourse, power-knowledge and genealogy were used to inform data analysis of clinical teaching work revealing aspects and issues that have not previously been reported. Findings revealed how clinical teachers use their own personal curricula to inform their teaching work. Additionally findings demonstrate a complex interplay of power-knowledge relations between clinical teachers and students, between universities and clinical settings, as well as the influence of time and other factors on disciplining clinical teaching work.

This study concludes that personal curricula operating during clinical teaching reflect realities of clinical practice and whilst not necessarily negative, they also compete with theoretical aspects of courses. Increased awareness of personal curricula is needed to ensure that they are used effectively with without negative impact on student learning. Questions are raised about the suitability of current teaching models in achieving their intended outcomes as the impact of such factors as personal curricula and nursing practice discourses widen the theory-practice gap. These findings challenge schools of nursing to develop new, more appropriate clinical teaching models. The study also concludes that relationships between clinical teachers and students have changed dramatically since the transfer of nurse education into the higher sector. The emergence of maternal-child relationships warrant care and support if educational expectations are to be met and potential for conflict is minimised. Overall, the study adds significantly to current understandings of clinical nursing education and provides a basis for future developments in the area.

# Chapter 1

# INTRODUCTION

Clinical education is an integral component of undergraduate nurse education. In many cases, this component accounts for up to fifty percent of entire preparatory programs. Furthermore, this educational component most often occurs at locations other than the home university, such as in hospitals, community and other external health care venues. The distancing of clinical education from the physical settings in which theoretical learning and teaching occurs has subsequently distanced nurse academics from clinical aspects of courses. Over time, the distancing has led to the development of clinical teacher positions directed towards ensuring ongoing supervision and teaching of students within clinical settings. In Victoria, Australia these roles have developed under such guises as sessional clinical teacher, clinical teaching associate (secondee) and preceptor.

Whilst an extensive amount of research has explored characteristics of clinical teachers and clinical teaching, largely through perceptions of their effectiveness, little is known from clinical teachers about how they perceive their work, factors that shape them, and what clinical teachers themselves shape. It is the development of clinical teaching both from historical and current perspectives that formed the basis for this unique study

which will add new understandings to existing knowledge around this important area of nurse education.

## 1.1 Study overview

An approach, informed by the work of French philosopher and historian Michel Foucault, was chosen to provide appropriate theoretical underpinnings for exploring social, political and other influences on the development of clinical teaching in undergraduate nursing programs in the State of Victoria, Australia. Conducted in two phases, the study sought to explore factors influencing and shaping clinical teaching work. It also examined influences that clinical teachers have on clinical education. Three main key questions formed the basis for the study:

1. What historically has shaped clinical teaching in undergraduate nurse education within Victoria?
2. How do discourses identified through the literature review and historical inquiry currently work to shape clinical teaching in undergraduate nurse education in Victoria?
3. Are there key components of clinical teaching in undergraduate nurse education within Victoria, and if so, what are they and how do they operate?

The study was designed in two separate phases. The small scale first phase was aimed at providing a foundation on which to build the second, and larger, part of the study. Phase one involved exploring discourses that impacted on the development of clinical teaching models in undergraduate nurse education, immediately prior to, and following, the

transfer of Victorian nurse education into the higher education sector which began in earnest in 1991. This was undertaken to provide an understanding of factors that underpinned the development of early clinical teaching models, some which are still currently used. For the purpose of drawing valid conclusions in this phase, data were sourced through two different methods. Interviews were conducted with three individuals employed as nurse academics around the time of the transfer. Secondly, historical documentation from that period was collected. This data was sourced from many areas including conference proceedings, journal articles and Nurses Board of Victoria. The combination of different sources provided for rich descriptions and interpretations, and a solid foundation on which to undertake the second phase.

The larger, second phase of the study explored in detail clinical teaching work within current constructs, and the factors which influenced and shaped the development of currently existing forms of teaching. It also sought to explore how clinical teachers influenced the clinical education of their undergraduate nursing students. In order to access the data needed for this phase and answer the research questions, semi-structured interviews were conducted with nine current clinical teachers. Within this group, there was representation from each of the predominant clinical teaching models used in Victoria, resulting in three sessional clinical teachers, three clinical teaching associates and three preceptors being interviewed. The findings of this phase revealed aspects of clinical teaching work which have not been previously recognised hence build significantly on understandings around this area.

## 1.2 My personal positioning

The decision to pursue research into this topic area emerged from my own experiences as a nurse and clinical teacher for undergraduate nursing students. In 1990 I moved from a clinical nursing role into work as a sessional clinical teacher for a college of advanced education (later becoming amalgamated into a university) with no formal teaching experience. Four years after commencing that role, I was offered an academic position in the university. My role incorporated the coordination of clinical education for an entire undergraduate nursing degree program. It was the acquired experience from having exposure to two often different perspectives on undergraduate clinical teaching, that is, academic and clinical practice, that positioned me to have an appreciation of experiences described, and language used, by clinical teachers, as well as academic curriculum frameworks and expectations. It also prompted me to question what shapes clinical teaching work and what clinical teachers in turn shape.

Due to my previous involvement in clinical teaching, I recognised a need to maintain a distance from what I was finding throughout the study and limit any potential bias this might bring. I was very aware that my own experience may not be similar to that of individuals working as clinical teachers at the time of this study. In addition, there was a potential for me to be influenced by my own roles both in clinical teaching and in the academy. Hence, throughout the study I was conscious of the need to keep my own experience distant from what I was unearthing through the data, allowing it to assist in understanding the findings but not clouding or influencing the analysis.

### *1.3 Thesis construction*

This thesis is constructed in three main parts. The first part provides an overview and critique of existing literature around clinical education, firstly from structural and organisational perspectives and then from more personal, teaching and learning perspectives. Subsequently, Chapter 2 provides a broad overview of clinical education in undergraduate nursing curricula and some of the influences on it. It explores theoretical models described as underpinning clinical education in nursing, including the theory-practice gap, structure of clinical education in undergraduate nursing programs, and models for the delivery of clinical teaching. Finally, it examines discourses impacting on clinical education in nursing that emerged from the available literature. Chapter 3 builds on the previous chapter, focusing at a more personal level to examine available literature around both teaching and learning in clinical settings. The need to include both was based on recognition that both sides of clinical teaching work are equally important and directly influence each other. The chapter explores the nature of teaching in clinical settings and the roles and work of clinical teachers. Finally, this chapter then explores experiences of learning in clinical settings including exploration of literature around professional socialisation, influences from the clinical environment, student experience and stress, recognising that teaching and learning are delicately intertwined.

The second part of the thesis provides background surrounding the development of the study undertaken with both nurse academics and clinical teachers in nursing. It includes both the theoretical and methodological considerations surrounding the study's

development. Chapter 4 describes the theoretical considerations selected to underpin and inform the study. It explores post modern thinking through the contribution of the works of Michel Foucault. This discussion clarifies my own positioning through the work of Foucault and how his work was used to inform the study and uncover the information being sought. Chapter 5 presents the methodological pathway followed in the study. This includes detailing the two phases undertaken, issues around participant recruitment and ethical considerations, and data collection methods. It also presents a discussion of issues surrounding data analysis and steps taken to maintain validity of the findings.

The third section of the thesis presents the findings and conclusions drawn from the two phases of data collection. Chapter 6 presents the findings from the genealogical analysis presenting discourses emerging around the transfer of nurse education into the higher education sector. This involved interviews with nurse academics from the time of transfer, as well as detailed exploration of a variety of documentary sources from around that period. The chapter presents a discussion around discourses impacting on the work of nurse academics within the tertiary education sector at the time and which led to the development of new models for the provision of clinical teaching, some of which are still used in current contexts. Chapter 7 provides an introduction to each of the participants interviewed in the second phase of the study. These individual considerations provide a foundation for understanding participants' contributions within the study findings.

Chapters 8, 9, and 10 present the findings as they emerged from the second phase. Hence, chapter 8 presents a broad presentation of socio-political factors influencing the development of clinical teaching at the present time. It highlights the contribution of a range of discourses including academic, management, and institutional discourses, and introduces the concept of personal curricula in clinical teaching work. Chapter 9 outlines how temporal constructions emerged as influential in the development of clinical teaching work. It discusses how clinical teachers managed time to seek equity and balance as well as to discipline clinical teaching. Chapter 10 explores the intricate web of relationships that emerged as integral to the development and maintenance of clinical teaching work. It describes how participants positioned themselves in maternal-child relationships with students, as well as how they perceived key relations with universities, hospital staff and patients. Chapter 11 presents an overall discussion, integrating both the literature review and the findings of both phases of this study discussing areas around curricula conflict, theory-practice relationships and clinical teaching work. It presents limitations of the study and discusses potential areas for future research developments. Finally, Chapter 12 considers reflections on the study, discusses implications of the findings and offers suggestions for future development of clinical education in undergraduate nurse education.

# Chapter 2

# CLINICAL EDUCATION IN NURSING

Clinical education forms a significant proportion of pre-registration Bachelor of Nursing programs within Australia consisting of as much as fifty percent of degree programs. Much has been written around the area of clinical education in nursing. An extensive literature base exists around the area, with the voices of nurse academics or students emerging as dominant. Whilst pivotal to the process of clinical education for undergraduate nursing students, the voices of clinicians[1], patients and health care institutions are rarely represented, and marginalised to the outer. As a consequence, the literature does not fully represent all interests surrounding clinical nurse education nor does it provide insight into all perspectives.

This chapter provides a discussion of available literature related to clinical education from a structural and organisational perspective. It provides a generalised background to the area, including ways in which clinical education delivery is constructed, models used for the provision of clinical education, along with the place of clinical education in the preparation of future registered nurses including conceptual models. Finally, it examines a range of discourses presenting through the literature surrounding the area of clinical education in undergraduate nursing curricula.

---

[1] The term 'clinician' is used within this thesis to indicate a practising nurse who works in a ward setting.

## 2.1 Background into clinical education

Various authors have attempted to define the essence of clinical education. The role of clinical education in the development of nurses is complex with many dimensions (Chan, 2001), and is poorly defined. According to Mellish and Brink (1990, p.217), "Clinical teaching is the means by which student nurses learn to apply the theory of nursing so that an integration of theoretical knowledge and practical skills in the clinical situation becomes the art and science of nursing". A number of authors have recognised clinical education as providing opportunities for the application of classroom learning into 'real' clinical situations (Dunn, Stockhausen, Thornton & Barnard, 1995; Gross, Aysse & Tracey, 1993; Hwa, 1998). Furthermore, the provision of clinical placements for students creates an 'interface' between classroom theory and real aspects of clinical practice (Cope, Cuthbertson & Stoddart, 2000). It is here, according to Myrick and Yonge (2001) that "students begin to operationalize the theories that have been at the forefront of their classroom experiences" (p.465).

The skills component of nursing practice forms only part of the role of clinical education in students' development. Working alongside other nursing and health professionals allows students to become socialised into professional nursing roles (Fothergill-Bourbonnais & Higuchi, 1995; Oermann, 1996), developing "qualities and abilities characteristic of competent professionals" (Williams, 2001, p.135). Such skills include the development of clinical judgement in patient care (Kermode, 1987; Oermann, 1996)

along with development of confidence and independence in the delivery of nursing care (Löfmark, Carlsson & Wikblad, 2001).

Unlike the classroom environment, the environment in which clinical education takes place changes continually, consequently increasing the complexity and unpredictability for learning that occurs there (Nahas & Yam, 2001). Changes increasing the challenges that students confront include the rapid growth in knowledge in such areas of health and illness (Tanner, 1998) or be the result of the lack of available resources (Edmond, 2001). Discussion around these factors will be expanded further within this chapter.

## *2.2 Theoretical models of clinical education*

A number of authors have attempted to conceptualise the ongoing process of clinical teaching as it occurs in nursing education. Two of these conceptualisations are well acknowledged and published, those being, White and Ewan's Clinical Learning Cycle (White & Ewan, 1991) and Stockhausen's Clinical Learning Spiral (Stockhausen, 1994). They share a number of aspects, including situating clinical practicum experience within a broader pedagogical context. As such, the authors focus on clinical practice, not as isolated from the theoretical aspects of learning, but part of a larger process.

White and Ewan (1991) developed a cyclical model for positioning the clinical education component of nursing education. The cycle commences within the university setting with preparatory theoretical learning which is followed by, or concurrent with, clinical laboratory learning. Within the laboratory students can apply learned principles

and concepts, as well as practise clinical skills, within a controlled, non-threatening environment. A briefing phase then provides students with preparation for the clinical experience ensuring that maximum benefit can be gained from the experience through such exercises as exploring their own, university, and health care setting expectations. The clinical practice (practicum) immediately follows, and on completion of the practicum, debriefing takes place. The debriefing provides avenues for evaluating progress towards identified learning outcomes, opportunities for giving and receiving feedback and exploring clinical experiences in more detail to enhance depth of understanding. A follow-up evaluation phase provides formal feedback and evaluation of the experience, whilst offering direction for students about future learning experiences.

Stockhausen (1994) provided a spiral model with many similarities to that of White and Ewan's cyclical model, with an added emphasis on the reflective nature of clinical learning. As such Stockhausen's model provides a framework for promoting reflective nursing practice. According to Stockhausen, the Clinical Learning Spiral "incorporates theoretical elements of clinical education and structures the management of the clinical experience" (1994, p.364). The model consists of four phases. The first, *preparative phase,* allows students to plan for the clinical experience and their role in clinical settings. This occurs within both classroom and laboratory sessions, along with briefing sessions. The second, *constructive phase*, deals with the actual development of skills within the clinical practice (practicum) environment. Here, students work with clinical teachers in providing patient care and developing interpersonal relationships with others

in the clinical setting. The third, *reflective phase*, exists as a debriefing stage. Students are provided with opportunities to highlight significant events, and explore them to achieve a deeper and more meaningful understanding. Finally, students enter the *reconstructive phase* where following the process of reflection, they develop goals which can be acted upon in subsequent clinical experiences.

## 2.3 The theory-practice divide

Despite sound theoretical models being described, the presence of a gap between what students encounter in theoretical classroom experiences and the application of that knowledge into clinical nursing practice has been widely researched and hypothesised. This has occurred both outside and within nursing with a great deal of the literature emanating from the United Kingdom. Numerous authors have described the existence of a divide between theory and practice within nursing (Corlett, 2000; Ferguson & Jinks, 1994; Landers, 2000; Ousey, 2000, Spouse, 2001). Cook (1991) contended the concept of a gap between theory and practice is primarily due to a "conflict of theories between those taught in the school of nursing (and intended to be implemented in the clinical setting) and the theories which underpin the actual practices which nurses engage in the clinical area" (p.1467). Street (1990) argued this gap has been reinforced by positivist paradigms where it is assumed that the application of knowledge is how practice develops, and therefore the human elements of nursing care are ignored. However, there is some descent about whether or not a theory practice gap actually exists. Larsen, Adamsen, Bjerregaard and Madsen (2002) argued that theory and practice 'exist in their own right as theoretical knowledge and practical knowledge' (p.204). These authors

argue that the perception that a gap exists is socially constructed and needs to be challenged.

There is agreement between authors that where a gap is thought to exist, the theory-practice gap is both complex and multifactorial in nature (Landers 2000; McCaugherty, 1991). McCaugherty (1991) suggests two fundamental reasons for students perceiving a gap between the classroom and clinical practice. Firstly, theoretical learning can lead to a misrepresentation of clinical nursing practice on the part of the student, and secondly, that nursing is so complex it cannot be captured entirely in theoretical representations. The existence of a divide has been attributed by some to the fault of academia producing theories that are “vague and abstract” and cannot realistically inform clinical nursing practice (Speedy, 1989) and academics who are removed from clinical practice (Cave, 1994). Priest and Roberts (1998) further suggest that schools of nursing have contributed to the gap by separating student assessment items into theoretical and clinical assignments, artificially dividing theory and practice. In addition, the dynamic nature of clinical practice will mean that students may have not been taught particular theory prior to encountering a situation, or that theoretical learning may be forgotten if time has elapsed since the initial learning occurred (Corlett, 2000).

However, the theory-practice gap may not be the result of differences between academic teaching and learning and experiences in clinical settings. Lauder, Reynolds and Angus (1999) discussed the concept of knowledge transfer as “the ability to apply knowledge gained in one situation to bear in another situation, or to use metacognitive strategies to

act in a new and novel situation" (p.480). These authors argued that problems in the actual transfer of knowledge from one area to another are directly implicated in the perception of a theory-practice divide. They cited situational factors such as the length of training time, lack of familiarity with one's current clinical environment, short clinical placements, and differences between the pace of learning and that of clinical practice as contributing to impaired knowledge transfer.

The changing nature of nursing practice contexts may also contribute to a theory-practice gap. Hewison and Wildman (1996) purported the emergence of a new perspective on the gap emanating from within practice elements of nursing. They suggest that the environment in which nursing is now practised is motivated by financial imperatives driving increased patient throughput. As a result, holistic aspects of care are being lost. Students, having been taught from holistic paradigms, subsequently experience conflict when their underpinning theory is not realised in practice as social and psychological aspects of care can be lost (McCaugherty, 1991). In a similar vain, Porter and Ryan (1996) described in their findings from a small case study that ward staff felt that they did not have the resources (time or people) to work to bridge the gap through implementing nursing theories despite seeing benefits for patient care. According to Hilton (1996) this results in students perpetuating 'traditional, ritualistic practices' and being critical of nurse academics teaching concepts that are not applicable in practice. Despite receiving appropriate classroom theory, therefore, actual clinical practice may not correlate (McCaugherty, 1991). The failure by academia to recognise changes in nursing practice is argued by Rolfe (1996) as further adding to this divide

where the "gap is a consequence of the way in which theory has failed to keep pace with changes in the concept and practice of nursing" (p.3).

There are conflicting views around whether or not the theory-practice gap is seen to be beneficial or not. In her study exploring teachers', students' and preceptors' perspectives on the theory practice gap, Corlett (2000) reported that some teachers found the gap to be positive, encouraging students to develop their problem based learning and reflection skills. However, students found it frustrating, with a tendency to place clinical practice knowledge higher than academic learning (Corlett, 2000). Rafferty and Allcock (1996) argued that the theory-practice gap is actually beneficial as it allows for ongoing changes to occur in both nurse education and clinical practice environments.

Literature on the topic of the theory-practice gap suggests that closing it entirely is not a realistic expectation. Cook (1991) asserted that efforts in closing the gap would be doomed, but that attempting to narrow it is realistic because a clear, definitive understanding of why the gap actually exists is not evident. Rafferty and Allcock (1996) concurred arguing that both theory and practice are dynamic in nature, always changing and thus always contributing to a divide. However, many authors have written about means by which the theory-practice gap can be minimised. Interestingly, some of these are theoretically-based whilst others are very practically oriented. Ousey (2000) asserts the need for education and health care providers to work together in bridging the theory-practice gap to ultimately deliver the best care for patients with practitioners understanding the basis of that care. A number of authors have described how

encouraging reflective practice can assist with narrowing the gap (Carr, 1996; Penney & Warelow, 1999; Rolfe, 1997; Warelow, 1997). This approach allows for theory to be generated out of practice, building nursing knowledge that is aligned with clinical practice, hence allowing nursing practice to inform nursing theory (Speedy, 1989).

From a practical perspective, a number of authors have described models for supporting students in clinical settings that might serve to reduce the gap. These include the use of joint appointments (McKenna & Roberts, 1999) or lecturer practitioner-roles (Williamson & Webb, 2001) whereby an individual is employed concurrently within a university and a clinical agency and the use of clinical mentors (Chow & Suen, 2001) and preceptors (Armitage & Burnard, 1991). However, to date there is no evidence of that these approaches are having their desired effects.

## *2.4 Structure of clinical education*

Structuring of clinical placements for undergraduate students within Australia is generally initiated and developed by each individual school of nursing. Clinical placements have been structured as a result of many considerations such as established ratios of clinical teacher to students, how clinical placements are arranged and their sequencing within courses. Barnard and Dunn (1994) suggested that with a dearth of supporting literature to direct the development of clinical programs, this aspect is often "founded on previous experience, ease of implementation, educational supposition, and economic constraints" (p.420).

Ratios for clinical teaching in Australia have traditionally involved eight students to each clinical teacher (Barnard & Dunn, 1994). Whilst this has been maintained over time, Reid (1994) found that many schools of nursing would consider much lower ratios if the necessary resources were available. Certainly, where higher ratios are involved the ability of the clinical teacher to supervise the delivery of patient care and prevention of student error warrants consideration (Schuster, Fitzgerald, McCarthy & McDougal, 1997).

Length of clinical placements is also subject to variability between schools of nursing (Heath, 2002) reflecting different approaches to curriculum development. Reid (1994) found that three forms of clinical placements existed within the Australian context. These forms included "(1) block placements for several continuous days at a time, on a recurring basis, over a period of several weeks; (2) weekly placement for one or two days a week throughout a semester; (3) a combination of these two" (p.190). Furthermore, the length of the clinical day varied considerably "from full eight-hour shifts to one or two hours" (Reid, 1994, p.190). Ultimately, the individual nurse registration board has determined the amount of clinical experience required within a course, and these vary among states and territories (Barnard & Dunn, 1994).

## *2.5 Models for the delivery of clinical education*

A range of models for clinical teaching have evolved since the transfer of nurse education into the tertiary education sector. Initially following the transfer, nurse academics from within schools of nursing accompanied students in clinical areas for the

purposes of providing clinical education. Due to a range of issues, the introduction of new models for providing clinical teaching emerged including sessional clinical teacher, clinical teaching associate (secondee) and preceptor. Within recent years, newer more collaborative models are also beginning to emerge.

### 2.5.1 The nurse academic as clinical teacher

Following the transfer of nurse education into the tertiary education sector, nurse academics from within individual schools of nursing provided classroom theory for students, then entered the clinical field with students to provide clinical teaching and facilitate the integration of theoretical and clinical learning. With progressive increases in on campus responsibilities for academic staff, increased workload led to the majority of academic staff becoming less involved, or not involved at all, in clinical teaching (Reid, 1994). The effective use of time has been a significant factor for academic staff. As time spent in clinical teaching increases, potentially less time becomes available for other expected academic pursuits (Schuster et al. 1997).

Academic discourses have significantly contributed to the development of nurse academics' roles away from clinical teaching elements. A climate has evolved where research and scholarship, as well as administrative responsibilities, for academics receive priority over clinical teaching resulting in less value being placed over these activities (Brown, Forrest & Pollock, 1998). According to Wong and Wong (1987) the value placed upon clinical teaching by educational administrators has resulted in nurse academics shunning clinical teaching in favour of other, more highly valued, intellectual

pursuits. Myrick (1991) perceived that "clinical teaching is deemed as low status and even punitive within the modus operandi of the university setting" (p.44).

A consequence of the shift by nurse academics away from the clinical practice area has been the resulting further complications with academic staff potentially losing touch with the realities of clinical nursing practice (Myrick, 1991). Concern over the loss of clinical credibility in nurse academics emerged as a significant theme within nursing literature (Acton, Gough & McCormack, 1992; Cave, 1994; Heath, 2002) as nurse education began to contend with the demands for effective clinical education for nursing students, in part, contributing to the evolution of new models for the delivery of clinical education.

### 2.5.2 Sessional clinical teacher

The emergence of the sessional clinical teacher model occurred, at least in part, as a result of the shift by nurse academics away from clinical teaching ventures (Myrick, 1991). In this approach, clinical teachers are employed by universities for clinical teaching on a casual employment basis. The model potentially brings with it economic benefits for schools of nursing, as sessional clinical teachers are only employed as needed for the duration of students' clinical placements (Myrick, 1991; Napthine, 1996). A drawback for both academic staff and sessional clinical teachers undertaking clinical teaching is that the sessional clinical teacher enters the health care venue as a visitor. Consequently they may know little about particular procedures and policies in these

institutions (Packer, 1994) which in turn potentially impacts upon students' experiences and the effectiveness of their learning outcomes.

For individuals employed as sessional clinical teachers, however, the outlook is not necessarily as positive as it can be for universities with a number of issues identified as affecting the role. Progressively, there has been a reduction in student clinical contact in undergraduate nursing programs. Subsequently, a reduced availability of work for sessional clinical teachers within Australian contexts has had a negative impact on recruitment and retention. This has resulted in difficulties attracting suitable individuals into sessional clinical teaching roles. The situation is further compounded with a perception that clinical teaching is poorly remunerated and offers little employment security (Napthine, 1996). A subsequently high turnover has meant that often individuals fulfilling roles as sessional clinical teachers may be inexperienced as teachers and thus unprepared for the complexity of clinical teaching demands (Duke, 1996; Myrick, 1991; Napthine, 1996).

### 2.5.3 Secondee/ Clinical Teaching Associate

The need for yet another model of clinical teaching emerged from conflict being experienced by nursing faculty. Increasing demands were being placed upon nurse academics from within the tertiary education sector for greater academic productivity in the form of research and scholarship. Simultaneously, being a practice-based discipline requiring the preparation of students for health care settings, there was a further demand from within the health care sector for nurse academics to maintain currency of clinical

nursing practice (DeVoogd & Salbenblatt, 1989; Phillips & Kaempfer, 1987). The clinical teaching associate (CTA) model for clinical teaching thus evolved as the next phase in undergraduate clinical education in the United States of America in the mid to late 1980s, and followed in Australia in the mid-1990s. This role has continued to develop under different titles such as clinical affiliate (Davies, Turner & Osborne, 1999). The interpretation and implementation of CTA roles has been poorly defined with the role having been implemented in a range of different ways. A common feature is that a CTA is a clinical practitioner who works with undergraduate nursing students during clinical practicum. In many of the examples in the literature, the CTA maintains a clinical workload whilst supervising from one to four students, however, this generally relates to adaptations within the USA (DeVoogd & Salbenblatt, 1989; Baird, Bopp, Kruckenberg Schofer, Langenberg & Matheis-Kraft, 1994; Hunsberger, Baumann, Lappan, Carter, Bowman & Goddard, 2000).

With the introduction of the CTA model, the concept of collaboration has emerged as important in guiding the role, and was not recognisable in earlier literature around clinical education. Much is written about the nature of the CTA relationship whereby the nurse academic and clinician work collaboratively to provide clinical teaching required for students (DeVoogd & Salbenblatt, 1989; Hunsberger et al., 2000; Phillips & Kaempfer, 1987; Weber, 1993). However, the existence of true collaboration is debatable. Within the relationship, the nurse academic remains in control of the learning experience of students, although Hunsberger et al. (2000) suggest that the relationship is ‘non-hierarchical’ with a sharing of power. Regardless of terminology, the academic

ensures that students meet prescribed learning requirements and oversees evaluation processes. The CTA is described as being a clinical role model, resource person (Baird et al. 1994) and supervisor who shares 'knowledge and expertise' (Weber, 1993). However, less emphasis is placed upon the actual teaching dimension of the role.

### 2.5.4 Preceptor

With continuing issues of high academic workloads and diminishing economic resources for supporting educational programs, many universities began to introduce preceptor models as means for supporting students in clinical experience placements. Preceptor models were not new to nurse education having been introduced in the United States in the 1960s (Myrick, 1988b), however, their use in local contexts has primarily occurred since the mid 1990s. They were significantly different to previously used models as "a student is under the direct supervision of a practicing nurse (preceptor) in a one-to-one relationship coupled with indirect supervision by nursing faculty" (Hunsberger et al. 2000, p.279) rather than in a group with a clinical teacher having primary responsibility for students and their learning in the clinical environment.

The introduction of the preceptor model for clinical teaching brought with it a shift in dominant discourses with the emergence of new discourses in clinical education. Certainly, economic discourses continued to be influential. Myrick (1988a) highlighted economic factors as being significant in schools of nursing considering the model, especially as they allowed for teacher to student ratios to be kept low. The removal of

cost implications (Bowles, 1995) for academic institutions may be seen to be one factor for universities to keenly embrace the model.

The introduction of clinicians into the clinical teaching sphere also brought with it industrial discourses within clinical practice environments. The evidence of these occurs widely throughout the literature and signifies issues surrounding the shift in responsibility for the clinical education of nursing students. Preceptors add the responsibility of student supervision and teaching to their allocated patient workloads. The issues of being too busy (Allen, 2000; Yonge, Krahn, Trojan & Reid, 1997) and having lack of time to provide teaching for students (Coates & Gormley, 1997; Öhrling, 2000) have been documented outcomes of the preceptor role. This has occurred in a climate where nursing workloads have increased, reducing abilities to support students (Bennett, 2001) and in an environment of staff shortages and high patient turnover (Edmond, 2001). The difficulty in being able to maintain the preceptor role with other workload (Allen, 2000) has been interpreted to be significant in the emergence of 'burnout' described in relation to the preceptor role (Beattie, 1998; Dibert & Goldenberg, 1995) as a result of additional stress of being allocated nursing students (Yonge et al. 1997). Edmond (2001) argued that although nurses may be eager to act as preceptors, the teaching commitment is usually unrecognised and undervalued.

Burnout in nurses acting as preceptors has resulted in the emergence of industrial discourses. Not all nurses within a clinical practice setting elect to act as preceptors for students with a core group of experienced, permanent staff taking on disproportionate

loads prominent role in supporting students (Bennett, 2001; Dibert & Goldenberg, 1995). This certainly contributes to burnout becoming an issue (Ryan-Nicholls, 2004). Kaviani and Stillwell (2000) highlighted that the preceptor's workload and the supportiveness of the clinical setting can impact upon the student's overall relationship with the preceptor. Furthermore, the selection of preceptors occurs more often on who is available at the time students are attending, rather than decisions based upon interest in clinical teaching and qualifications (Beattie, 1998; Letizia & Jennrich, 1998; Myrick, 1994). This situation becomes more compounding as Tanner (1998) highlights, with fewer preceptors being available in acute care settings as a consequence of higher patient acuity and decreasing length of stay, which leads to changes in the staffing mix. Grealish and Carroll (1998) propose that the combination of burnout and decreased staffing levels will reduce the number of clinicians available to adopt preceptor roles in the future. There is literature indicating that this situation is already occurring within nurse education in Canada (Ryan-Nicholls, 2004). Consequently, this model may be short lived in the evolutionary process of clinical education.

A significant group of discourses emerging with the introduction of the preceptor model have been the shift from academically-driven clinical experiences to clinically-driven experiences. There is evidence to suggest a significant shift away from academic discourses to an increased prominence of clinical discourses with the adoption of preceptor models. This is different to other models of clinical teaching. An emphasis with the preceptor model has shifted from traditional teaching elements to role modelling aspects, including the role of the preceptor in assisting students to become

socialised and familiarised into clinical areas (Letizia & Jennrich, 1998; Madison, Watson & Knight, 1994). Hence, being a role model is now considered to be a significant aspect in preceptor roles that had previously received lesser emphasis in other clinical teaching models (Armitage & Burnard,1991; Henry & Enunsa, 1986; Infante, 1985; Öhrling, 2000, Perry, 1988).

The introduction of the preceptor role has also been argued to provide students with greater opportunities to develop safe and competent nursing practice (Beattie, 1998) as well as a higher level of independent practice than in non-preceptored models (Brehaut , Turik & Wade, 1998). However, some authors have taken the position that this model has served to transfer responsibility for the development of clinical learning and application of theory to practice onto staff working within the clinical setting as well as their employer thus moving the onus away from academic staff (Bowles, 1995; Beattie, 1998). This shift may result in potential difficulties for students and their learning, however, Perry (1988) suggested that this may actually assist students to maximise experiences in the clinical placement. Further, Byrd, Hood and Youtsey (1997) suggested that whilst preceptors value clinical competence, they may be unwilling to take on the role with underprepared students. Furthermore, it has been suggested that if nurse preceptors were inadequately prepared, they may actually have a negative impact on students' learning experiences (Bennett, 2001).

Given time constraints inherent in balancing role demands, preceptors may also have inadequate time to assist students to relate theory to practice (Corlett, 2000) placing

patient care demands ahead of teaching (Coates & Gormley, 1997; Myrick, 1994). The workload demands of the preceptor may even lead to periods of time when the student is unsupported or unsupervised (Fagerberg & Ekman, 1998; Shin, 2000) Furthermore, where preceptors are not required to have previous teaching experience, the learner may be placed at a disadvantage (Myrick, 1994). Ferguson and Calder (1993) suggested that educators have higher standards than preceptors, whilst Phillips and Duke (2001) found that preceptors asked more lower level questions which may interfere with the development of students' critical thinking skills.

### 2.5.5 Emerging models

Within recent literature, newer models for clinical teaching are beginning to emerge. Many of these have evolved as combinations of existing models, whilst some models described have evolved with the recent transfer of nurse education in the United Kingdom. The need to search out new and more effective models suggests an air of displeasure with existing approaches. With the introduction of Project 2000 in the United Kingdom in the late 1980s and early 1990s, new approaches to supporting nursing students in clinical placements made their way into nursing literature. The transfer of nurse education in the U.K. was less informed by models previously used in other countries around the world. Clinical teaching models used in previous hospital-based courses became superseded by a range of new approaches (Glen & Clark, 1999). New clinical teaching models and terminology evolved with key roles being identified, primarily that of Nurse Teacher, Mentor, Link Teacher and Lecturer Practitioner.

The primary role of the Nurse Teacher in the United Kingdom has been largely directed towards providing academic teaching for students within college environments and would not usually be involved in delivery of any direct patient care (Corlett, 2000). Debate has ensued within the literature about the ongoing maintenance of clinical credibility for this group (Burke, 1997; Carlisle, Kirk & Luker, 1997; Cave, 1994), similarly as it has with nurse academics elsewhere. Within the teaching structure, mentors provide direct clinical teaching support for students in similar ways to that described elsewhere for preceptor roles, that is, providing student teaching, support and assessment (Phillips, Davies & Neary, 1996). In clinical settings Link Teachers have been employed to liaise between colleges and clinical teaching settings (Cave, 1994) and ensure that students' allocated practice environments are able to meet educational requirements (Ramage, 2004). In this role, no direct patient care is usually undertaken (Corlett, 2000). The Lecturer Practitioner is a less clearly defined role emerging from Project 2000. Ramage (2004) argued that this role entails negotiating on multiple levels and lacks a consistent role definition across clinical settings. It is usually a joint appointment between college and clinical agency creating a role that combines both classroom teaching along with provision of direct patient care (Cave, 1994). Contributing to the unclear nature of the role is the individual and complex nature of implementation across different institutions (Elcock, 1998).

The development of new approaches continues to emerge through the literature as models for the provision of optimal student clinical teaching and support remain elusive. However, newly described models offer little more than a relabelling of previously

employed approaches indicating a search for a guise not yet discovered. Andrews and Roberts (2003) described the implementation of a Clinical Guide at one university in the United Kingdom. In facilitating the model, experienced nurses were chosen to support individual students through the entire three years of their preparatory programme. However, whilst providing professional role modelling, the Clinical Guide was not responsible for teaching, learning or assessment, similar to a mentor elsewhere in the world. Clinical teaching within these models has become relegated to ward nurses working directly with students. Hence, it does not offer an alternative, but rather an additional approach to clinical teaching.

In yet another approach within the United Kingdom, Clarke, Gibb, and Ramprogus (2003) describe the implementation of a Practice Placement Facilitator (PPF) across three health trusts. This model involves joint appointments between a health trust and a university similar to that of the Link Teacher described earlier. Through their increased knowledge of academic curricula, it is argued that these individuals can assist application of theory into practice, reducing the theory-practice gap, and assist clinical staff to deal with student issues that may arise.

## 2.6 Discourses impacting on clinical education

From the available literature, a number of dominant discourses can be identified that play a direct role in shaping clinical education on a broad level. These will be examined individually in greater detail, but include industrial, economic, competitive and collaborative discourses.

### 2.6.1 Workplace and Industrial discourses

The current range of clinical teaching models has led to the emergence of a number of industrial issues over recent years. Significantly, the recruitment and retention of clinical teachers has been noted by a number of authors. This has been attributed to, certainly in part, by a perceived lack of value placed upon the work of clinical teachers (Duke, 1996; Schuster et al. 1997; Wong & Wong, 1987). Acknowledging this fact, Napthine (1996) identified a number of other negative aspects of performing the role of sessional clinical teaching. These include inadequate payments for the role performed and lack of security that may further impact on the retention of clinical teachers.

Furthermore, whilst the recruitment of sufficient numbers of clinical teachers may not be a significant problem for many schools of nursing, recruiting nurses with the required combination of skills may well pose difficulties (Wellard, Williams & Bethune, 2000). This may effectively result in students frequently being supervised by clinical teachers without the skills necessary for the actual clinical environment hosting the student and impact on learning outcomes for students.

### 2.6.2 Economic and resource implications

The provision of clinical education for undergraduate nursing students is dependent upon support from within both the health and tertiary education sectors. With economic constraints placing increasing pressure on both areas, the vulnerability of clinical education to economic factors has led to its structure being shaped in response. This may be partially attributed to different expectations and agendas between health care

providers and university schools of nursing (Napthine, 1996; Reid, 1994) whilst funding models are not adequately supporting undergraduate clinical education (Senate Community Affairs Reference Committee (2002). In a study of undergraduate pre-registration programs conducted in Australia, Wellard et al. (2000) found that reduced funding within both sectors influenced the actual model/s selected for clinical teaching of students. Furthermore, these factors have influenced the numbers of contact hours provided for students in clinical placement areas along with the scope of experiences students can access within their courses. In the 1994 National Review of Nursing Education in Australia, Reid (1994) highlighted a potential for future difficulties if schools of nursing need to find increased resources to support clinical placements. Insufficient resourcing could lead to a need "to increase the commitment of academic staff to clinical education, to reduce the range and/or length of clinical placements, or to run down the quality of clinical teaching" (p.196). However, by time of the 2002 National Review, resourcing clinical education remained problematic with suggestions that the costs of such clinical programs are resulting in nursing education being seen as unattractive to universities and unsustainable (Heath, 2002).

Much has been written about the impact on management of workload for clinicians involved in clinical teaching and the inherent resource implications within practice settings. A significant amount of this literature describes the increase on workload and decrease in productivity for clinicians when working with an undergraduate student. However, few studies have examined the potential benefits for the service provider of student placements in clinical settings. Lloyd Jones and Akehurst (1999; 2000) explored

the potential value of students in clinical areas in the context of Project 2000 in the United Kingdom. Whilst difficult to cost, the authors concluded that "…in terms of real resources, the value of the student activity to the service provider in relation to such placements appears to outweigh the value of the time spent by qualified staff on their supervision and education" (Lloyd Jones & Akehurst, 2000, p.435).

Support for the sessional clinical teacher may be seen to have economic benefits for schools of nursing. Reid (1994) noted that this model provided universities with flexibility by employing individuals for short periods of time only as required. However, funding for this model has also been described as problematic. According to Bennett (2001), the relative funding model applied to nurse education does not sufficiently reflect the costs necessary in maintaining a ratio of one clinical teacher to eight students.

### 2.6.3 Competitive discourses

The environment of clinical education may also be viewed as competitive between individual schools of nursing. Much of the competitive nature has evolved as a result of a number of schools of nursing and other health professions vying for what have become a reducing number of available clinical placements for students (Heath, 2002; Lumby, 1989; Reid, 1994; Senate Community Affairs Reference Committee, 2002). Universities seek to place students in areas relevant to individual curricula at particular times. The situation is compounded as schools seek to place students at similar times. The constraints imposed by university teaching calendars have resulted in fewer weeks being available to meet clinical learning requirements. The competitiveness is further

increasing as more places are being sought to support the education of enrolled nurses (second level nurses) and other health professionals (Bennett, 2001; Heath, 2001), in a context where overall patient bed numbers are in decline (Bennett, 2001).

Competitive discourses are also evident between health care venues and schools of nursing. The National Review of Nurse Education in the Higher Sector (Reid 1994) highlighted the issue of differing expectations of nurse education between the two areas. Lumby (1989) suggested "competing goals within the clinical area as well as the specific philosophies and procedures on which patient and student care are based must be considered…" (p.299). Furthermore, classroom theory and clinical practice may not always correlate with a variety of approaches to individual nursing skills from nurse to nurse, ward to ward and agency to agency (McCaugherty 1991). A state of competition emerges as each area seeks to meet its requirements and assert itself as the more significant and important.

### 2.6.4 Discourses of collaboration

#### 2.6.4.1 Partnerships

Recent literature surrounding clinical education in nursing has seen the emergence of discourses of collaboration. Soon after the transfer of nurse education into the tertiary education sector, the responsibility for clinical education of undergraduate nursing students appeared to rest solely with educational institutions. The need to include clinicians and health care institutions in the scope of responsibility for clinical education

has begun to emanate through the academic literature with discourses of collaboration increasing in prevalence since the mid-1990s. A number of factors appear to have influenced this shift in focus.

With the clinical education of undergraduate nursing students being considered by tertiary institutions and health care agencies as the overall responsibility of the education sector, the contribution of staff within the health service has often been overlooked or left disregarded. However, the shifting balance of responsibility for student learning outcomes has been evidenced through the emergence of more collaborative terminology. In the early 1990s, the CTA model evolved which appears to have been one of the early moves towards collaboration between education and service. Part of the impetus for seeking this model related to increasing faculty responsibilities with regard to research and scholarship and less time for clinical teaching responsibilities (Gross et al. 1993; Shah & Pennypacker, 1992). Hunsberger et al. (2000) agreed that the need for increased faculty productivity in terms of research is part of the shift towards greater collaboration, but also suggested that the growth in technology in acute clinical settings is challenging for faculty members to keep pace with. Beeman (2001) concurred that it is becoming increasingly difficult for faculty to maintain clinical expertise and maintain a safe environment for students to learn in. In addition, students are exposed in university settings to pure academic approaches developing students' "generic competencies and theory" (Heath, 2002, p.165). Heath (2002) advocates greater collaboration between nurses and academics to jointly develop students' clinical learning experiences.

Towards the late 1990s, the notion of partnership increased in prominence within the nursing literature. This concept is being evidenced through increasing relationships between university schools of nursing and clinical agencies. According to Edmond (2001) the "present culture of 'clinical education by default', unavailability of resources and few formal collaborative structures between education institutions and service providers cannot sustain the complex demands and pace of the evolution of professional nursing practice" (p.258). However, examples of collaborative arrangements are growing. Davies et al. (1999) described a project to enhance clinical learning at the Australian Catholic University in Brisbane where a clinical partnership model was used for undergraduate nursing students. Within the model, the university sought to establish greater collaboration with selected clinical agencies. The authors suggested that stronger relationships led to a number of benefits for all involved, including streamlining of clinical placements with increased rationalisation of agencies, professional recognition for registered nurses in clinical teaching, and remuneration for the agencies. In their evaluation of the model, the authors highlighted dominant themes emerging as familiarity, acceptance and trust, these being multifaceted. However, such collaborative approaches may have a secondary effect, as other schools of nursing may be turned away from accessing placements.

Patterson and Cruickshank (1996) described another form of collaboration where the partnerships existed in the form of reflection sessions that involved students, clinical teachers, faculty and staff from clinical agencies. The authors discussed the benefits of

such partnerships as promoting understanding of roles and purpose of the clinical practicum as well as increasing overall awareness for all participants.

The simultaneous evolution of preceptor roles for supporting undergraduate nursing students also runs alongside arguments for collaboration and partnership. Beeman (2001) outlined the introduction of preceptors for junior nursing students in acute clinical settings. Using arguments that faculty were less available to provide direct clinical teaching, the author argued for shifting some teaching responsibility onto clinicians with academic support as collaborative. Similarly, Nordgren, Richardson and Laurella (1998) discussed a project where beginning nursing students were precepted in a collaborative model. These authors related the necessity to adopt such a model due to decreasing clinical and faculty resources, and faculty workloads.

Discourses of collaboration also become evident in areas where joint initiatives are undertaken such as joint appointments. McKenna and Roberts (1999) argued that joint appointments may assist with bridging the theory-practice gap in clinical settings. They defined joint appointments as “a variety of arrangements whereby concurrent employment occurs within an educational institution and a clinical setting” (p.14). They proposed that joint appointments provide support for students as well as leading to improved quality of patient care through academic endeavours.

#### 2.6.4.2 Interprofessional clinical education

In very recent health literature, increasing numbers of references are being made to professional collaboration in teaching and learning in shared clinical environments. Terminology such as 'interprofessional' and 'multiprofessional', are being used to describe both clinical and classroom learning experiences for combined groups of health care professionals, including nurses. Barr, Hammick, Koppel and Reeves (1999) defined interprofessional education as occurring when "two or more professions learn from and about one another to promote collaborative practice" (p.536). Multiprofessional education, they suggest, is broader and occurs "when two or more professions learn side by side" (p.536) but not necessarily from each other.

Using multiprofessional approaches to clinical learning in nursing and other health professions has been argued as having numerous benefits. Glen and Reeves (2004) asserted that interprofessional education in nursing and medicine assists with developing professional identities and each profession's sense of belonging within the broader scope of health care provision. Interprofessional learning opportunities have been suggested as assisting in developing teamwork between professional groups (Cooke, Chew-Graham, Boggis & Wakefield, 2003) by providing increased awareness and recognition of each others' roles (Morison, Boohan, Jenkins & Moutray, 2003).

A large amount of the literature around multiprofessional health teaching describes individual programs developed to support collaborative clinical learning between

nursing and medical students (Cooke et al. 2003; Morison et al. 2003; Ross & Southgate, 2000; Tucker, Wakefield, Boggis, Lawson, Roberts & Gooch, 2003) whilst a few include other health professionals such as occupational therapy, physiotherapy (Reeves, Freeth, McCrorie & Perry, 2002) dental (Reeves, 2000) and pharmacy (Horsburgh, Lamdin & Williamson, 2001) students.

### 2.6.5 Discourses of globalisation

Recently, there has been a worldwide trend toward providing education across international boundaries. Elements of this shift have been evident in nursing education, including the area of clinical education. Increasingly, examples of nursing schools offering students opportunities to undertake clinical experiences in overseas locations are emerging within the nursing literature. Such placements have been suggested as being influenced by the increasing multicultural composition of societies, and resulting changes in health care settings, that require nurses who are responsive to diverse patient groups and their needs (Heuer, Bengiamin & Downey, 2001; Thompson, Boore & Deeny, 2000). One means by which they can achieve this is to provide opportunities for students to experience what it is like being a minority within a foreign culture (Duffy, Harju, Huittinen & Traynor, 1999; Grant & McKenna, 2003) and encouraging appreciation of cultural differences (Haloburdo & Thompson, 1998). International clinical placements have also been argued to allow students opportunities to develop increased awareness of global issues (Goldberg and Brancato, 1998). These opportunities may also assist students to develop broader understandings of nursing

cultures and models for health care systems (Goldberg & Brancato, 1998; Duffy et al. 1999; Grant & McKenna, 2003; Scully, Birchfield & Munro, 1998).

Sending students internationally for clinical placement experiences poses new challenges for clinical nurse education. Clinical teaching models previously used to facilitate clinical learning in such types of learning experiences may well be inappropriate as issues relating to distance play a role. Preceptors have been identified as providing student support during international placements (Goldberg & Brancato, 1998; Grant & McKenna, 2003). However the nature of international placements, limits students' access to faculty from their home school of nursing, with contact limited through email, facsimile or postal mail.Students may need to manage preceptorship issues by themselves (Yonge, 1997). As international clinical placements increase, new clinical teaching models to adequately and appropriately support such endeavours need to develop.

## 2.7 Conclusion

This chapter has described literature representing macro components of clinical education in nursing. This suggests that issues in clinical education are widely represented within nursing literature. Some authors have developed theoretical models to represent how nursing students learn through clinical experiences, whilst others have described the existence of a gap between theoretical learning and clinical practice. Various teaching models have been described for supporting student learning in practice, along with benefits and limitations of each; the three main models which have been

further explored in this current study. Finally, the literature reveals a range of discourses impacting on the delivery of clinical education in nursing that play a role in shaping it and which will inform this current study. These factors include both longer standing factors such as economics, whilst new discourses are emerging to influence development of clinical education such as competition, collaboration and globalisation.

# Chapter 3

# TEACHING AND LEARNING IN CLINICAL SETTINGS

The previous chapter provided a discussion of the available literature surrounding clinical education in undergraduate nursing programs, including structure and models. This chapter takes an approach that deals at a more personal level in examining the area of clinical education. It reviews the literature dealing with issues, and exposes some emerging factors involved, in teaching and learning within clinical nursing environments. The examination of students' experiences has also been incorporated within the chapter. Students are intimately affected by clinical teaching activities through their involvement in teaching and learning processes so to omit this side would be negligent in a study such as this. Through exploring students' perspectives an enhanced understanding of clinical teachers' work can be gained and hence serve to inform the current study.

A large proportion of the available literature around clinical teaching and learning deals with either the role definition of clinical teachers and their effectiveness, or students' experiences of clinical learning. That literature which deals with the role of clinical teachers does not directly articulate factors that influence their work, the main focus of this study, but suggests the input of nursing practice and academic discourses that do have an impact. These studies cast light on many aspects important to the current study.

In reviewing existing literature, it is notable that the voices of some groups crucial to the clinical teaching and learning process, namely clinicians and patients, are not represented at all within the literature. Clinical teachers' perspectives are represented but this is very limited. The findings emerging from this study, therefore, may assist with building the body of knowledge from clinical teachers' perspectives and allow greater understanding of this vital component of nursing education.

## 3.1 Teaching in clinical settings

Clinical teaching is an entity within nurse education that offers up many challenges for an incumbent. It involves assuming multiple responsibilities, including supervision of students and their learning, safety and wellbeing of patients allocated to students, and conforming with requirements of the clinical setting (Boughn, 1992; Oermann, 1998a; 1998b). This is further compounded by geographical factors including distance from employing universities and an unstable, ever changing clinical teaching setting (Finn, King & Thorburn, 2000).Within that setting clinical teachers and students constitute "a temporary system within the permanent culture of the clinical area" (Paterson, 1997, p.197), whilst the nature of clinical teaching work is largely sessional and transient itself (Wellard et al. 2000).

Smyth (1988) explored the concept of marginality and clinical teaching, concluding that clinical teachers were placed in marginal positions both in academia and clinical environments. They were marginalised from the university in physical ways, being located away from campuses in health care settings, often without clear guidelines or

defined relationships. A lack of familiarity with curricula and role clarity (Finn et al. 2000; Wellard et al. 2000) further accentuates perceived isolation. Smyth (1988) suggested that in clinical settings, acceptance into the group was dependent on relationships that could be built with ward staff. However, within those settings clinical teachers possessed no authority to be able to manage such aspects as resources. Similarly, Ferguson (1996) noted that clinical teachers often felt like they did not belong anywhere, describing them as being "in no man's land" (p.838). Such feelings may be lessened, however, where individuals are undertaking clinical teaching within ward settings in which they have previously worked as nurses (Paterson, 1997).

### 3.1.1 The work of clinical teachers

Much of the literature surrounding clinical teaching in nursing focuses on the roles and effectiveness of clinical teachers. Clinical teaching work is generally accepted as encompassing role modelling for students, facilitation of clinical learning, being a resource person, providing feedback and assessment. However, these expectations are often poorly articulated or defined which contributes to an overall lack of clarity of clinical teaching work but are underpinned generally by clinical nursing and academic discourses. Most of the available literature represents the perspectives of nurse academics and students with only a few studies located that have acknowledged the positions of clinical teachers themselves, thus missing important data. In this section, literature around clinical teaching functions will be explored in greater detail.

#### 3.1.1.1 Role model

The concept of the clinical teacher as role model presents frequently within the nursing literature but is poorly defined. Phillips and Duke (2001) asserted that universities have expectations that clinical teachers role model those characteristics that are integral to nursing roles but little is evident about what universities actually expect in this regard. This was confirmed by Howie (1988) who suggested that clinical teacher role modelling is central to students' socialisation into nursing roles.

A few authors have attempted to unravel what this type of role modelling actually entails. Emerging discussion suggests that this clinical teaching function is driven by nursing discourses that reinforce desired clinical nursing practice along with professional nursing roles and behaviours. Less evidence is present to suggest that the role modelling function includes academic behaviours and attitudes. Langridge and Hauck (1998) interviewed final year nursing students to explore role modelling experiences in the clinical setting. They described how students perceived the core of role modelling in clinical teaching as generic attributes including valuing teaching and learning; showing commitment to the nursing profession; being a knowledgeable and skilled practitioner; having effective communication; and being open and approachable.

In developing a questionnaire for distribution to students to explore role modelling, Wiseman (1994) was much more specific in relating the role modelling function to clinical nursing practice. She identified twenty eight role model behaviours that included such components as demonstrating nursing procedures, reporting appropriately,

interacting confidently, caring for students and patients, providing constructive feedback, being flexible and organised.

Role modelling for students may be more evident where clinical teachers are concurrently involved in the direct delivery of patient care. In exploring students' perceptions of preceptoring, Öhrling and Hallberg (2000) suggested that role modelling included providing "concrete illustrations" for students via their clinical work, or through their "narrations and talk" (p.31). Campbell, Larrivee, Field, Day and Reutter (1994) explored the socialisation of nursing students into the nursing environment. Interviewing students revealed that role models provided for the majority of their knowledge acquisition in clinical settings. This was achieved through teachers' sound organisational skills, positive relationships with students, patients and staff, and practising nursing in an ideal and caring way. Finally, Windsor (1987) suggested clinical teachers role model by demonstrating professional behaviours such as physical appearance, respect, and ethical behaviour.

Tensions are evident in the literature about what students expect and to what degree clinical teachers are able to provide role modelling for students. Jinks (1997) found that clinical teachers did not view themselves as credible role models for nursing students because they were not modelling clinical nursing roles, rather modelling clinical teaching. Clinical teachers believed that role modelling of clinical practice behaviours was carried out by clinical ward nurses and students' own peers. Langridge and Hauck (1998) supported this, finding role modelling from clinical teachers may involve more

communication and professional, rather than direct patient care, components. This reinforces the suggestion that role modelling occurs more readily where the clinical teacher is assuming responsibility for patient care whilst being responsible for students such as in preceptor roles.

#### 3.1.1.2 Support and facilitation for learning

Facilitating and supporting learning are primary functions for clinical teachers and these occur in a number of different ways. By promoting the application of classroom theory, academic influences through nursing curricula play a central role in this aspect of clinical teaching and facilitation. Koh (2002) identified that assisting students to integrate theory to practice is an important component of clinical facilitation. Such integration is promoted through encouraging students to reflect on their own clinical experiences and relate them to underlying theory. The use of questioning as a teaching strategy for encouraging such reflection in clinical settings has been recognised by a number of authors (Ng & Duke, 2000; Phillips & Duke, 2001; Windsor, 1987).

Selection of appropriate and relevant clinical experiences for students is well recognised as another component of facilitating learning. It is suggested that this element further supports academic curricula by identifying experiences that support previous learning. Fothergill-Bourbonnais and Higuchi (1995) argued that the selection of appropriate clinical learning experiences is multifaceted and “warrants the consideration of the educational institution’s curricular goals, the learning environments which are best able to meet these goals, the clinical expertise of the teacher, and the students themselves”

(p.38). This includes recognising opportunities for learning in clinical areas that may be unfamiliar for students and that students are not able to identify (Paterson, 1998). However, while other authors provide little detail in this regard, it would appear that this is a crucial element in the clinical facilitation process that requires greater attention. It is, therefore, questionable in light of limited research as to what extent this occurs in practice, given that many clinical teachers are unfamiliar with academic curricula through inadequate preparation for their clinical teaching work (Wellard et al. 2000).

Clinical teachers provide support for students and their learning in many other ways that support academic approaches to teaching and learning such as self directed learning. The notion of the clinical teacher as ‘coach’ in the teaching and learning process was suggested by Grealish (2000) and Kaviani and Stillwell (2000). These authors have suggested that students are ‘coached’ by being provided with encouragement in identifying their own learning needs and developing their cognitive and psychomotor skills. Other authors have identified the need for clinical teachers to individualise learning according to students’ particular needs. Ng and Duke (2000) found that students wanted clinical teachers to know them as individuals in order that their experiences could be planned according to their needs; hence the development of a close interpersonal relationship was necessary. These authors suggest students need to be able “to learn in their own way and at their own pace” (p.40). Simultaneously, students need to be able to develop a sense of independence in their nursing role.

However, there is some disagreement about the degree of support that facilitates or obstructs students in their clinical learning learning. In their study of students' clinical learning experiences, Löfmark and Wikblad (2001) found that facilitating factors for students included being allowed to work independently and to take responsibility. On the other hand, Öhrling and Hallberg (2000) found that students wanted preceptors to take the responsibility for patients' safety as well as students' learning.

Clinical teachers provide support in ways that offer students security and comfort during clinical experiences similar to those experienced through maternal relationships. Öhrling and Hallberg (2001) suggested that preceptors 'sheltered' students during clinical experiences through such activities as undertaking negotiation with others, identifying learning needs, and taking responsibility for student learning. In a similar vain, support given to students by clinical teachers has been described as similar to the process of 'mothering' (Nahas, 2000; Lopez, 2003). In exploring Jordanian nursing students', Nahas (2000) found that clinical teaching encounters were viewed as similar to those that would occur between a mother and child, involving such activities as "guiding, protecting, assisting, understanding, and supporting the "child" (student) throughout the clinical experience" (Nahas, 2000, p.262).

Whilst being a resource person for students is widely recognised within the literature as a clinical teaching function, what this actually entails is somewhat illusive as few authors have provided much detail resulting in a lack of clarity. O'Callaghan and Slevin (2003) suggested that registered nurses facilitating clinical placements for

supernumerary students use their own experiences as a teaching resource for students. Hence, teaching is nursing practice, rather than academically, directed. In their study, Kaviani and Stillwell (2000) found that students valued preceptors who made themselves available for discussing issues arising and in that way acted as resource people. Finally, in their study Ng and Duke (2000) found that students saw teachers as resource providers in guiding them towards meeting their clinical objectives. From this perspective, the resource role is academically driven, rather than by clinical nursing practice. Acting as a resource person is a support role played by clinical teachers, however, the literature fails to clearly define this aspect or provide direction for clinical teachers in carrying it out.

#### 3.1.1.3 Assessment, feedback and questioning

Another important academic activity undertaken by clinical teachers involves the assessment of students' clinical practice and the provision of feedback to students and the university. Informed by academic discourses, assessment of student clinical performance provides monitoring of individuals' progress that informs student advancement through the course. However, it is also an activity that can be problematic and has been described as among the most difficult aspect (Higgins & Ochsner, 1989) for clinical teachers. In most situations clinical assessments are linked to learning objectives set by universities and written in controlled, academic settings. They provide evidence that students have met requirements set by professional registering authorities. However, achievement of learning objectives can pose difficulties within clinical settings bringing tensions between academic and clinical expectations. Students attend

many clinical settings within which exists even more variety (While, 1991). The unpredictability of clientele within a particular setting may limit the availability of learning opportunities and hence opportunities to meet requirements.

Tensions also emerge as clinical teachers frequently have different expectations of students, informed by their own clinical practice, to what universities may hold. Hence, clinical teachers may influence clinical assessment processes. In a study conducted by Williams, Wellard and Bethune (2001) concern was raised about clinical assessment with suggestions that some clinical teachers assessed students on their potential rather than on actual performance. This suggests that clinical teachers make value judgements of students. Further, these authors found that clinical teachers tended to assess students according to their own set of expectations, or by comparing student performance against that of registered nurses. Hence, assessment criteria were informed by clinical nursing discourses, rather than academic ones, with a subsequent undermining of academic curricula. These authors also found that this occurs in response to poor understanding of the curricula in which students are enrolled (Wellard et al. 2000) leading clinical teachers to assess students according to criteria they feel comfortable with. To further compound, and add uncertainty to, this situation, a study by Calman, Watson, Norman, Redfern and Murrells (2002) concluded that clinical teachers received inadequate preparation to use clinical assessment tools.

Clinical assessment can prompt tensions to arise between clinical teachers' personal, caring feelings and academic requirements. Where a student's performance requires

questioning, clinical teachers can exhibit signs of uncertainty and anxiety (Smith, McKoy & Richardson, 2001). In their study, Finn et al. (2000) suggested that clinical teachers were unsure about clinical assessment requirements and had concerns about giving out poor results. In addition, where a student's performance was considered to be unsatisfactory, clinical teachers questioned the accuracy of their own judgements (Scanlan, Care & Gessler, 2001). This further supports the findings of Wellard et al. (2000) that clinical teachers are poorly prepared for the academic aspects of their work.

The use of feedback is important in relaying to students the strength of their clinical performance. According to Glover (2000), feedback allows students to be able to realistically rate their practice and to address weaknesses. Her study found that students valued immediate, positive, behaviour-focused feedback to allow them to improve practice as needed. However, clinical assessments also pose a potential for clinical teachers to control students and their behaviour. Reutter, Field, Campbell and Day (1997) suggested that being in control of the assessment process, university staff "have the capacity to selectively reward and sanction student behaviour" (p.154). In those models where clinical teachers are employed by universities, this may lead students to conform to the expectations of the assessor in order to secure success in the placement and potentially progress to the next level of the program. However, these assessments could also be seen to assist with shaping the work of these sessional clinical teachers.

One of the means presented in the literature by which clinical teachers can evaluate students' underlying knowledge bases is through questioning. However, available

research suggests that this aspect, too, is not well executed. Sellappah, Hussey, Blackmore and McMurray (1998) evaluated clinical teachers' use of questioning. Their findings concluded that clinical teachers predominantly asked low level questions which could be the result of a lack of familiarity with curricula, or limited knowledge and skill with questioning techniques. Even those clinical teachers in their study with extensive clinical teaching experience did not ask high level questions. The researchers asserted that clinical teachers required assistance with developing high level questions. In comparing questioning by clinical teachers and preceptors, Phillips and Duke (2001) found that whilst clinical teachers asked more questions than preceptors, both groups asked predominantly lower level questions. These authors suggested that these may limit the development of students' critical thinking and that it is an area that universities should pay attention to.

### 3.1.2 Clinical teaching challenges

The area of clinical teaching in undergraduate nursing programs is fraught with challenges and problems and these are reflected within the literature. How these reflect on learning outcomes for students, however, is not directly clear despite a number of different aspects being raised. Levels of teaching expertise possessed by sessional clinical teachers was identified by Wong and Wong (1987) as particularly problematic. These authors argued that whilst an individual practitioner may be a skilled clinician, it does not necessarily transpire that the person will also be a competent teacher. Different skills and knowledge are required in academic and clinical nursing roles. In an environment where clinicians are increasingly assuming preceptor roles, this issue is

further compounded. Preceptors have responsibility for patient care workloads as well as students. Subsequently, clinical responsibilities can make a preceptor too busy to undertake teaching aspects of the role (Yonge et al. 1997).

Another complicating factor relates to poor preparation of clinical teachers and this has been partly discussed previously in this chapter. In their study, Wellard et al. (2000) concluded that clinical teachers lacked familiarity with students' academic curricula due to receiving little or no preparation for their roles. This leads to a range of possible consequences for students including problems with clinical assessment. In a later article, these authors argued that such under-preparation led clinical teachers to teach and assess according to their own expectations and normalised standards (Williams et al. 2001). Furthermore, clinical teachers may be teaching students in clinical settings with which the teachers themselves are unfamiliar (Brennan & Hutt, 2001). The compounded result could lead to clinical teachers having poor understanding of academic curricula, leading teachers and putting students into situations that may be either too difficult or too easy for them (Scanlan et al. 2001). These factors may mean that tensions can arise for both students and clinical teachers as tensions between academic requirements and clinical nursing practice come together.

Geographical and other characteristics of health care settings can also influence clinical teaching. These clinical settings can be unpredictable, are unstructured and clinical teachers have little control over them. Students may be exposed to a multitude of unplanned experiences involving patients, medical or nursing staff that require clinical

teacher guidance (Wong & Wong, 1987) and that fall outside of the completed stage of a student's education. Students may also encounter ambiguous and complex situations that clinical teachers need to assist them to deal with (Taylor, 2000). In addition, Williams et al. (2001) highlighted that clinical teachers may often be responsible for students spread across a number of different wards or departments. This situation makes effective teaching in such unpredictable circumstances, and assessment of student performance, difficult to achieve. Compounding the situation, some clinical placement venues are long distances from the university making it more difficult for schools of nursing to provide direct support for clinical teachers in day to day execution of their roles.

### 3.1.3 Clinical teaching effectiveness

One area that is extensively covered within the nursing literature involves the evaluation of clinical teaching effectiveness. A large number of nurse researchers have sought to examine the effectiveness of particular clinical teaching behaviours within undergraduate nursing programs. The measurement of these behaviours is largely studied from the perspectives of students or university-based nursing academics using quantitative data collection tools. Unfortunately, the perspectives of other key stakeholders, including health care agencies, patients and clinical teachers themselves, are largely silenced. The lack of data exploring clinical teachers' own perceptions of clinical teaching effectiveness is particularly noteworthy, and perhaps reflects the low value placed on the role.

In 1979, O'Shea and Parsons undertook a foundational study to evaluate clinical teaching effectiveness in nursing; a study which paved the way for multiple future replications despite being relatively small in size and lacking generalisability. These researchers sought to examine what teacher behaviours both students and faculty members considered were effective and ineffective for clinical learning. Three broad areas emerged: *evaluative behaviours*, *instructive/assistive behaviours*, and *personal characteristics*. They found differences existed in responses of senior and junior students with regard to some teaching behaviours. For example, seniors rated giving positive and honest feedback as important. Significantly, they also found that faculty members identified role modelling as helpful for learning five times more than students. All groups identified teacher availability as most facilitative of clinical learning.

Knox and Mogan (1985) developed the Nursing Clinical Teacher Effectiveness Inventory (NCTEI), in part building on the work of O'Shea and Parsons (1979). The tool consisted of 48 clinical teacher behaviours grouped into five categories*: teaching ability*; *nursing competence*; *personality traits*; *interpersonal relationship* and *evaluation*. Students and academic staff were asked to rate specific clinical teaching behaviours on a seven point Likert scale. They concluded that both groups valued role modelling, approachability and fostering mutual respect as the highest for those clinical teachers considered 'best'. Students valued clinical teachers who demonstrated enthusiasm, allowed student independence, and did not belittle them. Academic staff, however, viewed effective clinical teachers as those who elicited broad nursing knowledge and stimulated students' interest.

Many replication studies have been undertaken using Knox and Mogan's original tool, and these studies have been covered across many countries including the United States (Nehring, 1990; Sieh & Bell 1994), Greece (Kotzabassaki, Panou, Dimou, Karabagli, Koutsopoulou & Ikonomou,1997), Hong Kong (Li, 1997), Israel (Benor & Leviyof, 1997) and Australia (Lee, Cholowski & Williams, 2002). Generally, the study findings supported each other suggesting that similarities exist around the world regarding student and academic expectations of clinical teachers. Overall, students valued characteristics that support their clinical learning. These included the clinical teacher being a sound role model for practice, enjoying nursing and displaying competence and clinical judgement (Benor & Leviyof, 1997; Kotzabassaki et al. 1997; Lee et al. 2002; Mogan & Knox, 1987; Nehring, 1990; Sieh & Bell, 1994). Furthermore, students valued being corrected in a manner that was not belittling (Kotzabassaki et al. 1997; Mogan & Knox, 1987; Li, 1997; Sieh & Bell, 1994). From the perspectives of academic staff, skills that supported student learning were most highly valued. These included having broad knowledge, stimulating the interest of students and assisting students with their strengths and weaknesses (Mogan & Knox, 1987). Academic staff also valued clinical teachers who displayed mutual respect (Sieh & Bell, 1994) and provide encouragement for students through sound communication skills (Mogan & Knox, 1987; Kotzabassaki et al. 1997; Nehring, 1990). Of particular interest, Lee et al. (2002) found that neither students nor academic staff ranked clinical teachers' teaching ability as of high importance.

Another group of studies have drawn upon the work of Brown (1981) to evaluate perceptions of effective clinical teachers in the United States (Bergman & Gaitskill 1990), Jordan (Nahas, Nour & Al-Nobani, 1999) and Hong Kong (Nahas & Yam, 2001). Brown (1991) developed a tool known as the Clinical Teacher Characteristics Instrument (CTCI) covering the areas of professional competence, relationships with students, and personal qualities. However, again, these studies are limited only to the perspectives of students, with only Bergman and Gaitskill's (1990) study, also having included nurse academics. Overall, these studies found that students highly valued clinical teachers' professional competence (Bergman & Gaitskill 1990; Nahas et al. 1999; Nahas & Yam, 2001). Bergman and Gaitskill (1990) concluded that both faculty and students "favour articulate, knowledgeable clinical instructors who are "objective and fair" in student evaluation" (p. 33). They found that faculty members placed higher importance on the teacher's interest on patients than students did, whilst students were more concerned about communication aspects. Faculty also rated highly the teacher's relationships with students as more important than professional competence, which they state is contradictory to Brown's findings.

Not all studies have completely omitted the perspectives of clinical teachers from studies of their effectiveness. Krichbaum (1994) sought to explore effective clinical teaching by preceptors in critical care areas for undergraduate students through questionnaires to students and preceptors, as well as observation. She used a tool that encompassed 24 specific clinical teaching behaviours organised under the categories of organisation, preparation, setting of expectations; asking questions; answering questions; facilitating

discussion; explaining; feedback; role modelling and attitudes of preceptor/instructor. The author concluded that student learning is significantly related to particular teaching behaviours employed by preceptors. These include using objectives, providing practise opportunities, effective questioning, the provision of specific and timely feedback, using an evidence base for providing feedback, and displaying enthusiasm and interest in the learner's progress.

Overall, there is a large body of available literature that deals with clinical teacher effectiveness in nurse education. Most of this, however, is from the perspectives of students and nurse academics. The literature suggests that students value those characteristics that support them to develop their own practice, such as role modelling and their transition into clinical settings. Academic staff appear to value those attributes that allow for transfer of theory into practice and also which support students in clinical settings. What is absent from these studies is what clinical teachers themselves, and others, involved in clinical education such as health care personnel, perceive as effective clinical teaching characteristics.

## 3.2 Learning in clinical settings

Whilst the focus of this study is primarily that of clinical teaching, it would be remiss not to explore issues surrounding clinical learning. Clinical teachers are primarily employed to support students onto wards and encourage successful clinical learning. Within the teaching-learning binary, clinical teachers may be seen to potentially assume dominant positions over learning with teaching being afforded the primary position. This

section explores experiences of clinical learning for undergraduate nursing students, seeking to provide greater understanding of the position of the key individuals from students' perspectives within clinical education as presented within the literature.

### 3.2.1 Professional socialisation

One of the goals of clinical education is to socialise students into professional nursing roles, a complex and multifaceted process that is difficult, if not impossible, to teach in a classroom environment. Howkins and Ewens (1999) defined socialisation in nursing as:

> … more than just learning the skills and behaviour of nursing, that it must also include the values and norms that are fundamental to knowing and understanding nursing (p.42)

Professional practising nurses become central to students' socialisation into nursing roles as clinical nursing discourses predominate. White and Ewan (1991) assert that a large proportion of professional socialisation is carried through 'hidden curricula' which convey information about professional interactions and institutional expectations. Students learn occupational aspects of such roles by participating in nursing activities that allow them to undertake such roles themselves once registered (Holland, 1999). Windsor (1987) found that students developed their professional socialisation by observing the work of ward nurses, participating in nursing functions in order to "learn how to act like a nurse" (p151). In their study in the United Kingdom, Fitzpatrick, While and Roberts (1996) found that students reported clinical nurses as key in their professional development. Students valued positive role models as exemplars for performance. However, there is also acknowledgement that students bring prior

experiences into their nursing socialisation which involves making changes to their own personal ideas. With ongoing changes throughout their education, the process of socialisation becomes one that is dynamic in nature (Howkins & Ewens, 1999).

The development of students' professional identities emerges through clinical placements and working alongside nursing professionals assisting their adaptation to the environment and the health care team (Addis & Karadag, 2003). Secrest, Norwood and Keatley (2003) explored the meaning of professionalism for baccalaureate nursing students at different year levels. Students in their study described feeling the need to belong in clinical settings, and this included being valued within nursing teams. They also valued having knowledge and being competent in practice as well as receiving affirmation from others to build their sense of being a professional.

Processes by which nursing students at different year levels experience being socialised was explored in detail by Reutter et al. (1997) in Canada where students undertake a four year degree program. In their first year, students were socialised largely through the classroom, unable to discuss how nursing values are enacted in practice and are largely passive in their learning. In their second year, students placed more emphasis on applying theory to practice, coping with 'real' nursing situations. At this time, students tended to be focused on their own learning, seeing patients as providing opportunities for meeting their learning needs and were vulnerable to feedback. In the third year, students began to feel like nurses, possessing many nursing skills. Here, they were less

dependent on their clinical teacher. Finally, in fourth year, students worked to prepare themselves to practise as registered nurses.

### 3.2.2 The clinical learning environment

The clinical learning environment has been shown to play a major role in facilitating learning for nursing students. According to Papp, Markkanen and von Bonsdorff (2003) the clinical learning environment is diverse, including physical ward settings, staff, patients and clinical teachers. They suggested that where the academic setting is controlled, the clinical learning environment is much more difficult to control. Hence, it becomes more challenging for overlaying academic curricula and planning an environment for clinical learning. Accordingly, these authors also proposed that the clinical environment experienced by students can be divided into two separate environments, the nursing environment and learning environment. They purported that the nursing environment includes components around the delivery of nursing care. On the other hand, the learning environment is fostered as clinical teachers develop rapport and cooperation with clinical staff to facilitate students' learning experiences.

Whilst it has been recognised that clinicians contribute to clinical learning for students, it has also been argued that students contribute back into the clinical environment through assisting with clinical practice demands. A study by Zisberg, Bar-Tal and Krulik (2003) measured nursing care provided by clinicians both with and without the presence of a nursing student. Their findings confirmed that nurses actually provided higher quality of care when they were working with a student, than when they were working

alone. The researchers concluded that the presence of nursing students, therefore, enhanced the quality of care delivered to patients within that ward setting. They suggested that the presence of students led staff to undertake “professional introspection” (p.106) leading nurses to evaluate their actions more.

### 3.2.3 Challenge and confusion: Experiences of clinical learning

Numerous studies, mainly using qualitative methods, have explored nursing students’ experiences of learning in clinical settings. These studies suggest that clinical experiences are fraught with uncertainty, provoking feelings of challenge and confusion. Contributing to these feelings, clinical environments can present conflict and contradiction for students undertaking clinical experiences. On arriving at their clinical placement agencies, students enter into new areas with unfamiliar staff, patients, routines and often an unknown clinical teacher. Students need to be able to adapt to the new social environment as they may question why they are there, often experiencing role confusion through not knowing what is expected of them (Neill, McCoy, Parry, Cohran, Curtis & Ransom, 1998) and being expected to conform to accepted behaviours and attitudes within those settings (Paterson, Osborne & Gregory, 2004). Their feelings of confusion may be further compounded by feelings of abandonment when students are left alone with patients (Beck, 1993; Shin, 2000). This may not be an unusual situation for students to find themselves in. Polifroni, Packard, Shah and MacAvoy (1995) suggested that students may not have direct supervision for up to 75% of their clinical time.

The concept of ‘reality shock’ in nursing was first described by Kramer (1974) in discussing emotional reactions of new nurse graduates on entering clinical practice; their reactions being due to conflicting values, ways of doing things, unexpected or unwanted experiences. There is evidence to suggest, too, that undergraduate students also experience reality shock as tensions between academic and clinical nursing discourses contribute to their experiences. In a study of junior nursing students in Korea, Shin (2000) found that students experienced reality shock with the “realization that practice in the clinical setting was quite different from what the students had imagined” (p.261). Beck (1993) found that students encountered reality shock when patients did not receive what students perceived to be appropriate care as a result of low staff numbers, and where they felt nurses had been unresponsive to patients’ needs. Similarly, Chapman and Orb (2000) found students perceived that their university learning had been too ideological and out of place in the ‘real world’ of clinical practice. Students consequently adapted their practice according to whether they were working with their clinical teacher or ward staff, a circumstance also described earlier by Wilson and Startup (1991). Tensions between classroom and clinical expectations led students to practise in the ‘school way’ when clinical teachers were present, but in the ‘ward way’ when working with nurses on the ward (Wilson & Startup, 1991).

Differences in the delivery of patient care between theory and practice environments can also be challenging for students (Melia, 1984). Students enter clinical settings armed with nursing theory acquired in the classroom that focuses on total, holistic patient care. However, such approaches to care rarely occur in practice and this can be confronting

for students (Bennett, 2001; Greenwood, 1993). Greenwood (1993) argued that in practice the focus of nursing is on patients' disease states, not on the person, and that nursing in practice is "technical nursing" (p.1474). Yong (1996) interviewed nine second year students and discovered that these students experienced many disparities between classroom and clinical practice. These included differences in values from those taught in university, different ways of carrying out nursing procedures, varying expectations between nursing staff and differing perspectives on university-based nursing education. Such disparities culminated in feelings of powerlessness, a finding also described by Kelly (1993) in her study of students undertaking their final clinical placement. Hence, clinical teachers play central roles in minimising negative effects for students that arise from disparities between classroom environments and clinical practice. Positive approaches to the socialisation of students can assist with balancing out the impact of the different cultures. On the other hand, negativity may result in students rejecting those values of the academic institution and accepting those existing in clinical settings (Shead, 1991). However, no literature could be sourced that indicated whether the reverse situation also occurred, that is, rejection of values emanating from within clinical settings.

Establishing relationships in clinical settings can also prove challenging for nursing students and this may ultimately impact on learning outcomes. Relationships with clinical teachers, ward staff and patients are fundamental in enhancing learning experiences (Chapman & Orb, 2000). In their study of early nursing experiences of students in Hong Kong, Wong and Lee (2000) found that students rated interpersonal

relationships commonly among their critical incidents. These incidents involved nursing staff in around two thirds of incidents, and patients in the other one third. The authors established that approximately half of these events were positive whilst the other half were negative, leading respectively to conducive and non-conducive learning environments. Conducive environments may include those where students are readily accepted. In her study, Nolan (1998) concluded that for learning to occur students needed to be accepted by ward staff and patients, and this usually develops with time. However, students may not receive required support from ward staff as recruitment and retention problems mean that many experienced nurses who would normally have provided them with support leave their workplaces (Endacott, Scholes, Freeman & Cooper, 2003).

Relationships with clinical teachers were reported as central in studies involving students and clinical learning. Wilson (1994) found that students wanted to "look good" to their clinical teacher as that teacher would be collecting evidence towards their clinical assessment. However, they expressed feeling uncertainty about what the expectations of the teacher actually were. In her study, Windsor (1987) found students' relationships with their clinical teachers were important elements in their clinical experiences. They wanted positive and negative feedback as an indication of their progress in their placements and the presence of the teacher when they were performing skills for the first time. In their study exploring preceptor and student relationships, Mamchur and Myrick (2003) found that conflict in the relationship could have lingering effects on students' self image and health.

Clinical teachers need to be aware of differing student expectations at varying stages within their education. Löfmark and Wikblad (2001) studied the experiences of final year nursing students in Sweden to identify factors that facilitated and obstructed their learning in clinical settings. They found that students wanted to be allowed to take responsibility and have independence in patient care delivery, valuing feedback for their own self-confidence. They valued being taken seriously and receiving positive feedback, and expressed frustration at inadequate supervision or situations where a clinical teacher was not interested in their learning.

### 3.2.4 Stress in clinical learning

Clinical settings can present enormous challenges for nursing students. Upon entering these clinical areas, students encounter environments that are unpredictable, dynamic and which cannot be controlled. Within these settings, students assume little autonomy and control which can have stress-provoking effects.

> …student nurses lack both formal authority and the knowledge about nursing rituals, routines and the norms which are necessary for their legitimate status in the profession. At this point, the feeling of marginality can become so intense that they almost completely lose their sense of self. (Andersson, 1995, p.133)

Within clinical practice settings students often encounter patients with unpredictability surrounding their care. For some students this can be challenging, whilst for others it can evoke significant anxiety (Oermann & Standfest, 1997; Sheu, Lin & Hwang, 2002). New clinical rotations (Shipton, 2002) and initial experiences (Kleehammer & Keck, 1990; Mahat, 1998) can contribute greatly to stress responses. Increasing use of

technology to support nursing care delivery also contributes to stress within these environments (Clarke & Ruffin, 1992). In addition, conflict between what students actually see in practice and what they have learnt in university contributes further (Evans & Kelly, 2004; Lindop, 1991).

However stress is not only induced on entering new clinical areas, but anticipatory stress too can emerge. In her study of junior nursing students in Israel, Admi (1997) found that students' perceived stress prior to clinical placements was significantly less than that actually experienced in placements. She also found that stress at the beginning of a placement was greater than at the end, while Jones and Johnston (1997) found that stress among junior students was intense prior to a clinical placement and after their initial hospital experiences. Anxiety in clinical settings has the potential to interfere with concentration and ability of students to learn (Meisenhelder, 1987). In order to facilitate learning, therefore, clinical teachers need to provide stress support in a non-threatening way for students (Kleehammer & Keck, 1990).

The technical nature of contemporary nursing practice can further contribute to students' experiences of stress. In clinical settings students are able to practise clinical nursing skills on 'real' patients; skills that have previously only been performed on mannequins or models, or in some other type of simulation. Cooke (1996) found that students were anxious about having to perform technical nursing skills on 'real' patients especially administering injections and other medications. They expressed concern about causing harm, not performing the procedure correctly, and of making mistakes. Pagana (1988)

also found students expressed similar fears of making errors with most of these being related to interfering with patients' wellbeing. Doing procedures for the first time and questioning their own lack of experience was found by Shipton (2002) to be anxiety-producing for students in her study. The lack of self perception as competent was also identified by Beck (1993) as a stressor for beginning students. These experiences are not, however, restricted only to nursing students. Medical students, too, have been shown to experience stress relating to feelings of inadequacy in patient care provision and having insufficient knowledge (Radcliffe & Lester, 2003) so may reflect a broader phenomenon related to clinical learning in health care.

The development of relationships and communication in clinical settings has also been found to greatly contribute to student stress in these settings. Where ward staff do not welcome or help students, students may experience stress (Birx & Baldwin, 2002). Cooke (1996) found that students needed to be valued within clinical settings and to 'fit in'. However, the need to communicate with patients, nurses, clinical teachers, doctors and other members of the health care team is stressful (Cooke, 1996; Mahat, 1998). Shipton (2002) explored in detail clinical relationships and their contribution to stress. Clinical teachers were perceived by students to evoke stress through the conduct of evaluation, moody or incompetent behaviours, and their observation of students. Ward nursing staff also contributed to student stress through negative attitudes and comments. Shipton also concluded that relationships with peers could also be stress-inducing where there was competition between students, or if another student was seen to be "dependent or clinging" (p.246) on them. In their study, Timmins and Kaliszer (2002) found that

68% of students questioned reported relationships with ward nursing staff as stressful, whilst they found that around one third of students found their relationships with clinical teachers as causing some stress.

A few studies have sought to explore coping strategies employed by nursing students in the context of stress induced around clinical placements. According to Melia (1984) nursing students try to "fit it" to each transient clinical environment as a means for managing moving from nursing school to clinical placement. Chapman and Orb (2001) explored the coping strategies used by nursing students in clinical settings. They identified students' needs to be able to talk over issues that arise and sharing experiences through the student "grapevine" as important. Students identified 'playing the game' and being whatever nursing staff and clinical teachers wanted them to be as assisting their survival. This echoed McLeland and Williams' (2002) description of students' experiences in being marginalised by ward expectations of subservience. Chapman and Orb (2001) suggested that students would only do what they were required to do as important for conserving their energy but ensuring they passed for their survival in the course. This selective approach was an important strategy for managing clinical demands as well as those outside of the placements such as family, personal activities (Clarke & Ruffin, 1992) and other academic work (Mahat, 1998). Hamill (1995) concluded that nursing students resorted to numerous means in order to cope with their stress, including such means as crying, binge eating, talking with peers, socialising and drinking alcohol.

## 3.3 Conclusion

Clinical teaching and learning is abundantly represented in the nursing literature and this chapter has sought to explore these in light of the current study. Unlike the previous chapter, this one has focused on more personal aspects of teaching and learning of nursing in clinical settings. Across the area of clinical teaching, a great amount of the available literature represents the perspectives of nurse academics and students, especially with regard to effectiveness. Much focus is given to clinical teaching aspects valued by these groups such as role modelling, facilitation and assessment. Literature around learning in clinical settings explores such areas as socialisation, impact of clinical learning environment and issues arising for students. What is not clear through the literature are which factors directly influence clinical teaching work and how these inform clinical teaching practices as is the focus of this study. The next chapter introduces the theoretical underpinnings informed by Foucault that informed the study to allow exploration these particular areas and inform a greater understanding of them and build upon the information presented within the literature review.

# Chapter 4

# THEORETICAL CONSIDERATIONS

The literature review demonstrated clinical teaching in undergraduate nurse education as a complex, variable and often poorly valued area of nursing. For a variety of reasons, clinical teaching models are constructed in a range of guises both within Australian and international contexts. These models include the sessional clinical teacher, clinical teaching associate (CTA) and preceptor. Through the literature review it became clear that the development of clinical teaching approaches has been shaped by a number of different factors such as economic and workplace discourses. For this study, it was decided to explore clinical teaching work in greater detail. Hence, decisions about which theoretical approach to use needed to draw upon thinking that would allow for these types of factors to be further exposed and explored.

In order to investigate what shapes, and is shaped by, clinical teaching, I consequently chose to undertake a critical analysis employing a theoretical framework informed by the work of the French philosopher Michel Foucault (1972; 1977; 1982;1984a; 1984b; 1984c). As will be described in this chapter his work offers opportunities for new perspectives on clinical teaching in nursing to be realised, enhancing our understanding of the development of clinical teaching work in undergraduate nurse education and build upon current knowledge in the area.

## *4.1 Philosophical foundations for the study*

The postmodern era heralded new directions in how people viewed reality and their existence from those of the preceding modern era. Modernity refers to the period of time between the mid 1400s to 1960 (Rolfe, 2001). However, the term 'modernity' is better associated with that around the Enlightenment project of the 18th century. This period saw a worldview that was dominated by science, and the notion that an ideal state could be achieved through science and rationality. Within the period, human thought was subsequently exemplified through deductive reasoning (Grassie, 1997).

The postmodern period began around the time of the end of the Second World War. Philosophical thinking at that time was strongly influenced by a number of different philosophers, predominantly those from France, including Lyotard, Derrida, Baudrillard and Foucault. Thinking from postmodernist positions varies greatly from that of the modern era. Underpinning various postmodern positions is rejection that a single perspective exists, rather than supporting transcendental notions imbedded in traditional science (Powers, 2001). In doing so, postmodernism "disavows the idea that human experience can be reduced to, and captured by, grand or totalizing theories" (Cheek, 2000 p.5). As such, it rejected theories that had previously sought to describe society and its structure.

Within postmodern approaches to thinking, knowledge is argued as developing out of power relations (Welch & Polifroni, 1999). Reality therefore, as a consequence, is regarded as being plural with no single truth. This leads postmodern thinkers to

recognise that there are multiple perspectives from which to view situations. Working from these perspectives, postmodern researchers employ multiple methods to explore phenomena under investigation (Cheek, 2000) hence there is no one approach to undertaking postmodern research.

## 4.2 Foucauldian perspectives

The current study is informed through the work of Michel Foucault. Foucault was considered both a philosopher and historian (McHoul & Grace, 1993) who rejected approaches of the Enlightenment and refused to align himself with traditional western social thought (Ball, 1990). However, many historians did not consider his work to be historical as it did not follow historical traditions, including failing to present a history of the past, not advancing historical causes, drawing on wide ranging resources and failing to identify causes or reasons (Marshall, 1990). Foucault was particularly interested in the experiences of minority groups such as prisoners and the mentally ill (Turner, 1997). According to Turner (1997), he developed three main contributions towards contemporary social thought – his analysis of power relations, concept of the modern self, and governmentality. Through the development of Foucault's widespread series of innovative concepts, researchers are provided with scope to allow for investigating social structures and the power structures embedded within them. In addition to his own work, Foucault built upon the work of others, extending traditional understandings of 'discourse' which developed into a large component of his work. Subsequently, discourse analysis carried a major role in informing the approaches of this study including the analysis of data. It allowed for exploring beyond what is known about

clinical teaching work and extending understandings around how clinical teachers shape their work within practice settings and balance conflicting demands from within clinical areas and universities.

### 4.2.1 Discourse

The concept of 'discourse' was a central component underpinning Foucault's approach, as one of the means by which power relations become evident and may be studied, and as integral to other Foucauldian concepts. Discourses can be seen to be the means by which communication occurs within a particular social setting. However, they are not solely represented by verbal interchange, but "well-bounded areas of social knowledge" (McHoul & Grace, 1993, p. 31). They can involve both language and practice, and can exist as knowledge structures that in turn "influence systems of practice" (Chambon, 1999). Foucault viewed discourse as that which occurs between disciplines, or bodies of knowledge, and practices of discipline. Discourses consist of practical realms that are bounded by their own particular rules and conditions. Furthermore, discourses are only applicable to the specific context in which they arise. Consisting of objects, operations, and theoretical options, discourses allow for writing, speaking and thinking within historical limits (McHoul & Grace, 1993). Discourses, themselves, become maintained by discursive practices which also involve the integration of power and knowledge (Manias & Street, 2000), as discourse "transmits and produces power; it reinforces it, but also undermines and exposes it, renders it fragile and makes it possible to thwart it" (Weedon, 1995, p.111).

Discourses are also historically bound. They are not transferable to different periods of time, remaining specific to the particular historical context in which they emerge. Foucault (1972) noted that a "discourse must not be referred to the distant presence of the origin, but treated as and when it occurs" (p.25). Discourses, then, are bound to the context of the time and situation, not being transferable to other moments in time or locations. Furthermore, at any one moment in time, a number of discourses may be operational (Cheek, 1998). These may intersect or overlap with each other (McHoul & Grace, 1993). Throughout the interplay of discourses, some will be dominant while others will be relegated to the margins (Cheek, 1998) so at any one time there will be many discursive frameworks impacting on our thinking (Cheek, 2000). They draw upon each other to produce new ways of thinking about issues (Carabine, 2001). Foucault described in *The Archaeology of Knowledge* how he perceived that discourses develop, introducing the concept of the *discursive formation*.

> Whenever one can describe, between a number of statements, such a system of dispersion, whenever, between objects, types of statement, concepts, or thematic choices, one can define a regularity (an order, correlations, positions and functionings, transformations), we will say, for the sake of convenience, that we are dealing with a *discursive formation.* (Foucault, 1972, p.38)

In developing his concept of discursive formation, Foucault identified rules of formation that allow individual discourses to be constructed, and which also allow for them to be uncovered. The first of these rules involved what he called the *formation of objects*. This included identifying conditions that were necessary for the emergence of the particular discourse at the particular time in which it

surfaced. As such it involved exploring relations between "institutions, economic and social processes, behavioural patterns, systems of norms, techniques, types of classification, modes of characterization" (Foucault, 1972, p.45).

Foucault used the terminology *formation of enunciative modalities* as a means for uncovering the laws underpinning discursive formations. These enunciative modalities indicate who and in what environments people are able to speak within a discourse. Foucault (1972) suggested that the first question to be asked in revealing such laws involved identifying who was actually speaking. "Who is afforded the right to use this sort of language (*langage)*? Who is qualified to do so?" (p.50). The next step involved giving consideration to the site or location at which the discourse was considered to be legitimate. This then involved identifying where it was enacted and under what conditions it became applied. The third stage in identifying the formation of enunciative modalities involved determining and defining the positions of the subject in relation to the discourse.

The next component Foucault described in establishing discursive formations involved the *formation of concepts*. Here, the organisation of statements within a discourse was considered to determine their appearance and circulation. In describing this, Foucault (1972) referred to forms of *succession*, *coexistence* and *procedures of intervention*. Succession involved exploring the arrangement of statements, including how they depend on each other and recur. Coexistence reflected the use of statements that may be used within other discourses, or are no

longer used but form part of what Foucault coined, the *field of memory*. Procedures of intervention alluded to identifying those processes that use statements already in existence but are rearranged within the particular discursive framework to make a new meaning or whole.

The process of language in the context of social practice has been understood as constituting discourse (Dant, 1991). As Weedon (1995) outlined, language is the place where our subjectivity is constructed. As such, language is what constructs our social reality. For Foucault, language is only one component of discourse and what constitutes social reality. It is through analysing the interplay of discourses, that we can seek to understand social situations, including power relations. Hence, in undertaking a Foucauldian analysis, the researcher examines a range of aspects relating to discourse, including who is speaking, who has the right to use the language, and what qualifies them to do so, the institutional context of the speaker and the positions of the subject in the situation (Foucault, 1972).

### 4.2.2 Power-knowledge relations

Foucault's work changed in focus as he developed his ideas. From his work on discourse, he moved to develop concepts around power, knowledge and the subject. He shifted his thinking from *archaeology* (Foucault, 1972) towards that of *genealogy* (Foucault, 1984a). As a result, his notion of power developed, offering a fresh approach to understanding how it works. Foucault rejected traditional juridical models of power questioning their legitimacy (Cutrofello, 1994). His description of power thus differed

extensively from that of earlier philosophers, with his idea of power being closely intertwined with knowledge rather than existing in isolation.

> We should admit that power produces knowledge (and not simply by encouraging it because it serves power of by applying it because it is useful); that power and knowledge directly imply on another; that there is no power relation without the correlative constitution of a field of knowledge, nor any knowledge that does not presuppose and constitute at the same time power relations. (Foucault, 1977, p.27)

Dreyfus and Rabinow (1982) described Foucault's concept of power as being a particular form of power that serves to organise the population. Of significance, Foucault explained power to be something that is exercised and not possessed (Foucault, 1984c; Manias & Street, 2000) by any one person or group, nor is it repressive (Caputo & Yount, 1993). Power is perceived to be multidirectional, not top-down but occurring at all levels (Marshall, 1989) and "extending in all directions and operating at all levels in any given situation" (Cheek, 1998, p.87). Moreover, unlike other interpretations, Foucault's power can be seen to be positive as well as negative (Marshall, 1989) and productive (Manias & Street, 2000). Cheek (1998) suggested that in shaping what might be perceived as truths, power "works in determining the boundaries of the possibilities of what can be known, spoken and thought about in particular settings at particular times" (p.86).

> But in thinking of the mechanisms of power, I am thinking rather of its capillary form of existence, the point where power reaches into the very grain of individuals, touches their bodies and inserts itself into their actions and attitudes, their discourses, learning processes and everyday lives (Foucault, 1980d).

The interconnected nature of knowledge and power outlined by Foucault has been well documented by both himself and a number of commentators of his work. Foucault argued that, "Power produces knowledge…power and knowledge directly imply one another" (Foucault, 1984c, p.174) whilst it is that knowledge that allows for power to disseminate (Caputo & Yount, 1993). According to Bevir (1999), "all knowledge arises out of a power complex; regimes of power define what counts as a meaningful utterance, what topics are to be investigated, how facts are to be produced". These regimes of power lead to the development of rules about who has the authority to decide how to use information, and about the collection of information. Dzuric (1999) highlighted that as new knowledge is acquired, a shift in power relations occurs as individuals learn about and enact the newly obtained knowledge.

Where power exists, so too do tensions and resistance, or points of resistance (Caputo & Yount, 1993) where people have capacity to resist the power (Bevir, 1999). Foucault (1982) described how struggles result as people resisted the effects of power. He described these as being linked to "struggles against the privileges of knowledge" (p.212). Hence, "power and resistance both constitute and are constituted by each other" (Powers, 2001, p.17) and will be located together where power relations exist.

In the context of the present study, examining power-knowledge relationships is crucial to understanding how the development of clinical teaching has been historically, and is currently, situated. It seeks to expose the interconnectedness of political, social,

economic, educational and other discourses and how they exercise power-knowledge relations to shape clinical education.

### 4.2.3 Discipline

Discipline is central to the exercise of power. In two of his more significant works, *Discipline and Punish* and *The Birth of the Clinic,* Foucault dealt with the concept of discipline in great detail through his studies in prisons. His analysis dealt closely with how power-knowledge relations are enacted through a range of processes that influenced the subject through the utilisation of disciplinary power. Foucault coined the term 'docile body' to describe the subject on whom discipline is subjected and practised, and subsequently whom activity becomes disciplined.

> Thus discipline produces subjected and practised bodies, 'docile' bodies. Discipline increases the forces of the body (in economic terms of utility) and diminishes these same forces (in political terms of obedience). In short, it dissociates power from the body; on the one hand, it turns it into an 'aptitude', a 'capacity', which it seeks to increase; on the other hand, it reverses the course of the energy, the power that might result from it, and turns it into a relation of strict subjection. (Foucault, 1977, p. 138)

He described a series of techniques that are used to discipline. The three predominant techniques are explained. First, the *art of distributions* uses enclosures and partitioning to distribute individuals within spaces to create those 'docile', disciplined individuals. Within the distribution, each individual has their own space, with collectives broken up (Foucault, 1977) to reduce collective power. Within hospital settings, patients are partitioned into their own spaces – units, wards and rooms. When groups of nursing

students are present in these settings, the groups are usually divided up with individual students allocated to specific wards and subsequently patients' and they work within that patient's space. Two students would rarely work together. *Functional sites* are thus established that "correspond not only to the need to supervise, to break dangerous communications, but also to create a useful space" (Foucault, 1977).

Second, regulating bodies through the *control of activity* contributes to the use of disciplinary techniques. Here, the use of time is important as one such technique. "Power is articulated directly onto time; it assures its control and guarantees its use" (Foucault, 1977, p.160). Within educational contexts, Foucault described how time acts in a disciplinary fashion actioned through curricula, timetables and examinations. The application of this thinking has particular significance in this study of clinical education in nursing occurring in health settings where time is used to order practice and clinical education, and becomes important within the findings of this study.

"Time measured and paid must also be a time without impurities or defects; a time of good quality, throughout which the body is constantly applied to its exercise" (Foucault, 1977, p.151). Quality of time can be ensured through constant supervision and timetables. In clinical teaching situations, constant supervision of students by clinical teachers and ward nurses assists with ensuring students experience quality of time, not tainted by other activities. Timetables, in the form of shift times, dictate when students should be present in clinical settings reinforcing the discipline. *Body-object articulation* serves to discipline the body through defining "each of the relations that the body must

have with the object that it manipulates" (Foucault, 1977, p.153). In executing clinical nursing skills such as wound dressing or injections, students follow taught steps within each of the nursing procedures. When students are performing such skills in practice, they are supervised by trained staff, either clinical teacher or ward staff, to ensure that there is 'correct' execution of the procedure.

In the third technique which Foucault called the *organisation of geneses*, discipline is seen as "machinery for adding up and capitalizing time" (Foucault, 1977, p.157). In military contexts, time is divided into "successive or parallel segments, each of which must end at a specific time" (Foucault, 1977, p.157), through isolating training and practice periods with new recruits being separated from veterans; and through organising common activities, developed in ranked succession. Such division and organisation of time became used within educational settings, and is a feature of undergraduate nurse education.

> It is this disciplinary time that was gradually imposed on pedagogical practice – specializing the time of training and detaching it from the adult time, from the time of mastery; arranging different stages, separated from one another by graded examinations; drawing up programmes, each of which must take place during a particular stage and which involves exercises of increasing difficulty; qualifying individuals according to the way in which they progress through these series. (Foucault, 1997, p. 159).

Such use of disciplinary time has direct relevance to the delivery of clinical education within undergraduate nursing programs. Academic curricula prescribe when classes take place, and when clinical placements occur dividing them up into discrete components. Each clinical placement has particular criteria for mastery at

different stages throughout the course. Students are generally required to pass each segment of the course to progress onto the next, hence disciplining their progress towards completion.

Foucault described three instruments for determining the success of disciplinary power on maintaining 'docile bodies'. These strategies being: hierarchical observation, normalising judgement and the examination. *Hierarchical observation* provides a mechanism to exercise discipline through observation, and hence prompt coercion of desired behaviours. Surveillance of individuals' activities allow power relations to become clearly visible to the individual on whom it acts, polices, controls, checks and promotes obedience (Foucault, 1977).

> The perfect disciplinary apparatus would make it possible for a single gaze to see everything constantly. A central point would be both the source of light illuminating everything, and a locus of convergence for everything that must be known: a perfect eye that nothing would escape and a centre towards which all gazes would be turned (Foucault, 1977, p.173)

The use of surveillance, which Foucault referred to as 'panopticism', was argued as the means for power to function within society. Discipline was exercised not through direct action, but from forces that act through discourses and power-knowledge relationships on the subject. He described the *panopticon* as a structure that allowed for individuals to be constantly observed at every point by supervisors, and where each individual was placed in a fixed place not knowing whether they were being observed. The intended outcome of this was:

> …to induce in the inmate a state of conscious and permanent visibility that assures the automatic functioning of power. So, to arrange things that the surveillance is permanent in its effects, even if it is discontinuous in its action; that the perfection of power should tend to render its actual exercise unnecessary; that this architectural apparatus should be a machine for creating and sustaining a power relation independent of the person who exercises it; in short, that the inmates should be caught up in a power situation of which they are themselves the bearers (Foucault, 1977, p.201).

Observation and surveillance are used in the supervisory activities of clinical teachers. Through constant monitoring of students' activities and levels of performance, behaviours in the clinical setting can be subjected to ongoing discipline. This occurs at every stage, whether the clinical teacher is present or not. Similar to the panopticon, clinical teachers use techniques to ensure constant observation at every point during students' placements. Drawing on feedback from ward staff when they may not be physically present is one means clinical teachers employ to ensure that students conform to disciplinary requirements regardless of whether they are being directly observed by the teacher or clinicians.

In *The Birth of the Clinic,* Foucault (1973) studied medicine and social influences on the development of concepts central to the field. Emerging from that work was the notion of the *clinical gaze* which involved classifying patients and their conditions into symptoms and signs as a means of imparting order and control over them and their conditions.

> An inspecting gaze, a gaze which each individual under its weight will end by interiorising to the point that he is his own overseer, each individual thus exercising this surveillance over, and against, himself. A superb formula: power exercised continuously and for what turns out to be minimal cost (Foucault, 1980a).

In categorising patients according to their clinical conditions, they could be normalised according to predetermined criteria and imparted the "power of decision and intervention" (Foucault, 1973, p.89) to doctors. From this work, Foucault later developed his ideas around normalisation as a disciplinary technique.

> The perpetual penalty that traverses all points and supervises every instant in the disciplinary institutions compares, differentiates, hierarchizes, homogenizes, excludes. In short, it *normalizes* (Foucault, 1977, p.183).

*Normalising judgement* (Foucault, 1977) was used to describe ways in which disciplinary methods were used to ensure that individuals conformed to acceptable standards and how these are maintained (Dzuric, 1999). "In a sense, the power of normalization imposes homogeneity; but it individualizes by making it possible to measure gaps, to determine levels, to fix specialities and to render the differences useful by fitting them into one another" (Foucault, 1977, p. 184). According to Carabine (2001) normalisation produces a standard measure upon which all will be evaluated as conforming to accepted patterns or standards of behaviour.

According to Foucault (1977) discipline takes control of four different types of individual characteristics. McHoul and Grace (1993) elaborated more on these highlighting their relevance to investigation and their roles in normalisation. Firstly, individuals are segmented into similar groups such as students or clinical teachers. This may even involve physical partitioning into particular areas, and away from other groups. Secondly, activities of the groups are controlled, often by time constraints. The

third method involves organising particular periods or stages of training, where acquisition of mastery at particular levels is monitored. Finally, general coordination of parts results in the organisation of a general whole.

> The discourse of discipline has nothing in common with that of law, rule, or sovereign will. The disciplines may well be the carriers of a discourse that speaks of a rule, but this is not the juridical rule deriving from sovereignty, but a natural rule, a norm. The code they come to define is not that of law but of normalisation. (Foucault, 1980b, p.106).

The study of disciplinary power can, therefore, assist with understanding the power-knowledge relations acting upon subjects within societies. It can also provide insight into both dominant and marginal discourses that serve to shape individuals or groups within their unique contexts. Within the present study, examination of disciplinary power extends the understanding of factors shaping clinical teaching and providing control over clinical teaching work.

### 4.2.4 Subject

How individuals become constituted as subjects through discursive practices was a significant focus within Foucault's later work. He concerned himself with understanding how subjects are produced as a result of discursive constructions and power-knowledge relations, whilst acknowledging the importance of the subject to the process. He identified that "while the human subject is placed in relations of production and signification, he is equally placed in power relations which are very complex" (Foucault, 1982, p.209). Power, therefore, plays a major role on the subject in a range of ways. It:

> applies itself to immediate everyday life which categorizes the individual, marks him by his own individuality, attaches him to his own identity, imposes a law of truth on him which he must recognize and which others have to recognize in him.' (Foucault, 1982, p.212).

Through the interplay of power-knowledge relations, the subject experiences struggles. Foucault (1982) identified three types of resulting struggle that individuals may encounter. Firstly, there are struggles resulting from domination. This can include such types of domination as social, religious or racial domination. Secondly, there are struggles 'against forms of exploitation which separate individuals from what they produce' (p.212). Finally, according to Foucault, there are struggles that tie individuals to themselves and which submit them to others, such as through subjectivity or submission.

Within the context of the present study, exploring how discourses act on subjects (clinical teachers) is central to understanding power-knowledge relations that serve to shape individuals' approaches to clinical teaching work. This understanding assisted in illuminating struggles that emerged as a result of the interplay of a range of those relations so as to contribute to a much deeper understanding of clinical education and those factors influencing it.

### 4.2.5 Multiplicity of Truths

Central to the work of postmodern thinkers is the notion that multiple realities exist, that is, there is no one overriding 'truth' in any situation. Reality can be described "as comprised of multiple voices, views and representations" (Cheek, 2000, p.19). Foucault,

too, made the idea of multiple realities (truths) central in his work. Truth, he contended, "is linked in a circular relation with systems of power which produce and sustain it, and to effects of power which it induces and which extend it" (Foucault, 1980c). These realities therefore, inform the discourses which are predominant in any society, and may be unique to that particular group.

> Each society has its regimes of truth, its "general politics" of truth: that is, the types of discourse which it accepts and makes function as true; the mechanisms and instances which enables one to distinguish true and false statements, the means by which each is sanctioned; the techniques and procedures accorded value in the acquisition of truth; the status of those who are charged with saying what counts as true. (Foucault, 1984a, p73)

Adopting an approach informed by Foucauldian perspectives, therefore, needs to provide scope for acknowledging a range of realities as they exist within the group or groups under investigation. This study seeks to explore multiple realities and perspectives surrounding clinical teaching work in Victoria through interviews with a number of clinical teachers, ensuring that the realities of different sub-groups, that is, sessional clinical teachers, clinical teaching associates and preceptors are all integrated and considered.

### 4.2.6 Genealogy

Genealogy is an approach to historical research introduced by Foucault in the 1970s, after he revised his earlier method known as 'archaeology' (Foucault, 1972). It incorporated his concept of the dimensions of power relations (Kendall & Wickham, 1999). However, unlike traditional approaches to historical investigation, genealogy

examines the occurrence of individual events without making broad generalisations about them. One significant aspect of genealogy relates to its capacity to highlight 'turning points' by allowing shifts in dominant discourses to be uncovered (Chambon, 1999) over historical periods of time. In doing so, genealogy allows for the revelation of truths, power relations and varieties of knowledge that were central in the development of particular discourses (Popkewitz & Brennan, 1997). The significance of undertaking genealogical enquiry is largely to understand the context by which current situations have evolved. "We have to know the historical conditions which motivate our conceptualization. We need a historical awareness of our present circumstances" (Foucault, 1982, p.209).

Genealogy also differs from traditional histories through its focus on seeking to explore the effects of discourses on the subject. As Foucault (1984b) outlined it seeks "to expose a body totally imprinted by history and the process of history's destruction of the body" (p. 83). This is achieved through identifying and examining ways in which power-knowledge relations work to shape the individual (Foucault, 1984b).

The concept of power-knowledge relations is integral to genealogy. According to McNay (1992) history is founded on a continual struggle between different blocks of power. Each one of these in constructed through discourse and seeks to assert its own domination. Furthermore, knowledge is produced within historically specific regimes of power. With this, each society constructs its own truths that serve to normalise and regulate the society. McNay viewed the role of genealogist as involving the uncovering

of multiple factors and processes shaping events through historical constraints. Within the present study, genealogy was employed to provide a framework for understanding discourses that were operating with the development of initial clinical teaching following the transfer of undergraduate nurse education into the tertiary education sector. Hence, power-knowledge relations integral to their evolution were explored.

### 4.2.7 Criticism of Foucault's work

Foucault's work has been employed across a number of discipline areas; however, it has not been without criticism. Much of this critique has been directed towards his conceptualisations around power and knowledge. In particular, critics have suggested that his thinking lacked depth, with it being built around wide, generalised ideals (Flyvberg, 1998; Touey, 1998) that presented incomplete conceptions of power (Wolin, 1988). To add to this, Wolin (1988) argued that in developing his general approaches, Foucault had recreated similar totalising thinking for which he had been critical of classical theory.

For Rorty (1986), difficulties regarding Foucault's work were related more to the genealogical component. He suggested that Foucault redescribed work presented in the past and merely supplemented "helpful hints on how to avoid being trapped by old historiographical assumptions" (p.47). Furthermore, he perceived Foucault's genealogical work to be negative rather than positive, identifying gaps in the development of underlying theory and genealogy as a method.

Debate has been stimulated as critics have described their interpretations of Foucault's ideas. Mills (2003) purported that Foucault's propositions around the operation of power are often misunderstood. Mills argued that Foucault drew heavily on Nietzsche's earlier work on force relations, to develop his thinking of power as not centralised or systemic. Resulting analyses then are "more coincidental or pragmatic" (Mills, 2003, p.255) which have alluded some critics.

Interestingly, strong debate has ensued in the field of business where Foucault's work has been used by an increasing number of authors for analysing institutional politics. Foucault's own studies were limited to such areas as imprisonment and health. Wolin (1988) asserted that by ignoring such areas as economics, political science and law meant that Foucault's works neglected areas where power relations were heavily involved. Another critic of his work, Neimark (1990, 1994) suggested that Foucault's work was too ideological to work effectively in the field of economics because it failed to take sides in social conflict found in capitalism. This, she argued, did not therefore encourage challenge within institutions or practices. However, one of her opponents in the field, Grey (1994) counteracted her argument suggesting that her views had oversimplified Foucault's approach, enhancing the argument that Foucault and his ideas are often misunderstood.

A number of feminist authors have expressed disappointment at a lack of consideration of gender issues within Foucault's works. This was described by McNay (1992) as "gender blindness".

> One important criticism has been that Foucault's analysis does not pay enough attention to the gendered nature of disciplinary techniques on the body and that this oversight perpetuates a "gender blindness" that has always predominated in social theory. (p32-33)

However, many feminist authors have acknowledged possibilities for describing women's experiences through Foucault's work that has not been possible with other theoretical positions. By envisioning Foucault as offering a standpoint that allows for understanding bodies and sex as socially constructed (Ramazanoğlu, 1993) feminists have been able to use his work, explaining power relations where other social theory has been unsuccessful.

Some feminists have viewed Foucault's work as potentially undermining emancipatory processes for women (Sawicki, 1991). Sanders (1998) asserted that Foucault's gender-neutral subjects resulted in femininity being subsumed into masculine experience which served to silence female experience that may be different to that of males. Sanders highlighted that Foucault's lack of acknowledgment of female experience in creating subjects resulted in a failure to take into consideration experiences of maternity and maternal-infant relationships. Simons (1996) however, contested that mothers actually assumed powerful positions within society, arguing that constructions of motherhood within society place children in subordinate positions. Mothers have the power to exercise control over their children and ultimately influence social roles that children will take on as adults. Through nurturing roles, they shape children's development through discipline, teaching, and imposing social order. Whilst the relevance of

motherhood and Foucault may not yet be evident, this area is significant to the findings of this current study as will be described in chapter ten.

As has been demonstrated within this chapter, Foucault's work has been challenged by many authors drawing strong critique that questions its applicability for research purposes. Criticism has been specifically directed towards his concept of power and that his work fails to recognise gender issues are largely related to misunderstandings of his work. While not neglecting the foundations of these challenges, Foucault's work was still considered to offer significant benefits for this study. Certainly, his perspectives on power-knowledge relations, discourse and genealogy, for example, offered unique opportunities to develop new understandings around clinical teaching work in nurse education that the work of other philosophers did not. Moreover, his approach also offered opportunities to undertake historically-based investigation. Overall, therefore, the perceived benefits of using Foucault's ideas in this study were considered to strongly outweigh those arguments against his work.

## *4.3 Conclusion*

Postmodern approaches to thinking challenge totalising views on reality and present opportunities for investigating existing phenomena from multiple perspectives. Foucault, whilst not aligning himself directly to postmodernism, offered a range of concepts that allow for viewing complexities within the world, including through discourses and how power-knowledge relations work within them. The application of Foucauldian concepts, such as power-knowledge relations, discourse and genealogy, provided a foundation

suitable for the current study and allowed for exploration of factors influencing clinical teaching work in nursing within this study. Whilst recognising strengths in applying Foucauldian concepts, it has also responded to some of the criticism directed to his thinking and acknowledged limitations and positioned his thinking in the current study.

# Chapter 5

# METHODOLOGY

The previous chapter described the theoretical basis, through the work of Foucault, on which this study was developed. This chapter builds on those ideas, discussing how that theoretical knowledge was used to develop the approaches taken. It begins by providing a general overview of the development of the two phases of the study including key questions that were explored and how these developed. Data collection methods used in each phase are discussed, along with issues surrounding the recruitment of participants. Relevant ethical considerations impacting upon the execution of the study are also identified and their management discussed. Approaches to data analysis, through the use of discourse analysis are presented. Finally, issues surrounding the validity of data in the study are discussed in detail.

## *5.1 Overview of the study*

This study sought to critically examine two main perspectives of undergraduate clinical nurse education in Victoria, these being:

- historical backgrounds informing clinical teaching within Victoria immediately prior to, and following, the transfer of nurse education into the tertiary education sector; and,

- the predominant clinical teaching approach presently in existence within undergraduate nursing courses in Victoria, primarily sessional clinical teacher, associate clinical teacher and preceptor.

In examining these positions, the study considered various components of each model that has lead to the unique identity of each, as well as providing comparisons and contrasts between clinical teachers' own perceptions of their clinical teaching work. Through analysis of emerging discourses, the study explored factors that served to shape and contain the different approaches to clinical teaching work, and in turn, examine what clinical teachers themselves have control over and subsequently, shape. Due to the potential scope of the study, it was determined that restricting it to encompass the State of Victoria only was appropriate. It has been acknowledged, however, that factors impacting on the development of clinical teaching outside of Victoria may vary. Given this, the study was directed towards answering the following key questions:

- What discourses shaped clinical teaching in undergraduate nurse education in Victoria from an historical perspective?
- How do factors identified through the literature review and historical inquiry currently work to shape clinical teaching in undergraduate nurse education within Victoria?
- Are there key components of clinical teaching in undergraduate nurse education in Victoria, and if so, what are they and how do they operate?

The key questions emerged from within the extensive literature review undertaken in the early stages of the study. Overlaying the main questions to be asked was the philosophical positioning chosen for the study, that of Foucauldian perspectives outlined in the previous chapter.

## 5.2 Phases in the study

### Phase One: Genealogical (historical) inquiry

The first phase of the study involved undertaking a limited examination of historical aspects of clinical teaching work. Using the principles of Foucault's description of genealogy (Foucault, 1984a, 1984b), the primary purpose of this phase was to identify dominant discourses impacting on the development, prior to, and following the transfer of, nurse education into the higher education sector in Australia. Fitzpatrick (1993) highlighted the benefits of seeking an historical perspective as it "connects us with a heritage and confers on us an identity, personally and professionally" (p.360). Furthermore, it "brings historical research in nursing into an active and useful mode, while continuing to expand the knowledge and understanding of the profession's genesis and evolution for more esoteric reasons" (Fitzpatrick 1993 p.362).

Within the current study, a limited genealogical analysis was considered appropriate for assisting with positioning and determining the context of development for early models of clinical teaching which were used at the time of the transfer of nurse education into

the higher education sector. An historical examination in this study was undertaken to provide a foundational understanding of the factors that influenced the development of clinical teaching approaches that are presently in use.

The main data collection methods employed during this phase were semi-structured interviews and documentation analysis. Semi-structured interviews were selected as the appropriate approach for this study as they provided some guide for the developments of the dialogue, however, also allowed for new issues and topics to emerge that may not have surfaced during the literature review. Minichello, Aroni, Timewell and Alexander (1995) state that this type of interview "is focused on the issues that are central to the research question, but the type of questioning and discussion allow for greater flexibility" (p.65). According to Morse and Field (1995) the "semi-structured interview is used when the researcher knows most of the questions to ask but cannot predict the answers" (p.94).

As this phase was intended to support the second, and larger phase, of the study, and to provide further insight into the context for the development of current approaches to clinical education, only three key informant interviews were undertaken. These interviews were conducted with nurses who were in employed in key academic roles prior to, and following, the transfer of nurse education into the tertiary education sector. Given that the numbers of available individuals for this phase was limited, identification and recruitment of potential participants was managed by word of mouth. These individuals were contacted by telephone and if they were interested in participating,

were sent the Plain Language Statement and an interview time arranged. During these interviews, a number of guiding questions were posed in order to generate the discussion. These questions were:

- Can you describe your recollections of clinical teaching as they existed prior to the transfer of nurse education into the tertiary sector?
- Can you describe the factors that influenced the initial clinical teaching immediately following the transfer of nurse education into the tertiary sector?
- What model for clinical teaching was adopted initially?
- What was the rationale for adopting that particular model?

From these guiding questions, a wealth of detailed data emerged which will be explored in later chapters. In order to provide some cross checking of interview data, as well as enhance the overall component of the study, a limited exploration of historical documentation relevant to the period of time under investigation was undertaken. Accessing information from a range of sources, assisted with achieving validity of the findings of this phase. According to Brink (1991) verifying what is discovered from one source with one or more other sources, assists with ensuring that the conclusions drawn are valid. Using this approach, individual interview findings were checked against other interviews as well as documentary evidence for consistency. Information was sourced from a range of areas including:

- Conference proceedings exploring the transfer of nurse education to the higher education sector,
- Minutes of Victorian Nursing Council meetings,
- Government reports and other publications incorporating issues relating to the transfer of nurse education sector,
- Journal articles from around the time of the transfer.

### Phase Two: Exploring the contemporary context of clinical teaching

The second phase of the study was designed to investigate factors influencing clinical teaching within the current climate in Victoria. In-depth interviews were the chosen method for obtaining data for this phase of the study. From the literature review it became evident that there were different issues emerging in relation to the different models for clinical teaching. For this reason, it was decided that data collection needed to include perspectives from the three main models of clinical teaching used within Victoria, that is, sessional clinical teacher, clinical teaching associate and preceptor. This facilitated the identification and understanding of factors that might have been specific to a particular model.

As with the phase one interviews, a series of guiding questions were formulated to direct the discussions in the interview without providing a strict interview schedule. The following questions provided the necessary direction:

- How would you describe your role as a (sessional clinical teacher/clinical teaching associate/preceptor)?
- Can you describe the teaching component of your role?
- Are there other key components of your role that you are able to identify and describe?
- A number of factors may influence the way in which you execute your role. Can you describe the factors that you perceive influence your clinical teaching role?
- What difficulties do you experience in carrying out your clinical teaching role?
- Do you perceive any means for minimising the difficulties you have identified?

## *5.3 Criteria for inclusion and recruitment of participants*

As a consequence of the two distinct phases of this study, the criteria of eligibility for inclusion, and the methods employed to recruit suitable participants were different. These will be summarised according to the relevant phase.

### Phase One

Phase one of the study sought historical information about the factors impacting on the development of initial clinical teaching models following the transfer of nurse education into the higher education sector within Victoria. In order to obtain this information it was decided to recruit individuals who were nursing education leaders at the time of the transfer, that is, were involved with undergraduate nurse education through the transitional period. This ensured that participants had intimate knowledge of situations leading up to the transfer, and those evolving following the transfer. It was

acknowledged that within the State of Victoria that there were a limited number of people who met the criteria, and most of these people were now in retirement.

In order to limit the size of this phase of the study (the minor phase of the study), it was deemed that interviews with approximately three people would provide sufficient information, and this would be supplemented and validated by detailed documentation analysis. Three potential participants were identified through personal contacts, and contact made by telephone to invite participation in the study. Following telephone contact, a letter of invitation and Plain Language Statement (Appendix 2) outlining the study and their involvement should they agree to participate, were forwarded by mail. This was followed up soon after by telephone. All individuals approached agreed to participate. A mutually agreed time and place was established with each participant for interviews to be conducted.

## Phase Two

Phase two of the study sought information regarding contemporary contexts of clinical teaching in undergraduate nursing programs in Victoria. Given that various models of clinical teaching exist, it was determined to invite three groups of individuals to participate in this part of the study. This allowed for the consideration of multiple perspectives, or realities, to emerge. It was determined therefore, that potential participants would include three to five participants in each of the following groups:

- Registered nurses employed by universities as sessional clinical teachers for undergraduate nursing students.
- Registered nurses employed by health care institutions who are seconded to provide clinical teaching for undergraduate nursing students during clinical placements, and who return to their clinical nursing position following the placement (clinical teaching associates).
- Registered nurses who acted as preceptors for undergraduate nursing students.

Participation into this phase of the study was invited by advertisement within the Australian Nursing Journal. The researcher's work telephone number was provided as an initial point of contact for interested individuals. The advertisement resulted in four responses, two from metropolitan Melbourne, and two from rural Victoria. Of these, three individuals had worked as sessional clinical teachers for undergraduate nursing students, whilst the other had worked as a clinical teaching associate. All had been involved in clinical teaching for a number of years. Following the initial telephone contact being made by interested individuals, a letter of invitation and Plain Language Statement (Appendix 2) outlining the study and their involvement should they agree to participate, were forwarded by mail. This was followed up soon after by telephone. All individuals approached agreed to participate. With each person a mutually suitable time and place to conduct the interview was determined. Following these initial interviews, word of mouth led to more interest in the study, leading to nine individuals in total agreeing to participate.

## *5.4 Ethical considerations of the study*

A number of ethical issues were considered in undertaking this study, including addressing formal approval processes and ethical implications revolving around confidentiality, anonymity and informed consent for participants and the information they provided through the interviews. Ethical approval for the conduct of this study was sought and obtained from the Deakin University Ethics Committee.

Ethical considerations were recognised and incorporated into all stages of the research process. Kvale (1996) discussed how ethical issues exist within seven stages of the research process involving interviews, that is, during thematising, designing, interview situation, transcription, analysis, verification, and reporting. Subsequently, ethical issues were considered within each of the stages of the current study.

As with any study involving humans, confidentiality of participants and their information was an important consideration within this study. According to Kvale (1996) confidentiality in research "implies that private data identifying the subjects will not be reported" (p.114). Within the context of the interviews there was a potential for information to emerge which related to third parties such as educational institutions, or that was particularly controversial. In the reporting of findings of this study, a number of quotations made by individuals during interviews have been included verbatim. In order to protect the confidentiality of participants, psuedonyms were used for each participant. Participants were informed prior to their consent that the allocation of a pseudonym

would be used to protect their identity. Furthermore, where institutions, health or education, were named within interviews, these names were omitted in the reporting process.

Another important ethical consideration in research involving humans centres around obtaining informed consent from potential participants prior to commencing data collection. This involves informing potential participants about the overall purpose of the research, the main features of the design, and any possible risks and/or benefits from their participation in the study (Kvale 1996). Within this study, participants were well informed about the aims of the study and the types of information being sought. Each potential participant was provided with a Plain Language Statement specifically developed for each phase of the study. This provided details about the study and the expectations of the participant. Participation in the study was purely voluntary and individuals were free to withdraw from the study at any time. The Plain Language Statement was supplemented with verbal answers to questions or requests for more information. Individuals agreeing to participate in the study were then provided with a consent form indicating their willingness to participate in the study, prior to the commencement of the interview.

## *5.5 Data collection – Semi-Structured Interviews*

Semi-structured interviews were chosen as the data collection tool for both phases one and two of the study. In addition, phase one data was supplemented through the collection of documentary material around the transfer of nurse education into the higher

education sector. Semi-structured interviews provided a means for exploring each participant's perception of reality, by allowing for the discussion to develop in directions participants wanted to pursue. A schedule of topics or questions usually guides the interview, however, no fixed questions or order exists (Kvale, 1996; Minichello, Aroni, Timewell & Alexander, 1995). Morse and Field (1995) suggest that this approach to interviewing is appropriate where the interviewer is familiar with the types of questions to be asked but is unsure of what the responses will be.

## 5.6 Data analysis

Data analysis for this study occurred in two stages. Phase one interviews were transcribed by the researcher and interpreted, along with relevant documentation, with the following considerations guiding the analysis:

- Identification of discursive positions that impacted on the initial development of clinical teaching,
- Comparison of emerging discourses that impacted on the historical development of clinical teaching, including both dominant and marginal,
- Establishing the essential facts or 'truths' that emerged from both interviews and document analysis.

Phase two analysis examined the transcripts of interviews with current clinical teachers so the considerations guiding their analysis were a little different. The following guided phase two analysis:

- Identification of discursive positions that impact upon various clinical teaching in present contexts, both dominant and marginal discourses
- Comparison of discourses emerging from the different interviews
- Establishing essential facts or 'truths' that emerged from the interviews

## 5.7 Discourse analysis

The process of undertaking discourse analysis has been described in depth by a number of authors. According to Powers (2001), discourse analysis aims to interpret discourse by examining power relations within historically bound situations. Cheek (2000) expanded this describing the analysis of discourse as situating texts within "social, cultural, political and historical contexts" (p.43). In describing archaeology, Foucault spoke of historical discourse analysis as examining "discontinuities, ruptures, gaps, entirely new forms of positivity and of sudden redistribution" (1972, p.169). Consequently, in undertaking an historical discourse analysis, as in phase one of this study, analysing the historical conditions constituting change in dominant discourses was also significant. In addition, according to McHoul and Grace (1993), Foucault described three places related to discourse where discontinuity could occur. These are within the discourse itself, 'mutations' within the discourse as the discourse alters, and more broadly between two or more discourses.

Lupton (1992) discussed the existence of two main dimensions in which discourse analysis occurs, these being textual and contextual. The textual dimension centres around how discourses are structured, such as through language, grammar, use of

metaphors and topics. Contextual, on the other hand, is concerned with the social and other interactions surrounding the development of discourse such as political or cultural input.

There is no one set approach to undertaking a discourse analysis. Powers (2001) argued that the chosen approach depends upon emphasis placed by the researcher on the chosen methodology, as well as the nature of the discourse being investigated. Although prescriptive in nature, Powers provides some direction for undertaking discourse analysis through the development of objectives specific to the process:

- to document the historical conditions of the existence of the discourse in genealogy;
- to describe the socially constructed system of power/knowledge in a structural analysis; and
- to analyze the effects of the discourse within the web of social power relations in a power analytic.

(Powers, 2001, p. 54)

In order to interrogate the data and analyse emerging discourses within the current study, a number of questions were asked during the process of discourse analysis. These included:

Who is speaking and on behalf of who?

Who is silent?

Who is the subject of the particular discourse?

What contradictory positions are adopted by participants?

What power-knowledge relationships exist?

The development of the questions was informed by the philosophical approaches presented by Foucault. Furthermore, the ideas presented by other authors around the process of discourse analysis were incorporated to ensure the data was being appropriate interrogated, and that the conclusions drawn were consistent with the chosen methodology.

## *5.8 Issues of validity*

Issues surrounding validity in qualitative research have been debated over many years as social scientists offer little agreement about processes for maintaining rigor in such studies (Rubin, 2000). Tensions have been described as existing between notions of purist research and approaches that recognise pluralism, and between achieving rigor within qualitative approaches whilst remaining creative (Sandelowski, 1993; Whittemore, Chase & Mandle, 2001). Cresswell and Miller (2000) argue that choices made in regard to procedures for validity are influenced by both the researchers' lens and paradigm assumptions.

Various types of validity suitable for application in qualitative research have been postulated and many of these have informed validity of this study. Brink (1991) discussed approaches to validity for qualitative research. *Pragmatic validity*, she contested, involves using multiple data collection methods and procedures on the same content area to reduce constant error. Lather (1993) introduced four frames of validity applicable to poststructuralist, feminist study she described as “counter-practices of authority” (p.677), these being: *ironic validity*, *paralogical validity*, *rhizomatic validity* and *voluptuous validity*. Ironic validity, she argued, employs the use of simulacra referred to as “copies without originals” (from Baudrillard). Lather views science as tending toward attempts to create complete representations of the world, resisting partial and incomplete accounts that might present through the voices of participants and the “insufficiencies of language” (p.685). The second frame presented by Lather was referred to as “Lyotardian paralogy/neo-pragmatic validity” (p.678) or “paralogical validity” (p.686). This concept of validity “fosters differences and heterogeneity” (p.686). It allows for contradictions and tensions in daily practice. In doing so, it searches for areas of “instability” and allows multiplicities of language and experience to emerge.

The third frame of validity described by Lather (1993) was referred to as “Derridean rigour/rhizomatic validity” (p.680). Here, Lather applied the metaphor of rhizome, “systems with underground stems and aerial roots, whose fruits are tubers and bulbs” (p.680) reflecting the complexities of problems existing as multidimensional and multidirectional, and not occurring in linear formats. It takes a view that there are

multiple openings and networks that work against authoritative constraints, hence allowing for hidden discourses to be uncovered.

The final frame of validity described by Lather (1993) is that of “voluptuous validity/situated validity” (p.681). Within this frame, Lather argues that “authority then comes from engagement and self-reflectivity, not distanced ‘objectivity’ and the bugaboo of relativism is displaced” (p.682). This allows for a position allowing a researcher to directly engage within the research process rather than taking a neutral, objective position and encourages reflexivity. She suggests that in doing so, a text is created that is “bounded and unbounded, closed and open” (p.686).

The work of other authors, too, has served to further inform validity structures within this study. Johnson (1997) offered five forms of validity, which although are less theoretically informed than Lather’s work, offered some direction for maintaining rigour and validity. *Descriptive validity*, he described, involves the factual accuracy of researchers’ accounts. This, he argued, could be achieved through having a number of researchers involved in interpreting data. In the current study, this process involved the student researcher, main supervisor and associate supervisor. *Interpretive validity* refers to how accurately meaning is portrayed. He argues that interpretive validity requires that the “researcher get inside the heads of the participants, look through the participants’ eyes, and see and feel what they see and feel” (p.285) suggesting participant feedback or ‘member checking’ as being a useful strategy. *Theoretical validity*, he suggests, involves the “degree that a theoretical explanation developed from a research study fits the data

and, therefore, is credible and defensible" (p.286). Here, he suggests peer review as an appropriate method for testing theory and interpretations. The fourth form of validity described by Johnson is that of *internal validity*. This he describes as steps taken to identify and justify cause and effect relationships, suggesting triangulation of methods and data collection as assisting to achieve this. Finally, Johnson referred to *external validity* as important when seeking to generalise findings into other settings or groups of people. The findings of this current study were not considered to be generalisable to other groups, settings or even time periods so this aspect was not seen to be relevant.

With the many issues in mind, aspects surrounding validity were important for this current research. The following describes approaches undertaken to support the research validity and rigor whilst recognising the uniqueness, and relevance of the chosen methodological approach.

### 5.8.1 Representing participants

Initially the accuracy of data and representations were important. Easton, McComish and Greenberg (2000) identified three areas where problems could effect interview transcription: equipment failure, environmental hazards and transcription errors. In this study, interview transcription followed a path that worked to ensure both validity and reliability of transcripts, that is, transcripts provided a close reflection of the interview, including both the verbal and non-verbal aspects. To prevent equipment failure, tapes and recorders were checked prior to each interview. Whilst Easton et al. (2000) suggested setting up interviews to avoid interruptions, these did occur within some of

the interviews. It was important for the researcher to recap questions and where discussions were at in order to avoid disruptions to the flow of ideas.

Audio taped interviews were transcribed verbatim by the researcher and supplemented with field notes reflecting components of the interview that were not verbal, such as facial expressions and responses as recommended by Poland and Pederson (1998) and Poland (1995) and could only have been possible with the interviewer also being the researcher as recommended by Easton et al. (2000). This was done in recognition that transcripts may only partially represent what actually occurred (Sandelowski, 1994). Rose and Webb (1998) asserted that the use of field notes as providing supplementary data collection contribute to a study's methodological rigor.

Repeated listening to tapes alongside printed transcripts allowed for identification of interpolation and correcting of transcripts where necessary. Interpolation involves the intentional or unintentional alteration of words or grammar within a transcript (Mishler, 1991) potentially altering the intention of the interviewee. Furthermore, repeated listening to tapes allowed for better understanding and analysis of content, a process recommended by Seidman (1998). Areas of emphasis which had been missed or misrepresented were then able to be clarified providing closer representation of what occurred in the interviews (Wellard & McKenna, 2001).

In typing accounts of interviews, notation approaches were taken to ensure that transcripts were consistent and could be easily interpreted, however, no formal

convention was adopted. Within the chosen approach, speed of speech, pause length and body language was signified at the appropriate place within the transcript text.

### 5.8.2 Drawing conclusions

Strategies were employed to ensure that conclusions drawn from the interviews were accurately represented and reflected participants' intentions. Respondent validation, or member checking, has been suggested by a number of authors as a means for confirming credibility of narrative accounts (Cresswell & Miller, 2000; Sandelowski, 1993). According to Cresswell and Miller (2000), this serves to ensure that findings reflect participants' own realities. Summaries from each interview were developed that reflected my initial interpretations of what participants had said. These were then sent to participants who were asked to review the interpretations and provided validation and any additional comments. This approach was undertaken to provide participants with initial interpretations drawn from the data, rather than providing raw data in the form of transcripts. Providing summaries, rather than raw data, not only provided early interpretations to be provided to participants, but also recognised that participants may not accept elements of raw data such as observed non-verbal behaviours or intonation drawn from field notes (Long & Johnson, 2000) that would be present in transcripts. However, although it did not pose any issues in this study, it was also acknowledged that the process of the initial interview may have impacted on participants' original discussions and they may have since changed perspective, a criticism raised around respondent validation (Angen, 2000).

In addition to involving participants to assist validation of interpretations, peer review also played a large role throughout this study. Creswell and Miller (2000) described the role of a peer reviewer as adding credibility by providing support, challenging assumptions and asking difficult questions optimally over the entire course of a study. Throughout this entire study, I have been fortunate to have had close and regular meetings with my main supervisor who has provided all of those attributes described. For the latter stages, when most of the analysis occurred, I was fortunate to have had an associate supervisor who also provided these qualities. Consequently, I have been able to bounce my interpretations off them and have my ideas challenged and extended. This has added more to the overall validity of the findings.

Within the first phase of the study, triangulation methods were also used to assist with verifying interpretations and conclusions in creating an historical account of clinical education around the transfer of nursing into the higher education sector. Although triangulation approaches may vary (Long & Johnson, 2000; Miles and Huberman, 1994), they do allow for systems of interconnected data to be used to create a description of a particular entity (Holliday, 2002) from convergence of a number of data sources (Cresswell & Miller, 2000). In this phase of the study, data were drawn from a range of sources, that is, participant interviews, archival records, conference proceedings, government documentations and journal articles. As a result, those data drawn from written documentation were able to be verified with other sources, including interviews.

Systematic approaches to drawing conclusions also added to the validity within the study. Sandelowski (1995) asserted that premature closure of analysis is a serious methodological violation and described a process for proceeding with analysis which reflects that undertaken throughout this study. Within this study, the analysis was given extensive time and process. In preparing data, transcripts were created using audiotaped interview data and field notes which were then "proofed" along side the tapes from which they originated. Meticulous reading and re-reading of transcripts allowed for developing a feel for the data as a whole and allowed patterns and themes to emerge. Clustering (Miles & Huberman, 1994) then allowed for sorting of information into categories. Within some of the categories, metaphors (Miles & Huberman, 1994) were developed in later stages of analysis. These provided for more rich descriptions, and for understanding of, the phenomena being described.

### 5.8.3 Representing the chosen paradigm

Retaining focus on the chosen theoretical framework throughout the research process contributed to rigor in the study. Koch (1996) argues that "Rigour and legitimacy are tied to the way in which a research paradigm's ontology and epistemology inform the interpretive framework brought to the question" (p.178). Within this study, the work of Foucault was used to inform each stage. This included informing the ways in which literature were analysed and described, data collection methods chosen, development of interview questions, analysis and presentation of findings. From a Foucauldian perspective, data in each of these stages needed, therefore, to be viewed in the context of

where they were arising, and that the subjects were historically and culturally positioned (Ceci, Limacher & McLeod, 2002).

By adopting a postmodern perspective for this study, the existence of multiple realities was acknowledged. However, as purported by Pyett (2003) it was not sufficient merely to accept on face value what was said by participants. Rather, this needed to be subjected to detailed examination of aspects that had contributed to their views, that is, theoretical knowledge was applied to the historical and contextual nature of what was said to develop my interpretations.

### 5.8.4 Reflexivity

Reflexivity acknowledges that the researcher in qualitative research is a part of the environmental context and culture that is being studied (Altheide & Johnson, 1994) and does not seek to divide parts of them in understanding the whole situation (Rose & Webb, 1998). Cresswell and Miller (2000) argued that for purposes of validity, researchers have a responsibility to disclose the assumptions, personal beliefs and biases that they bring into a study, which will also serve to create trust in presented findings (Pyett, 2003). Whilst this is important, researchers should be undergoing continual self-critique recognising that it is unavoidable for personal interests to become incorporated into the study (Koch & Harrington, 1998). Throughout this study I have been open and conscious about the beliefs and assumptions that I brought into the study. My own background is closely linked to those of the participants having begun in academia as a sessional clinical teacher for three years, and then as a clinical coordinator in a

university school of nursing for eight years. Throughout that time I have developed many opinions and values in relation to undergraduate clinical education. In carrying out my analysis I remained respectful that interpretations drawn were done so according to what participants said and felt, even if my own views differed (Pyett, 2003). However, these interpretations were, I feel, enhanced because I was able to understand participants' experiences and what these meant to them. Overall, I feel that this enhanced understanding has reflected itself within the findings.

## *5.9 Conclusion*

This chapter has provided a description of methodology by which each of the two phases of this study progressed. It has provided an overview of the construction of the study and the key questions that were explored. Strategies and considerations employed for the recruitment of suitable participants and data collection have been described. In addition, issues surrounding data analysis have been discussed through the use of discourse analysis and the application of Foucauldian concepts. Strategies undertaken to ensure validity of data collection and analysis within the study have also been discussed at length. Finally, the chapter has also presented a range of potential ethical considerations raised within the course of the study and how these were addressed at various stages, including how validity of interview findings was ensured. The next chapter presents the findings from the first phase of the study.

# Chapter 6

## CHANGING TIMES IN AUSTRALIAN NURSE EDUCATION

Understanding factors that influenced the development of early clinical teaching approaches was considered important for understanding clinical teaching work in current contexts. Hence, phase one was conducted to provide foundational knowledge for the second, larger one. This chapter presents an interpretation of the transfer of nurse education to the tertiary education sector in Victoria that assisted in developing that knowledge. Employing genealogical perspectives of Foucault, recollections of the era were examined through the voices of three individuals, Amy, Patricia and Joan, who were nurse academics prior to, and/or following the transfer into the higher education sector. They all had experience around both hospital and higher education approaches to nurse education and were interviewed to uncover their interpretations of the time. Their contributions were extended through examination of historical documentation relating to the time of the move, predominantly from journal articles and reports from the period. An examination of discourses and power-knowledge relations existing immediately prior to, and following, the transfer of nurse education forms the basis of this chapter.

A fundamental component of the work of Foucault in reconstituting histories was described as the notion of discontinuity. Using this concept, the historian seeks to identify breaks in continuity, that is "the incidence of interruptions" (Foucault, 1972, p.4) rather than examining predefined periods of time as has been undertaken in

traditional historical research. Through applying Foucauldian approaches, the historian analyses discourses surrounding episodes of transformation, in order to represent history from multiple perspectives. The transfer of nurse education into the tertiary education sector in Australia represents such an episode of discontinuity, evidenced through the shift from hospital-based nurse training. Significantly, as the following discussion will indicate, shifts in dominant discourses were particularly evident around the time, along with alterations in power-knowledge relations.

## *6.1 Academic voices*

To enhance the quality of findings obtained during this phase, three individuals who had been nurse academics from around the period of the transfer of nurse education in Victoria were interviewed. These individuals were identified through personal contacts of the research supervisor and others, contacted personally and invited to share their recollections. The three participants were very open to discussing their experiences and gave freely and honestly during the interviews. Each participant provided a unique vantage point from which they viewed nurse education around the transfer and this directly influenced the way in which findings are presented in the chapter. The following describes these individuals and their distinctive individual standpoints.

**AMY**

Amy was the first person interviewed in this phase. Not being directly involved in the transfer, Amy had worked as a nursing supervisor in Australia and the United Kingdom. Soon after the transfer she moved to a college of advanced education to teach in an early

nursing program where students received their theory in the college and undertook clinical placements in hospitals. At the time, being an academic, Amy was also expected to go into clinical placements with students to provide their clinical teaching. She experienced the initial struggles in “sorting out” clinical teaching and spoke about how Australian schools of nursing looked towards the United States for guiding standards for clinical practicum. Amy took career leave around the time that sessional teaching models were beginning to emerge.

**PATRICIA**

Patricia was a nurse and a high school teacher who entered the sphere of nurse education in 1975, moving directly into a college of advanced education. Despite having no nurse education experience, Patricia had extensive experience in teaching in secondary schools in Victoria. She was employed to write a college-based curriculum for the particular institute employing her, and had some exposure to students on campus as a local hospital was using some teaching space there. Eventually, Patricia became involved in teaching into the program.

Patricia spoke passionately about her involvement as a nurse academic in the early transitional diploma-based nursing programs. She also discussed how she spent time in the United States studying educational models being used in nursing there at the time, and having meetings with renowned nurse educational theorists including Kramer and Infante. Her descriptions revealed significant insight into different teaching and learning approaches, and struggles in establishing nursing within the higher education sector.

**JOAN**

Joan provided a perspective different from those of Amy and Patricia. Unlike them, Joan had been directly involved in hospital-based nurse education for four years prior to her move to a pilot program within the higher education sector. Hence, she possessed an intimate understanding of the differences between hospital and college-based programs. This gave her a unique insight to discuss nurse education prior to, and during, the transfer to higher education. This situation is reflected in detailed descriptions and many quotes originating directly from Joan early in the discussion following this section. However, similarly to Amy and Patricia, Joan outlined the role of influences emerging from the United States in developing early diploma courses in Australia.

## *6.2 Hospital-based nurse training*

Nurse training courses began to be offered by individual hospitals in Victoria in the 1860s mainly as a means for "securing reliable staff, bound to serve the institution for a certain period" (Trembath & Hellier, 1987). Over time, individual curricula became regulated. However, up to the transfer of nurse education to the higher education sector, a range of dominant discourses impacted on the ways in which these courses for nurse "training" were delivered. These discourses were to become superseded by a range of different discourses after the transfer; however, all of the discourses were significant to the shaping of nurse education and training within the era of their existence. Foucault (1972) reaffirmed this concept describing the place of discourse as being "treated as and when it occurs" (p.25). His notion of struggle (Foucault, 1982) also becomes relevant

here in examining the changing power-knowledge relationships and the subsequent effects on the subject.

### 6.2.1 The dominance of medical discourses in nurse training

The presence of medical discourses assisted the shaping of traditional hospital nurse training courses. These programs focused primarily on illness models with heavy emphases on disease processes as medically centred knowledge was afforded privilege over nursing knowledge. The ways of thinking about nursing practice therefore, centred on illness, with medicine central to the overall delivery of health care. Within this curriculum context, wellness perspectives were virtually left out of nursing curricula; their importance not recognised until later. Doctors delivered significant components of theoretical content reinforcing illness contexts and teaching according to their own needs (Trembath & Hellier, 1987). Nurse educators in a hospital school of nursing were left largely to “topping up” the nursing aspects for presented disease processes as largely doctors within each hospital influenced the implementation of curricula. Consequently, doctors played influencing roles in the delivery of nurse education having substantial control over what nurses were exposed to and able to learn, and resulting in a “modified medical model” (McMillan & Dwyer, 1989) disciplining the learning of nursing students and normalising the development of registered nurses. Tensions emerged as senior nurses began to question this approach to nurse preparation within health care delivery at the time. Joan highlighted the increasingly limiting nature of this approach to nursing practice that was becoming outdated with growth in contemporary health care contexts such as community health:

Joan: *Much of the teaching, in fact all of it, was in an acute care setting so students were learning how to be involved in providing care within a sick role, rather than perhaps expanding their understandings of nursing beyond the hospital.*

The move towards tertiary based nursing education initiated a change in the roles that doctors would play in the development of nursing curricula. Nurses had decided that they needed to be instrumental in determining their own curriculum directions and to be responsible for presenting the content. The shift away from medically-oriented curricula obviously left doctors out of an area that had been largely driven by them so resistance to the move was to be expected. Discontinuity of power-knowledge relations saw nursing knowledge being afforded new privilege over that of medical knowledge. Resulting tensions were evident. McMillan and Dwyer (1989) discussed a letter submitted by the Royal Australian College of Surgeons to an Inquiry on Professional Nursing Issues in Nursing in 1987. In the letter, concern was expressed over the potential decreased quality of patient care, changes in theory taught to nurses that may adversely affect patients, fostering unreasonable professional expectations for nurses and breakdowns in nurse-doctor relationships as a result of transferring nurse education out of hospital environments. Clearly, resistance from nursing towards medical involvement in nurse education led to further resistance to the transfer by doctors. Doctors perceived that their knowledge was vital for the education of nurses. They had driven nursing curricula in the past and were subsequently to be eliminated from the process.

However, resistance from medical ranks to the move of nurse education into the tertiary education sector was not evidenced through the perspectives adopted by nurses and educationalists. In 1984 a Western Australian inquiry into nurse education, conducted by the Western Australian Post Secondary Education Commission, highlighted that patients had a right to be cared for by properly qualified staff, and that was not the case where students were allocated to provide direct care for patients (Pullman, 1984) as in hospital-based models. Certainly, this view conflicted with that of surgeons who believed that the quality of care provided to patients would decline with the shift.

### 6.2.2 Being an employee

The presence of workplace discourses shaped the early development of nurse training within hospital contexts. In hospital-based, apprentice-style nurse training programs the student was perceived by the hospital as an employee first and a student second (Dunlop, 1992). This "apprentice" model saw the student nurse as "both a servant of the hospital, devoting part of her time to the care of patients, for which she is paid; and a student, devoting part of her time to lectures, study, and other classroom activities" (Ramsay, 1970, p.91). The paid employment status of student nurses within the model served to reaffirm the primary responsibility of the student as worker rather than student, as Roberts (1981) suggested "the salaried nursing student (was) at the disposal of the hospital" (p.49). Subsequently, students' work was disciplined through financial remuneration, reaffirming the dominant position of work responsibilities over their own learning needs and potentiating tensions between being a student and an employee simultaneously.

Within hospital nursing training, discourses emerging from the workplace dominated as educational discourses were relegated to the margins in the process. Meeting labour force needs within hospitals, students assumed their allocated proportions of the patient workload and were required to provide the necessary care for these designated patients. Much of the teaching and learning that did occur took place in ward areas in "an unco-ordinated and inconsistent manner" (Bolton, 1981, p.35) and "opportunistic", being directed by what was taking place in the ward at the time (Reid, 1994). Often it was immediate senior students who taught the more junior students, not registered nurses (Bessant & Bessant, 1991). Meanwhile, relevant theoretical instruction often failed to precede clinical placement in a particular area resulting in students being ill-prepared to care for patients in that setting (Pullman, 1984).

Certainly, the terminology surrounding 'training' used during this time highlighted the apprentice nature of nurse education at the time where the focus was more on task-based, on-the-job training than being educationally directed. Joan further stressed the dearth in educational preparation for students within the model along with the task-based practice focus for the student nurse's learning:

Joan: *…the focus was really on what had to be done, what the student had to learn was a set of skills and approaches to various aspects of patient care, so there was little emphasis on understanding what and why and how to modify from the norm.*

Within this analysis, tensions were evident through the use of terminology around the shift of nurse education into the tertiary sector, "education" relating to formal education such as that occurring in higher education institutions and "training" being that which was delivered in a workplace context. An underlying assumption presented whereby training was predominantly seen to be practice based whilst education was more theoretically informed or focussed. Cheek (2000) described the notion of binary oppositions in the use of language, "whereby one term is always prior or dominant to the other which is secondary or subordinate" (p.58). More often references are made to 'education and training' than to 'training and education'. Here, it can be seen that the notion of education is afforded supremacy over training and perceived to have higher value. If education is seen to favour theoretical aspects, whilst training is perceived to involve predominantly practice, then ultimately the theoretical aspects of nurse education are afforded supremacy. Certainly, this ideal provided impetus for many groups within nursing to promote the transfer as nursing sought to be seen in a higher regard, but also the emergence of new tensions.

Tensions were evident in hospital based training which further suggested marginalisation of students' educational needs. Often junior nursing students undertaking hospital courses were poorly supervised in the clinical area (Pullman, 1984). Very often they would be given their direction from more senior students in ward settings. This reflected both traditional hierarchical influences within nursing "with an emphasis on obedience and conformity" (Place, 1985) as well as the minimalist level of educational support provided for learners. According to Russell (1990) the need for

clinical teaching support for learners was identified in the 1960s. The clinical teacher was a "trained nurse employed specifically to supervise and teach nurses in the clinical areas" (Russell, 1990, p.67). However, whilst some hospitals were fortunate enough to have a clinical teacher to provide support for learners, many did not. The result was that the Charge Nurse assumed most of the control for any learning processes and provided feedback and assessment for students amongst other roles, reflecting traditional authoritarian aspects of nursing, as highlighted by Joan:

Joan: *…the roles prior to the transfer were very much incorporated with the role of the charge nurse. She was the person who not only…functioned as the person in charge of the ward but also had a role in the teaching and education of nurses, and perhaps by default the role of the nurses more senior to the learning student was involved in handing on and teaching the practices to other nurses….*

From a Foucauldian perspective, this power-knowledge relationship imposed a disciplinary structure over students. According to Foucault (1977) hierarchical observation provides a means for surveillance as a controlling force, whilst normalising judgement uses both rewards and punishment for controlling purposes. Overall, little regard was given to students' learning needs or learning outcomes, more on their completion of work to be done, which was monitored through ongoing surveillance and supervision. Little attention was paid to students' needs to be able to apply classroom theory into clinical practice, rather attention focussed upon their completion of set tasks as Joan again discussed:

Joan: *…the focus was on a working ethic of completing some, so much of the work and tasks and students were allocated to various aspects of care according to their abilities to carry them out.*

However, the role of the charge nurse often also involved a final assessment of students' clinical performances during their time on the ward, where nurse educators from within schools of nursing had little control over clinical learning (Pittman, 1982). Foucault (1977) described the examination as "a normalizing gaze, a surveillance, that makes it possible to qualify, to classify and to punish" (p.184). Through utilisation of an assessment, the charge nurses' role also employed normalising judgement in the ability to pass or fail the student serving to promote conformity of students. Nursing students, therefore, had little control over their learning or their work (Bolton, 1981). Hospitals increasingly became sites for struggle between educational discourses relating to students' learning needs and hospitals' needs to provide for the care of their patients.

## *6.3 Moving towards tertiary based nurse preparation*

From the 1970s nurses around Australia began questioning the way in which students were being prepared for roles as registered nurses. Besides issues surrounding students' status, a number of dominant discourses, including professional, feminist and educational, influenced political action from various interested parties that subsequently led to a government inquiry being conducted into the provision of nurse education and training. The tension between workplace and educational discourses continued with the hospital-based system being considered rigid and oppressive in nature and not

supportive of students in learner roles. It was argued that clinical placements were not being suitably coordinated with classroom learning in a context where students were employed as labour often caring for acutely ill patients without the necessary educational preparation. Students were not encouraged to be innovative or question aspects of patient care (Sax, 1978).

The presence of economic discourses also was becoming evident as calculations suggested that college education was perceived to be cheaper than hospital training. As tertiary based nursing programs were evolving nationally, the federal government agreed to provide the funding for nurse education within the higher education sector (Lusk, Russell, Rodgers & Wilson-Barnett, 2001).

Furthermore, of particular relevance at the time was the shift towards increasing the social status of women. A change to nursing was seen to reflect political action toward this (Hart, 1985) as a positive move. At the time there was much impetus through increased activity by feminist interest groups seeking improved opportunities for women. According to Russell (1988), the women's liberation movement was seeking greater equality of opportunity for women in education and employment. In his written announcement that the transfer would occur, the then Prime Minister, R.J. Hawke reflected the gender pursuit that the transfer would lead to "a better trained and more responsive workforce, increased employment opportunities for qualified nursing personnel, increased education and vocational opportunities, particularly for women…" (Australian Nursing Federation, 1984, p.26).

In conjunction with feminist discourses, strong professional discourses assisted with the drive towards shifting nurse education. There was a perception by many nurses that the status of nursing needed improvement. It was felt that the poor perception of nursing within the wider community was leading to difficulties in recruiting and retaining nurses (Russell, 1988). According to Francis and Humphreys (1999) it was not only about increasing the status of nursing, but ensuring that nurses were being prepared at a level commensurate with that of other health professionals, a notion that has been raised earlier by Duke (1975).

It was also argued that there was a need for a more flexible workforce that was better able to respond to the changing needs within the health care system, a point that has been highlighted previously in this chapter. According to one academic interviewed within the current study, the shift was needed to improve the skill and understanding of nurses in a changing health care environment.

Joan: *Certainly in the eighties and nineties there was a real increase in technology and nurses had to become more skilled in handling that technology and with it we saw more patients who were more acutely ill that required, therefore a lot more…understanding on the part of students and obviously registered nurses as to how to deliver care.*

Certainly discourses surrounding the growth in medical technology were impacting upon many areas of health care and this also existed within evolving nursing practice. Rapid

growth in available technology to support health care delivery demanded the acquisition of new skills for nurses in an increasingly complex health care environment that hospital-based programs could not offer. Different types of knowledge were needed and at a greater depth (Russell, 1988). Industry groups from within nursing recognised the need for a change to the ways in which students were being prepared for their roles as registered nurses primarily driven by discourses of professionalism. A conference examining nurse education held in the Australian Capital Territory in 1975 emphasised that change to nursing education was needed as it was falling behind that of other professions. Existing training systems were providing poor correlation between theory and practice, hospital-based courses placed an 'over-emphasis' on hospital contexts of care, and needs in relation to the general public and nursing practice had changed (Duke, 1975). According to Hamilton (1990) the federal government perceived that the move would provide "a more appropriately educated, flexible and career oriented registered nurse….able to meet the current and future nursing needs of the Australian community" (p.1).

Overall, a number of factors were seen to have worked towards influencing the transfer. However, the pressure for change may have only represented the positions of vocal segments of the nursing community. Herdman (1995) suggested that nurse leaders believed the transfer of nurse education to tertiary institutions would provide "improved status and autonomy, and that it has improved the standard of care" (p.71). Furthermore, Herdman asserted that practising (bedside) nurses may have had different views and

been marginalised in the process with their voices being left unheard. An absence of literature representing these individuals strongly supports this proposition.

## 6.4 Entering new territories

A number of pilot programs for the preparation of registered nurses were established in Colleges of Advanced Education[2] across Australia, and from 1974 to 1978 six pilot courses existed nationally (Sax, 1978). The first pilot program in Victoria commenced at the College of Nursing, Australia in 1974 following State Government approval in August 1973 (Victorian Nursing Council, 1973a). The pilot program was a Diploma of Nursing course with an initial intake totalling eighteen students (Donaghue, 1975). The program was tightly regulated and prescribed by the Victorian Nursing Council, such had been the role of the council in overseeing the many hospital-based training programs around the State. Approval from the Victorian Nursing Council included assurances to be made by the College of Nursing, Australia that clinical experience included at least ninety percent of areas prescribed by the Nurses (General Nursing) Regulations 1972. In addition, clinical experience was to be closely supervised and evaluated by faculty staff and that it remained closely related to theoretical classroom learning. Finally, clinical experience would be gained at agencies that were affiliated with the College of Nursing, Australia and under arrangements that had been approved by the Victorian Nursing Council (Victorian Nursing Council, 1973).

[2] In 1989 the Federal Government unified higher education. In this process, Colleges of Advanced Education either became universities or were amalgamated into existing universities (Smith, 1999).

Many other Colleges of Advanced Education quickly began to follow the move by the College of Nursing, Australia seeking approval for tertiary education programs for the preparation of registered nurses (Victorian Nursing Council, 1974a, 1974b, 1976a,1976b). In 1977 the Commonwealth Government announced the establishment of a committee to examine the education and training of nurses. In August 1978, the Committee of Inquiry into Nurse Education and Training released its final report, highlighting many concerns with the delivery of hospital-based nurse training programs and produced a number of recommendations for the future preparation of registered nurses. Within the report, discrepancies between classroom and clinical teaching were highlighted. It was noted that theoretical input was often unrelated to what students were experiencing in clinical areas, or alternatively that clinical areas to which students were being allocated were unrelated to areas of previous classroom learning. Furthermore, it was identified that in a number of hospital-based training programs, clinical instructors were not present, so students were given little assistance to apply classroom learning into clinical situations. In addition, the report concluded that students were underprepared for “strange and often traumatic situations” that they may encounter in clinical areas (Sax, 1978 p.42). However, it was not until 1984 that the Federal Government announced that it would support States with transferring nurse education from hospitals to tertiary education institutions, with the transfer to be complete by 1993. It was perceived that the system would be able to produce a registered nurse better equipped to meet existing and future needs of the Australian population (Department of Community Services and Health, 1990).

From the observations and concerns identified, the report made a number of recommendations for consideration in the future regarding the delivery of nurse education programs. Of note among the recommendations were a number involving strategies for improving learning in clinical situations. These included providing an increase in the clinical placements offered in community settings, with more balance between these and hospital placements. Placements needed to be more related to the students' educational requirements and less towards the personnel needs of clinical areas. It was identified by the Committee that students' clinical learning would be best managed by lecturers who would provide the clinical instruction whilst liaising with staff within the host agency (Sax, 1978). This heralded a positioning of educational discourses over practice, health care related discourses, and hence a discontinuity of supremacy of these discourses.

The move of nurse education into tertiary education settings saw dramatic changes to the ways in which theory and clinical experience were offered. Here, too, over the period of transition into the sector, a range of new dominant discourses emerged that further served to shape the development of the new academic discipline, and more specifically these discourses shaped the development of clinical education and its delivery.

## *6.5 Tertiary-based nurse education*

The disruption in nurse education during the transition from hospitals to colleges of advanced education saw a shift in the dominant discourses shaping its development. From an emphasis on workplace discourses, new discourses emerged including

academic and pedagogical discourses. As occurs with periods of disruption, the shifting of discourses resulted in a range of conflict emerging through changing power-knowledge relations.

### 6.5.1 Moving into academia

The move of nurse education into the tertiary sector exposed it to a range of new discourses emanating from within academia, especially workplace and academic discourses. For nurses who had made the move into academia, their roles began to be shaped by a range of demands from within the tertiary sector where, according to Speedy (1990), "unfamiliarity with functioning in a collegial, loosely-coupled system appeared to cause confusion" (p.39). Initially, nurse academics assumed responsibility for both the classroom teaching, and clinical teaching when students were undertaking placements within health care agencies. However, this occurred at the same time as the new academics were adjusting to other requirements expected generally of other academics in higher education settings, namely, research, scholarship and community service. Consequently, many academics found a workload that consisted of all components as unmanageable as they struggled to realise an appropriate and realistic workload level. Amy offered some insight into these early challenges.

Amy: *…it was just extraordinary expectations on the academic staff because you had to give lectures in the morning and sometimes students might have been on night duty so you were expected to be looking after students on night duty and then still be expected to give the lectures at nine o'clock in the morning.*

With the diversity of demands on academics working in the tertiary sector so difficult to manage, the responsibilities of clinical teaching were seen by many academics as needing to be removed from their workloads, reconstructing the approach from which they had come and had moved to work against. Contributing to this view was a perception from within the higher education sector, which placed lower value on clinical teaching than other academic pursuits, for the construction of new knowledge such as research and scholarship. This prompted many academics to see little personal value in undertaking clinical teaching. This compounded a perspective that placed low value on the delivery of clinical teaching resulting in it being seen to be largely hospital-based as in previous training courses, whilst others perceived it to be a lower status role and relegated it to the margins. However, Amy perceived that clinical teaching was valued at different times, depending upon other situations, so the perception at this time may not have been an enduring one.

Amy: *I think there's a pendulum somewhere that at some stages clinical is valued more than others and its not to say at the beginning it wasn't valued but we were trying to make some sort of sense of valuing theory as underpinning the clinical and I suspect in the early days it was probably a standalone…*

In line with the notion of marginalisation proposed by Hall, Stevens and Meleis (1994) clinical teaching became removed from the central core of nurse education, and relegated to the periphery. The perception of lower value of this teaching pursuit continued to add fuel to the underlying assumptions from within academic circles of

supremacy of theory over practice and relegated clinical teaching to sessional clinical teachers employed purely to supervise and teach students in clinical settings. Patricia highlighted the existence of an elitist perception held by some academics at the time that demonstrated the lower value that was placed upon the clinical components of the teaching and learning process, seen to be part of the old 'training' system.

Patricia: *Clinical teaching in the clinical area, particularly of a hospital, is not considered to be a high status job. So, consequently, it was worse then because people thought all their Christmas's had come at once. They'd got a job in a university, and they weren't going to be doing any of this stuff that demeaned them to be back to what they used to do when they were in hospital schools.*

However, not all nurse academics viewed clinical teaching as of lower importance than classroom teaching. Certainly, for many senior nurse academics there was sound reasoning behind academic staff undertaking the teaching of students in clinical environments. With new nursing curricula being developed and implemented, holistic approaches to nursing care emerged as dominant. Patients were being seen as clients who effectively were consumers of health and nursing care. Furthermore, no longer were patients viewed according to their particular illnesses, but more broadly, in terms of wellness and illness, and with physical, psychological, social and other needs that needed to be managed in achieving total patient care including the prevention of disease and health promotion (McMillan & Dwyer, 1989; Russell, 1988). This approach provided nursing with a dimension of care, divergent from traditional approaches offered through medical models of care, allowing nursing to establish its own unique

and professional approach to patient care management, a direction that had been supported by the Federal Government at the time (Hamilton, 1989). The emergence of the "Nursing Process" was seen as providing a concept-based framework to allow for describing nursing in a holistic approach (McCue, 1981). In order to facilitate a new way of thinking about nursing care planning, many nurse academics believed they needed to be at the clinical face to ensure students were able to apply theory to practice effectively and minimise the possibility of a theory-practice gap through constructing learning experiences to support that thinking.

Joan: *…we were also trying to develop a new model of care and therefore, it became important in doing so that we did it as thoroughly as we knew how. So, it was a practice for the classroom teacher who was also the clinical teacher to move out into the agency the day before the student was allocated to have the field experience and to personally select patients that she saw as meeting the students' learning needs.*

Joan clearly saw the need for classroom teachers to have some control over students' clinical learning experiences through preparation and selection of appropriate patients prior to students' arrival. However, the time constraints in managing such an approach were difficult for academic staff to maintain presenting conflict for the initial execution of tertiary-based curricula. Pressure on clinical teaching also emanated from within the health care sector through expectations that academic staff accompanying students on clinical placements be current with clinical practice in addition to possessing up-to-date underpinning theoretical knowledge. Amy discussed these tensions and introduced how

the emergence of a sessional clinical teacher became a means for managing the difficulties.

Amy: *I don't think it (clinical teaching) was necessarily an abdication by the academic staff per se. I think there was just other pressures there. And it may be from the hospital…that the hospital expected you to be a very skilled clinician as well and so you realised that you couldn't meet all the expectations of both organisations. So the simplest way was to create a role for a clinical supervisor or a clinical supervision role.*

### 6.5.2 The emergence of pedagogical discourses

The move to the tertiary education sector allowed nursing students to assume primarily student roles, rather than employee roles, for the first time. Being located within educational institutions provided scope for emphasis to be placed upon student learning processes and outcomes, and focussing primarily on the student as a learner. Joan described how understanding learning processes meant that teaching and learning approaches needed to be developed.

Joan: *…there is more understanding of learning, and it isn't a matter of just filling an empty vessel, that there are dual responsibilities and so forth.*

Educators were mindful that curricula in the higher education sector focussed around students' learning needs rather than the needs of health care institutions, "with the

pressures and contradictions of work in the hospital ward alleviated" (Francis & Humphreys, 1999, p.86) whilst providing better complementing of theory and practice:

Patricia: *...part of the aims that I saw of the tertiary education change was that they (students) learn, they practice something related to what they'd been learning.*

The need for students to be more involved in the learning process was also gaining momentum at this time. As McMillan and Dwyer (1989) outline, nurse educators at the time were strongly advocating for students to be more "self-directed in their approach to learning and that clinical experiences should be carefully selected to match the theoretical course content" (p.14). Much of this could be attributed to the evolution occurring within education as new pedagogical theories were emerging and educators across many disciplines were questioning the effectiveness of traditional teaching and learning approaches. The result was seen in the introduction of many pedagogical approaches that centred on the learner, not on the teacher as had been previously predominant.

The move towards new curricula that provided better congruence between theoretical and clinical learning was unknown territory for many nurse academics at the time. Some schools of nursing sought assistance from North American academics who had already developed this area, but new struggles emerged. Some of these schools tried to translate North American nursing models into local contexts regardless of particular local issues, with various degrees of success as Joan highlights:

Joan: *…they brought with them some ideas as well as tried to fit them as appropriately as possible to our social conditions and they were ways that were tried and true to some extent realising that health systems are not the same in any one country but I guess there was that prototype which served to provide some basis for how things were structured here.*

### 6.5.3 Wards as contexts for struggle

Following the transfer to the higher education sector, acceptance of new approaches to nurse education saw ward areas become sites of struggles as academic and clinical discourses intersected. A number of discourses identified earlier led to the development of issues for clinicians following the transfer of nurse education. Clinicians, whose voices had been relatively unheard during the transfer process, displayed evidence of struggle with the changes. Joan evidenced clinicians' cautious approaches through a need to protect patients from college students whose knowledge and abilities were poorly understood:

Joan: *…it wasn't always easy because of the difficulty in having everyone accept the fact that we had moved into a college situation. And I think there was a lot of anxiety as to whether it was the wisest thing to do and I think there was some protection of patients or seeming need to protect patients and I suppose protect themselves too.*

It was in clinical settings where academic and clinical aspects of nurse education confronted each other. The higher level of basic education being developed posed

difficulties for registered nurses trained in hospital-based programs. These issues were described by Joan as resulting in fear for their future careers. For her, there was a responsibility to ensure that nurses with both types of preparation were able to coexist and develop higher levels of patient care delivery.

Joan: *…there was a lot of anxiety that perhaps nurses unless they came through a college system would not be… respected or…would be denied lots of opportunities but it didn't work out that way…but there was a need to ensure that at the end of the day nurses who came through one system and the other were able to work with one another and…improve the quality of care.*

With the transition of nurse education, it was students who often felt the effects of resulting tensions arising in clinical areas. Not wanting to be seen as different within these tenuous environments students often sought ways to fit in to hospital settings. Joan related an example of students seeking to conform to existing hospital culture. Through dressing in traditional nursing student apparel, rather than proposed executive student dress, they perceived being able to socialise into the environment more successfully.

Joan: *…in one extraordinary situation where there was a choice to be made regarding uniforms [for students]…some of the teachers at the college were suggesting more executive type uniforms and the students just rejected that outright. They wanted long capes down to the ankles…they wanted to be pioneers…but they didn't want to be different that they were marked women or men.*

Struggles also existed for nurse graduates from higher education programs in being able to adapt to their clinical environments once they had become registered nurses. In a period of transition, it did take time for the new approach to nurse education to be readily accepted into nursing practice, with a main proportion of registered nursing staff at the time being from hospital-based nursing programs. Graduates, who had been educated in the higher education sector, often found that approaches to nursing that had been described and taught in the college classroom had not found their way into clinical practice. The struggle to adapt to more traditional nursing practice, according to Joan, led many to leave the profession prematurely.

Joan: *...they [graduates] saw themselves as working within a system which wouldn't allow them to practise as they had been taught and yet it wasn't feasible for them to behave in that way, and I think we lost a lot.*

### 6.5.4 Evolution of clinical teaching models

The evolution of early clinical teaching models was influenced by both academic and political factors. The changing role of the nurse teacher to a more academically focussed one meant that being in both classroom and clinical settings was difficult to maintain due to time factors and other role demands within the academic environment. This situation, as Patricia highlighted, meant that division between academic and clinical roles was necessary in order to do justice to each component.

Patricia: *...it was pretty amazing that...you were teaching in the classroom and then having to go into the clinical setting and you had to be in all places. You had to be everybody to everybody, and we broke that up.*

When nurse education had finally moved into the higher education it was a government objective to quickly increase student numbers within that sector. While some nurse academics had taught small numbers in early programs, and were able to monitor both classroom and clinical learning experiences, as student numbers grew it was recognised that adequate numbers of clinical placements needed to be accessed. The Victorian Nursing Council (1976d) maintained control over nurse preparations programs even within colleges of advanced education, stipulating a clinical teacher to student ratio of between 1:6 and 1:8 in clinical areas. The ratio was to be dependent upon experience of students and the nature of the clinical practice area. Subsequently, increasing student numbers meant that existing faculty could no longer supervise all students in clinical settings. Amy and Patricia both described how the need for employing sessional staff to supervise students emerged out of the growth in student population.

Amy: *...we had to start finding clinical places for them [students] then you couldn't have that one person trying to do every placement so...some of those things [employing sessional staff] occurred because an expansion of student numbers and with the transition the commitment of the government was for an expansion of numbers.*

Patricia: *We couldn't get enough people [to do clinical teaching]…we [one university] were at one stage taking 300 first year students…and it really meant that if you wanted to have a person go out with every ten of them you had to have sessional people.*

Employing sessional clinical teachers to supervise students' clinical learning experiences brought with it new challenges to be confronted. Due to economic factors becoming evident in maintaining clinical practicum, clinical teachers often had little preparation. This resulted in a lack of familiarity with the particular curriculum of the course students were enrolled in. This situation was vastly different than previously when academics themselves would provide clinical teaching. For Amy, this issue meant that sessional clinical teachers might not have the relationship with the curriculum that academics did which raised concerns within the academy.

Amy: *…we found that really when you have a clinical teacher who's not familiar with the curriculum then they teach what they think nurses need to know in the clinical and not necessarily according to principles… whilst you might say you want students to have a particular experience it's a bit more precarious…when you have someone who doesn't necessarily have the vested interest of the curriculum as a guiding principle to clinical.*

In establishing the nature of the new sessional clinical teacher role, it was quickly recognised that approaches to clinical teaching had become different than those that had

been instigated by nurse academics in clinical settings. As Amy highlighted, divisions between classroom learning via the curriculum and clinical learning experiences were feared. This culminated further in what Joan discussed as difference between the two models which meant that conceptually the sessional clinical teacher was more of a facilitator than a teacher in an academic sense.

Joan: *…we've changed where we see the clinical teachers role being different [from that of the first academic clinical teaching model]…she's a facilitator rather than one who was much more involved in a more didactic way.*

Economic discourses, too, influenced the ways in which clinical education evolved. It was quickly acknowledged that clinical education was a costly component in the delivery of nurse education. Predominantly, rationalist influences began to emerge in order to ensure expenditure by the college remained manageable. Joan discussed how eventually colleges sought to extend clinical teaching ratios, that is, have more students per clinical teacher to reduce clinical expenditure.

Joan: *…money certainly influenced clinical teaching ratios. It influenced the clinical hours the students would have and it influenced where they would have it too because some venues required less clinical support than others so it was shaped a lot by the reality, not only the realities but certainly economic issues.*

## 6.6 Conclusion

The move of nurse education into the higher education sector heralded a major shift. Throughout this chapter, discussion of a range of dominant discourses impacting on the shift towards tertiary education for the preparation of nurses has been presented. Within the hospital-based nursing programs, the student was seen as an employee with responsibilities to an employer. Curricula were driven largely by dominant medical discourses. A range of emerging discourses promoted a move for nurse education to higher education institutions. These included professional, feminist, education and technological discourses. Following the transfer new discourses emerged as dominant. These included academic and pedagogical discourses. Evidence suggests that in the early stages, clinical wards became sites of struggle as registered nurses and students adapted to the changes. New clinical teaching models emerged and economic discourses again played an important role. The findings from this part of the study highlight the multifactorial nature of nurse education evolution, and the multiple truths implied in seeking an understanding of it. The construction of this knowledge provided a context from which to move into the larger and more detailed part of this study.

# Chapter 7

# THE PARTICIPANTS

The previous chapter described factors that were influential around the transfer of nurse education into the higher sector, including the emergence of the sessional clinical teacher role. However, as highlighted through the literature review, other models for the provision of clinical teaching have since developed as a result of other factors. In the current context within Victoria, there are three main approaches used to organise clinical teaching in undergraduate nursing programs. These continue to include the sessional clinical teacher, along with clinical teaching associates and preceptors.

The second phase of the study sought to explore factors that influence current clinical teaching work. Individuals who offered to participate in this phase of the study provided unique insights into their experiences of clinical teaching. The participants came from a range of different clinical teaching environments including three different models of clinical teaching, as well as metropolitan and rural settings. This served to provide diversity in their responses and perspectives. There was also great diversity in the duration over which participants had been clinical teaching. I did not know any of them prior to our interviews, but they generously offered their knowledge and experiences for discussion, aspects at times that were sensitive in nature. The purpose of this chapter is to introduce the participants whose voices have been represented in phase two of the

study prior to discussing the findings from the interviews with them. Through interviews with each of them, the ways in which clinical teaching is constructed can be better understood than they may have been previously.

## MICHELLE

Michelle was a Registered Nurse in her late forties who regularly worked as a sessional clinical teacher. At the time of our meeting, she had ten years of experience in clinical teaching with undergraduate nursing students from university programs. Her original nursing qualification was gained through a hospital-based training program. Michelle's early clinical teaching experiences occurred for universities in metropolitan Melbourne. At the time of the interview, Michelle was undertaking clinical teaching for a rural university campus in Victoria on a sessional basis, which she had done for the past few years. Her current clinical teaching experience occurred most often with students in the first and second years of the Bachelor of Nursing course. Michelle did not possess a teaching qualification but had done a small amount of on campus teaching in the Bachelor of Nursing course. When no clinical teaching was available from the university, Michelle worked at a local private hospital where her clinical teaching also often occurred. She had also done some clinical teaching at an aged care facility located in the town. Michelle was keen to speak with me and she chose to meet with me in a quiet room at a local hotel in the town in which she lives. This provided a comfortable environment where Michelle was able to speak openly with me without having disruptions from the work environment or from her family.

**ANDREW**

Andrew was a Registered Nurse who also worked as a Sessional Clinical Teacher for Bachelor of Nursing students. His initial nurse education was undertaken through a hospital-based training program. At the time of the meeting, he undertook clinical teaching for a rural university campus in country Victoria, in a different town from Michelle. Andrew combined this with working at the local base hospital where his clinical teaching also occurred, and had done so for approximately five years. In his clinical role, Andrew was involved in staff development assisting new graduates, along with assisting with the management of his clinical unit.

At the time of our meeting Andrew did not possess formal teaching qualifications but had studied at tertiary level himself, having completed a nursing degree ten years ago. He also had been involved in some on campus tutorial and laboratory teaching into the Bachelor of Nursing course on a sessional basis. Having been in clinical teaching for a number of years, he brought a lot of experience and knowledge to our interview. Andrew welcomed me into his home for the interview. Whilst there were a few small distractions, Andrew spoke openly about his experiences and was eager to share these which revealed a great deal of frustration with the way in which clinical teaching was perceived by the university sector, along with his passion for ensuring optimal student learning opportunities.

**FAYE**

Faye was a senior Registered Nurse who worked at a large Melbourne metropolitan hospital and had done so for a number of years in a staff development role for the specialist unit in which she was employed. Within this role, Faye had acted as a Clinical Teaching Associate for many undergraduate nursing students who came from a range of different Bachelor of Nursing programs. Her work had involved her being seconded to teach them during their stays within the unit over a period of six years. To ensure that students were well supported in her unit, she also allocated them a buddy[3] to work closely on direct patient care. I met with Faye at her office in a university nursing school where she had been working in a teaching role with postgraduate nursing students. Faye was very well qualified within her clinical specialty and at the time was also herself currently undertaking doctoral studies in nursing. However, she did not possess any formal teaching qualifications. She was keen for me to explore her experiences which she described openly and in great detail.

**SARAH**

Sarah was a Registered Nurse and Midwife who undertook clinical teaching for two different universities as a Sessional Clinical Teacher. Her clinical teaching involved both undergraduate and postgraduate students, primarily in midwifery areas. Her teaching occurred in large metropolitan Melbourne hospitals. Sarah had received some limited preparation for clinical teaching through a five week clinical teaching short course

[3] The term 'buddy' is commonly used to describe a registered nurse who a student works alongside. Teaching is not considered part of a buddy's role but the domain of the clinical teacher who oversees the students' experience and learning.

offered by a hospital. However, she expressed that this provided an inadequate grounding for the role. She possessed postgraduate nursing qualifications but no formal teaching preparation.

Sarah was drawn to clinical teaching through a perception that it offered her a means to develop her minimal public speaking skills and she was also seeking flexible employment that provided her with regular working hours. When we met, she expressed her disillusionment with nursing in the health care sector. Sarah did clinical teaching for just over one year and when we met was no longer performing this role. However, she was keen to share her clinical teaching experiences with me. At the time of the interview, she was employed in community health nursing where opportunities for student clinical teaching were limited. Our interview took place in her office at the community centre where she was employed. This provided a quiet environment with minimal distractions and was comfortable for Sarah to be able to speak openly about her experiences.

**PAULA**

Paula was a Registered Nurse who worked in a specialist paediatric unit of a large metropolitan Melbourne teaching hospital. When we met, Paula's regular day-to-day role involved providing staff development for people working within that specialist unit, usually nursing staff. This function predominantly involved providing support for new nursing graduates working in the unit as well as coordinating clinical placements for postgraduate nursing students.

For a number of weeks each year, Paula was seconded away from her normal duties in the paediatric medical unit to function as a Clinical Teaching Associate for undergraduate nursing students undertaking clinical placements within the wards where she regularly worked. Hence, Paula's clinical teaching took place in an environment with which she was very familiar. At the time, she had worked in the unit for seven years but expressed feeling that she was only learning the clinical teaching side of the role. Even in a short period of time, Paula had experienced having to teach students from a number of different universities. This had consequently exposed her to a number of different undergraduate curricula and approaches to clinical education. Paula chose to meet with me in her office within the clinical unit. Unexpectedly given the nature of the unit, this provided a quiet location where Paula was comfortable in describing her experiences. Paula had undertaken her basic nursing education in a university environment but had not undertaken formal teaching preparation.

**ANN**

Ann was a Registered Nurse who also worked in a specialist clinical unit of a large metropolitan Melbourne teaching hospital. When we met, Ann's regular day-to-day role involved providing staff development for people working within that specialist unit, predominantly providing education and coordinating student placements. For a number of weeks each year, Ann was seconded away from her normal duties to function as a Clinical Teaching Associate for undergraduate nursing students undertaking clinical placements within the unit. Hence, Ann's clinical teaching also took place in a familiar

environment. At the time of our meeting, she had been doing this for a couple of years and had experienced teaching students from a number of different universities. This had consequently exposed Ann to a number of different undergraduate curricula. Ann invited me to meet with her in her office within the unit. There, she was able to openly discuss her experiences with me. Ann had undertaken her undergraduate nurse preparation in a university but had not undertaken any formal teaching preparation.

**JANE**

Jane was a Registered Nurse who worked in a surgical ward of a medium-sized metropolitan Melbourne public hospital. In that unit, she was a Clinical Nurse Specialist providing in-service education for staff members there. When I met Jane she was an experienced preceptor, having worked with a number of undergraduate nursing students from across all year levels and who originated from a variety of schools of nursing, as well as for new graduates early in their Graduate Nurse Program[4]. Her preceptor role took place in the ward on which she regularly worked so occurred in a familiar location. Jane was passionate about her clinical teaching role, enjoying the challenges presented and expressed finding herself regularly learning from the students she supported. She described appreciating those occasions when she had time to seek out learning opportunities for students with whom she worked. Jane had undertaken her initial nursing education at university, but had no formal teaching preparation. Jane and I met

[4] In Australia, the Graduate Nurse Program is a supported transition year following successful completion of a Bachelor of Nursing course. Graduates are employed by a health care agency during this year and provided with some further education by that agency.

in an office on the ward where she worked. Whilst there were a few distractions during our interview, Jane felt able to openly discuss her experiences in that place.

**CAROLINE**

Caroline was another Clinical Nurse Specialist who worked in a middle-sized Melbourne metropolitan public hospital on a busy surgical ward. She graduated from a university-based nursing course ten years prior to our meeting. Having worked interstate following graduation, she had only worked in her current clinical role for one year.

Caroline regularly acted as a preceptor for undergraduate nursing students in the unit where she worked. She expressed possessing a love of teaching, and wanting to be a teacher as a teenager but feeling that school teachers were poorly respected. Instead, she decided to become a nurse where she could be respected but still have a teaching role. Despite this, Caroline did not have a teaching qualification and indicated that she would not be seeking one either in the near future. During our interview, she was eager to talk about her passion for passing onto nursing students the knowledge she had acquired during her career. She expressed having feelings of frustration towards the lack of support she received in her role as a preceptor, especially directed towards the universities from where the students came.

**TRUDY**

When we met, Trudy had been a Registered Nurse for four years. She too, graduated from a university-based bachelor degree program but had received no formal teaching preparation. She was employed as a Clinical Nurse Specialist in a busy surgical ward of

a middle-sized metropolitan Melbourne hospital. In that role she organised the education program for staff within her ward. In addition to this, she regularly worked as a preceptor for undergraduate nursing students from a range of universities. At times she described experiencing frustrations with balancing patient care and a student simultaneously. Being relatively new out of university at the time of our meeting, Trudy discussed being very conscious of what nursing students experienced during their clinical placements, retaining an awareness of how university education was structured. She spoke of enjoying working with students and seeking out learning opportunities for them. In our discussion, Trudy talked about finding her role with students personally rewarding even though it could be extremely tiring to maintain.

# Chapter 8

# SOCIO-POLITICAL CONSTRUCTIONS OF CLINICAL TEACHING

Clinical environments are constantly challenging and changing. Experiences of clinical teachers and students depend on multiple factors within these settings. Through the interviews with clinical teachers in the second phase of this study, a number of factors emerged as central in the social construction of clinical teachers' work. Through the interviews with participants, discourses emerged that influenced the clinical teaching of undergraduate nursing students. Exploring these discourses revealed a range of existing tensions and power-knowledge relations illuminating the complexities inherent in the scope of clinical teaching work. This exploration exposed ways in which clinical teachers exercise normalising judgement as a means for disciplining the learning of students, and how other discourses disciplined them in the execution of their clinical activities. Participants talked openly in the interviews about their experiences, exhibiting willingness to help others learn more about clinical teaching from their experiences. It is acknowledged that within this chapter, only the voices of clinical teachers are heard, and therefore, only their perspectives are explored. The viewpoints of those who are not heard, such as students, patients, clinicians, and nurse academics, are not the focus of this study and their viewpoints may differ from what is presented here.

A range of discourses around the education of nursing students were identified as influential in the development of clinical teaching. In the discussions, academic approaches to nurse education were questioned by clinical teachers. The analysis of interview transcripts revealed that educational discourses were informed by not only the academic curriculum but also through the existence of "personal curricula" constructed, implemented and reinforced by clinical teachers themselves. The meeting of these in the context of clinical settings revealed the presence of tensions where both the formal and informal curricula come into play.

## *8.1 Educational discourses and impact of academic curricula*

Academic discourses play a central role in reproducing a predetermined type of nursing graduate. Preparatory courses are structured in their approach. Learning objectives guide students' learning around a particular topic area, and following a period of engagement with relevant content, learning is evaluated. Within university settings, this is a well disciplined process. However, in clinical settings other discourses impact on the execution of learning driven by university curricula.

### 8.1.1 Use of clinical learning objectives

Influences from within 'academic' curricula were acknowledged as important by participants in this study for providing direction for clinical teaching experiences for clinical teachers. This was evident through participants' acknowledgement that academic expectations by universities guided some of their teaching and learning. The setting of learning objectives by lecturers in the academy provided a means by which to

guide the direction of clinical placements for students. In setting learning objectives, nursing schools can have a direct impact on students' learning, normalising expectations of them and seeking for particular levels of performance to be achieved. In doing this, clinical objectives form one disciplinary technique normalising the development of nurses, and directing the work of clinical teachers. Whilst there may be variation between individual universities, clinical objectives were recognised by participants as providing an indication of what universities expected of their students during clinical placements. Sarah, in her role as a sessional clinical teacher, envisaged learning objectives as stating what students were expected to achieve during particular placements. She foresaw a need for her to help students to achieve them.

Sarah: *Basically looking at the objectives that the University sets out and hoping that the students meet them or at least are exposed to circumstances that they are supposed to be getting out of that clinical placement.* (SCT3, 9-11)

Clinical teachers understood universities expected them to ensure learning objectives were met. This can be seen as a disciplining of the clinical teacher, as well as disciplining student learning. However, the degree by which universities disciplined the work of clinical teachers did vary. From Paula's perspective, working as a clinical teaching associate for a number of different schools of nursing, the amount of direction provided varied significantly between universities. She highlighted her experience of one particularly structured university.

Paula: *Different unis [universities] do different things and I find one uni in particular is very structured about the way they do things, here's the objective and this is what we expect these students to achieve* (CTA2 431-433)

For some clinical teachers, learning objectives set by the schools of nursing provided a foundation for establishing the direction of student learning. However, often these objectives were supplemented by clinical teachers encouraging students to examine and develop students' own learning objectives for the placement, allowing clinical practice discourses to be covertly recognised within the structure. Paula suggested that whilst university objectives were important, students were encouraged to also have their own additional aims for the placement and work towards these.

Paula: *…we have guidelines as to what the students' objectives are and what they're to achieve throughout the rotation…We do work towards them and we sort of ask the students as well what they're aiming to achieve out of the rotation.* (CTA2 146-154)

Reflecting the variation between universities, it was acknowledged in the interviews that different universities also differed in their expectations of clinical teachers. Whilst some participants voiced preferences for being self-directed, there was a perception by some clinical teachers that there should be more direction from the university on what they were expected to do as clinical teachers, indicating a preference for increased academic discipline over their work. Ann described feeling unclear, and that at times she had received minimal direction from some universities.

Ann: *…there is the basic level that you get the guidelines generally from the unis, an idea of what their experiences, what their lectures are, some unis don't always provide that information.* (CTA3 23-26)

However, not all clinical teachers sought more direction and discipline. There was evidence of tensions between perceptions of being guided by academically-driven objectives and perceptions that these objectives were limiting within clinical environments where clinical nursing discourses were afforded privilege. This resulted in a need for participants to work beyond the scope of the pre-set objectives. Andrew described feeling 'stifled' by university-generated clinical objectives, revealing tensions in his acceptance of approaches to clinical learning that were being directed from within universities. He found the pre-set objectives limiting and indicated that his own personal expectations came into play.

Andrew: *…you can work around most things you've just got to be a little bit broader and look outside the big picture, and I just find the university's criteria is very stifling at times, what they want them to learn.* (SCT2 954-957)

Clinical teachers generally recognised the importance of academically directed learning objectives in influencing clinical learning experiences but also acknowledged limitations in them. Furthermore, there was evidence of tensions existing between clinical teachers' acceptance of some theoretically-based, academic approaches to teaching and learning used in nursing classrooms, such as problem-based learning. Andrew openly described

his resistance to the use of problem-based learning in nursing curricula and could not see its potential value for clinical learning. His perception that the university was not providing a 'good' theory reflected his resistance to such academic approaches and what he perceived as a lack of relevance to clinical nursing practice.

Andrew: *They're [the university] not giving them a good theory anyway, a good basis especially with problem based learning. It doesn't work, it just doesn't work properly. It might work in other areas but not in nursing.* (SCT2 437-439)

### 8.1.2 Assessing clinical performance

The requirement for clinical teachers to assess student performance in clinical settings emerged as creating tensions for some of the participants. Assessment processes revealed an interesting conflict between professional nursing and clinical nursing discourses. Power-knowledge relations were evident where language used in assessment documents was highlighted as difficult to understand, especially for clinicians undertaking clinical teaching. This language, such as that contained in the Australian Nursing Council Competencies for Registered Nurses, is used by universities for assessing student performance in clinical settings. A lack of familiarity with the language used suggested that professional language of the nursing regulators was not normally afforded value in clinical practice areas and not commonly used by nurses in clinical settings. Jane described experiencing difficulty with student clinical assessment. She suggested that the language in the assessment tools made assessment an aspect of her work which she did not look forward to doing.

Jane: *Its kind of hard actually those evaluations. They're a bit tricky, the words and that, you know the things that you've gotta try and meet…*

Lisa: I suppose it varies too from university to university does it?

Jane: *Yep. Those evaluation things are a bit [hesitates] you think oh no not that again.* (PRE2 180-191)

Language used in clinical assessment documentation was not the only concern of participants that emerged in relation to student assessment. From Foucault's (1977) perspective, examination involves observation through surveillance, along with normalising judgement. The examination of a nursing student's clinical performance usually occurs towards the end of a clinical placement. Whilst normalising criteria are provided by universities to direct clinical teachers in these assessments, the ramifications of having to fail students provided tensions for some of the participants in the study. Paula described difficulties for her in having to make a decision that a student was not performing at a satisfactory level.

Paula: *…you think if I make the incorrect judgement or I deem this person to be unsafe or performing unsatisfactorily then they're going to fail this clinical and are they really that bad that they need to fail or is it just my ten days of trying to get this person to get up and do something…*(CTA2 599-603)

Paula's statement highlighted how she questioned her own judgement when dealing with a poorly performing student. She doubted her own ability to decide whether the student

was really as poorly functioning as she had thought. The statement suggested the existence of tensions between what the universities expected their students to achieve during their allocated time in the placement, and those expectations held by Paula herself that may have developed around other criteria. Such tensions are dealt with in more detail later in this chapter.

### 8.1.3 "Topping up"

As has been described, criticism of academic influences such as 'out-of-date' nurse academics was evident through some of the interviews. Academic discourses came into direct conflict with clinical nursing discourses that were afforded privilege in clinical settings by the clinical teachers. Classroom learning was valued lower by some participants, than that which takes place in clinical settings. Similar to Andrew's resistance to problem-based learning, participants alluded to tensions between what was being taught in the university and what was needed for students to be able to practise in the "real world". Some clinical teachers identified that their work included being able to "top-up" classroom learning in order to facilitate a transition to practice where they perceived classroom learning had only been superficial.

Andrew: *...they [the students] all come out and their knowledge is really superficial, really superficial.* (SCT2 305-306)

Power-knowledge relations emerged as participants described perceptions that nurse academics were often teaching out-of-date material, on topics which clinical teachers where much better informed about. What these clinical teachers perceived as inadequate

teaching necessitated clinical teachers having to undertake extra teaching in order to ensure students were getting 'correct' information. Hence, for the clinical teachers there was privileging of their position actually being in clinical settings, over being in academic institutions, which placed them in a stronger position to understand clinical learning needs than academics could. Lack of perceived credibility then served to relegate academic nurses away from clinical domains and into teaching only theory. Andrew was critical of nurse academics and his perception of their lack of current clinical knowledge, as he spoke about academics from one university he worked for.

Andrew: *...none of them has practised, the nearest one is six years, another one is twelve years and I don't know the last time [name] practised. They've got no perception of what it's like to work in a hospital, you know, I find it utterly ridiculous that people teach nursing and they don't work in the field and haven't for many, many years. They say they read up on things, and ...their knowledge is right up-to-date.* (SCT2 267-273)

Sarah also perceived a lack of current clinical knowledge held by nurse academics. At times, this situation required her to update students' classroom knowledge. She explained the need for diplomacy in meeting students' learning deficits to limit any negative image of their university lecturers, whilst affording herself a more knowledgeable position in the clinical environment.

Sarah: *You have to explain an awful lot. Yeah, right back to basics. And then sometimes the lecturers might be a bit out of touch as well. So you need to then update their [the students'] knowledge that they have received…Cause obviously they respect their lecturers but they can see that they might have been out of the clinical area for 5 years or more and things do move along and change, and new things happen. It depends on how you word it. You don't say oh God, she doesn't know anything. You just say well things have moved along, there has been a new development or recent research has shown that we just don't do it this way…*(SCT3 49-58)

Sarah attributed the poor knowledge and lack of clinical credibility of university nursing lecturers as due to changes occurring in health care settings since the academics last practised in clinical nursing roles. Her attitudes revealed tensions towards academically-based teaching which served to reinforce the perception that a gap exists between theory and practice.

## *8.2 Teaching from "personal curricula"*

A prominent area that emerged through the interviews with this group of clinical teachers was the existence of "personal curricula" that strongly influenced their clinical teaching. These curricula were created by clinical teachers themselves around what they considered nursing students needed to be able to do and know within clinical environments, and resulting from their resistance to academic approaches. Overall, discourses informing the "personal curricula" were imbedded in clinical practice with their emphasis on "doing" and teaching centred on clinical nursing practice and practical skills development. The interviews with participants revealed a range of normalising

practices that were used to reproduce clinical nurses capable of functioning in accordance with hospitals' needs. This subsequently worked to reproduce nurses similar to those emanating from previous hospital-training programs.

Clinical nursing discourses were seen to have a central function in driving personal curricula. One important normalising practice within personal curricula was demonstrated by Andrew in "filling in gaps" between what students had been taught within the academic setting and what he perceived was needed for practice within clinical nursing environments. Andrew described his perception that teaching in the classroom was focussed on an 'ideal' world situation. However, he saw a need to prepare them for the different, 'real world' of the hospital environment.

Andrew: *…working in a hospital is a lot different to the university environment and we teach people to do everything so, almost sterile in university and you get out in the real world and it doesn't work like that.* (SCT2 153-156)

Andrew's position revealed resistance towards academic curricula and classroom teaching. It also demonstrated tensions between academic and clinical knowledge and practice, with the resulting power-knowledge relations affording clinical practice privilege over academic learning. In a show of resistance, he further suggested that there was teaching undertaken in the clinical area that was above and beyond what was expected by universities and which was hidden from the university. The content for this

component of his personal curriculum further demonstrated tensions between academic and clinical power-knowledge relations.

Andrew: *…we do quite a few things that we don't tell the university about because to the university out there everything is in this square box, and this student's coming out for a placement that's supposed to concentrate on just this one area and it doesn't work like that.* (SCT2 941-944)

### 8.2.1 Adding a clinical skills dimension

Exploring uncovered "personal curricula" revealed a perception held by participants that students needed to possess different clinical skills from those that they believed students brought from the academy. The discussions demonstrated how nursing discourses informed the work of participants through the enactment of these personal curricula. These skills included such things as time management, bedside manner and various clinical nursing practices. Little value was placed on, or recognition given to, those skills that students had acquired in academic settings, rather there was evidence of privileging particular skills that were perceived by clinical teachers as important.

Trudy: *All I know is that here's a person that's come to me… I've been university trained and I put myself in their shoes and I think here's a person that's come to me. I probably have to tell them everything… I speak to them and say to them if I'm telling you stuff you already know, or you've already done somewhere, someone's taught you, let me know …so that I'm not wasting time and making them feel like they know nothing; they've come from university and they don't know anything or whatever. But sometimes I feel I've got to start from scratch, you know, then I've got to teach them time management skills…sometimes I've got to teach basic bedside manner.* (PRE1 163-176)

Trudy's reflections indicated her feeling that she needed to teach students 'everything' for them to be able to function in clinical settings, managing through enacting her personal curriculum. Trudy valued particular clinical nursing skills that students could do, with little emphasis placed upon the knowledge that they also brought with them. Whilst certain skills, such as time management and bedside manner, cannot be effectively taught in academic settings she felt that she had to start from the beginning teaching students clinical skills she perceived they needed in the clinical setting. Through reinforcing normalised clinical nursing practices, Trudy sought to reproduce clinical nurses who would function according to the requirements of that particular hospital setting.

### 8.2.2 Using experience

The development of personal curricula uncovered in the interviews appeared to be influenced by a range of aspects. Some of these emerged from clinical teachers' own clinical practice experiences. These experiences could be drawn from their personal encounters as nursing students, as previously identified by Trudy, or from teaching and encounters with other nursing students. Clinical teachers' own personal experiences of teaching students in clinical settings were multifactorial, and often unstructured. Participants identified commonly that they learned clinical teaching 'on the job' and through watching how others executed their jobs which served to make the process of developing clinical teaching practice an ongoing, cyclical one, reinforcing particular behaviours and attitudes. Michelle expressed how time and learning on the job had directed the development of her clinical teaching practices, whilst for Faye it was experiencing a situation and using reflection that facilitated what underpinned her personal curriculum.

Michelle: *...the university has certain expectations but I've certainly got my own which have developed over time and with my experience. Just learning on the job virtually.* (SCT1 22-24)

Faye: *...if you've had experience of a certain type of thing before and that occurs again then obviously that's much easier and that is just learning as you go along, reflecting on what you've done in the past and that kind of thing.* (CTA1 336-340)

Ann's past experiences as a student strongly influenced her clinical teaching. From her perspective, it was being able to recall past clinical learning experiences that she viewed made her an effective clinical teacher. She saw her ability to recall how she was treated as a student as placing her in a more powerful position to 'understand' students than another clinical teacher who was unable to make similar connections. Again, clinical nursing discourses played a central role in how Ann was able to develop her role, rather than identifying the academy as having influence over her clinical teaching.

Ann: *I think a lot of those things [past experiences as a student] come back into my mind…I had some hairy experiences and you remember that…It had an impact and I hope I never forget those things because once you forget and don't be in touch anymore is when you look like a clinical teacher that's got no idea, like is up in the clouds and they just don't understand…*(CTA3 382-388)

### 8.2.3 Applying assumptions

Personal curricula adopted by clinical teachers were informed by many of their own imbedded assumptions, especially with expectations of what students could be expected to know and do at particular year levels of their courses. A number of clinical teachers identified students' year of study as important in guiding their clinical teaching and expectations of students' performance. In doing so, clinical teachers exercised normalising judgement over academic discourses to determine their expectations of what students should be able to do at first, second and third year levels and measured students according to their own predetermined criteria. Students could, therefore, be disciplined into meeting orderly stages of performance levels required, not necessarily by the

academy, but by the clinical teachers themselves. This resulted in reproduction of hospital nurses similar to those of the clinical teacher.

Jane: *Generally at the start you sort of have an idea [of what students need]. You know they're first year, second year, get a feel of what they need.* (PRE2 9-12)

Caroline: *I think it's a variety…it depends on who you get. If it's a first year its basic nursing skills* (PRE1 154-156)

Unfortunately for students, assumptions held by clinical teachers meant that those who did not meet the level assumed might be seen to be unsatisfactory, whilst those who were higher achieving may have their educational development thwarted. Such expectations may not necessarily fit with those from the university curricula, and hence academic discourses become marginalised in the process. The set criteria of what students are able to do at different year levels may be supplemented by the clinical teacher's personal experience of being a student further enhancing the application of personal curricula.

Trudy: *I guess like depending on the year level, like first year obviously you're showing them, second years you're probably getting them in there to do a little bit more, and guiding them and assisting them whereas third years I just try and let them do it.* (PRE3 61-65)

Some flexibility was applied to the criteria for performance at particular year levels based upon what students had been doing in previous clinical placements. However, this

extra consideration appeared to be clinically-informed, rather than acknowledgement of what academic teaching and learning had been undertaken prior, again indicating privileging of clinical experience over academic learning.

Ann: *But it depends where they…we recently had ones [students] that were first rotation, I mean third years but they hadn't been out for ages and its like oh you poor things and then they had psych placements after that and I thought oh great…so you expect a lot more but because they hadn't, you know, because it was all a bit nervous for them and they'd forgotten lots of things I suppose those expectations were a bit more flexible.* (CTA3 573-579)

Imbedded assumptions informed personal curricula in other ways as well. Notions of trying to produce particular types of nurses were created by the participants. They indicated this in relation to seeking to reproduce a graduate who could function effectively in clinical practice settings as a hospital-based nurse, hence reinforcing the higher value placed on clinical practice over knowledge. Clinical teachers saw their roles as being integral to ensuring the production of 'good nurses' with 'good skills'. The concept of 'good' nurses was constructed through placing value on nurses being able to perform clinical skills in acute care hospital settings. There was a notion that participants held privileged positions, above clinicians and academics, to know what was needed in order to assist students to this ideal position. Michelle suggested a need for her to ensure high standards, however, her revelations implied that these high standards were clinically-related, reinforced clinical practice elements, and not those that were bound in academic knowledge or other elements of professional nursing.

Michelle: *I really want to have good nurses for the future and I'm very passionate about having high standards and there are certain things I don't agree with in the hospital setting, things I don't agree with the academics either…I just work with them and this is all I can do at this moment is keep these students so that they enjoy nursing and that they have good, good basic skills and that they want to improve.* (SCT1 246-252)

Other types of personal experiences were used by clinical teachers to inform the development of personal curricula. Faye described how her work with new graduate nurses directly informed what she taught undergraduate nursing students. She was aware of particular clinical skills that new graduate nurses were expected to perform and that she found herself having to teach to graduates when they arrived in the ward for clinical rotations.

Faye: *I think as a combination of my experience and also working with GNPs [nurses undertaking the Graduate Nurse Program] and knowing what they lack or some experiences that maybe they have not been exposed to its partly that. Its certainly partly knowledge of our ends and even where they [the students] are at and what they need to know so it's a kind of combination of knowledge that I already know, and knowledge that I pick up from working with others at different levels and things that are just so blatantly obvious like everybody needs to know* (CTA1 980-986)

Faye's expectation of the skills and knowledge new nurse graduates required further added to normalising processes imposed by clinical teachers on students. By placing

graduate performance expectations on students, informed by graduate year expectations, allowed for disciplining and shaping individuals who may later enter the graduate nurse program in that particular hospital.

### 8.2.4 Illness-centredness

Teaching in the clinical context is complex and often informed by what is occurring within the practice environment at any particular time, rather than on what had been covered in the classroom. Medical discourses, which had been afforded privilege in hospital-based nurse education programs were identified as valued by participants in this study and played a role in how they undertook their clinical teaching. The classification of experience based upon exposure to a variety of medical conditions was described by Michelle as advantageous. This was presented without acknowledgement for achievement of generic competencies as was the goal of university-based nursing curricula. In taking medically-oriented, illness-based approaches, nursing discourses such as wellness and patient-centred care are relegated to secondary positions. Michelle's discussion suggested that exposing students to a variety of patients with different medical conditions was important for her and her own curriculum expectations. Such an approach supported the reproduction of a clinical nurse with a medically-centred, rather than nursing-centred, grounding.

Michelle: *…sometimes the students [in rural settings] might not get exposed to some conditions like [in] the big hospitals. I think…the advantage for the students [rural] is that they also work in a very mixed area…if I give you an example off the surgical ward, they have orthopaedics, they have general surgical, they have plastics, they have gynae…so they actually get a wide range and so the students could be working with five patients…and all those patients could be completely different.* (SCT1 905-913)

The focus for clinical teachers on patients' medical conditions was seen to present problems at times. An allocation of students to some clinical areas, such as rehabilitation, was perceived to be of lower value than acute clinical areas. Rather than focussing on nursing fundamentals, practice areas such as rehabilitation required the teacher to assist students to work and tease out medically-based, and 'meaningful', learning. This approach was highlighted by Andrew who in certain settings explored patients' past histories to drive students' learning experiences, rather than fundamentals of providing nursing care.

Andrew: *…some of my students have to go to the rehab [rehabilitation] ward. Well you're not going to see brain surgery over there! You're not going to get cardiac patients over there so you have to be able to turn [it] around. OK, you've got a patient that's had a fractured NOF (neck of femur) and they're here or rehab…We don't concentrate on that so much, we look at their past history and see what other illnesses they've had and we concentrate on them and use them as learning tools.* (SCT2 915-921).

One method by which clinical teachers focussed clinical learning was through the use of case-based scenarios centred on patients who students were assisting to care for. These scenarios were driven by particular medical diagnoses on which nursing care was formulated. Interestingly, this approach was not limited to one particular type of clinical teacher, rather it was evident across the three groups. Paula discussed how patient cases were used to stimulate student learning and her role in 'filling in gaps' that she perceived existed in students' knowledge, inferring an inadequacy of classroom preparation:

Paula: *[we] might have a patient that has a particular illness and so what I would do is ask them what they know about that illness and more often than not they don't know a great deal about it so I fill them in on the gaps of those things and what type of things we might need to be doing for them or why we are doing a particular thing or why we are giving this drug.* (CTA2 55-60)

## *8.3 Management and institutional discourses*

A range of management discourses also influenced how clinical teachers executed their work. In many cases personal curricula were supported by them. Such aspects included working to institutional policies and procedures, human resource management, managing material resources, and time management.

### 8.3.1 Discipline in the ward

Hospitals have a broad influence on clinical teachers' work. In this study, participants spoke of the need to abide by hospital policies and protocols when in health care agencies which served to discipline what they did within each individual setting. Whilst

these policies served to direct and normalise the practices of all people working in the hospital, they also had an influence over the practice of clinical teachers and consequently, exerted a direct influence on clinical teaching practice. In order to conform to the disciplinary norms within the hospital setting, clinical teachers also needed to apply normalising judgement to discipline the practice of students under their care. This occurred in a climate that could disregard students' previous learning and skills development where they brought differing practices and experiences acquired elsewhere.

Faye: *I certainly think that…making students aware that while they are in the clinical area they practice within the guidelines of that clinical area and that can sometimes be difficult if they have been taught in a different way… And its just a case of trying to explain to them the policies of the units that they are working in are there for reasons…So, although they are used to it from their policy of their university doing it one way that when they go into clinical areas they must respect what the policies of that clinical area are and to step outside the boundaries of that clinical area does not give them protection. They have to work within those policies as a student. And we do emphasise that as students they are…not legally responsible for what they do but they are morally… and therefore they should be working within guidelines.* (CTA1 124-149)

Policies allowed clinical venues to exercise normalising judgement on the practices of clinical teachers and students ensuring that procedures were undertaken similarly every time. This reproduced one set of accepted practices within each particular institution.

Michelle demonstrated how she used policies within her teaching hospital to directly influence what she taught and how she expected students to practice. There was no acknowledgement of what students had been taught in the university, further marginalising the place of classroom learning. Her approach to teaching assisted with reproducing a hospital nurse capable of practising according to the guidelines in that particular institution.

Michelle: *…[after] a couple of days, the drain tubes are ready to come out so I line up the student and I say, now these drain tubes will be coming out tomorrow…and I get them to get the policy manual and I say now this policy manual, I want you to find where it is in this policy manual because in 18 months time you're going to be a registered nurse and you have to abide by the policies of that institution.* (SCT1 130-138)

It was not only clinical nursing procedures that influenced clinical teaching. Philosophical and theological principles underpinning the way in which individual hospitals functioned also exerted an influence. Michelle discussed how the private hospital in which she taught was run by the Catholic Church. Little recognition was evident of students' own philosophical beliefs, and Michelle indicated a need for her to ensure that students had a sound understanding of those principles at play within the institution.

Michelle: *…because I'm in a catholic hospital, I have to abide by their policies of course. I let the students know where the policies are and the philosophies and the mission and all that sort of stuff, that's important. The students have to know that. It's a private hospital where I'm at, and that influences my practice also…resources in private hospitals are often limited as compared to the public sector.* (SCT1 426-432)

Michelle's discussion raised another issue. For her, there was a clear difference between practising in the public and private health care sectors. Resource availability was seen to be a factor limiting her ability to teach as she perceived that private hospitals were more conscious of expenditure on necessary resources, such as consumables, than public hospital settings. This, in turn, could impact upon how students were able to practise clinical skills that used such resources.

### 8.3.2 Human resource issues

A range of human resource issues emerged throughout the interviews that impacted on establishing support for clinical teaching. These issues revolved around day to day staffing issues impacting on clinical environments, as well as recruitment and retention issues. While teaching is expected to be part of registered nurses' roles, such expectation is difficult to implement when day to day staffing issues are already problematic. Sessional clinical teachers and clinical teaching associates in this study indicated they had a degree of dependence on ward staff to act as buddies for students and to support effective supervision. However, this dependence was highlighted as problematic with an

increasingly part-time and casual workforce, with increasing numbers of bank[5] and agency[6] staff being employed within health care settings. Michelle explained how in her rural town, this situation led to a lack of continuity for students and their learning, as they may not work with the same person for a number of days. As a consequence, the situation placed increased pressure on the small numbers of permanent ward staff members to continually work with students.

Michelle: *[In] country areas…we haven't got the full time nurses and so its absolutely impossible to get someone [a student] to work with the same nurse for the five days in a row 'cause [because] I want the students to do a roster all together…I get them to do mostly earlies [morning shifts] cause that's when most of the work's happening. Say they're working with a staff member that day, and that staff member's on the next day, I'll get them to buddy with that [person] …sometimes I will change, …[if] the students and the staff members don't get on or the staff member's having a rough trot [difficult period] for whatever reason or they've had a whole string of students.* (SCT1 531-543)

Clinical teachers expressed concern that non-permanent (casual) members of staff lacked familiarity with the particular ward environments and ways in which things might be done there. These nurses needed time for orienting themselves without having the added burden of being buddied with students. However, despite being an unsatisfactory situation, staffing constraints still required students to buddy with casual nurses. Trudy

[5] Bank nurses are casual employees employed by the hospital in which they undertake their employment.
[6] Agency nurses are casual employees employed by a nursing agency and sent to different hospitals as required for their employment.

described how shortages of registered nurses within her ward meant that there were often insufficient numbers of permanent staff for students to work alongside, resulting in them having to work with casual staff.

Trudy: *sometimes we have up to five students on a shift and…that gets difficult on the ward because we don't have enough staff to allocate to those students. We've got seven people on the floor, a couple of them could be Div 2s [Enrolled Nurses] so that whichever RNs [Registered Nurses] are there are going to have students whether they want it or not and sometimes they get doubled up with bank staff…people that we've never even seen before* (PRE3 613-620)

Casualisation of the nursing workforce was noted to produce other negative effects on clinical teaching. Casual employees may be unfamiliar with the actual clinical practice setting to which they are allocated. Michelle expressed concerns that these staff often experienced uncertainty regarding their own practice which may be problematic for student learning. She feared that students often perceived this uncertainty as being made to feel unwelcome or lacking clear direction from the registered nurse. This may lead them to feeling "lost" or abandoned.

Michelle: *…bank staff are often unsure of their own skills and they're unsure of where the students are at because they haven't worked with them very much so the students feel like lost and often the students will say oh she didn't even care, she didn't want me there or he didn't want me there.* (SCT1 781-784)

Continual demand on permanent ward staff members to buddy students was identified by participants as leading to an increasing reluctance by nurses to accept working with students. This reluctance was reportedly often related to the perceived tiresome nature of working with a student. At times, ward staff may actually be allocated larger patient workloads during times they were also allocated students, due to a perception that students are able to assume a portion of the load.

Michelle: *…staff members have actually refused 'I'm not working with students'. Because its exhaustive and it slows down their work. I'm very mindful sometimes the staff actually get more patients and so I've had to speak to unit managers about that and that's overstepping the bounds there. I have to say look these students are slowing down the staff especially the younger ones…* (SCT1 543-549)

Tensions presented between working with students in the ward environment and managing work demands. Preceptors in this study revealed difficulties in carrying out their various roles due to a lack of understanding or interest from ward colleagues of the additional workload associated with buddying students. They identified a lack of support from ward colleagues as an important issue. Frequently, also there was a perception within ward areas that students added to the staffing profile, providing an extra pair of hands to help cover the clinical workload. Trudy expressed concern that her ward colleagues lacked appreciation for the teaching aspect expected of her and the added responsibility of supervising a student in the clinical area.

Trudy: *Some people will just have the attitude she's right [alright], she's got someone to help her and they don't really understand that it is extra work for you to be doing it.* (PRE3 175-177)

Trudy: *Like everyone goes, yep, you can have it, you can have it. You deal with it. You know, but don't really realise that it is a lot of extra responsibility.* (PRE3 200-203)

Personal feelings attained privilege for many ward nurses over professional responsibility. Apart from the tiring nature of working with a student, Ann identified reluctance by some ward staff to act as buddies for students because of a perception that there should be some reward for their participation. She indicated that many registered nurses did not recognise their role in developing the nursing profession through teaching undergraduate students.

Ann: *…the staff sometimes make your life difficult because they don't want to be doubled with someone…because its tiring. I think the issue is it is tiring and they don't get anything for it, they don't get anything back. They think it is a burden.* (CTA3 638-641)

Recruitment and retention issues impacted on clinical teaching in other ways as well. Some participants identified that there was a potential through working with students to identify those who may be future employees of that particular clinical setting. Clinical placements provided opportunities to explore students' individual potentials and suitability to the individual clinical area. At the time of the study, recruitment and retention strategies were failing to fill all positions for new nurse graduates in Victoria

and there was competition to fill all available places in order to secure funding that followed. Through the 'gaze' of the clinical teacher, students became subjects under surveillance. For students who aspired to work in that institution, the presence of this gaze provided a disciplinary mechanism, ensuring normalisation of their practice to that promoted within the institution. Faye described how in her role as a clinical teaching associate she sought out potential future employees for her clinical area.

Faye: *…you get other students that you just know from day one that they're going to be…the ones that you want in the future…we send them down to the GNP [Graduate Nurse Program] office…if they apply, we think they should get a place. It doesn't necessarily mean to say that they will get a place but it just means that because they get a thousand people applying that if your name is down there then you are much more…likely to be successful.* (CTA1 806-819)

For Paula, whilst the intention was less deliberate, it was still indicated that she had particular expectations of third year students that provided evidence for later employment. These expectations served to provide a disciplinary mechanism for students who may be seeking graduate employment opportunities within the health network to conform to a level of practice acceptable within that setting.

Paula: *I like to put to the students too, particularly the third years that the way that you come across in these clinical rotations now will reflect on you getting a position next year.* (CTA2 637-639)

### 8.3.3 Coordinating loyalties

When clinicians undertake clinical teaching intermittently, there are ward responsibilities in addition to those expected by universities. Clinical teaching associates referred to issues in managing workload demands from ward staff whilst hosting students. For these clinical teachers, there were commonly demands by ward staff for teaching while students were present in the ward. Tensions existed between clinical expectations and academic learning requirements. At times these could be managed but presented challenges at others. Faye was regularly employed in a staff development role but taught undergraduate students when they were on placement in the unit. She was often able to address clinicians' needs, but also saw the need to place students' needs first, and thus strike a balance. She described tensions that she experienced as being employed by a health care network but simultaneously being responsible to the university when students were on placement with her.

Faye: *I suppose that it's a kind of two-edged sword because you are being paid by a university to look after their students and the position I'm in is that…I actually belonged to a [health care] network and therefore your loyalties are kind of with the network but at the same time during that two week period then you have to be seen as responsible to the university…that can be fairly difficult and it's a bit of ebb and flow being able to respond to your network but highlighting to people that during this two week period you are not actually available for anything other than…minor issues that can be sorted relatively easily.* (CTA1 75-86)

Paula described similar experiences in her role. She outlined difficulties in being able to decline ward staff requests for assistance, resulting in her workload being significantly increased. For her, tensions existed between being able to balance the demands of both groups despite being employed by the universities at these times.

Paula: *I guess the drawbacks are that during the two weeks of the rotations for the students, because I come from the wards as well I find that I am getting the ward staff asking for my time as well. They want questions and they want help with things so that drawback would be you really should be able to say no I'm not doing that at the moment but you can't so that is the only drawback. Your workload gets doubled.* (CTA2 188-193)

The nature of practice-centred teaching also had a potential to impact upon the ways in which some clinical teachers managed other work demands and exposed tensions between loyalties to a student and those to patients. For a preceptor working alongside a student, many regular, daily nursing care activities become teaching episodes. This approach further reinforced the value placed on 'doing' rather than 'knowing', the privileging of practice as well as the influence of patient care on teaching episodes. Trudy articulated how her regular patient care activities become teaching activities, altering the context of the nursing practice role.

Trudy: *You have to stop and think about it, explain every step of everything you do…you come in in the morning and you walk up to a bed, open the drug chart, check your care plan and you write down your plan for the day. You can't just do that [with a student]. You take them, you explain the patient, you explain their condition, you go through their meds [medications], you explain all about, you get them to do the care plan. …You have to sort of step back and…explain exactly what you are doing and why you are doing it…its just a matter of not being on autopilot. You have to stop yourself from being on that autopilot and just stop and explain everything that you do.* (PRE3 232-244)

Trudy described having to stop herself 'being on autopilot' when working alongside a student. The presence of a student altered the way in which her regular nursing role could be carried out. She perceived a need to explain everything done and encountered, bringing together both patient and student needs, along with educational and nursing discourses. However, these activities and the need for continual patient care influenced the type of teaching undertaken and also indirectly served to influence the enactment of her personal curriculum.

## 8.4 Conclusion

Teaching in clinical settings is influenced by many complex factors. Interviews with clinical teachers in the second phase of this study revealed a range of discourses, along with power-knowledge relationships, that served to socially construct clinical teaching, highlighting tensions and resistance existing at a variety of levels. The chapter has highlighted how clinical teachers worked within personal curricula, largely informed by

assumptions and created around their own experience and clinical practice, whilst acknowledging a role for academic curricula. Tensions between medical and nursing discourses in underpinning teaching also surfaced. The discussion has explored how clinical teachers used normalising judgement in ways that assisted with disciplining the learning of nursing students.

# Chapter 9

# IT'S A JUGGLING ACT!

Temporal constructions emerged as central factors influencing the work of clinical teachers in this study. Participants described both how they shaped time around their work and how time shaped their work practices. Specifically, participants spoke widely about a range of situations influenced by, or which influenced, time and time management in clinical teaching. Concepts such as equity, quality and continuity emerged as influencing clinical teachers' attempts to balance and juggle workloads. This occurred whilst they sought to maintain their sense of control and discipline over their work practices as well as to influence learning experiences for students. Hence, they used time as a means of providing discipline over students but time was also used as a disciplinary technique over the teachers themselves. This chapter reveals how time was used to by the clinical teachers interviewed as a means for shaping and disciplining clinical teaching, and accordingly how time was used to discipline their work. In doing so, the discussion reveals where tensions emerged as other factors limited their ability to illicit control over disciplinary time.

## *9.1 Seeking balance and equity*

Foucault (1977) suggested that "power is directly articulated onto time; it assures its control and guarantees its use" (p.160). Throughout the interviews participants described strategies that allowed them to discipline students and themselves through shaping of

clinical practicum time. They described their workloads in many ways, seeking balance to be achieved whilst maintaining a sense of equity. Concepts of balance and juggling time emerged as participants described how they sought to maintain control over temporal practices. Participants provided evidence of using time management as a means of imposing discipline over their own work practices. This may be, in part, a result of their experience as nurses in the first instance, where their own previous normalisation through ritualisation of tasks occurred through their daily nursing practice. In her study, Waterworth (2003) identified that nurses constantly employed temporal reference frameworks in managing their day to day workloads which supports this intimation.

### 9.1.1 Discourses of equality

Discourses of equality emerged as important in clinical teachers' management of time and students' learning. Participants reported a need to equitably divide their time into equal components for students so that each student could have an equal amount of time with the clinical teacher in direct teaching contexts. Participants viewed this as a necessary strategy as it was impossible to be with all allocated students at any one time. Yet through this strategy each student also became a disciplined, 'docile body'. The student could be subjected to a period of constant supervision, ensuring a focus on what clinical teachers wanted them to do, and hence eliminated any outside disturbance. This is a surveillance practice, which according to Foucault (1977) serves to maximise the quality use of time and ensure that subjects are normalised, in this case, students into nursing practice. For Paula, allowing students to have equal amounts of time with her

was important for equity reasons and for her to be able to monitor students' activities. The situation was compounded when she was responsible for students who were working across two different shifts, usually set up by the health care agency[7]. For her to work with each student, Paula would arrange her shift to cover part of each of the students' shift times. The use of shifts within nursing practice also disciplined students through determining when they were required to be present in ward settings. Finally, this strict time structure, structured how Paula, herself, functioned around those constraints.

Paula: *You are here for an eight hour shift and ideally you want to be able to spend time with both groups of students…I think its really important that both shifts get to have equal access…to their clinical teacher…. You might start at 10 am and go home at 6 o'clock so that you get to see both spectrums of them.* (CTA2, 351- 358)

Tensions between participants' abilities to manage and control clinical time and influences from within universities did emerge commonly with all participants and indicated a struggle to achieve a sense of control. There was a perception that a particular amount of time was necessary with each student to provide adequate supervision over clinical learning. Michelle expressed a perception of not having enough time to do her job "properly" with students which resulted in her not fulfilling her role effectively. She suggested that having less than eight students would allow her to increase surveillance and hence the discipline over which her allocated students were subjected in order to have greater control over their learning.

[7] Students worked across two different time period 7am-3pm, or 2pm-10pm.

Michelle: *I don't have enough time with the students. I've had eight students in a group for ages that is too many. You cannot do your job properly with eight students. I don't feel I can, that has always been an issue with me at the uni. (SCT1 759-763)*

Each clinical teacher allocated clinical teaching time differently and other factors within the environment often made conscious approaches to organising clinical placements very difficult to operationalise and created tensions. Andrew described his attempts to divide time equally in hour long segments for students. However, his ability to control these time periods had lessened in recent times as he received less paid hours from the university[8] and it became more difficult to evenly divide the day into time segments. Tensions between Andrew's attempts to be able to have equal surveillance time with each of his students, and as a consequence of economic discourses emanating from the university, were evident.

Andrew: *I try to spend roughly one hour a day with each student but the problem is (the university) has now cut our teaching hours, clinical teaching days. (SCT2 148-149)*

Tensions surfaced, too, between being able to manage time equitably and the impact of nursing discourses influencing tasks around patient care. For Ann, being able to divide her time equally was disrupted when students were difficult to contact, being involved

[8] The employing university had reduced the length of a clinical day from eight to seven hours so that Andrew was employed for less hours per week.

with many diversions both off and around the ward such as break times, medical rounds or other clinical procedures. She described how these limitations had an impact on planning her time and subsequently reduced her ability to maintain ongoing supervision of those students' activities.

Ann: *…generally you float between different areas, you try to at least, … you want to see every one of them [students] for a small amount of time but sometimes it is not applicable. They might be at tea or they might be .. doing a wash on a patient and you know it is not always appropriate to go in … but you hope then to make it a time at a later date to catch up, but that doesn't always work because you might get carried away with one other student. (CTA3 298-303)*

Contradictions also surfaced in the discussions surrounding the division of time. Participants argued the need to divide time equally across all students, yet they also an identified the need for individualisation, where a student needing extra attention could be given a concentrated amount of time with the clinical teacher.

Through continual subjection to disciplinary practices, the practice of the student as 'docile body' could be trained according to a normalised standard. This ensured that students could be maintained at an equal level of performance. Michelle contradicted her own discussion around providing equal segments of time relating that she would often spend extended periods of time with individual students, requiring adjustments to her set timetable. For her, longer time spent with a student was equated with quality time and knowing the students better. When interpreted from a Foucauldian standpoint, however, this is suggestive of a strategy for reworking time in order to ensure that a poorly

performing student could be brought to a normalised standard at which other students were performing. Concentrated time provided her with more opportunities to discipline such students through constantly subjecting them to her supervision and surveillance, minimising any potential distractions, and having the "body constantly applied to exercise" (Foucault, 1977, p.151) through continual involvement in nursing work.

Michelle: *I might spend two hours with one student. We might be doing a procedure…that gives me quality time with that student and that patient and I get to know the students much better. (SCT1 521-523)*

In seeking concentrated time with a student, Michelle indicated that she would negotiate with ward staff to take control over the care of a particular patient with a student during a day. Subsequently, the care of that patient was used in order to have a student continually supervised for an extended period of time. She described the care that would be provided over that time and through functioning as a role model, she would articulate normalised nursing practices for the student to emulate and reproduce.

Michelle: *I'll say to the staff, 'O.K. this student and I, we will…wash this patient and give this person their medication and do the pain relief and do the emotional side, the whole bit'. And we might spend two hours with that person, that patient, that resident or client. And… I'll tell the staff… 'if I want help I'll come and get you'. We will take a long time and I go through it very thoroughly with the student and I get in there and I actually wash the patient and then just role model (SCT1 95-101)*

A need to spend more concentrated time with some individual students revealed the existence of tensions for clinical teachers in their temporal practices. The need to spend additional time with one student, whilst ensuring that other students were receiving adequate attention, and hence keeping the process equitable, was difficult to balance at times. A perceived need for ongoing supervision and monitoring of all students was also seen to be necessary to ensure that each student remained disciplined and performing in a 'correct' manner. Faye raised the issue of managing a student with a clinical performance deficit and how she was able to rationalise the need to spend extra time with that one student to get them to a predetermined standard of performance. This provides an example of how time was used by participants as a means for achieving normalisation of student performance, in itself a disciplinary process. Faye expressed a need to seek a balance between getting the student to a satisfactory performance level whilst still monitoring the performance of the other students.

Faye: *… if you have a student with a problem and you're going to have to spend a lot more time with that student it means that the other students are going to get less of you… I rationalise that by saying that I am trying to get this person up to the standard that they need to be at and if the others are bobbing along … I'll just keep an eye on them … and so that can be really difficult and it can make you feel really, really kind of bad for other students who may need your time…and even though you are not spending a great deal of time with them you still kind of keep your finger on the pulse. (CTA1 344-362)*

Participants valued having equal time segments with each student in order to provide for equitable supervision of all students and their activities. Where one individual student required additional clinical teacher time, there was a perception of having to find ways in which to make up the lost time with other students. While this reinforced an ideal of equity, it also allowed participants to regain disciplinary control that may have been minimised during the time spent with the one student. One strategy clinical teachers used was to seek the assistance of ward staff to maintain a disciplinary environment over other students' activities, ensuring conformity to clinical nursing expectations. For Andrew, having to spend two entire days with one student experiencing difficulties served to discipline his own use of time. He expressed having to rely on ward staff to watch over the other students, but also a need to 'make up' with other students for the missed time with them. Power-knowledge relations in the form of being able to 'trust' students emerged as central to ongoing disciplinary control when the clinical teacher was absent.

*Andrew:* *…even just between myself and the students there's got to be trust because I can't be with them for the whole eight hours. I've gotta be able to trust them to do what I expect them to do and if you have a … you've just got to approach that … I had a woman last … I ended up spending two whole days just with her, now then I have to try and make it up to the other students in another way… but you know it was just so important that time was spent with this person to get them through otherwise there was going to be a lot of problems. (SCT2 822-832)*

Andrew described how needing to spend additional time with one student was necessary to avoid 'problems', that is, a student who did not fit the expected level of performance. Ann, in a similar situation, expressed feeling unhappy in having to spend extra time with one student and consequently having other students 'missing out' on her support. The student's needs worked to discipline Ann's own time allocation hence creating tensions with the way she had sought to initially allocate her time and ensure that all students received equal supervision and consequently, control. However unlike other participants, she did identify that often a balance existed where many other students required minimal support so that less time needed to be spent with them. Requiring less surveillance, these students had exhibited a desired level of practice and adherence to disciplinary controls, such as normalised practices and behaviours within the clinical setting.

Ann: *… with that particular girl that was not performing I spent heaps of time…you don't want to spend too much time [with her] … it might hinder her and make her feel uncomfortable but I can remember thinking …the other students would have missed out on my support which isn't fair but sometimes you've gotta weigh things up and you look at some students and think you don't even need me around, like they are just breezing through especially when they are in third year some of them (CTA3 311-319)*

## 9.2 Educational versus nursing discourses

In his discussions, Foucault (1977) described how the use of timetables is employed to discipline practice. He explained how these become used to establish rhythms, impose structures and regulate cycles where repetition could be promoted. In doing so, practices

became normalised and controlled. He identified that such practices were adopted in a range of occupational settings, including hospital and educational institutions. Participants in this study emphasised how the use of timetables allowed them to discipline students, and also how timetables worked to discipline their own clinical teaching practices.

Disciplinary time, according to Foucault (1977), involves organising learning time into segments and stages, with each having their own qualifying processes allowing students to progress onto the following stage. Informed by pedagogical theories, the use of timetables for the three years of nursing curricula in each school of nursing stipulates the times clinical practice occurs and disciplines the learning process. It is usual in Victorian schools of nursing for clinical placements to occur over one, two or four weeks. Each clinical placement has set learning objectives that discipline students into particular performance patterns and levels of achievement to develop a nurse of a particular type for that particular stage.

Whilst clinical learning objectives set by an individual university may be achievable in a particular clinical placement, tensions surfaced in the interviews as participants discussed limitations on their work imposed through academic curricula. These involved difficulties arising from short duration of clinical placements (imposed through curricula), such as one or two weeks, and participants' abilities to meet their own, not universities', requirements of students informed by nursing discourses (their own personal curricula). These tensions between what clinical teachers expected of students,

and what the university through the curriculum expected as outcomes, were revealed through references to time, its management and the constraints occurring as a result of time factors.

### 9.2.1 Not enough time!

Participants in the study spoke about durations of clinical placement time as limiting what they were able to achieve with students, and ultimately how they perceived students' abilities to consolidate clinical learning. They were critical of clinical placements with durations of either one or two week lengths. Their discussions continued to reflect on their use of "personal curricula", as discussed in the previous chapter, highlighting what they perceived was the purpose of clinical placements. These discussions revealed the dominance of clinical nursing discourses often being privileged over educational discourses.

Participants concurred that clinical placements were too short for achieving what they considered to be meaningful student outcomes. From a Foucauldian perspective, more time with students would allow clinical teachers to have greater surveillance and time to discipline students, normalising them according to their own expectations. Their focus on clinical nursing practice marginalised the place of academic curricula and the role of clinical learning objectives in guiding the direction of the placement. This led to participants resisting universities' attempts to guide students' learning and the direction of their clinical teaching work. On the other hand, clinical nursing skills and socialisation into the nursing workforce were privileged. Andrew perceived that the

clinical placement provided students with opportunities to get to know broader aspects of clinical work, for example hospital functioning, rather than providing discrete clinical learning experiences grounded in the academic curriculum that students were undertaking. He argued that students needed more time with him, hence meeting the needs of his personal curriculum rather than the needs of the university. Time limitations created tensions around his ability to enforce his personal curricula on students.

Andrew: *What would make clinical teaching better was if you had more time with the students definitely, like two week blocks just isn't enough, isn't enough. When they aren't used to the hospital it takes them two, three, four days to get used to the place and how it runs and all that and then they're gone six days later. They're just getting into the run of the place. They need more placements and that is one big thing they don't spend enough time in hospital …. (SCT2 998-1007)*

A need for sufficient time in which to impart aspects of personal curricula was reinforced as participants discussed clinical placement durations. Clinical placements of what were perceived as short in duration were not valued by participants being described as 'useless' and 'time wasting', despite having set learning objectives within the allocated time frames. Ann spoke about feeling frustrated during times when students entered her clinical area for a placement of one week's duration and that she was not required to assess their performance for that period. She indicated that to her the assessment was an important part of how she monitored and managed students' learning experiences and hence allowed her discipline and control over those processes.

Ann: *We've recently had groups come through for a week and it was a mess… They didn't have to be assessed on anything in that time it was just clinical placement, just being here I think… A week was just to me a waste, in a way it wasn't a waste of time but I think it was because I think the first day is a wasted day and the fact that they, not wasted for them I suppose but it feels like its wasted for us … and a little bit of orientation and support and giving some information, there goes one day and they have only got four left. (CTA3 56-72)*

Clinical teachers often develop close and dependent relationships with students. The resulting power-knowledge relations facilitate the use of disciplinary practices to reinforce particular student behaviours. However, the short time durations with students emerged as a factor that reduced the effectiveness of these relations and limited the establishment of disciplinary structures which act to normalise students' clinical practice toward the development of a particular type of nurse. Sarah highlighted how having students for a specific one week clinical placement created tensions. For her, one week placements were problematic in that there was little time to develop a rapport with students and this was necessary to development of what she called 'significant' relationships. Resulting from this was her lessened ability to discipline their development and ultimately, normalise their nursing practice according to her own needs.

Sarah: *I only had two groups of undergraduates for a week each so a couple of them did [have personal issues] but they weren't significant. I didn't have them long enough to know or build a rapport. I mean a week isn't a long time. (SCT3 335-338)*

Paula expressed similar feelings towards the lengths of students' clinical placements. From her perspective, students were only starting to feel comfortable after two weeks in the unit before returning to the university. This situation reduced her ability to discipline students into the practices and routines within her particular clinical unit.

Paula: *… you seem to spend that first week really working intensively with them and maybe the first two days of the second week doing that as well and by the Wednesday of the second week they're working really well, they are managing their patients and coming and going and feeling really comfortable and then two days later you send them away and you have another group coming through. (CTA2 711-716)*

For Michelle the lack of clinical placement time was manifested in a disregard for the academic curriculum and what students had learnt. She had an interest in what students did not know, or had not been taught within the university that she perceived as necessary to know for practice within the clinical setting in which she was teaching. For her, nursing discourses were privileged over educational ones and time was perceived to be a limitation for her imparting her personal curriculum informed by nursing discourses, while academic learning was relegated to the margins being considered less relevant.

Michelle: *…I do try and pick up what they’re [students] missing out at the uni. I say …have you covered X, Y and Z? I know our time’s limited here, I want to make sure you learn as much as you can. You’ve only got two weeks here you learn as much as you can.* (SCT1 724-728)

Academic discourses again emerged as conflicting with clinical nursing discourses as participants spoke about a need for greater continuity in placements for students. As well as discussing their need to spend longer periods of time with students, they perceived that too much academic time occurred between clinical placements, arguing students needed more clinical and less classroom time. Tensions surfaced in the discussions between how time could be effectively used to ensure continuity when other constraints meant that this was often unable to be achieved. Perceptions that longer and more consistent clinical placements were necessary were usually driven by clinical nursing discourses and a desire of participants to enact their personal curricula. Andrew referred to a need for students to become socialised into clinical nursing settings before ‘doing stuff’, emphasising the performance of clinical nursing tasks. His position marginalised academic expectations and suggested a privileging of clinical nursing over educational discourses.

Andrew: *…it gets very hard and two weeks isn’t enough time in a lot of ways. It would be great if you could have the students for four weeks because they need to acclimatise to the place for a start and get to know people and get their confidence up with people before they start jumping in and offering to do stuff. Whereas, only out for two weeks, they’re just getting to know the place and then they’re out of there. (SCT2 470-476)*

For Ann, too, the lack of what she considered to be a suitable amount of time between placements was an inhibitory factor in being able to promote student development in the clinical area. Again, her focus was on clinical nursing skills without acknowledgement of goals within each academic curriculum. She perceived that the situation resulted in her having to provide teaching in areas that had been covered previously. To ensure that students' practice conformed to ward routines and procedures she needed to resubject students to ways of carrying out basic nursing skills specific to where they were undertaking their placements.

Ann: *... its so hard cause they come in third year but they might be first rotation third year, they may not have had a placement for nearly six months, if they have had Chrissy [Christmas] break and all of that and they're just lost, so you've gotta bring them back to basics before you can even give them any, throw anything too heavy at them. (CTA3 554-560)*

Continuity of clinical learning experiences was also identified as being influenced by academic timetabling limitations. Here, tensions emerged with university students only being available on weekdays, but the nature of nursing making it a seven day per week profession. Being able to work with the same registered nurse for the duration of a clinical placement was seen by participants as providing continuity for learning. However, as Ann highlighted, being able to facilitate continuity of working with the

same person posed a problem because full time staff worked a mixture of shifts, including weekends whilst students did not[9].

Ann: *... with the rosters half the time there's the full time people are the ones that are around because the students don't work weekends (CTA3 652-655)*

Faye also recognised the tensions with students being available for clinical placements only on weekdays, yet registered nurses being available to work across seven days of the week. Having to manage the constraints, she had settled on a total of five or six shifts in a two week period, where the student worked with the one ward staff member as the best possibility for implementing a model of continuity.

Faye: *The only problem we have with preceptors is that it is very difficult…given the constraints of the university Monday to Friday studentship to have a preceptor who's with that student the whole time. I aim out of the nine shifts that they are normally on the ward to try and get a preceptor who will work with them five or six shifts. (CTA1 43-48)*

### 9.2.2 Time and Expectation setting

Clinical teachers in this study indicated using time as a means for measuring student performance and achievements over the course of clinical placements. It was indicated that some clinical teachers set performance expectations according to particular time

[9] Nursing students generally work morning or afternoon shifts on week days only so do not follow ward staff onto weekend shifts. This situation, however, is changing as students are beginning to work across all seven days in the week.

frames within a clinical placement. In a sense, this involved a perception of different stages within the duration of a clinical placement. As with strategies described earlier in this chapter, setting expectations throughout clinical placements serves to discipline student development towards a normalised set of criteria. Importantly, these criteria were not set by the university but from within clinical settings, or by clinical teachers themselves. Paula, for example, perceived that the numbers of patients being cared for by students indicated different levels of clinical development. She indicated having an expectation that students were expected to manage a four patient load by their second week of a placement. She outlined what criteria she expected to be met insofar as being able to manage those patients.

Paula: *I guess our [clinical agency staff] aim with those students [highly achieving on clinical] that do breeze through is that by the time they hit their second week they're managing a full patient load, they're able to manage four patients, their time, what needs to happen for those patients and instigating everything that needs to be done so what I say to them is you're responsible for these patients now and the nurse that you are working with, although is responsible as well, what I want you to be able to achieve is prioritizing care for those patients for the day so when something needs to be done you go to that nurse and say I need to do this now can you come and supervise me or you page me to come and do that for you rather than waiting for the nurse to come and see you about it. (CTA2 384-394)*

The concept of expecting particular levels of practice at different stages in a student's undergraduate course was explored in an earlier chapter. Each clinical teacher's personal curricula have influence over the construction of such expectations.

## 9.3 Balancing workload demands

For clinical teaching associates and preceptors, time demands bring conflict as they attempt to manage dual roles, that is, teaching undergraduate students and patient care or staff education responsibilities. As both groups undertake their teaching within their regular workplace, regular demands can interfere with temporary demands in finding quality or meaningful time to spend with students. Different employment discourses, therefore, emerged from within hospitals and universities. Resulting tensions surfaced when individuals were confronted by responsibilities to regular employers but having additional responsibilities to another temporary one. In her role as a clinical teaching associate, Faye highlighted that it was impossible for her to work with students for what she described as 'meaningful' lengths of time. Other workplace demands in her role meant that she had to depend on buddies who she allocated to work with students but not necessarily teach them. She described her role as merely checking up on students' progress on a daily basis. Daily checking provided Faye with some ability to supervise students, however, some of the disciplining of students was delegated to buddies but monitored by Faye.

Faye: *…to work with each one of them for any meaningful length of time is just impossible. So I tend to preceptor all my students and I check how they are going every day. (CTA1 15-17)*

### 9.3.1 Trading time

Not only do clinical teachers shape time to discipline students, they are also disciplined themselves by time. Clinical teaching associates and preceptors in the study employed a range of strategies to manage competing employment demands, and these facilitated achieving some balance through the trading of time. Where a clinical teacher assumed dual roles existing simultaneously, this concept of trading time was an important feature in overall workload control and managing the competing workforce discourses. Tensions were evident as participants discussed times when their responsibilities to two employers, hospitals and universities, occurred simultaneously. Despite being paid by the temporary employer for the duration of the clinical placement, the inability to divorce themselves from regular responsibilities was driven by the employee relationships with the permanent employer.

Strategies were discussed that involved using time that had been initially allocated to student teaching to do other, work related, activities as these arose, and then using work related time to pay back the time taken previously. This was an issue predominantly expressed by the three clinical teaching associates. Paula, who was new to clinical teaching described how, despite having demands relating to her regular employment, she had to prioritise student learning highest during the time that students were around. However, this resulted in marginalising the teaching and support needs of ward staff which she found difficult to reconcile. Paula further outlined that if there was available time after student teaching time, she then would then attempt to attend to some ward

staff related demands. In doing so, she privileged the needs of the university over those of the hospital, her usual employer, during clinical time.

Paula: *I mean I have ideas that yes this is what I need to do tomorrow and sometimes those tomorrow things get put to the next day and the next day and ultimately when you have students, the students tend to, they are your priority, you need to give all of your time to them and if you happen to have some spare time in that day then you can help the ward staff with whatever it is that they are asking you about. (CTA2 367-372)*

Tensions created by having competing responsibilities were also identified by Ann. She related having similar experiences as Paula, being expected to undertake staff development activities when students were on placement, a period when her time was actually being paid for by a university. She experienced struggles between the needs of her temporary employer (the university) concurrently with those of her regular, permanent employer (the hospital). Where she had been expected by the hospital to provide staff development, Ann saw a need to provide equivalent time back to students later, hence undertaking her own 'time trading'. However, Ann also highlighted that some student and ward staff teaching episodes could overlap, not being clearly owned by a particular group and these could be managed simultaneously.

Ann: *It's like ... I am going to be paid by the uni but I need to do an hour session here so I'm just gonna have to, in the hope that…l I will give back another hour to the students somewhere else. So with the staff though,… depending on what the question or what they want you to do you can often get around it generally. And it all just sort of blends in because you would be out on the ward supporting the students and often they [the students] can be involved in whatever the issue or discussion is too. (CTA2 415-423)*

Clinical teachers acting in dual roles developed strategies for managing competing employment demands over time. Having had greater experience than the other two clinical teaching associates, Faye had developed her own strategies for managing competing demands and that a need existed for trading-off different demands. From her perspective, as long as a balance was achieved, and the university got what she perceived as value for its money that was the main driving factor. The more dominant power-knowledge relations developed with her employer led to some student-related activities needing to occur outside of allocated clinical time in order to achieve that need for balance.

Faye: *…it's getting a balance. I mean I am not saying that if I'm the clinical teacher I don't do anything for my other job because obviously there are things that sometimes just need to hum along. But what I'm saying is that it is a balance and you balance out the work that you do with the students and the prior work and the post work because there is always documentation to fill in so you balance it all out so as you know that you are giving the University 100% value for money for the clinical teaching that you are doing for those students. (CTA1 779-786)*

Competing demands from students and ward staff could not always be managed easily and trading time was not always achievable. This resulted in further tensions and increases in workload for clinical teachers in the study. Paula described that she was often unable to deny or delay ward staff requests for assistance. She had previously developed power-knowledge relations with ward staff that had disciplined them to seek her out when a need arose, along with a regular responsibility to her employer to manage these requests. As a result, she found herself accommodating their requests even when responsible for students. This approach led to her increasing her overall workload as she sought to maintain her surveillance of both staff and students as well.

Paula: *I guess the drawbacks are that during the two weeks of the rotations for the students, because I come from the wards as well I find that I am getting the ward staff asking for my time as well. They want questions and they want help with things so that drawback would be you really should be able to say no I'm not doing that at the moment but you can't so that is the only drawback. Your workload gets doubled. (CTA2 188-193)*

### 9.3.2 Not being on autopilot

In some clinical teaching models, predominantly preceptor models, individuals found themselves responsible for both nursing care for allocated patients and teaching of students. For these clinical teachers, simultaneous patient care responsibilities and student teaching roles, meant balancing and management of time emerged as important issues. As employees of the particular health care institutions, these nurses were paid to

provide nursing care to their allocated patients and therefore had a direct responsibility to their employer, the hospital. Whilst being in a clinical teaching role, they were not removed from regular patient care responsibilities and continued to be paid by their regular employers, the hospitals. However, relationships between universities and hospitals meant that students were provided with clinical learning opportunities and also needed to be supported during clinical practicum. Whilst not receiving financial remuneration directly from the university, there was an expectation from the regular employer that students would be supervised and taught by ward staff, thus being an expectation of the employer.

In preceptor model situations, clinical nursing discourses directly confront educational discourses. Participants in the study, who were also preceptors, described tensions in managing the two different roles and revealed differences in how they sought to achieve outcomes that met both patients' and students' needs within their usual shift timeframes. Delivering patient care and being able to teach students simultaneously was raised as potentially difficult by Caroline in her role as a preceptor. She described experiences of being allocated patients who were sicker and therefore, more time-consuming to care for, requiring a range of nursing tasks, as well as a student who needed teaching. She emphasised the importance of strict time management in getting through the tasks required within her day. A need to provide both explanations to patients, and also to students, meant that time management became increasingly difficult to achieve over the course of a day. This further resulted in tensions for her as she perceived that ward

nursing management were focused only on those issues involving patient care outcomes, and not teaching and learning outcomes for students.

Caroline: *Sometimes… the person who’s allocating you an area sometimes thinks oh well you’ve got a really hard person [patient] who might need two [staff] and they might allocate you that really difficult patient, not a difficult patient but a patient who is time consuming and they say oh you’ve got two people so I’ll allocate you that. However, it really sets you back even more than if you were on your own because, um, you have to explain to that person. First of all you’ve got to explain to the patient what you’ll do then you’ve got to explain to the…student what you are doing and then it might take two attempts to do whatever you want to do and it becomes quite hard…and how you overcome that is,… you can allocate the student to do something while you’re attending a difficult task shall we say for that patient… So, that’s the way we are because your time management has to be spot on otherwise you just go way back. You lose the plot and that’s the end of the story. (PRE1 28-45)*

Pressures to fulfil two roles meant accommodating through restructuring workloads. Trudy, in her role as a preceptor, identified the need to manage time when maintaining a patient load with a student. For her it was trying to do more in a shorter amount of time that was important for ensuring that time management was effective.

Trudy: *But when you've had that really heavy load I mean, generally on a normal daily basis you go home you know, just completely stuffed and um, it wears you out a lot more mentally ..., more than anything but you have try and fit a lot more into a shorter amount of time as well. (PRE3 466-471)*

Trudy continued to describe difficulties in managing time whilst being responsible for a student and patient load expressing a need for 'juggling'. In recognising educational factors, she discussed how she allowed students to take the time that they need to successfully undertake procedures rather than rushing them through. This extended normal time management dramatically, initially privileging education over clinical nursing. However, she also spoke of her expectations that once learning episodes had been completed, that students would help her catch up with the lost time to manage her assigned patient workload, ensuring that patient care needs did not become uncontrollable or marginalised.

Trudy: *I find it very difficult especially with time management and things because I'm the sort of person that I will take two hours to do the drug round if that's how long it takes them to do, and I will get the MIMS for them, and not try and rush them through it and things like that. Um, but again dependent on the year level of the student I think, like by the time they've got to third year they're quite good with their personal hygiene and their obs and things like that so they can help you catch up. Um, but generally I try and focus on the bigger issues like if they, if they need to do a drug round then I'll take the time to do the drug round but then I'll sort of leave them and go and get all my showers done and my obs done and try and*

> *get everything done. If they need to do a dressing then maybe we'll do that once I've caught up with my time, but it is hard to juggle it. (PRE3 88-102)*

Having a student assist with maintaining normal time management, however, was not always possible for Trudy. Where there was a supervising clinical teacher also assuming responsibility for students' learning, she expressed frustration that at times she would work for an extended period of time with a student, and then the clinical teacher would take the student off somewhere else. This meant that she alone needed to regain control over the time management for her allocated patient load creating conflict between the educational and clinical practice roles.

Trudy: *you are juggling with a lot of things. You're trying to get your normal workload done as well as teach a student. You have, like sometimes you'll spend like two hours doing your medication round and then the clinical teacher will whisk them away to do something else and its sort of like you know, I just spent all that time. I need her to help me now to catch up. That's a big problem. (PRE3 151-153)*

Jane, also a preceptor, found that the degree to which her time management was effected was also dependent upon the particular student, so individuality emerged as an important factor. Her perception was that if students were having difficulties, they required more time, and that resulted in her time management being disrupted than if the student was managing well. Hence, for Jane, educational requirements were at times afforded privilege over her clinical nursing responsibilities.

Jane: *It depends upon the student. If their knowledge is really good you can get through a bit easier. If they're struggling you spend a lot more time teaching. (PRE2 21-23)*

Paula succinctly summarised the change in her work focus as a result of having to teach a student as well as maintain a normal patient load. She spoke of having to stop herself "being on autopilot" inferring that her regular clinical work was largely automatically undertaken whilst when a student was present, she needed to slow down the pace of her work, and provide ongoing education. The educational role directly impacted, therefore, on how she executed her regular, clinical nursing work.

Paula: *So, I think its just a matter of not being on autopilot. You have to stop yourself from being on that autopilot and just stop and explain everything that you do. (CTA2 242-244)*

## 9.5 Conclusion

Temporal references commonly appeared in the interviews with participants. These proved to be instrumental in guiding clinical teaching encounters. Participants commonly referred to time-related issues with managing their work loads and the ways in which time influenced their work loads. Concepts of balance, equity, continuity, quantity and quality emerged as the more significant influences on guiding clinical teaching and the use of time. Importantly, it has revealed the conflict between competing discourses, commonly educational and clinical nursing discourses, and how these impact

on time use and management. Overall, this chapter has allowed for illumination of an area of clinical teaching in nursing that has been largely unexplored previously, offering an enhanced understanding of influences on those roles.

# Chapter 10

# BUILDING RELATIONSHIPS

Clinical teachers interact with many different people in managing their hospital-based roles. Within the interviews, participants identified and discussed key complex relationships that were important for how they executed their clinical teaching. They spoke of relationships with students, agency (ward) staff, universities, patients and with other clinical teachers. The nature of relationships was multi-factorial and constructed at a number of different levels; however, these relationships were influenced largely by the clinical teacher adopting a maternal capacity towards students. This chapter explores how power-knowledge relations are enacted and shape different relationships fundamental to the clinical teaching role. It explores how participants position themselves within complex environments to facilitate learning experiences for students.

## *10.1 Maternal-child relationships*

Examining relationships described by participants between clinical teachers and students revealed the existence of deep and personal relationships, unlike teacher-student relationships experienced by students within university settings. These relationships, however, were very similar in nature to those seen between mothers and their children. Maternal discourses were revealed as participants discussed their practices of nurturing and protecting, supporting and motivating, guiding and disciplining students for whom they assumed responsibility in clinical settings.

### 10.1.1 Nurturing and protecting

In caring for their children, mothers seek to nurture and protect them from negative experiences and influences. Participants in this study spoke widely about how they both nurtured and protected nursing students during the course of their clinical placements. Nurturing was a very personal role component for the participants in this group. They spoke about how they 'mothered' students by being sensitive to their emotional and social wellbeing during clinical practicum and assisted them to deal with issues arising, as highlighted by Faye:

Faye: *I suppose saying being a mother is very sexist but being aware of the psychological and social aspects of being on clinical placements…and being there as a bit of sounding board for students about issues that might not have anything to do with the clinical placement.., so just.. being able to be there for them on a personal level but obviously not to such an extent that you know they're in your office the whole time but to an extent that they feel comfortable that if they've got an issue that they think's affecting them they will be able to kind of come to you with that.* (CTA1 542-550)

Personal nurturing for students emerged through the interviews on a range of levels. Participants recognised having a role to play in nurturing where students were living away from home during placements having need to seek out parental-type advice. This reinforced the development of dependency on clinical teachers and the construction of their roles as having a maternal component. Where students were away from home for

the duration of clinical placements, participants found themselves stepping in to assist them to deal with arising personal issues and this was not always limited within allocated clinical timeframes. With participants being similar ages to many students' own mothers, maternal-child relationships were further reinforced as students would take their personal issues readily to the clinical teacher as they might normally take to a parent at home. Students subsequently become positioned subordinately as children to the "knowing" adult.

Michelle: *They have a lot of issues just with their age and…sometimes they come to me, not that I encourage that but only if they wish, only cause they're 19 or 20 year olds and often being country they're living away from home. You know their parents might be off somewhere, they're sharing houses or living in the university accommodation and they have lots of issues. Some of them things like um, this is like personal, you know, they might not have slept the night before. You know, they might do a late early and they haven't slept because there's been a party or something like that, university accommodation you know that sort of thing. So that's personal, that, that's definitely a role of mine. I sometimes feel like I'm mother.* (SCT1 65-76)

Caroline: *…sometimes you end up…being sort of a mother or a sister to this person, especially if they're from overseas or interstate and I've had that before, … but you end up being a support person to this, to this person inside and out of work sometimes* (PRE1 257-267)

By assisting students to deal with personal issues in a way that a mother might, the maternal-child approach to the relationship was reinforced; hence the subordinate and dependent positioning of the student within the relationship could be maintained. As a result, relationships became normalised by each of the participants. Importantly, the perception of the clinical teacher as a 'mother' in this study was not limited to female participants. Andrew referred to his role as being maternal in ensuring that students were aware of the support services available to them in the clinical setting. This suggests that whilst the role is a gendered one, it can be assumed by males who support students in clinical settings, and could result from the gendered nature of the nursing role more generally.

Andrew: *…its [the students'] first time away from home, its quite easy to get caught up in the system… It's hard for them like that and they don't know that all the support services are there, um, when they first come there. So you, you do provide that sort of, motherly role… to them in a lot of ways*. (SCT2 680-685)

It was not only personal problems that participants suggested that students would take to them. Within the context of clinical teaching relationships, it emerged that students would also take their triumphs to clinical teachers as they might normally take home to their mothers. This could include skills performed for the first time or other positive experiences. The activity of referring such events to clinical teachers served to further reinforce maternal-child relationships experienced between teachers and students. Through the personal nurturing occurring within the relationship, students sought

positive affirmation and reinforcement of behaviours that conformed to clinical teachers' expectations hence having a disciplining effect as well.

Faye: *So although teaching's part of it and being a resource…it's also kind of being like a bit like a mum and ear to … even just to listen to them if they want to tell you something that is really exciting…I keep saying to them, you know, if you've learnt something that you think's really positive bring that as well you know.* (CTA1 560-567)

Protecting students from harm in a maternal way was also recognised by participants as important. Just as mothers would protect their young within new environments, they described needing to ensure that students were safe and comfortable within their clinical environments and were being cared for by ward staff. These clinical teachers saw a need within their roles to identify situations that may place students at risk and ensure that their safety was maintained. Inherently, teachers used their previous knowledge and experience to position themselves as knowledgeable about potential risks, that students themselves as juniors, may not be able to identify or defend themselves against. The need for ongoing liaison with staff was one means for approaching this as highlighted by Sarah:

Sarah: *A lot of it is liaising with the…staff as well as you know… helping them figure out what the student is there for and… to smooth over any sort of issues as well and to look at the students' safety.* (SCT3 19-21)

Protection also involved monitoring ward staff who were working with students indicating that clinical teachers themselves held a degree of control over clinicians too. In many instances participants expressed being able to elicit control over who could act as buddies for their students. They spoke of a need for ensuring that their young were working alongside individuals who would care for them when they as clinical teacher could not be around, similar to that as a mother would when leaving her child with a carer. They enacted this by ensuring that clinical nurses responsible for buddying with students understood at what stages students were in their development, enjoyed teaching within their roles, and were positive practitioners.

Faye: *…you have those people that you know they are just in tune with the students, they love teaching, they love teaching at a clinical level and they actually have an affinity with the students and so you try your best to make sure they are with those kinds of people who really encourage them.* (CTA1 318-322)

Paula: *…you choose them [buddies] because you get the people who put their hand up and say let me have the students, I love it and I think it's great and you know in the back of your mind, you love it but you're no good at it and you're not going to have students.* (CTA2 334-337)

### 10.1.2 Supporting and guiding

Throughout childhood, mothers provide support, motivation and encouragement for their children as they grow. Maternal discourses were uncovered within this study through participants' descriptions of how they employed practices to support, guide and

encourage students within clinical settings. These practices emerged in both physical and psychological aspects of relationships but could be differentiated from those more personal nurturing and protective practices described in the previous section.

Nursing students often enter clinical settings naïve to institutional practices and functions. Participants described their roles in terms of providing information for students that would serve to guide and support their time within the particular clinical agency. This often was practical 'survival' information and largely formulated through clinical teachers' own specific institutional understandings. A need to provide students with such information was seen by participants to make the clinical teacher's role easier to perform as a result. As indicated by Ann this approach performed more than one function.

Ann: *…and knowing… even down to the problems with car parking and when the bus runs and… if you get stranded you can just go to security and they'll drop you off at your car and things like that I think make it far more easier to do your job and to support them.* (CTA3 246-252)

Mothers, too, regularly provide information for their children that assists them to survive in their individual social environments. They also employ encouraging strategies to promote the development of independence throughout childhood on a continuum from total dependence gradually through to independence. Participants in this study spoke of approaches employed for encouraging students to optimise their learning experiences as

well as promoting the development of independence within a nursing role, and with expectations of students at different levels. The learning was controlled in a state which positioned principles of adult learning marginally, and further reinforced the subordinate positioning of students within these relationships.

Andrew: *They'll [the students] be standing back or do whatever so you've got to encourage them to be a little bit more forward and put themselves forward and ask for things* (SCT2 97-99)

Trudy: *…at the moment I'm trying to let them find their feet and let them do their own thing without me being over their shoulder all the time but I guess like depending on the year level, like first year obviously you're showing them, second years you're probably getting them in there to do it a little bit more, and guiding them and assisting them whereas third years I just try and let them do it.* (PRE3 59-65)

Nursing students are initially taught clinical nursing skills within a simulated environment located at their university campus. It is during their clinical placements in health care agencies that they begin to practise these skills on 'real' patients. Clinical teachers continually provide encouragement and guidance for students in their application and refinement of clinical nursing skills. Whilst psychological support and encouragement is important, a physical element of note emerged in one interview. Michelle described how she provided physical support in students' skills development when removing a wound drainage tube for the first time. Her description reflected an approach that a parent might employ to teach a child to tie their shoe laces. Michelle spoke of holding students' hands through the performance of the clinical skill. She

argued that this approach was employed to provide reassurance for the student, but it also indicates a level of physical control over the student's performance.

Michelle: *And the students often, some of them feel really, really nervous. I usually double glove with them…and sometimes I actually put my hand on their hands. Cause often they're shaking… so I just hold them by the wrists there [indicates on self], gently, and often… I help them pull the drain tube out or, or if they're doing a swab or a wipe whatever I actually direct where the hand goes because they're shaking.* (SCT1 157-166)

Foucault (1977) referred to 'body-object articulation' as a disciplinary process that "defines each of the relations that the body must have with the object that it manipulates" (p.152-153). In assisting students to carry out clinical nursing procedures by physically guiding the movement of their hands, Michelle highlighted the execution of disciplinary action on students' performance of the skill. It is through such discipline guiding the physical gestures that subsequently the execution of the procedure becomes replicated according to her expectations. Furthermore, the normalising effect of applying particular steps to the procedure served to reinforce and replicate that approach to undertaking the procedure.

Variations in the ways in which nursing procedures are expected to be performed can occur between various universities and clinical agencies. As a result, tensions can arise when students have been taught a particular way and they subsequently see a different approach being employed in the clinical setting. Compounding this, clinicians may have

poor techniques or use short cuts in executing clinical skills. Being a role model for students was seen by participants as being significant in guiding their professional development. This involved demonstrating practice as students had been taught in the university and was presented in nursing textbooks as accepted practice.

Trudy: *…they're watching what you're doing and how you're doing it. You need to make sure that you're doing everything properly so that they pick up on that. That they don't pick up bad habits of yours and things like that. (laughs)* (PRE3 10-25)

### 10.1.3 Laying down the rules

Providing discipline for their young is a key component of maternal roles. Discipline provides guidelines for children to recognise appropriate behavioural boundaries within particular social and cultural constructs as well as maintaining safety within those environments. Participants in this study revealed a range of practices within their clinical teaching that allowed for students to be disciplined in ways similar to those that a mother would use for her child. They described strategies of informing students of expectations at the commencement of clinical placements and for undertaking surveillance processes to maintain the ongoing discipline of their students in clinical areas.

Michelle: *I'm fairly strict and I lay the law down the first day big time. Right, then I don't have any problems. For the first week they're on guard a little bit and nervous, nervous with me and nervous with the environment, and the second week they start to relax a little bit and then their learning really enhances*. (SCT1 83-87)

Attention to students following ‘rules’ was described throughout the interviews. Participants spoke of the importance of students conforming to sets of rules and as such served to discipline their behaviours in clinical settings. Clinical agencies have clearly defined rules by which employees must function, many of these are written whilst others are reinforced through particular ways of behaving and practising. Undergraduate nursing students emerge from universities where different sets of rules govern behaviours and practices. At times these rules may conflict with those of clinical agencies hence leading to tensions arising. Clinical teachers, as minders of students during clinical time, see themselves as bringing together the agencies and students, having a responsibility to the host agency by ensuring that in that clinical setting, local rules are abided by. This privileging of clinical rules over those that students have learned within university settings can lead to difficulties for students. For example, students may have been taught to perform a clinical skill in a certain way that is distinctly different to that practised in the host agency resulting in tension and personal conflict for these students. Where conformity is demanded, this marginalises the significance of previous classroom learning and privileges clinical practices adding to the existence of the theory-practice gap experienced by students.

Faye: *I certainly think that ... making the students aware that while they are in the clinical area they practice within the guidelines of that clinical area and that can sometimes be difficult if they have been taught in a different way.* (CTA1 124-127)

It is not only institutional rules that clinical teachers seek to enforce. Participants indicated having sets of their own rules for student performance within clinical areas that served to further discipline students' behaviours and practices. The rules reflected their own expectations of students that had developed over time and through experience, and on an individual basis. Overall, the application of these rules served to reinforce the production of disciplined students, and ultimately, nurses who would conform to the dominant culture existing within the health care agency. Andrew described presenting his own set of rules to students on the first day of the clinical placement:

Andrew: *I have developed my own little package that I go through with the students on the first day… what I expect of them and confidentiality is one of the big things in that… because I go over it at the start I think they've had it drummed into them…*(SCT2 718-731)

Ongoing surveillance strategies throughout clinical placements allowed for continued student conformity and maintenance of control by clinical teachers. Clinical teachers expected that students had responsibility for contributing to general ward activity whilst they were there on clinical placements, rather than purely meeting their clinical learning objectives set by the university. Through ongoing, often discrete, dialogue with buddies and other staff, clinical teachers maintained knowledge of students' activities even in their absence. This continual surveillance ensured that students did not stray while clinical teachers were with other students. Faye described needing to know exactly what students were doing and informing students that she was keeping track of their activities.

Faye: *Picking out the tricky students who are just there to pass the placement and not really do the work and kind of challenging them. I mean you'll get students sometimes who will tell untruths to their preceptor about what they should and shouldn't be doing and it's trying to kind of, not catch them out but make them aware that you know exactly what's going on, that your finger's on the pulse and you know exactly what they're doing and that they won't get away with that…* (CTA1 282-290)

Workload demands on clinical teachers with patient care loads could add to the discipline placed onto students. Nursing practice is disciplined in its own way through medical discourses, that require particular procedures be carried out on patients at particular times of the day and night. Working alongside a practitioner results in a nursing student being similarly disciplined according to these patient care regimens. This can provide difficulties where a student may be unclear of expectations or appears unmotivated to conform.

Trudy: *Whereas with the others [unmotivated students], you're chasing them every two seconds and trying to get them to learn as well so I'm sort of, like behind them saying OK we do have something due now do you know what it is, do you think you can do it. You know, you're constantly trying to push them to do things.* (PRE3 314-319)

Michelle: *Um, things like injections, and IVs [intravenous injections], I'm very, very strict with medications. I say to the students you are not to give any IVs, um, or IM [intramuscular] injections or subcutaneous until you have been witnessed either by myself or by the staff….* (SCT1 172-175)

Clinical teacher and student relationships are close and personal at times. This section has provided evidence to support the conclusion that maternal discourses strongly influence the development of those relationships through nurturance, guidance, protection, and discipline.

## *10.2 Clinical teacher-university relationships*

Relationships between clinical teachers and universities were revealed throughout these interviews as central to clinical teachers and their work. Depending upon the clinical teaching model employed, the direct influence from universities on clinical teachers and their practices varies. Sessional clinical teachers are employed directly by universities to oversee students' experiences for the duration of clinical placements. Clinical teaching associates are employed by hospitals and seconded to oversee students for the duration of placements. Health care agencies employing them are remunerated by universities for providing clinical teaching services. Preceptors are employed solely by health care agencies, not seconded, but assume responsibility for a student for the placement length. Under this arrangement, generally no financial interactions occur.

Being employed by universities, sessional clinical teachers enter into direct employee-employer relationships. The provision of financial payment for work completed leads to the universities being in a powerful position that serves to discipline the practice of clinical teachers. The sessional nature of the employment means that clinical teachers who do not conform to university expectations may not receive further work in the future. Hence, a power relationship exists that serves to discipline the work of clinical

teachers. The resulting transient state of this role may contribute to a perception held by clinical teachers of their low value for the university. Andrew perceived that convenience, rather than valuing of his skills, influenced his gaining sessional teaching employment with a university.

*Andrew:* *I'm just someone that happens to be handy and help them [the university] out when they need… There's certainly no consideration for any skills or expertise I might think I've got. That means nothing to them. And its obvious that they don't care… about the skills of their clinical teachers because they will get anyone. They've actually asked an employment agency in town here if they would be interested in supplying clinical teachers for them, and they've told them that they don't care what skill level they've got.* (SCT2 44-51)

For the duration of clinical placements, clinical teaching associates (secondees) find themselves in a similar relationship with universities to that of sessional teachers. However, on completion of the clinical placement they return to the employ of the health care agency. Responsibilities to two employers can create tensions where academic discourses around meeting students' learning needs, and clinical discourses driving her regular employment come into competition. For Faye, this was managed by creating a conscious perception that she was acting in the interests of the university when responsible for nursing students.

Faye: *…it's a kind of two edged sword because you are being paid by a university to look after their students and … I actually belonged to a network and therefore your loyalties are kind of with the network but at the same time during that two week period then you have to be seen as being responsible to the university.* (CTA1 75-80)

### 10.2.1 Visibility

A lack of visibility of university staff in clinical practice settings was a criticism raised throughout the interviews with participants. Whilst technically academic staff themselves, and representatives of the universities, many participants did not readily acknowledge this. They voiced expectations that they should receive contact through physical presence or via telephone with academic staff during clinical placements. Working alongside hospital staff for every clinical teaching day, and subject to policies and guidelines there, participants found themselves identifying with clinicians and subsequently experiencing mixed loyalties. The situation was compounded due to geographical distance from the universities but as Sarah suggested, resulting tensions led to a need for 'juggling'.

Sarah: *I felt a loyalty to [the university] but they were so distant I would hardly ever physically go there maybe three or four times a year and contact on the phone might be every few weeks. Whereas the Hospital, I was there every day but I wasn't a member of their staff… but I'm accountable to both. Yeah, it was interesting juggling that sort of thing.* (SCT3 285-289)

The nature of working as a clinical teacher involves a minimal amount of direct supervision unlike that found in other work roles. Clinical teachers, in their previous clinical nursing roles, were likely to have experienced autocratic, hierarchical supervision through constant surveillance by senior nurses, doctors and hospital administrators. However, as clinical teachers they assume more independent, autonomous and self-directed positions. Within this study, a need for feedback from the universities was raised by participants. Having been previously normalised through the ongoing surveillance present in nursing, clinical teachers had been conditioned to require a dependency on their employee relationship. This led to a need for feedback and affirmation transmitted through a visible presence. The resulting lack of visibility led to tensions in the role and feelings of negativity towards the universities as their employers in clinical teaching contexts.

Ann: *They're [the students] just put out on their placement and that is it, they're left with it. I mean I could teach them bad things…Could be misleading, contradicting everything they have been taught.* (CTA3 884-888)

The lack of physical visibility of academic staff in clinical areas also led to the emergence of secrecy with some events hidden from academic staff. Whilst clinical placements might be disciplined through academic expectations, the lack of surveillance by universities allowed for resistant practices to emerge. Participants identified using unsupervised situations as opportunities to impose their own expectations informed by

their own personal curricula. Andrew described the mechanisms by which he opposed university constraints, involving students in the execution.

Andrew: *I've had students that I've had to send to some areas to learn certain things that we don't tell the university about. As a matter of fact we do quite a few things that we don't tell the university about because to the university out there everything is in this square box, and this student's coming out for a placement that's supposed to concentrate on just this one area and it doesn't work like that. If there's an opportunity for the student to learn something that broadens their horizons they've gotta grab it while they can cause they might not get that opportunity for another two or three years. And you know, I've been told that, you know, students aren't allowed to go here there and everywhere but (pause) we have a little agreement with the students and what the university doesn't know doesn't hurt them.* (SCT2 939-950)

### 10.2.2 Disciplining clinical teaching

Despite a distancing from the location of clinical teaching, universities employ practices that serve to discipline activities occurring within clinical placements and hence the work of clinical teachers. It was around this area where power-knowledge relations emerged and both contradictions and tensions also surfaced.

#### 10.2.2.1 Clinical assessments of students

Clinical assessments are used to evaluate students' levels of competence usually at the end of a clinical rotation. Through universities setting criteria for achievement, these assessments serve to act upon students as 'docile bodies' to standardise, and hence,

discipline their practice. This practice serves to lead to the replication of a particular, desirable type of graduate. However, clinical assessments not only serve to discipline students' development but also the work of clinical teachers. Assessments define what clinical teachers are required to evaluate and at what level, along with defining what clinical teachers are expected to assist students to achieve. However, the use of academic jargon was found to reinforce power-knowledge relations which served to marginalise clinical teachers from 'academia' as indicated by Jane.

Jane: *It's kind of hard actually those evaluations (nervously laughs). They're a bit tricky, the words and that that you know the things that ...you've gotta try and meet*. (PRE3 180-182)

These power-knowledge relations then set up points of resistance where clinical teachers are critical of having to complete assessments or feel they have inadequate information to complete them perceiving them as a burden. Andrew used the analogy of being thrown 'in at the deep end' to describe his feelings of helplessness with relation to completing students' clinical assessments.

Andrew: *They don't tell you how to fill out the eight page assessment on each ... student. That's eight pages and it takes roughly an hour each to do those so they [the university] just throw you in at the deep end.* (SCT2 24-27)

#### 10.2.2.2 Clinical learning objectives and guidelines

Clinical learning objectives and guidelines are provided by universities with the aim of directing students' clinical placements more generally. Clinical objectives provide statements about particular knowledge, skills and attitudes students are expected to achieve whilst guidelines offer general expectations and direction for placements. In providing these, universities can discipline students and clinical teachers' activities in certain directions. In doing so, they normalise practice to produce a student with prescribed attributes. Michelle expressed the importance of these in directing her role.

Michelle: *…their[universities] expectations, their guidelines which we're given… their objectives for the students that influences my practice.* (SCT1 345-346)

Set clinical learning objectives on their own do not provide the complete direction for clinical experiences. Knowledge of the clinical practice area places clinical teachers in positions to expand upon the university's objectives. Using their knowledge of potential learning experiences, they often develop further learning objectives informed by their own expectations of what students should be able to achieve, and further enacting personal curricula and adding to the disciplining of 'docile' students. It can also lead to the emergence of tensions between academic and clinical aspects of the learning experience as indicated by Andrew's expression of difficulty in being able to measure them.

Andrew: *…when they come out they've got this [booklet] with the objectives in the front page, it's a ten page… thing that they come out with and second page they're supposed to put down their learning objectives. Everyone's objectives are the same whether they're in first year or third year… You can't measure them.* (SCT2 443-453)

#### 10.2.2.3 Challenging positions

In the complexity of clinical teaching, clinical teachers are not positioned in wholly directed positions in their relationships with universities. Universities are in a dependent relationship with health care agencies for access to clinical placements for their students. Students become guests in the health care agency, not being employees, with the agencies having some control over their experiences. They can reject university requests for places, and furthermore can place conditions upon places offered. Faye described how as a clinical teaching associate, she had bargaining power over one university and the students who were offered places.

Faye: *…we didn't used to take 2nd year students, we took them to begin with and we found that they were flailing in the clinical area. They didn't know what they were doing, ... they just were not having a good experience so we got back in touch with the Universities… and said this isn't working for us and it is not working for your students. And we won't take your students from now on that were 2nd years and the University said but we really need the places and we felt pressured but we said no we want to hold up the integrity of this as a clinical placement. So the University went away and did some work and actually came back with a proposal that they'd said we will teach our students X, Y & Z if you will take them so we did*

> *for a trial period and that worked out really well… now we do take 2nd years …I think that was good from a network point of view that you were able to influence the development of the curriculum.* (CTA1 197-227)

Michelle described being able to use her knowledge of physical constraints within the clinical setting to provide her with leverage to refuse one university's requests for her to assume responsibility for more students than she wanted.

Michelle: *…fortunately the hospital I'm working at they've just closed a ward right so I had to ring the university and say the ward's closed, I'm only going to take six students. I was very firm about it and um, so they had no comeback. So I got six students. It was wonderful, so that time is now not an issue cause I've got six students, its great.* (SCT1 763-768)

Overall, relationships between clinical teachers and universities were perceived by participants as inadequate. Tensions in relationships were evident between demands from clinical settings in which they were physically embedded, and the demands from universities for clinical teaching of students. Participants perceived a lack of value by the university, of them and their roles. They described a need for greater visibility from the university in providing feedback and direction with their work, in effect requiring greater surveillance of their work by the employer. However, they indicated through their discussion of clinical objectives, guidelines and assessments that their work was still shaped by universities.

## *10.3 Relations with clinicians*

Clinically practising ward nurses possess responsibilities for patient care delivery through the control of their employing health care agency via set procedures and policies for performance. Clinicians work within allocated ward spaces caring for patients within those spaces. The work occurring within these spaces is disciplined by both medical and institutional discourses which guide the overall functioning of these nurses. However, clinicians have control over who can, and who cannot, enter such spaces. Clinical teachers, on the other hand, often enter clinical settings as outsiders. They have responsibilities to their employing universities to ensure that students have access to clinical opportunities that will allow for learning objectives to be met. This situation results in clinical teachers needing to negotiate for access to patients' bedsides and potentially opens up environments for tensions to arise. Continual negotiations form an important role in facilitating and maintaining students' entry into these controlled spaces.

Michelle: *You know that is exhausting the diplomacy part … At the end I'm absolutely exhausted…the talking. I have to negotiate the whole time – negotiate with theatre staff, negotiate with doctors, just everybody…*(SCT1 551-556)

### 10.3.1 Familiarity

It was evident through the interviews that participants valued highly a sense of familiarity with clinical settings and the clinicians within them. Being known in the

clinical setting allowed for doors to open that would not normally be available, including ease of access to patients' bedsides where learning could take place. Knowledge of the setting gave them insight into selecting clinicians to buddy with students, and finally it helped them to understand clinicians' workloads and avoid tensions arising that might impact on teaching and learning.

Clinicians are given responsibility for the provision of care to their allocated patients by their employing health care agency. Their work is subsequently disciplined by a range of medical and organisational discourses. In turn they are powerfully positioned to restrict student and clinical teacher access to patients. They have control over the clinical space, which is also patient space, in that care responsibility. Clinical teachers, however, are responsible to universities for the teaching and learning of their allocated students within that same setting. In order to be able to do this, they must negotiate access into the work space of the clinician to have access to patients. Participants valued knowing the clinicians prior to clinical placements. In many cases participants indicated having worked as nurses in the same institution where they were performing the clinical teaching and this meant that they were familiar to ward staff. Sarah identified that being seen as legitimate in the clinical setting was important as well as providing ease of access.

Sarah: *…doors open a bit easier …especially to closed access. Or you can be in a place supervising the students or something like that and people won't look at you and give you that look to say what are you do here, cause you are a familiar face. You don't have to explain to every single person all the time*. (SCT3 226-230)

Being seen to have functioned in a nursing role was also considered advantageous to facilitating positive relationships with staff. Not only providing familiarity, this contributed to being seen as credible in the eyes of clinicians and gaining acceptance into the staffing in the ward. Ultimately, this promoted access into the patient domain and to clinical teaching opportunities.

Michelle: *I think ...I have enhanced my good relationship with the staff. I have high, ... standards of work practice myself so a lot of the staff have actually worked with me. I work all throughout the hospital except theatres, I haven't worked in the theatre area, um so they see my own standard so my own role modeling, so that's good rapport with the staff...*(SCT1 221-226)

Clinical teachers perceived an important responsibility was to access learning experiences that met clinical learning objectives set by universities. Clinical teachers were often powerfully positioned within ward areas being able to evaluate patient mix within those areas and to allocate students accordingly. In allocating students, clinical teachers also considered personalities and experience of those clinicians responsible for the care of patients in particular areas. In discussing this, participants placed value on being familiar with the personalities of staff in the wards. They used this knowledge to

ensure that students were buddied with people who would be supportive and positive influences on clinical learning. Andrew suggested the ways in which individuals provided role modelling in their nursing roles was an important consideration in selecting buddies for his students, even though based upon his own idea of what constituted a 'good' role model.

Andrew: *You try to buddy them up with the people that you feel are good role models…* (SCT2 162-163)

Clinical teachers often have a number of students in different ward areas at any one time. Maintaining ongoing surveillance at all times is therefore difficult to achieve. Using ward staff to provide a watch over student activity at times when they were not around was considered important by participants. Knowing staff personalities previously meant that clinical teachers were able to evaluate feedback being presented to them from staff, determining whether that feedback was fair and balanced or not.

Sarah: *… you know all the staff if you have worked there before so that's a huge difference and you tend to know the staff personalities so if a student has a problem with a particular staff member then you can put it into context and have some order.* (SCT3 220-223)

### 10.3.2 Workloads and reciprocity

For buddies and preceptors to provide supervision of students throughout clinical days, participants identified providing reciprocal assistance when clinicians' workloads become uncontrolled was important. There was recognition that working with students

meant clinicians effectively had double workloads which could interfere with their functioning and ability to meet requirements of care for their allocated patients.

Paula: *Lot's of the staff comment that taking a student almost doubles your workload because you can't just go about your way of doing things and plod along, you have to explain everything that you are doing because they want to know so it does double your day.* (CTA2 819-822)

Ann asserted that this doubling of workload resulted in clinicians being hesitant to work with students.

Ann: *It just takes you so much longer to do the basic things and you know when you are busy and the wards can be very busy at certain points in time that's probably when ... they're [clinicians] a bit hesitant to having all these students and the fact that it is gonna just put them further and further behind and they don't have time to explain things, just do it that way so they often make them do it and don't explain because they don't have time to explain, just go and do this… And that's the way it is because if you are busy …everything has to still be done.* (CTA3 989-998)

For clinicians there is little personal benefit gained in working with nursing students and many refuse to take on the added burden of having a student. However, clinicians are central to the success of current clinical teaching models where students are supervised by registered nursing staff such as in the preceptorship model. This positions clinicians powerfully in being able to accept or refuse a student. Hence,

being able to encourage clinicians to continue to work with students is important for clinical teachers to ensure continuity of student supervision. Participants spoke of how they compensated for clinicians' loss of workload control by assisting them to catch up. Andrew discussed how he promoted a reciprocal approach to the demands of patient care.

Andrew: *most of them are really good like that now and they know that I'm, um, normally around anyway so they don't mind if it takes them ten minutes longer to do something with a student they know that they can always catch up later on cause, you know, I'll be around and we can give them a hand to do something else which would make it a bit quicker for them.* (SCT2 223-228)

Overall, relationship building between clinicians and clinical teachers was highlighted as fundamental in being able to provide student access into patient care areas. They described a need to undertake continual negotiation in order to ensure that this could be maintained. In addition, they discussed being dependent on clinicians to provide surveillance of students when they could not be physically present. They identified constraints placed on clinicians in effectively assuming two workloads and a need to assist clinicians with completing workload requirements when a student's presence had placed them behind.

## 10.4 Relationships with patients

Patients are critical players in students' clinical learning through providing access to opportunities for enacting theoretical classroom learning. However, the interviews undertaken within the context of this study revealed that the relationships between clinical teachers and patients, despite this importance, are marginalised. Participants were asked to describe their relationships with patients. These revealed a general reliance on patients as teaching material, normalised through classification according to their physical condition. Little did participants talk of interpersonal relationships with patients or regard for their wellbeing, rather they spoke of the uses of patients as assisting teaching processes.

### 10.4.1 The patient as 'docile body'

Patients are important sources of clinical learning. Foucault (1973) described medicine using clinical gaze to group and classify conditions through symptoms and signs. Informed by a similar medical tradition, clinical teachers in nursing were seen to use clinical gaze to normalise patients into conditions and cases or into procedures to be carried out. The patient as subject became relegated to a 'docile body' manipulated and categorised for the purpose of teaching. Allocation of students to patients was reported by participants to be often decided based upon particular clinical conditions, rather than on holistic approaches to care. Andrew described ensuring students were allocated a 'mix' inferring that he valued patients' with variety of clinical conditions as optimal for clinical learning but also how clinical conditions were valuable teaching resources.

Andrew: *You try to give a mix [of patient conditions] anyway… They've got some medical illness or something so you can usually… she's got CA [cancer] of her only remaining kidney so you can use that as a learning tool anyway because her renal function goes off and you know, you can go through why that goes off and what you'd expect in her outcomes and the causes and all that sort of stuff...* (SCT2 902-910)

Teaching episodes can become centred around patients' conditions without the involvement of patients themselves. This further reinforces the perception that the patient is a medical condition rather than a person with social, cultural, psychological and other needs. Paula indicated a distanced relationship from patients in her clinical teaching role. Her concern rested with students' understandings on a daily basis of the medical conditions of their allocated patients, omitting personal aspects from the discussion. Allowing medical discourses to become privileged resulted in marginalisation of those discourses which reflected holism and on which nursing practice is purported to be built. Such approaches merely served to reinforce medical approaches to the provision of nursing care.

Paula: *…every day they [the students] get questioned by me as to what patients they're looking after, what's wrong with the patients, what do they know about their illnesses, what type of things do they need to consider for those illnesses.* (CTA2 35-38)

Not only did participants categorise patients according to their medical diagnosis but they also categorised them according to nursing procedures or 'tasks' to be done. Whilst

recognising that the patient was central to teaching and learning, Caroline spoke of patients in terms of tasks or skills to be performed, rather than on their individual and holistic needs.

Caroline: *The patient sits in the centre of the whole process, that's quite right and anything we do or whatever tasks or skills we learnt is centred around those patients because they are specific for those people…*(PRE1 486-491)

Increased technicalisation of nursing leads clinicians to concentrate on tasks to be done rather than on individual patients' needs. A focus on tasks to be achieved can result in neglect of holistic care delivery for allocated patients. In reinforcing the focus on technical aspects of nursing practice in teaching, Trudy admitted looking for procedures for students to do, even using other nurses' allocated patients to achieve this. Observing such practice could reinforce for students the focus on clinical procedures and shape their future practice effectively omitting holistic care from their repertoires.

Trudy: *I really listen in handover and try and pick things up like if there's a nasogastric to go in or a catheter to come out or you know staples to come out, all those sort of things. Even if they're not my patients I'll go to those people straight after handover and say look don't do it, let us do it…*(PRE3 521-526)

Marginalisation of patients also occurs with both clinical teacher and student in the room providing nursing care. Lack of personal interaction can lead to teaching sessions becoming centred around a particular procedure on a certain body part, rather than

involving the patient in the experience. Trudy spoke of how it was common when undertaking a procedure with a student for them to discuss the patient, over the patient without involvement.

Trudy: *And I think the patient does get forgotten a lot. …you get so focussed on your tasks that you're doing that you forget that its actually a person there behind that suture line or you know, like and I try to explain that to the patient so that they don't feel like they're being left out of the whole thing cause you might stand there and discuss the patient and the patient's right there and you're you know, you're discussing their condition or whatever over the top of them, I mean you don't want them to feel like you're being rude or anything like that.* (PRE3 714-723)

Even in their marginal and confined positions, patients still possess some power within their relationships with clinical teachers. Whilst little direct personal interaction occurred between the two, participants articulated that patients were still able to pressure them to ensure that students were supervised whilst working with them. They suggested that patients felt secure knowing that qualified staff were overseeing the work that students were doing.

Michelle: *They [patients] want to know the students are supervised… they want to be able to build up trust with that student and I'm very, very mindful of that of course. You know, so safety and patients are [important]… you'll be here. Oh yes I'll be here definitely…*(SCT1 431-435)

Preceptors in the execution of their work possess dual responsibilities, for care of allocated patients and for teaching of allocated students. Participants in this study who were also preceptors revealed some contradictions leading from the duality of their positions. Effectively moving into their nursing roles, they revealed at times having to act to protect patients from students. Subsequently, it was in the nursing components of their work that they recognised more personal, holistic approaches to care. This aspect was not revealed in their discussions around their teaching but revealed the existence of tensions where the two positions collided.

Trudy: *…sometimes you'll have been looking after patients for quite a few days and some of them are really sort of fragile and … really stress out about things…you try and keep the student away … they're in a fragile state, they're really sort of emotionally unstable as well and if you go in there saying this student's going to practise their injections on you and things … that sort of contributes to their state … you make an executive decision to try and maybe put the student in other places rather than with that particular patient.* (PRE3 640-652)

Relationships with patients would appear to be central for clinical teaching to occur. However, participants in this study marginalised the personal nature of such relationships. Greater attention was placed upon the patient as a 'docile body' forming teaching material through their medical conditions or procedures to be done. Sadly, the dominance of medical discourses meant that holistic care on which nursing is argued to be based was largely omitted from teaching episodes.

## 10.5 Conclusion

The development and maintenance of relationships in clinical settings is fundamental to effective student teaching. This chapter has highlighted the existence of key relationships with students, universities, clinicians and patients for clinical teachers. The nature of these relationships has been further uncovered through this study. Student-clinical teacher relationships emerged as being shaped by maternal discourses through activities such as nurturing, protecting, supporting, guiding and providing discipline. Relationships with universities were criticised through a lack of visibility in clinical settings but their influence on disciplining clinical teaching still existed. Value was placed on familiarity in developing relationships with clinicians, whilst patients emerged as marginalised, ‘docile bodies’ that offered teaching opportunities through clinical conditions and nursing procedures to be performed.

# Chapter 11

# REFLECTING ON COMPLEXITIES

> *But for anyone who has actually taught a professional practicum, the predicament is that classroom knowledge is only part – and by no means the most important part – of what counts in practice.*
>
> (Schon, 1995, p.29)

The quote from Schon recognises that education in professions, which also have practice components, is influenced not only from within but also beyond the classroom. Clinical education in undergraduate nursing courses is complex, and is shaped by a range of dominant and marginal discourses that impact on the development of power-knowledge relations. These discourses interact and impact on each other, creating numerous tensions and discontinuities. The findings of this study have demonstrated how multiple discourses influenced the ways in which clinical teachers carried out their work.

Within this study, I have sought to expose discourses impacting on the work of clinical teachers in Victoria, both through an extensive literature review and collection of data from a range of sources, to seek to address the initial questions. Employing the work of Foucault to guide the study has been very beneficial, facilitating the revelation of a range of discourses that impact on clinical teaching, and has exposed tensions and conflict emerging through the interplay of these discourses. The two-phase approach to exploring historical influences on clinical teaching along with the interplay of discourses influencing clinical teaching work in current situations has resulted in unique findings

that add to existing understandings of clinical teaching work in undergraduate nurse education. This chapter seeks to discuss and evaluate the main findings and suggest possibilities for future directions in managing clinical teaching work and the delivery of nursing curricula.

## 11.1 Curricular confrontations

One of the primary and recurring findings of this study was the way in which intended curricula informed by academic discourses, and personal curricula informed by a range of nursing and other discourses, were juxtaposed throughout clinical teaching work. While academic curricula were active through clinical learning objectives and assessments, personal curricula were found to guide a large amount of the teaching work of clinical teachers in this study. These assumed prominent positions and were often informed by personal experience as well as individual underlying assumptions such as where students should be at particular stages of their education, and driven largely by clinical nursing discourses rather than academic ones.

The concept of ‘personal curricula’ is a new concept as it has not been described elsewhere. However, there are some clear parallels with what have been described in this study as ‘personal curricula’ and ‘hidden curricula’ that have been occasionally described in the literature, however, there are also some distinct differences. A number of authors have described the existence of hidden curricula, with some of these emerging in nursing (Cook, 1991; Ferguson & Jinks, 1994; Mayson & Hayward, 1994). The concept of a hidden curriculum has been defined as being different to that of the

intended, or taught, curriculum so has parallels with the concept of personal curricula as it is not that which is intended by faculty. Marinker (1997) discussed the hidden curriculum in medicine as one which is not discussed, but from which teachers teach and students subsequently learn. Portelli (1993) indicated that the hidden curriculum, in contrast to the intended curriculum, had four meanings, these being; unofficial expectations, unintended learning outcomes, implicit messages or curricula that are created by students themselves. The first three of these were evident in the findings of the current study. Sambell and McDowell (1998) described the hidden curriculum as a 'de facto curriculum' informed by what teachers and students actually do "on the ground" (p.392). Here, too, parallels can be drawn as personal curricula in this study were found to be informed mostly by clinical nursing discourses. What makes personal curricula uniquely different is that these unintended curricula were not found to be overt or hidden in this study as previous descriptions assert. While literature has widely noted the existence of unintended, or hidden curricula, the findings of this study challenge the 'hiddenness' of it. At least some elements of unintended curricula are overt and hence, a more apt definition is that of personal curricula. Furthermore, available literature suggests that hidden curricula generally exist as singular in nature. Most literature accounts refer to a 'hidden curriculum' (Cook, 1991; Portelli, 1993; Sambell & Dowell, 1998), however, this study has demonstrated that there is more than one unintended, or personal, curriculum operating within clinical education in nursing at any one time, as clinical teachers bring different personal curricula into those environments.

Clinical teachers in this study applied personal curricula, drawn from combinations of their own nursing experience and underlying assumptions, to subsequently set their own normalising expectations of students. These were juxtaposed with university expectations of students, as students became subjected to two sets of expectations. This finding supports and extends that of Williams et al. (2001) who found that clinical teachers tended to assess students according to their own set of normalised expectations. This, however, forms only one component of the operation of personal curricula and the scope of influence is far greater. Every clinical teacher comes from their own unique background. As was evident through the study, these backgrounds can become influential in student learning outcomes. It has also been suggested that hidden curricula emerge from within health care agencies as well, and as highlighted by Mayson and Hayward (1994), from patients. Whilst not evident in this study, the influence of clinical nursing discourses would indicate that patients can also have a role in the development of personal curricula.

The overall impact of personal curricula on student learning has not be identified through this study. However, nurse academics should not immediately discount their value and seek to minimise their effects. Nursing practice is diverse with different approaches to similar procedures being commonly encountered by students. The application of personal curricula has the potential to enhance learning experiences, adding richness to the stability of theory taught within the academy as well as reflect the nature of nursing practice. This may, in fact, be beneficial for students and assist them in managing the range of different practices they will encounter as graduates.

Caution is warranted before encouraging adoption of all personal curricula into the mainstream of clinical teaching. With multiple personal curricula existing, students' learning may be fractured as they come across many different variations during their three year course through encounters with multiple clinical teachers. Addressing this as an issue needs to occur at a number of levels. Schools of Nursing need to take steps to manage the influence of personal curricula, as these can present detrimental influences (Ferguson & Jinks, 1994) which may result in negative consequences (Cook, 1991) for students and their learning. Clinical teachers need to be aware of the implications of how their personal curricula influence their teaching work. Cook (1991) contended that consciousness-raising to reduce hidden curricula is important for teachers in nursing. In identifying the links between power and knowledge from Foucault's work, Cheek and Rudge (1994) suggested that "consciousness raising allows for the possibility of overcoming the often debilitating dualism between the personal and the political" (p.60). Consciousness raising endeavours, therefore, may expose aspects of personal curricula for clinical teachers so that they can be openly explored and their benefits evaluated. This will allow for positive aspects to be promoted while negative ones can be minimised.

Academic nursing curricula are not only challenged by personal curricula in the clinical setting, but also by medical models of care. The first phase of this study found that moving from medical into nursing discourses was a factor underpinning tertiary nurse education in Australia. However, this study has also identified difficulties in

implementing holistic models of nursing care into clinical practice settings where the environment is medically-oriented, and nursing and medical discourses come into direct conflict. Hence, there is misalignment between what universities are seeking to provide students and the realities of practice. Clinical teachers find themselves positioned between the two different models. Henderson (2002) identified that nurses' difficulties in applying holistic care was related to utilitarian nursing practices and little role modelling despite being previously educated about holistic care. Medical approaches to nursing care, afforded privilege and unchallenged, are being reinforced with each new generation of nurses. This situation lends itself to questioning of the theoretical positions underpinning academic nursing and those of clinical nursing practice settings which are dominated by medical approaches. It would seem timely, therefore, to re-evaluate the basis on which hospital nursing is delivered. It can be argued that academic nursing has implemented a direction that is nursing-focused but current practice in nursing has not moved with it. This has contributed to a gap between what is taught in theory and what is actually practiced.

## 11.2 Theory-practice relationship

The juxtaposition of academic and personal curricula leads to questions about the relationship between theory and practice. Much has been written about a theory-practice gap in nursing. The notion of reducing this gap was seen as one of the reasons for shifting nurse education from hospital-based training into the tertiary education sector. In early models of clinical teaching, nurse academics attended clinical placements with students after providing theory in the classroom. In phase one of this current study, this

approach was reported as minimising the gap but was short-lived due to the influence of academic discourses. However, as new clinical teaching models have developed so too it would appear has the size of the gap. This study has revealed differences between what is taught in theory and what is taught in practice – a finding that is not unique to this study or to nursing specifically. Personal curricula on the part of the clinical teacher certainly contribute to this situation, an element that has not previously been described. The existence of a gap has been argued to be contributed to by multiple other factors including complexity of nursing care that cannot be represented in theory (McCaugherty, 1991) and the dynamic nature of clinical nursing (Corlett, 2000).

This study raises questions about whether the theory-practice gap is more pronounced within particular models of clinical teaching, especially the clinical teaching associate or preceptor models. In these approaches, where dual responsibilities exist, patient care is often afforded privilege over student learning which may be left until patient care tasks are completed. As a result, teaching opportunities are largely influenced by the delivery of direct patient care, rather than on students' particular learning needs. Workload issues resulting in a lack of time for student teaching has been recognised by a number of other authors (Allen, 2000; Coates & Gormley, 1997; Myrick, 1994; Yonge et al. 1997). This situation should be of concern to both health care providers and schools of nursing. Given the influence of staff shortages and potential for preceptor burnout (Beattie, 1998; Dibert & Goldenberg, 1995), it is questionable whether the preceptor role is sustainable in its current format.

The findings of the study suggest that current clinical teaching models are not consistent in achieving what they are intended to. New approaches for the provision of clinical teaching need to be developed that provide greater articulation between theory and practice. If early intentions of tertiary education are taken into account, staff undertaking teaching in the clinical placements should also be teaching in the academy. This model had limitations for academic staff but the first phase of the study suggested that it allowed for integration of classroom and clinical learning. Adoption of models that build closer alignment of academic and clinical learning would substantially assist students with applying theory into practice. The employment of clinical lecturers who teach in simulated clinical practice laboratories within schools of nursing and then accompany students into clinical settings needs to be considered within the local context. In the United Kingdom, the lecturer practitioner model has been implemented in an attempt to minimise the divide between theory and practice. In general, these individuals have responsibilities for teaching in classroom settings as well as undertaking clinical practice. Whilst there is great variation in these roles (Fairbrother & Ford, 1998), such approaches to clinical teaching need to be considered to offer greater opportunities for working towards enhancing integration of classroom and clinical learning.

Institutional policies from within hospitals influence how nursing procedures are performed and these in turn influence clinical teaching and contribute to a gap between theory and practice. Evaluation of the role of hospitals' institutional policies on students' learning needs to occur. Greater collaboration in curriculum development should assist with greater streamlining and minimising differences. Discourses of collaboration were

discussed in chapter two as clinical partnerships such as joint appointments (McKenna & Roberts, 1999) increasingly emerge. The need for a move towards more collaborative approaches between academia and practice is further supported by the findings of this study. In moving this direction, increased collaboration between education and practice needs to be widely developed and encouraged.

## *11.3 Clinical teaching work*

One of the main benefits of this study has been the exploration into the complexity of clinical teaching work including the influences on clinical teachers as well as the influences that clinical teachers have. This area has previously been poorly recognised in the overwhelming amount of literature available concerning clinical teaching in nursing which has mainly involved the perspectives of nurse academics and students, but not clinical teachers. The application of Foucault's thinking has assisted in revealing unique information that adds to the limited body of knowledge around what clinical teachers do and the influences on their practice. The enhanced understandings this brings to schools of nursing should assist with awareness of the forces impacting on clinical teachers in the execution of their day-to-day work, the influences that clinical teachers have on students and their learning and how clinical teachers can be better supported.

Using the concepts of discipline and power-knowledge relations from Foucault's work has exposed ways in which clinical teaching work is disciplined. The work of clinical teachers was found to be disciplined through the application of academic practices such as timetabling, setting student learning objectives and needing to undertake prescribed

student clinical assessments. However, clinical teachers exerted influence over clinical teaching and learning through their own personal curricula. These curricula were informed by clinical nursing discourses hence the performance of clinical procedures was highly valued. This supports the work of Paterson (1994) who found that clinical teachers placed heavy emphasis on the performance and mastery of clinical nursing skills by students, and their role in providing supervision of these. This could be attributed in part to a lack of adequate preparation around requirements of the academic curricula (Wellard *et* al. 2000) leading clinical teachers to teach around what they are most comfortable with. Overall, it indicates a need for schools of nursing to provide greater preparation for clinical teachers around the academic curricula. Such costs, therefore, need to be balanced up against the costs of having curricula poorly supported and transposed into clinical practice.

Industrial discourses play a role in the work of some clinical teachers and these may cloud clinical teaching performance as curriculum and clinical practice expectations compete. Recruitment issues were found to influence clinical teachers in this study who also had responsibilities for recruiting new nursing graduates into their health care networks. As a result there is a potential for students to practise differently to what they may be expected to by their individual school of nursing in order to privilege the particular approaches used within the health care network if they are seeking to gain employment there at a later stage. This coercive lack of support for academic curricula, therefore, is a concerning situation and one that warrants further attention.

This study raised awareness of different models of clinical teaching and some of the factors influencing their execution. In some of these models difficulty can arise where the clinical teacher is responsible to two different employers, each with different objectives. The plight of preceptors in this study revealed the existence of tensions unique to themselves, between the delivery of patient care and teaching responsibilities for students as they naively sought to fulfil both roles, a phenomenon that has been reported elsewhere (Allen, 2000; Yonge et al. 1997). For clinical teaching associates and preceptors, conflicting loyalties emerged as they spoke about having responsibilities for two employers simultaneously whilst teaching students. Preceptors maintained patient care responsibilities, while clinical teaching associates maintained either patient care or staff development responsibilities. The conflicting loyalties became evident through tensions between their dual responsibilities in patient care or staff education, and academic learning needs of students. Often, preceptors assumed full regular workload as well as responsibility to support nursing students. This situation raises questions about the potential effectiveness of these models for clinical learning, especially the preceptor role. If patient care demands are afforded privilege over students' learning, then learning outcomes may be expected to be inadequate. However, preceptors seeking to fulfil their teaching obligations could also neglect important aspects of patient care that could ultimately lead to patient harm.

Problems with existing clinical teaching models are evident on a number of different levels. Each different model is constructed around different educational and practice demands. The previous section discussed the progressive growth in the divide between

theory and practice since the transfer of nurse education into the higher sector. With sessional clinical teacher models being costly to maintain along with increasing recruitment difficulties (Napthine, 1996), as well as questions raised in this study over the effectiveness of newer models such as the preceptor, it seems timely that schools of nursing re-evaluate the ways in which clinical teaching is delivered. The development of new models that promote collaboration between university and clinical practice areas, as well as support student learning and optimal patient care should be the goal.

An unexpected feature emerging through this study was the central role of time in the work of clinical teachers. Many previous studies have identified lack of time for teaching as being a major impediment to preceptor work (Beeman, 2001: Coates & Gormley, 1997; Stevenson, Doorley, Moddeman & Benson-Landau, 1995; Yonge et al. 1997), and perceived short lengths of clinical placements. However, no previous work has been identified that has considered the influence of time on clinical teaching work more generally and with relation to other clinical teaching models. The findings of this study offer unique insight into this area that until the present have not been acknowledged. Time played an enormous part as participants recalled trying to balance time demands through seeking equity and equality in clinical teaching. They used time to discipline and normalise student learning as well as to achieve their own work management. Given the scope of time references influencing clinical teachers in this study, it is interesting that this area has not been described in detail anywhere. This new knowledge can help nurse academics and nurses in health care settings to understand

more about influences on clinical teachers and their work. Through these enhanced understandings greater support mechanisms for clinical teaching work can be developed.

This study revealed that clinical teachers work within a mother-child relationship structure with their students. Maternal roles were predominant in participants' accounts not only from female participants in the study but also from the sole male participant. Clinical teachers spoke of their relationships with students that mimic support that a mother would provide a child, as well as their use of disciplinary techniques to mould students' development. Students' perceptions of clinical teachers as "mothers" has been reported elsewhere (Lopez, 2003; Nahas, 2000). However, clinical teachers having that perception of themselves has not been described before. The impact of maternal discourses on clinical teacher – student relations represents a huge shift from that of hospital-based programs where student relationships with charge nurses, as teachers and assessors, were informed by institutional, employer-employee discourses and were hierarchical and autocratic in nature.

That clinical teachers see themselves assuming maternal roles in relations with students raises questions about the intentions schools of nursing have with regard to clinical teachers. A need to support students in a maternal way could be problematic if that clinical teacher is also required to provide academic rigour and student discipline around clinical performance. A need to fail a student on their clinical performance may then create tensions with the maternal need to care and nurture the student. This may partially explain the assertion of Smith et al. (2001) that having to question a student's

performance was anxiety producing. While maternal-child relationships may appear inviting, they need to therefore be encouraged with great caution. Clinical teachers should be supported in developing relationships with their students that will optimise student learning but also provide scope to develop clinical teachers' abilities to provide necessary academic discipline where necessary. This should, therefore, be included within preparatory sessions for new clinical teachers.

## *11.4 Locating a place for this study*

The nursing literature is replete with studies around clinical education and which cover a multitude of dimensions. However, this study has explored clinical teaching using a unique and different approach to those described previously. In doing so, it has uncovered aspects around clinical teaching work not reported elsewhere. The study has revealed a range of discursive factors that have historically, and currently, influence clinical education in undergraduate nurse education in Victoria. In addressing the key questions it has raised more questions than it has answered, however, it has opened up new perspectives on clinical education. With the unearthing of new perspectives, numerous opportunities for further research and development of nurse education have emerged.

### 11.4.1 Limitations of this study

A number of issues emerged during the study that warrant some discussion. Firstly, phase one of the study was undertaken in order to develop a foundational understanding of how current clinical teaching models evolved. Whilst some exploration of clinical

education prior to the transfer was addressed, the main focus of this section was exploring the emergence of clinical teaching models within nursing higher education in Victoria. As this phase was intended only to provide background information to inform the larger, second phase, it comprised only a small portion of the entire study. In presenting the findings from this phase, discussion has been limited only to one chapter. However, the volume of material available lends itself to more extended examination and could have become an entire thesis in itself. If a distinct study of its own were possible, the discourses around the transfer could have been explored in greater detail.

The second phase of the study involved interviews with nine clinical teachers. The group consisted of three sessional clinical teachers, three clinical teaching associates, and three preceptors. These three resulting sub-groups were intentionally included to ensure that a cross section of existing clinical teaching models could be represented in the study. However, in collecting and analysing the data, it was evident that there were certain issues that related to each individual group, and were not issues for the other groups. The small size of each representative group has meant that their unique issues could not be explored in any specific detail. The scope of the study has not facilitated in depth analysis of issues distinctly pertinent to individual groups but these would certainly benefit from deeper, more specific, investigation.

Postmodern perspectives recognise the existence of multiple ways of seeing the world. This study explored the perspectives of one group of stakeholders only who have an involvement in undergraduate clinical teaching. However, its does not seek to represent

all clinical teachers and their experiences either. Individuals who volunteered to participate in this study emerged from acute medical surgical nursing areas and midwifery only. Hence, the perspectives of clinical teachers working in other practice areas, such as mental health and community health, are not represented and may be very different from those presented here. In addition, this study drew participants only from around the State of Victoria, Australia. Experiences of clinical teachers from other areas around Australia may prove to be completely different. Certainly, the transfer of nurse education into the higher sector occurred at individual State and territory levels and at varying times so models may have evolved differently.

Overall, the findings of this study cannot be taken to be representative of clinical teachers at large, rather they present the experiences of this particular group of individuals but they do provide new levels of understanding of clinical teaching work. Finally, whilst there are a number of individual perspectives represented within the study, there are other perspectives and voices that remain unrepresented and whose perceptions are equally valuable. These include nursing students, registered nurses working in wards where students undertake clinical placements, health care administrators, academic staff, other health care professionals and patients.

### 11.4.2 Opportunities for further research

The findings of this study have raised many more questions about clinical teaching, and as such, have opened many possibilities for subsequent research activities. Some of these arise directly from the limitations identified within the previous section. The

current study did reveal a number of commonalities in the discourses shaping clinical teaching. However, there were also discourses that impacted on only one particular model of clinical teaching. Studies that use a similar approach would be beneficial in exploring the experiences of each particular type of clinical teacher and their work in greater depth. This would be particularly insightful for clinical teaching associate and preceptor models where individuals carry additional responsibilities to student teaching.

The current study has only explored the perspectives of one group of stakeholders in clinical teaching processes. In interviewing clinical teachers, their voices have been afforded privilege and this has marginalised those of others. In order to allow for the voices and perspectives of other stakeholders to be heard, similar studies need to be undertaken with others, including health care agencies, universities, patients and other health care providers. Such studies would allow for greater understandings of existing power-knowledge relations surrounding, and discourses impacting on, the provision of undergraduate clinical nurse education. These, in turn, would lead to opportunities for the development of clinical teaching approaches that promote enhanced clinical learning for students.

This study has revealed a range of factors influencing how clinical teachers undertake their teaching work. What remains unclear is whether differences in the clinical teaching model or approach to teaching result in differences to what students actually learn and achieve during their clinical placements. Studies of the outcomes of different models on learning would therefore be beneficial. These should occur from a range of perspectives,

including all of the main stakeholders in the education process. Such information could assist with developing appropriate clinical teaching models that best meet the learning need of students and others involved in clinical teaching.

## *11.5 Conclusion*

Teaching work in clinical settings is complex and influenced by a range of multidirectional aspects. This study has facilitated uncovering unique aspects of this work including both influences on, and emanating from, clinical teachers. Despite intentions for the movement of nurse education into the higher education sector to offer seamless integration of theory and practice for students, this chapter raises questions about whether this has occurred as new models of clinical teaching have developed. Tensions present as clinical teachers teach from both personal and academic curricula, and tussles exist as practice becomes privileged over theory in clinical settings. It is argued that personal curricula may have both positive and negative outcomes for students so that further exploration of these is indicated. Where newer clinical teaching models have developed, competing responsibilities have changed the nature of clinical teaching work, leading to questions about their suitability in supporting learning.

# Chapter 12

# CONCLUSION

Clinical education forms a large component of Australian undergraduate nursing programs. It allows for the integration of classroom theory and clinical nursing practice. This component takes place outside of university settings, usually occurring within hospitals and other health care agencies. Throughout clinical education processes, numerous stakeholders are involved including not only students and clinical teachers, but university schools of nursing, health care agencies and their staff along with patients. The complexities involved in meeting students' learning needs in clinical environments result in a multidirectional web of power-knowledge relations and multiple, competing discourses. These, in turn, make clinical teaching work multifaceted.

This study set out to explore undergraduate clinical teaching by addressing three main key questions. These questions were developed to provide an historical and current exploration of clinical teaching work in undergraduate nurse education in Victoria. The questions were investigated from a unique perspective employing the work of Michel Foucault, firstly, historically around the time of the transfer of nurse education into the higher education sector, and then in current contexts. In doing so, the study has identified a number of discourses and complex power-knowledge relations impacting on the development of undergraduate clinical teaching in Victoria.

The first phase of the study provided a foundation on which to facilitate understanding of factors that influenced the development of clinical teaching models. It also explored factors driving nurse education around the time of the transfer into the higher education sector. A range of dominant discourses were uncovered through the interviews and collection of historical documentation that assisted with positioning the development of clinical teaching approaches currently in use. In hospital-based training programs, clinical education was marginalised as students were seen to be employees first and students second. Medical discourses played central roles in directing nurse training. Moves to transfer education into higher education were prompted through professional, feminist, economic, holistic and educational discourses. Following the transfer, initial work of nurse academics included supporting students in clinical settings. However, trying to balance new roles that included research and scholarship resulted in clinical teaching being provided initially by sessional employees. The focus of integrating academic curricula and clinical nursing practice was seen to become challenged as a result and the beginning of clinical teaching in current formats.

The second phase of the study sought to explore how discourses identified through the literature review and phase one currently work to shape clinical teaching work. In addition, it sought to identify whether there are key components of clinical teaching in undergraduate nurse education, and if so, how these operate. Through this phase, it became clear that key components do exist and they operate in complex ways. The study has revealed the existence of conflict between intended, academic curricula and clinical

teachers' own personal curricula and how these are used to inform their clinical teaching work. These personal curricula were informed by a range of factors including clinical teachers' past clinical nursing experiences along with underlying assumptions. This situation raises questions about whether clinical teachers should play larger roles in curriculum development and implementation.

A range of discourses, including management, institutional, academic and clinical, were identified that disciplined clinical teachers and students in this study. These discourses emerged simultaneously from within both universities and health care agencies. Intersection of the discourses was seen to often create tensions for clinical teachers where competing discourses led to conflict in their positioning such as experienced by preceptors who held clinical nursing, as well as teaching, positions at the same time. In addition, a range of temporal considerations emerged through disciplinary techniques. These were dominant influences in shaping the work of clinical teachers, largely influenced as they sought equity and discipline over students' learning. By understanding how discursive and temporal factors influence clinical teaching work, teachers can be better prepared to undertake their roles – an area that has previously been criticised for being poorly addressed.

Relations within clinical settings emerged as complex but important in teaching. Clinical teachers' perceptions of their relations with students as maternal-child in nature revealed an important change from those of teacher-student relations in hospital-based programs.

This finding prompted questions about the promotion of such relationships. For example, what impact might maternal relationships have in instances where a student is underperforming and in need of academic discipline? Other integral relations for clinical teachers emerged and included those with universities, clinical staff, health care agencies, and patients. One area that warrants further exploration relates to clinical teachers' relations with patients. It is a startling concern that despite rhetoric about holistic patient care, patients can still be marginalised and treated as a 'docile body' during teaching encounters.

From a personal perspective, the findings of this study have stimulated reflections on my own previous work as a clinical teacher and revealed an area of my work to which I was unaware. The research has challenged my insight into work that I undertook and led me to grapple with personal curricula that I unknowingly took into practice at the time. Upon reflection I have become aware that I brought personal expectations of students into my clinical teaching work. Many of these expectations were based upon my own experiences as a student in a hospital-based training program. Hence, I, too, sought to normalise students' development. Armed with this awareness, my approach to my clinical teaching work would certainly have been different.

As an academic, too, my ideas have been challenged through undertaking this study. Now being aware of the presence and impact of clinical teachers' personal curricula I have a role to play in increasing their awareness of these within their work. However, I

also have a responsibility to explore further how personal curricula carried by clinical teachers from my own school of nursing can be positively used. This will require clinical teachers to be more involved in undergraduate curriculum development processes than they currently are. Finally, it is clear that clinical teachers need greater preparation around the curriculum and for managing their clinical teaching work.

Carrying out this research has also provided other personal challenges. Prior to this current doctoral work my understanding of qualitative methods was very limited with previous research undertaken having strong quantitative foundations. The decision to make this shift was a deliberate, valuable and extremely enjoyable one. Whilst the journey has been exciting, I found myself challenged at various times over the study duration. Having read the work of many philosophers prior to settling on the work of Foucault to inform the study, I found myself engrossed in new, diverse knowledge and needing to settle on one approach. Foucault's work felt comfortable and offered my ideas for the study much scope to explore undergraduate clinical teaching in a way that had not been previously described. Hence, with this came some apprehension of the unknown. I had become familiar with much of Foucault's work through my reading but the challenge was in being able to transpose these ideas into a 'real' research situation. At times this became a struggle leading to periods where progress seemed impossible. Overall, however, the results of the journey are satisfying and the struggles worthwhile. It is hoped that the outcomes will be of benefit to the nursing profession. The utilisation

of Foucault's work has greatly benefited the study resulting in unique interpretations and enhanced understandings of clinical teaching work.

Outcomes of the study suggest that work is needed to provide clearer guidance and future direction around the work of clinical teachers. Further evaluation of clinical teaching models currently being used is warranted to ensure that there is alignment between anticipated and actual learning outcomes for students. This requires collaboration between schools of nursing and health care providers and may lead to the development of new clinical teaching approaches, along with ongoing monitoring and refinement of these approaches. Furthermore, clear boundaries need to be established around the development of clinical teacher-student relationships that promote optimal learning outcomes and support academic curricula.

In taking its unique approach, this study has allowed for new understandings of clinical teaching and the factors influencing them. Whilst raising more questions, it will add to existing knowledge in the area. It is hoped that this study will prompt further investigation into this important area, guiding the development of clinical teaching models that best meet the needs of nursing students, and the nursing profession generally into the future. Findings from this study suggest that ongoing investigations into clinical teaching work are justified. Perspectives from other stakeholders in clinical teaching would add more dimension to allow for greater understanding of factors that influence

clinical teaching work and ways in which to facilitate optimum student learning in clinical environments.

Clinical teaching work in undergraduate nurse education is complex and influenced by many different discourses, as raised through the literature and findings of this study. Some of these discourses work to influence and others to constrain the work of clinical teachers. The future directions of clinical teaching work in Australia remain unclear. New models for the delivery of clinical teaching may evolve as continued evaluation of existing models raises questions about their effectiveness. As the evolution occurs, many discourses impacting on clinical teaching work will be challenged through the emergence of other dominant discourses and evaluation of priorities. The findings of this study suggest that avenues for increased collaboration between schools of nursing and health care providers should be promoted to develop models that meet the needs of each area. In addition, greater preparation of clinical teachers around academic curricula and expectations, along with recognition and management of personal curricula is vital.

# REFERENCES


Acton, L., Gough, P., & McCormack, B. (1992). The clinical nurse tutor debate. *Nursing Times*, *88(32),* 38-40.

Addis, G., & Karadag, A. (2003). An evaluation of nurses' clinical teaching role in Turkey. *Nurse Education Today*, *23(1),* 27-33.

Admi, H. (1997). Nursing students' stress during the initial clinical experience. *Journal of Nursing Education*, *36(7),* 323-327.

Allen, C. (2000). Peers and partners: Working together to strengthen preceptorship in mental health nursing. *Journal of Psychiatric and Mental Health Nursing, 7(6)*,505-514.

Altheide, D.L., & Johnson, J.M. (1994). Criteria for assessing interpretive validity in qualitative research. In N.K. Denzin, & Y.S. Lincoln (Eds.), *Handbook of Qualitative Research* (pp.485-499). Thousand Oaks: SAGE.

Andersson, E.P. (1995). Marginality: Concept or reality in nursing education? *Journal of Advanced Nursing*, *21(1),* 131-136.

Andrews, M., & Roberts, D. (2003). Supporting student nurses learning in and through clinical practice: The role of the clinical guide. *Nurse Education Today*, *23(7),* 474-481.

Angen, M.J. (2000). Evaluating interpretive inquiry: Reviewing the validity debate and opening the dialogue. *Qualitative Health Research*, *10(3),* 378-395.

Armitage, P., & Burnard, P. (1991). Mentors or preceptors? Narrowing the theory-practice gap. *Nurse Education Today*, *11(3),* 225-229.

Australian Nursing Federation. (1984). On the record. *Australian Nurses Journal*, *14(4),* 26-30.

Baird, S.C., Bopp, A., Kruckenberg Schofer, K.K., Langenberg, A.S., & Matheis-Kraft, C. (1994). An innovative model for clinical teaching. *Nurse Educator*, *19(3),* 23-25.

Ball, S.J. (1990). Introducing Monsieur Foucault. In S.J. Ball (Ed.), *Foucault and Education: Discipline and Knowledge*, London: Routledge.

Barnard, A.G., & Dunn, S.V. (1994). Issues in the organization and structure of clinical education for undergraduate nursing programs. *Journal of Nursing Education*, *33(9),* 420-422.

Barr, H., Hammick, M., Koppel, I., & Reeves, S. (1999). Evaluating interprofessional education: Two systematic reviews for health and social care. *British Educational Research Journal*, *25(4),* 533-544.

Beattie, H. (1998). Clinical teaching models: A review of the role of preceptor in the undergraduate nursing program. *Australian Journal of Advanced Nursing*, *15(4),* 14-19.

Beck, C.T. (1993). Nursing students' initial clinical experience: A phenomenological study. *International Journal of Nursing Studies*, *30(6),* 489-497.

Beeman, R.Y. (2001). New partnerships between education and practice: Precepting junior nursing students in the acute care setting. *Journal of Nursing Education*, *40(3),* 132-134.

Bennett, M. (2001). *Nurse Recruitment and Retention Committee: Final Report May 2001*, Policy and Strategic Projects Division Victorian Government, Department of Human Services, Melbourne, Victoria.

Benor, D.E., & Leviyof, I. (1997). The development of students' perceptions of effective teaching: The ideal, best and poorest clinical teacher in nursing. *Journal of Nursing Education*, *36(5),* 206-211.

Bergman, K., & Gaitskill, T. (1990). Faculty and student perceptions of effective clinical teachers: An extension study. *Journal of Professional Nursing*, *6(1),* 33-44.

Bessant, J., & Bessant, B. (1991). *The Growth of a Profession: Nursing in Victoria 1930s – 1980s*. Melbourne: La Trobe University Press.

Bevir, M. (1999). Foucault and critique: Deploying agency against autonomy. *Political Theory*, *27(1),* 65-84.

Birx, E., & Baldwin, S. (2002). Nurturing staff-student relationships. *Journal of Nursing Education*, *41(2),* 86-88.

Bolton, G. (1981). A training in discipline and conformity. *Australian Nurses' Journal*, *11(4),* 34-36.

Boughn, S. (1992). An immodest proposal: Pay equity for nursing faculty who do clinical teaching. *Journal of Nursing Education*, *31(5),* 215-220.

Bowles, N. (1995). A critical appraisal of preceptorship. *Nursing Standard*, *9(45),* 25-28.

Brehaut, C.J., Turik, L.J., & Wade, K.E. (1998). A pilot study to compare the effectiveness of preceptored and nonpreceptored models of clinical education in promoting baccalaureate students' competence in public health nursing. *Journal of Nursing Education*, *37(8),* 376-380.

Brennan, A., & Hutt, R. (2001). The challenges and conflict of facilitating learning in practice: The experiences of two clinical nurse educators. *Nurse Education in Practice, 1(4),* 181-188.

Brink, P.J. (1991). Issues of reliability and validity. In J.M. Morse (Ed.), *Qualitative Nursing Research: A Contemporary Dialogue*, (Revised edition), Newbury Park: SAGE.

Brown, N. Forrest, S., & Pollock, L.C. (1998). The ideal role of the nurse teacher in the clinical area: A comparison of the perspectives of mental health, learning difficulties and general nurses. *Journal of Psychiatric and Mental Health Nursing*, *5(1),* 11-19.

Brown, S. (1981) Faculty and students' perceptions of effective clinical teachers. *Journal of Advanced Nursing*, *20(9),* 4-15.

Burke, L.M. (1997). Teachers of nursing – Presenting a new model of practice. *Journal of Nursing Management*, *5(5)*, 295-300.

Byrd, C.Y., Hood, L., & Youtsey, N. (1997). Student and preceptor perceptions of factors in a successful learning partnership. *Journal of Professional Nursing*, *13(6),* 344-351.

Calman, L., Watson, R., Norman, I., Redfern, S., & Murrells, T. (2002). Assessing practice of student nurses: Methods, preparation of assessors and student views. *Journal of Advanced Nursing*, *38(5),* 515-523.

Campbell, I.E, Larrivee, L., Field, P.A., Day, R.A., & Reutter, L. (1994). Learning to nurse in the clinical setting. *Journal of Advanced Nursing*, *20(6),* 1125-1131.

Caputo, J., & Yount, M. (1993) Institutions, normalization, and power. In J. Caputo, & M. Yount (Eds.), *Foucault and the Critique of Institutions* (pp. 3-23). Pennsylvania: Pennsylvania State University Press.

Carabine, J. (2001). Unmarried motherhood 1830-1990: A genealogical analysis. In M. Wetherell, S. Taylor, & S.J. Yates (Eds.), *Discourse as Data: A Guide for Analysis* (pp. 267-310). London: Open University.

Carlisle, C., Kirk, S., & Luker, K.A. (1997). The clinical role of nurse teachers within a Project 2000 course framework. *Journal of Advanced Nursing*, *25(2),* 386-395.

Carr, E.C.J. (1996). Reflecting on clinical practice: Hectoring talk or reality? *Journal of Clinical Nursing*, *5(5),* 289-295.

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

Ceci, C., Limacher, L.H., & McLeod, D.L. (2002). Language and power: Ascribing legitimacy to interpretive research. *Qualitative Health Research*, *12(5),* 713-720.

Chambon, A.S. (1994). Foucault's Approach: Making the Familiar Visible, In A.S. Chambon, A. Irving, & L. Epstein (Eds.), *Reading Foucault for Social Work* (pp. 51-81). New York: Columbia University Press.

Chan, D.S.K. (2001). Combining qualitative and quantitative methods in assessing hospital learning environments. *International Journal of Nursing Studies*, *38(4),* 447-459.

Chapman, R., & Orb, A. (2000). The nursing students' lived experience of clinical practice. *Australian Electronic Journal of Nursing Education*, *5(2),* Retrieved August 18, 2000, from http:www.scu.edu.au/schools/nhcp/aejne/vol5-2/chapmanrvol5_2.html

Chapman, R., & Orb, A. (2001). Coping strategies in clinical practice: The nursing students' lived experience. *Contemporary Nurse*, *11(1),* 95-102.

Cheek, J. (1998). Postmodern theory and nursing: Simply talking trivialities in high-sounding language. In H. Keleher, & F. McInerney (Eds.), *Nursing Matters: Critical Sociological Perspectives* (pp. 79-96). Sydney: Churchill Livingstone.

Cheek, J. (2000). *Postmodern and Poststructural Approaches to Nursing Research.* Thousand Oaks: SAGE.

Cheek, J., & Rudge, T. (1994). Been there, done that? Consciousness raising, critical theory and nurses. *Contemporary Nurse, 3(2),* 58-63.

Chow, F.L.W., & Suen, L.K.P. (2001). Clinical staff as mentors in pre-registration undergraduate nursing education: Students' perceptions of the mentors' roles and responsibilities. *Nurse Education Today, 21(5),* 350-358.

Clarke, C.L., Gibb, C.E., & Ramprogus, V. (2003). Clinical learning environments: An evaluation of an innovative role to support preregistration nursing placements. *Learning in Health and Social Care*, *2(2),* 105-115.

Clarke, V.A., & Ruffin, C.L. (1992). Perceived sources of stress among student nurses. *Contemporary Nurse*, *1(1),* 35-40.

Coates, V.E., & Gormley, E. (1997). Learning the practice of nursing: Views about preceptorship. *Nurse Education Today, 17(2),* 91-98.

Cook, S.H. (1991). Mind the theory/practice gap in nursing. *Journal of Advanced Nursing*, *16(12),* 1462-1469.

Cooke, M. (1996). Nursing students' perceptions of difficult or challenging clinical situations. *Journal of Advanced Nursing*, *24(6),* 1281-1287.

Cooke, S., Chew-Graham, C., Boggis, C., & Wakefield, A. (2003). 'I never realised that doctors were into feelings too': Changing student perceptions through interprofessional education. *Learning in Health and Social Care*, *2(3),* 137-146.

Cope, P., Cuthbertson, P., & Stoddart, B. (2000). Situated learning in the practice placement. *Journal of Advanced Nursing*, *31(4),* 850-856.

Corlett, J. (2000). The perceptions of nurse teachers, student nurses and preceptors of the theory-practice gap in nurse education. *Nurse Education Today*, *20(6),* 499-505.

Cresswell, J.W., & Miller, D.L. (2000). Determining validity in qualitative inquiry. *Theory into Practice*, *39(3),* 124-130.

Cutrofello, A. (1994). *Discipline and Critique: Kant, Poststructuralism, and the Problem of Resistance*. Albany: State University of New York.

Dant, T. (1991). *Knowledge, Ideology and Discourse*, London: Routledge.

Davies, E., Turner, C., & Osborne, Y. (1999). Evaluating a clinical partnership model for undergraduate nursing students. *Collegian*, *6(2),* 23-28.

Department of Community Services and Health. (1990). *Progress Report to Parliament: The Transfer of Nursing Education from Hospitals to the Tertiary Sector*, Department of Community Services and Health, Canberra.

DeVoogd, R., & Salbenblatt, C. (1989). The clinical teaching associate model: Advantages and disadvantages in practice. *Journal of Nursing Education*, *28(6),* 276-277.

Dibert, C., & Goldenberg, D. (1995). Preceptors' perceptions of benefits, rewards, supports and commitment to the preceptor role. *Journal of Advanced Nursing*, *21(6)*, 1144-1151.

Donaghue, S. (1975). *Goals in Nursing Education, Part 1: Changing Patterns of Nursing Education in Australia*, A study undertaken by Shirley Donaghue on behalf of the working party on "Goals in Nursing Education", Melbourne.

Dreyfus, H.L., & Rabinow, P. (1982). *Michel Foucault: Beyond Structuralism and Hermeneutics*, London: Harvester Press.

Duffy, M.E., Harju, L., Huittinen, L., & Trayner, C. (1999). An innovative model for international undergraduate education. *Nursing and Health Care Perspectives*, *20(1),* 26-31.

Duke, C. (1975). *Nurse Education - What Future? Goals in Nursing Education: report on a conference in the A.C.T.* Canberra: Centre for Continuing Education, Australian National University.

Duke, M. (1996). Clinical evaluation - difficulties experienced by sessional clinical teachers of nursing: a qualitative study. *Journal of Advanced Nursing, 23(2),* 408-414.

Dunlop, M. (1992). *Shaping Nursing Knowledge: An Interpretive Analysis of Curriculum Documents from NSW Australia*. Melbourne: Royal College of Nursing, Australia.

Dunn, S.V., Stockhausen, L., Thornton, R., & Barnard, A. (1995). The relationship between clinical education format and selected student learning outcomes, *Journal of Nursing Education. 34(1),* 16-24.

Dzuric, L.C. (1999). The necessity for and evolution of multiple paradigms for nursing: A poststructuralist perspective. In E.C. Polifroni, & M. Welch (Eds.), *Perspectives on Philosophy of Science in Nursing: An Historical and Contemporary Anthology* (pp. 491-497). Philadelphia: Lippincott Williams & Wilkins.

Easton, K.L., McComish, J.F., & Greenberg, R. (2000). Avoiding common pitfalls in qualitative data collection and transcription. *Qualitative Health Research*, *10(5),* 703-707.

Edmond, C.B. (2001). A new paradigm for practice education. *Nurse Education Today*, *21(4),* 251-259.

Elcock, K. (1998). Lecturer practitioner: A concept analysis. *Journal of Advanced Nursing*, *28(5),* 1092-1098.

Endacott, R., Scholes, J., Freeman, M., & Cooper, S. (2003). The reality of clinical learning in critical care settings: A practitioner:student gap? *Journal of Clinical Nursing*, *12(5),* 778-785.

Evans, W., & Kelly, B. (2004). Pre-registration diploma student nurse stress and coping measures. *Nurse Education Today, 24(6),* 473-482.

Fagerberg, I., & Ekman, S. (1998). Swedish nursing students' transition into nursing during education. *Western Journal of Nursing Research*, *20(5),* 602-620.

Fairbrother, P., & Ford, S. (1998). Lecturer practitioners: A literature review. *Journal of Advanced Nursing*, *27(2),* 274-279.

Ferguson, d.E. (1996). The lived experience of clinical educators. *Journal of Advanced Nursing*, *23(4),* 835-841.

Ferguson, K.E., & Jinks, A.M. (1994). Integrating what is taught with what is practised in the nursing curriculum: A multi-dimensional model. *Journal of Advanced Nursing, 20(4),* 687-695.

Ferguson, L.M., & Calder, B.L. (1993). A comparison of preceptor and educator valuing of nursing student clinical performance criteria. *Journal of Nursing Education*, *32(1),* 30-36.

Finn, T., King, J., & Thorburn, J. (2000). The educational needs of part time clinical facilitators. *Contemporary Nurse*, *9(2),* 132-139.

Fitzpatrick, J.M., While, A.E., & Roberts, J.D. (1996). Key influences on the professional socialisation and practice of students undertaking different pre-registration nurse education programmes in the United Kingdom. *International Journal of Nursing Studies, 33(5),* 506-518.

Fitzpatrick, M.L. (1993). Historical Research: The Method. In P.L. Munhall, & C.O. Boyd (Eds.), *Nursing Research: A Qualitative Perspective* (2nd ed., pp. 359-371).New York: National League for Nursing Press.

Flyvberg, B. (1998). Habermas and Foucault: Thinkers for civil society? *British Journal of Sociology, 49(2),* 210-233.

Fothergill-Bourbonnais, F., & Higuchi, K.S. (1995). Selecting clinical learning experiences: An analysis of the factors involved. *Journal of Nursing Education, 34(1),* 37-41.

Foucault, M. (1972). *The Archaeology of Knowledge*, London: Tavistock.

Foucault, M. (1973). *The Birth of the Clinic: An Archaeology of Medical Perception*. London: Tavistock.

Foucault, M. (1977). *Discipline and Punish: The Birth of the Prison.* London: Penguin.

Foucault, M. (1980a). The Eye of Power. In C. Gordon (Ed.), *Power/Knowledge: Selected Interviews and Other Writings 1972-1977* (pp. 146-165). London: Harvester Press.

Foucault, M. (1980b). Two Lectures. In C. Gordon (Ed.), *Power/Knowledge: Selected Interviews and Other Writings 1972-1977* (pp. 78-108). London: Harvester Press.

Foucault, M. (1980c). Truth and Power. In C. Gordon (Ed.), *Power/Knowledge: Selected Interviews and Other Writings 1972-1977* (pp. 109-133). London: Harvester Press.

Foucault, M. (1980d). Prison Talk. In C. Gordon (Ed.), *Power/Knowledge: Selected Interviews and Other Writings 1972-1977* (pp. 37-54). London: Harvester Press.

Foucault, M. (1982). Afterword: The Subject and Power, In H.L. Dreyfus, & P. Rabinow (Eds.), *Michel Foucault: Beyond Structuralism and Hermeneutics* (pp. 208-226). London: Harvester Press.

Foucault, M. (1984a). Truth and power. In P. Rabinow (Ed.), *The Foucault Reader* (pp. 51-75). London: Penguin.

Foucault, M. (1984b). Nietzche, Genealogy, History. In P. Rabinow (Ed.), *The Foucault Reader* (pp. 76-100). London: Penguin.

Foucault, M. (1984c).The body of the condemned. In P. Rabinow (Ed.), *The Foucault Reader* (pp. 170-178). London: Penguin.

Francis, B., & Humphreys, J. (1999). Rationalisation and professionalisation: A comparison of the transfer of registered nurse education to higher education in Australia and the UK. *Comparative Education, 35(1),* 81-96.

Glen, S., & Clark, A. (1999). Nurse education: A skill mix for the future. *Nurse Education Today, 19(1),* 12-19.

Glen, S., & Reeves, S. (2004). Developing interprofessional education in the pre-registration curricula: Mission impossible? *Nurse Education in Practice, 4(1),* 1-8.

Glover, P. (2000). ‘Feedback. I listened, reflected and utlized’: Third year nursing students’ perceptions and use of feedback in the clinical setting. *International Journal of Nursing Practice, 6(5),* 247-252.

Goldberg, L.K., & Brancato, V.C. (1998). International education: A United Kingdom nursing student partnership. *Nurse Educator, 23(5),* 30-34.

Grant, E., & McKenna, L. (2003). International clinical placements for undergraduate students. *Journal of Clinical Nursing, 12(4),* 529-535.

Grassie, W. (1997). Postmodernism: What one needs to know. *Zygon, 32(1),* 83-94.

Gray, M., & Smith, L.N. (1999). The professional socialization of diploma of higher education in nursing students (Project 2000): A longitudinal qualitative study. *Journal of Advanced Nursing, 29(3),* 639-647.

Grealish, L. (2000). The skills of coach are an essential element in clinical learning. *Journal of Nursing Education*, *39(5),* 231-233.

Grealish, L., & Carroll, G. (1998). Beyond preceptorship and supervision: A third clinical teaching model emerges for Australian nursing education. *Australian Journal of Advanced Nursing, 15(2),* 3-11.

Greenwood, J. (1993). The apparent desensitization of student nurses during their professional socialization: A cognitive perspective. *Journal of Advanced Nursing, 18(9),* 1471-1479.

Grey, C. (1994). Debating Foucault: A critical reply to Neimark. *Critical Perspectives in Accounting, 5(1),* 5-24.

Grose, J.W., Aysse, P., & Tracey, P. (1993). A creative clinical education model: Three views. *Nursing Outlook, 41(4),* 156-159.

Hall, J.M. (1999a). Marginalization revisited: Critical, postmodern, and liberation perspectives. *Advances in Nursing Science, 22(2),* 88-102.

Hall, M.M. (1999b). Breaking the silence: Marginalisation of registered nurses employed in nursing homes. *Contemporary Nurse, 8(1),* 232-237.

Hall, J.M., Stevens, P.E., & Meleis, A.I. (1994). Marginalization: A guiding concept for valuing diversity in nursing knowledge development. *Advances in Nursing Science, 16(4),* 23-41.

Haloburdo, E.P., & Thompson, M.A. (1998). A comparison of international learning experiences for baccalaureate nursing students: Developed and developing countries. *Journal of Nursing Education, 37(1),* 13-21.

Hamill, C. (1995). The phenomenon of stress as perceived by Project 2000 student nurses: A case study. *Journal of Advanced Nursing, 21(3),* 528-536.

Hamilton, S. (1989). *Progress Report to Parliament: The Transfer of Nursing Education from Hospitals to the Tertiary Sector (June 1989)*, Australian Government Publishing Service, Canberra.

Hamilton, S. (1990). *Progress Report to Parliament: The Transfer of Nursing Education from Hospitals to the Tertiary Sector (February 1990)*, Canberra: Australian Government Publishing Service.

Hart, G. (1985). College-based education: Background and bugs. *Australian Nurses Journal, 15(4),* 46-48.

Heath, P. (2001). *National Review of Nursing Education: Discussion Paper*. Canberra: Commonwealth of Australia.

Heath, P. (2002). *National Review of Nursing Education 2002: Our Duty of Care.* Canberra: Commonwealth of Australia.

Henderson, S. (2002). Factors impacting on nurses' transference of theoretical knowledge of holistic care into clinical practice. *Nurse Education in Practice, 2(4),* 244-250.

Henry, S.B., & Enunsa, K. (1986). Preceptorship in nursing service and education. In W.L. Holzemer (Ed.), *Review of Research in Nursing Education Volume I* (pp. 51-71), New York: National League for Nursing.

Herdman, E. (1995). Professionalisation, rationalisation and policy change: The transfer of pre-registration nurse education to the university sector'. In S.D. Short (Ed.), *Annual Review of Health Social Sciences: Health Policy* (pp. 61-78). Sydney: University of New South Wales.

Heuer, L., Bengiamin, M., & Downey, V.W. (2001). The impact of an international cultural experience on previously held stereotypes by American student nurses. *Multicultural Education, 9(1),* 26-29.

Hewison, A., & Wildman, S. (1996). The theory-practice gap in nursing: A new dimension. *Journal of Advanced Nursing, 24(4),* 754-761.

Higgins, B., & Ochsner, S. (1989). Two approaches to clinical evaluation. *Nurse Educator, 14(2),* 8-11.

Hilton, P. (1996). Clinical skills laboratories: Teaching practical nursing. *Nursing Standard, 10(37),* 44-47.

Holliday, A. (2002). *Doing and Writing Qualitative Research*. London, SAGE.

Holland, K. (1999). A journey to becoming: The student nurse in transition. *Journal of Advanced Nursing, 29(1),* 229-236.

Horsburgh, M., Lamdin, R., & Williamson, E. (2001). Multiprofessional learning: The attitudes of medical, nursing and pharmacy students to shared learning. *Medical Education, 35(9),* 876-883.

Howie, J. (1988). The effective clinical teacher: A role model. *Australian Journal of Advanced Nursing, 5(2)*, 23-26.

Howkins, E.J., & Ewens, A. (1999). How students experience professional socialisation. *International Journal of Nursing Studies, 36(1),* 41-49.

Hunsberger, M., Baumann, A., Lappan, J., Carter, N., Bowman, A., & Goddard, P. (2000). The synergism of expertise in clinical teaching: An integrative model for nursing education. *Journal of Nursing Education, 39(6),* 278-282.

Hwa, Y.L. (1998). Clinician-student interaction in the clinical setting. *Singapore Nursing Journal, 25(1),* 42-44.

Infante, M.S. (1985). *The Clinical Laboratory in Nursing Education*, New York: John Wiley & Sons.

Jinks, A.M. (1997). *Caring for Patients, Caring for Student Nurses*, London: Ashgate.

Johnson, R.B. (1997). Examining the validity structure of qualitative research. *Education, 118(2),* 282-292.

Jones, M.C., & Johnston, D.W. (1997). Distress, stress and coping in first-year student nurses. *Journal of Advanced Nursing, 26(3),* 475-482.

Kaviani, N., & Stillwell, Y. (2000). An evaluative study of clinical preceptorship. *Nurse Education Today, 20(3),* 218-226.

Kelly, B. (1993). The "real world" of hospital nursing practice as perceived by nursing undergraduates. *Journal of Professional Nursing, 9(1),* 27-33.

Kendall, G., & Wickham, G. (1999). *Using Foucault's Methods*. London: SAGE.

Kermode, S. (1987). Pre-clinical preparation of undergraduate nursing students. *Australian Journal of Advanced Nursing, 5(1),* 5-10.

Kitson, A.L. (2003) A comparative analysis of lay-caring and professional (nursing) caring relationships. *International Journal of Nursing Studies, 40(5),* 503-510.

Kleehammer, K., & Keck, J.F. (1990). Nursing student's perceptions of anxiety-producing situations in the clinical setting. *Journal of Nursing Education, 29(4),* 183-187.

Knox, J.E., & Mogan, J. (1985). Important clinical teacher behaviours as perceived by university nursing faculty, students and graduates. *Journal of Advanced Nursing, 10(1),* 25-30.

Koch, T. (1996). Implementation of a hermeneutic inquiry in nursing: Philosophy, rigour and representation. *Journal of Advanced Nursing, 24(1),* 174-184.

Koch, T., & Harrington, A. (1998).Reconceptualizing rigour: The case for reflexivity. *Journal of Advanced Nursing, 28(4),* 882-890.

Koh, L.C. (2002). The perceptions of nursing students of practice-based teaching. *Nurse Education in Practice, 2(1),* 35-43.

Kotzabassaki, S., Panou, M., Dimou, F., Karabagli, A., Koutsopoulou, B., & Ikonomou, U. (1997). Nursing students' and faculty's perceptions of the characteristics of 'best' and 'worst' clinical teachers: A replication study. *Journal of Advanced Nursing, 26(4),* 817-824.

Kramer, M. (1974). *Reality Shock: Why Nurses Leave Nursing*. St Louis: C.V. Mosby.

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

Kvale, S. (1996). *Interviews: An Introduction to Qualitative Research Interviewing*, Thousand Oaks: SAGE.

Landers, M.G. (2000). The theory-practice gap in nursing: The role of the nurse teacher. *Journal of Advanced Nursing, 32(6),* 1550-1556.

Langridge, M.E., & Hauck, Y.L. (1998). Perceptions of clinical role modelling: An exploration of nursing students' experiential learning. *Collegian, 5(4),* 22-27.

Larsen, K., Adamsen, L., Bjerregaard, L., & Madsen, J.K. (2002). There is no gap 'per se' between theory and practice: Research knowledge and clinical knowledge are developed in different contexts and follow their own logic. *Nursing Outlook, 50(5),* 204-212.

Lather, P. (1993). Fertile obsession: Validity after poststructuralism. *The Sociological Quarterly, 34(4),* 673-693.

Lauder, W., Reynolds, W., & Angus, N. (1999). Transfer of knowledge and skills: Some implications for nursing and nurse education. *Nurse Education Today, 19(6),* 480-487.

Lee, W-K., Cholowski, K., & Williams, A.K. (2002). Nursing students' and clinical educators' perceptions of characteristics of effective clinical educators in an Australian university school of nursing. *Journal of Advanced Nursing, 39(5),* 412-420.

Letizia, M., & Jennrich, J. (1998). A review of preceptorship in undergraduate nursing education: Implications for staff development. *Journal of Continuing Education in Nursing, 29(5),* 211-216.

Li, M.K. (1997). Perceptions of effective clinical teaching behaviours in a hospital-based nurse training programme. *Journal of Advanced Nursing, 26(6),* 1252-1261.

Lindop, E. (1991). Individual stress among nurses in training: Why some leave while others stay. *Nurse Education Today, 11(2),* 110-120.

Lloyd Jones, M., & Akehurst, R. (1999). The cost and value of pre-registration clinical placements for Project 2000 students. *Journal of Advanced Nursing, 30(1),* 169-178.

Lloyd Jones, M., & Akehurst, R. (2000). Should service providers be paid for providing pre-registration clinical placements? *Journal of Advanced Nursing, 32(2),* 432-436.

Löfmark, A., Carlsson, M., & Wikblad, K. (2001). Student nurses' perception of independence of supervision during clinical nursing practice. *Journal of Clinical Nursing, 10(1),* 86-93.

Löfmark, A., & Wikblad, K. (2001). Facilitating and obstructing factors for development of learning in clinical practice: A student perspective. *Journal of Advanced Nursing*, *34(1),* 43-50.

Long, T., & Johnson, M. (2000). Rigour, reliability and validity in qualitative research. *Clinical Effectiveness in Nursing, 4(1),* 30-37.

Lopez, V. (2003). Clinical teachers as caring mothers from the perspectives of Jordanian nursing students. *International Journal of Nursing Studies, 40(1),* 51-60.

Lumby, J. (1989). Preparation for practice. In G. Gray, & R. Pratt (Eds.), *Issues in Australian Nursing 2* (pp.291-310). Melbourne: Churchill Livingstone.

Lupton, D. (1992). Discourse analysis: A new methodology for understanding the ideologies of health and illness. *Australian Journal of Public Health, 16(2),* 145-150.

Lusk, B., Russell, R.L., Rodgers, J., & Wilson-Barnett, J. (2001). Preregistration nursing education in Australia, New Zealand, the United Kingdom, and the United States of America. *Journal of Nursing Education, 40(5),* 197-202.

Madison, J., Watson, K., & Knight, B.A. (1994). Mentors and preceptors in the nursing profession. *Contemporary Nurse, 3(3),* 121-126.

Mahat, G. (1998). Stress and coping: Junior baccalaureate nursing students in clinical settings. *Nursing Forum, 33(1),* 11-20.

Mamchur, C., & Myrick, F. (2003). Preceptorship and interpersonal conflict: A multidisciplinary study. *Journal of Advanced Nursing, 43(2),* 188-196.

Manias, E., & Street, A. (2000). Possibilities for critical social theory and Foucault's work: A toolbox approach. *Nursing Inquiry, 7(1),* 50-60.

Marinker, M. (1997). Myth, paradox and the hidden curriculum. *Medical Education, 31(4),* 293-298.

Marshall, J.D. (1989). Foucault and education. *Australian Journal of Education, 33(2),* 99-113.

Marshall, J.D. (1990). Foucault and educational research. In S.J. Ball (Ed.), *Foucault and Education: Disciplines and Knowledge* (pp. 11-28) London: Routledge.

Mayson, J., & Hayward, W. (1997). Learning to be a nurse: The contribution of the hidden curriculum in the clinical setting. *Nursing Praxis in New Zealand, 12(2),* 16-22.

McCaugherty, D. (1991). The theory-practice gap in nurse education: Its causes and possible solutions. Findings from an action research study. *Journal of Advanced Nursing, 16(9),* 1055-1061.

McCue, H. (1981). Clinical teaching and the nursing process – Implications for nurse teacher education. *Australian Nurses' Journal, 10(7),* 36-37.

McHoul, A., & Grace, W. (1993). *A Foucault Primer: Discourse, power and the subject.* Melbourne: Melbourne University Press.

McKenna, B., & Roberts, R. (1999). Bridging the theory-practice gap. *Kai Tiaki Nursing New Zealand, 5(2),* 14-16.

McLeland, A., & Williams, A. (2002). An emancipatory praxis study of nursing students on clinical practicum in New Zealand: Pushed to the peripheries. *Contemporary Nurse, 12(2),* 185-193.

McMillan, M.A., & Dwyer, J. (1989). Changing times changing paradigm (1): from hospital training and college education in Australia. *Nurse Education Today, 9(1),* 13-18.

McNay, L. (1992). *Foucault and Feminism: Power, Gender and the Self*. London: Polity Press.

Meisenhelder, J.B. (1987). Anxiety: A block to clinical learning. *Nurse Educator, 12(6),* 27-30.

Melander, S., & Roberts, C. (1994). Clinical teaching associate model: Creating effective BSN student/faculty/staff nurse triads. *Journal of Nursing Education, 33(9),* 422-425.

Melia, K.M. (1984). Student nurses' construction of occupational socialisation. *Sociology of Health and Illness, 6(2),* 132-151.

Meleis, A.I., & Im, E-O. (1999). Transcending marginalization in knowledge development. *Nursing Inquiry, 6(2),* 94-102.

Mellish, J.M., & Brink, H. (1990). *Teaching the Practice of Nursing: A text in nursing didactics*, Durban: Butterworths.

Miles, M.B., & Huberman, A.M. (1994). *Qualitative Data Analysis,* (2nd ed.). Thousand Oaks: SAGE.

Mills, C. (2003). Contesting the political: Butler and Foucault on power and resistance. *Journal of Political Philosophy, 11(3),* 253-272.

Minichello, V., Aroni, R., Timewell, E., & Alexander, L.(1995). *In-Depth Interviewing: Principles, Techniques, Analysis* (2nd ed.). Melbourne: Longman.

Mishler, E.G. (1991). Representing discourse: The rhetoric of transcription. *Journal of Narrative and Life History, 1(4),* 255-280.

Mogan, J., & Knox, J.E. (1987). Characteristics of 'best' and 'worst' clinical teachers as perceived by university nursing faculty and students. *Journal of Advanced Nursing, 12(3),* 331-337.

Morison, S., Boohan, M., Jenkins, J., & Moutray, M. (2003). Facilitating undergraduate interprofessional learning in healthcare: Comparing classroom and clinical learning for nursing and medical students. *Learning in Health and Social Care, 2(2),* 92-104.

Morse, J.M., & Field, P.A. (1995). *Qualitative Research Methods for Health Professionals*, (2nd ed.). Thousand Oaks: SAGE.

Myrick, F. (1988a). Preceptorship: A viable alternative clinical teaching strategy? *Journal of Advanced Nursing, 13(5),* 588-591.

Myrick, F. (1988b). Preceptorship - is it the answer to the problems in clinical teaching? *Journal of Nursing Education, 27(3),* 136-138.

Myrick, F. (1991). The plight of clinical teaching in baccalaureate nursing education. *Journal of Nursing Education, 30(1),* 44-46.

Myrick, F. (1994). Selecting clinical preceptors for basic baccalaureate nursing students: A critical issue in clinical teaching. *Journal of Advanced Nursing, 19(1),* 194-198.

Myrick, F., & Yonge, O.J. (2001). Creating a climate for critical thinking in the preceptorship experience. *Nurse Education Today, 21(6),* 461-467.

Nahas, V.L. (2000). A transcultural study of Jordanian nursing students' care encounters within the context of clinical education. *International Journal of Nursing Studies, 37,* 257-266.

Nahas, V., Nour, V., & Al-Nobani M. (1999). Jordanian undergraduate nursing students' perceptions of effective clinical teachers. *Nurse Education Today, 19(8),* 639-648.

Nahas, V.L., & Yam, B.M.C. (2001). Hong Kong nursing students' perceptions of effective clinical teachers. *Journal of Nursing Education, 40(5),* 233-237.

Napthine, R. (1996). Clinical education: A system under a pressure. *Australian Nursing Journal, 3(9),* 20-24.

Nehring, V. (1990). Nursing Clinical Teacher Effectiveness Inventory: A replication study of the characteristics of 'best' and 'worst' clinical teachers as perceived by nursing faculty and students. *Journal of Advanced Nursing, 15(8),* 934-940.

Neill, K.M., McCoy, A.K., Parry, C.B., Cohran, J., Curtis, J.C., & Ransom, R.B. (1998). The clinical experience of novice students in nursing. *Nurse Educator, 23(4),* 16-21.

Neimark, M. (1990). The King is Dead. Long live the King. *Critical Perspectives on Accounting, 1(1),* 103-114.

Neimark, M.K. (1994). Regicide revisited: Marx, Foucault and accounting. *Critical Perspectives on Accounting, 5(1),* 87-108.

Ng, J.L., & Duke, M. (2000). Students' perceptions of effective teaching and learning methods used by clinical teachers in Penang. *Singapore Nursing Journal, 27(3),* 38-45.

Nolan, C.A. (1998). Learning on clinical placement: The experience of six Australian student nurses. *Nurse Education Today, 18(8),* 622-629.

Nordgren, J., Richardson, S.J., & Laurella, V.B. (1998). A collaborative preceptor model for clinical teaching of beginning nursing students. *Nurse Educator, 23(3),* 27-32.

O'Callaghan, N., & Slevin, E. (2003). An investigation of the lived experiences of registered nurses facilitating supernumerary nursing students. *Nurse Education Today*, *23,* 123-130.

Oermann, M.H. (1996). Research on teaching in the clinical setting. In K.R. Stevens (ed.). *Review of Research in Nursing Education Volume VII* (pp. 91-126). New York: NLN Press.

Oermann, M.H. (1998a). Work-related stress of clinical nursing faculty. *Journal of Nursing Education, 37(7),* 302-304.

Oermann, M.H. (1998b). Role strain of clinical nursing faculty. *Journal of Professional Nursing, 14(6),* 329-334.

Oermann, M.H., & Standfest, K.M. (1997). Differences in stress and challenge in clinical practice among ADN and BSN students in varying clinical courses. *Journal of Nursing Education, 36(5),* 228-233.

Öhrling, K. (2000). *Being in the Space for Teaching-and-Learning: The Meaning of Preceptorship in Nurse Education*, Published doctoral dissertation, Lulea, Sweden: Lulea University of Technology.

Öhrling, K., & Hallberg, I.R. (2000). Student nurses' lived experience of preceptorship. Part 2 – the preceptor-preceptee relationship. *International Journal of Nursing Studies*, *37(1),* 25-36.

Öhrling, K., & Hallberg, I.R. (2001). Nurses' lived experience of being a preceptor. *Journal of Professional Nursing, 16(4),* 228-239.

O'Shea, H.S., & Parsons, M.K. (1979) Clinical instruction: Effective/and ineffective teacher behaviours. *Nursing Outlook, 27,* 411-415.

Ousey, K. (2000). Bridging the theory-practice gap? The role of the lecturer/practitioner in supporting pre-registration students gaining clinical experience in an orthopaedic unit. *Journal of Orthopaedic Nursing, 4(3),* 115-120.

Packer, J.L. (1994). Education for clinical practice: An alternative approach. *Journal of Nursing Education, 33(9),* 441-416.

Pagana, K.D. (1988). Stresses and threats reported by baccalaureate students in relation to an initial clinical experience. *Journal of Nursing Education, 27(9),* 418-424.

Papp, I., Markanen, M., & von Bonsdorff, M. (2003). Clinical environment as a learning environment: Student nurses' perceptions concerning clinical learning experiences. *Nurse Education Today, 23(4),* 262-268.

Paterson, B. (1994). The view from within: Perspectives of clinical teaching. *International Journal of Nursing Studies, 31(4),* 349-360.

Paterson, B.L. (1997). The negotiated order of clinical teaching. *Journal of Nursing Education, 36(5),* 197-205.

Paterson, B.L. (1998). Partnership in nursing education: A vision or a fantasy? *Nursing Outlook, 46(6),* 284-289.

Paterson, B.L., Osborne, M., & Gregory, D. (2004). How different can you be and still survive? Homogeneity and difference in clinical nursing education. *International Journal of Nursing Education Scholarship*, *1(1),* Retrieved October 10, 2004, from http://www.bepress.com/ijnes/vol1/iss1/art2

Patterson, E., & Cruickshank, D. (1996). Promoting purposeful partnerships. *Contemporary Nurse, 5(1),* 12-17.

Penney, W., & Warelow, P.J. (1999). Understanding the prattle of praxis. *Nursing Inquiry, 6(4),* 259-268.

Perry, M. (1988). Preceptorship in clinical nursing education: A social learning theory approach. *Australian Journal of Advanced Nursing, 5(3),* 19-25.

Phillips, N., & Duke, M. (2001). The questioning skills of clinical teachers and preceptors: A comparative study, *Journal of Advanced Nursing, 33(4),* 523-529.

Phillips, R.M., Davies, W.B., & Neary, M. (1996). The practitioner-teacher: A study in the introduction of mentors in the preregistration nurse education programme in Wales: Part 2. *Journal of Advanced Nursing, 23(6),* 1080-1088.

Phillips, S.J., & Kaempfer, S.H. (1987). Clinical teaching associate model: Implementation in a community hospital setting. *Journal of Professional Nursing, 3(3)*, 165-175.

Pittman, E. (1982). *The Role of the Nurse Administrator and Nurse-Educator: Part 1, Evaluation study of the Bachelor of Applied Science, Advanced Nursing Course, Lincoln Institute of Health Sciences,* Melbourne: College of Nursing Australia.

Place, B. (1985). *Nursing Education – Australian Made,* Seventeenth Florence Nightingale Oration, Melbourne: The National Florence Nightingale Committee.

Poland, B. (1995). Transcription quality as an aspect of rigor in qualitative research. *Qualitative Inquiry, 1(3),* 290-310.

Poland, B., & Pederson, A. (1998). Reading between the lines: Interpreting silences in qualitative research. *Qualitative Inquiry, 4(2),* 293-312.

Polifroni, E.C., Packard, S.A., Shah, H.S., & MacAvoy, S. (1995). Activities and interactions of baccalaureate nursing students in clinical practica. *Journal of Professional Nursing, 11(3),* 161-169.

Popkewitz, T.S., & Brennan, M. (1997). Restructing of social and political theory in education: Foucault and a social epistemology of school practices. *Educational Theory, 47(3),* 287-313

Portelli, J.P. (1993). Exposing the hidden curriculum. *Journal of Curriculum Studies, 25(4),* 343-358.

Porter, S., & Ryan, S. (1996) Breaking the boundaries between nursing and sociology: A critical realist ethnography of the theory-practice gap. *Journal of Advanced Nursing, 24(2),* 413-420.

Powers, P. (2001). *The Methodology of Discourse Analysis*. Massachussetts: Jones and Bartlett.

Priest, H., & Roberts, P. (1998). Assessing students' clinical performance. *Nursing Standard, 12(48),* 37-41.

Pullman, W.A. (1984). *Nursing Education in Western Australia: Report of the Committee of Inquiry into Nursing Education – Volume 1*, Western Australian Post Secondary Education Committee.

Pyett, P.M. (2003). Validation of qualitative research in the "real world". *Qualitative Health Research, 13(8),* 1170-1179.

Radcliffe, C., & Lester, H. (2003). Perceived stress during undergraduate medical training: A qualitative study. *Medical Education, 37(1),* 32-38.

Rafferty, A.M., & Allcock, N. (1996). The theory/practice 'gap': Taking issue with the issue. *Journal of Advanced Nursing, 23(4),* 685-691.

Ramage, C. (2004). Negotiating multiple roles: Link teachers in clinical nursing practice. *Journal of Advanced Nursing, 45(3),* 287-296.

Ramsay, A.H. (1970). *Report of the Committee of Enquiry into Nursing in Victoria*. Melbourne: Department of Health.

Ramazanoğlu, C. (1993). *Up Against Foucault: Explorations of Some Tensions between Foucault and Feminism*. London: Routledge.

Reeves, S. (2000). Community-based interprofessional education for medical, nursing and dental students. *Health and Social Care in the Community, 8(4),* 269-276.

Reeves, S., Freeth, D., McCrorie, P., & Perry, D. (2002). 'It teaches you want to expect in future…': Interprofessional learning on a training ward for medical, nursing, occupational therapy and physiotherapy students. *Medical Education, 36(4),* 337-344.

Reid, J.C. (1994). *Nursing Education in Australian Universities. Report of the National Review of Nurse Education in the Higher Education Sector. 1994 and beyond.* Canberra: Australian Government Publishing Service.

Reutter, L., Field, P.A., Campbell, I.E., & Day, R. (1997). Socialization into nursing: Nursing students as learners. *Journal of Nursing Education, 36(4),* 149-155.

Roberts, K. (1981). 'Futurizing' the curriculum – nursing education for the year 2000. *Australian Nurses' Journal, 11(3),* 49-52.

Robinson, S., & Hill, Y. (1995). Miracles take a little longer: Project 2000 and the health-promoting nurse. *International Journal of Nursing Studies, 32(6),* 568-579.

Rolfe, G. (1996). *Closing the Theory Practice Gap: A New Paradigm for Nursing*. London: Butterworth Heinemann.

Rolfe, G. (1997). Beyond expertise: Theory, practice and the reflexive practitioner. *Journal of Clinical Nursing, 6(2),* 93-97.

Rolfe, G. (2001). Postmodernism for healthcare workers in 13 easy steps. *Nurse Education Today, 21(1),* 38-47.

Rorty, R. (1986). Foucault and epistemology. In D.C. Hoy (Ed.), *Foucault: A Critical Reader* (pp. 41-50). London: Basil Blackwell.

Rose, K., & Webb, C. (1998). Analyzing data: Maintaining rigor in a qualitative study. *Qualitative Health Research, 8(4),* 556-562.

Ross, F., & Southgate, L. (2000). Learning together in medical and nursing training: Aspirations and activity. *Medical Education, 34(9),* 739-743.

Rubin, A. (2000). Standards for rigor in qualitative inquiry. *Research on Social Work Practice, 10(2),* 173-178.

Russell, R.L. (1988). Nursing education: A time for change 1960-1980. *Australian Journal of Advanced Nursing, 5(4),* 36-44.

Russell, R.L. (1990). *From Nightingale to Now: Nurse Education in Australia.* Sydney: Harcourt Brace Jovanovich.

Ryan-Nicholls, K.D. (2004). Preceptor recruitment and retention. *Canadian Nurse*, *100(6),* 19-22.

Sambell, K., & McDowell, L. (1998). The construction of the hidden curriculum: Messages and meanings in the assessment of student learning. *Assessment & Evaluation in Higher Education, 23(4),* 391-402.

Sandelowski, M. (1993). Rigor or rigor mortis: The problem of rigor in qualitative research revisited. *Advances in Nursing Science, 16(2),* 1-8.

Sandelowski, M. (1994). Notes on transcription. *Research in Nursing and Health, 17(4),* 311-314.

Sandelowski, M. (1995). Qualitative analysis: What it is and how to begin. *Research in Nursing and Health, 18(4),* 371-375.

Sanders, B. (1998). Why postmodern theory may be a problematic basis for therapeutic practice: A feminist perspective. *Australian New Zealand Journal of Family Therapy, 19(3),* 111-119.

Sawicki, J. (1991). *Disciplining Foucault: Feminism, Power and the Body*. New York: Routledge.

Sax, S. (1978). *Nurse Education and Training: Report of the Committee of Inquiry into Nurse Education and Training to the Tertiary Education Commission*, Canberra: AGPS.

Scanlan, J.M., Care, W.D., & Gessler, S. (2001). Dealing with the unsafe student in clinical practice. *Nurse Educator, 26(1),* 23-27.

Schön, D.A. (1995). Knowing-in-action: The new scholarship requires a new epistemology. *Change, 27(6)*, 27-34.

Schuster, P., Fitzgerald, D.C., McCarthy, P.A., & McDougal, D. (1997). Work load issues in clinical nursing education. *Journal of Professional Nursing, 13(3),* 154-159.

Scully, J., Birchfield, M., & Munro, L. (1998). An international nursing course: The health system, England. *Nursing and Health Care Perspectives, 19(5),* 208-213.

Secrest, J.A., Norwood, B.R., & Keatley, V.M. (2003). “I was actually a nurse”: The meaning of professionalism for baccalaureate nursing students. *Journal of Nursing Education, 42(2),* 77-82.

Seidman, I. (1998). *Interviewing as Qualitative Research*, New York: Teachers College Press.

Sellappah, S., Hussey, T., Blackmore, A.M., & McMurray, A. (1998). The use of questioning strategies by clinical teachers. *Journal of Advanced Nursing, 28(1),* 142-148.

Sellick, K., & Kanitsaki, O. (1991). A comparison of faculty and student perceptions of clinical nurse teacher behaviours. *Australian Journal of Advanced Nursing, 9(1),* 3-7.

Senate Community Affairs Reference Committee, Commonwealth of Australia. (2002). *The Patient Profession: Time for Action. Report on the Inquiry into Nursing.* Retrieved November 1, 2004, from http:www.aph.gov.au/senate/committee/clac_ctte/nursing/ /report/contents.htm

Shah, H.S., & Pennypacker, D.R. (1992). The clinical teaching partnership. *Nurse Educator, 17(2),* 10-12.

Shead, H. (1991). Role conflict in student nurses: Towards a positive approach for the 1990s. *Journal of Advanced Nursing, 16(6),* 736-740.

Sheu, S., Lin, H-S., & Hwang, S-L. (2002). Perceived stress and physio-psycho-social status of nursing students during their initial period of clinical practice: The effect of coping behaviors. *International Journal of Nursing Studies, 39(2),* 165-175.

Shin, K.R. (2000). The meaning of the clinical learning experience of Korean nursing students. *Journal of Nursing Education, 39(6),* 259-265.

Shipton, S.P. (2002). The process of seeking stress-care: Coping as experienced by senior baccalaureate nursing students in response to appraised clinical stress. *Journal of Nursing Education, 41(6),* 243-256.

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

Simons, J. (1996). Foucault’s mother. In S.J. Hekman (ed.) *Feminist Interpretations of Michel Foucault* (pp. 179-210). Pennsylvania: Pennsylvania State University Press.

Smith, M.H., McKoy, Y.D., & Richardson, J. (2001). Legal issues relating to dismissing students for clinical deficiencies. *Nurse Educator, 26(1),* 33-38.

Smith, R.G. (1999). *In Pursuit of Excellence: A History of the Royal College of Nursing, Australia 1949-99.* Melbourne: Oxford University Press.

Smyth, T. (1988). Marginality and the role of the clinical teacher. *Journal of Advanced Nursing, 13(5),* 621-630.

Speedy, S. (1989). Theory-practice debate: Setting the scene. *Australian Journal of Advanced Nursing, 6(3),* 12-20.

Speedy, S. (1990). *Nursing Faculty Development: From Principles to Practice*, Melbourne: Royal College of Nursing, Australia.

Spouse, J. (2001). Bridging theory and practice in the supervisory relationship: A sociocultural perspective. *Journal of Advanced Nursing*, 33(4), 512-522.

Stevenson, B., Doorley, J., Moddeman, G., & Benson-Landau, M. (1995). The preceptor experience: A qualitative study of perceptions of nurse preceptors regarding the preceptor role. *Journal of Nursing Staff Development, 11(3),* 160-165.

Stockhausen, L. (1994). The clinical learning spiral: A model to develop reflective practitioners. *Nurse Education Today, 14,* 363-371.

Street, A. (1990). *Nursing Practice: High, Hard Ground, Messy Swamps and the Pathways in Between.* Geelong: Deakin University.

Tanner, C.A. (1998). Tending to our clinical education. *Journal of Nursing Education, 37(8),* 335-336.

Taylor, P.A. (2000). Strategies for enhancing student learning by managing ambiguitieis in clinical settings. *Nurse Educator, 25(4),* 173-174.

Thompson, K., Boore, J., & Deeny, P. (2000). A comparison of an international experience for nursing students in developed and developing countries. *International Journal of Nursing Studies, 37(6),* 481-492.

Timmins, F., & Kaliszer, M. (2002). Aspects of nurse education programmes that frequently cause stress to nursing students – fact-finding sample survey. *Nurse Education Today, 22(3),* 203-211.

Touey, D. (1998). Foucault's apology. *Journal for the Theory of Social Behaviour, 28(1),* 83-106.

Trembath, R., & Hellier, D. (1987). *All Care and Responsibility – A History of Nursing in Victoria 1850-1934.* Melbourne: Florence Nightingale Committee.

Tucker, K., Wakefield, A., Boggis, C., Lawson, M, Roberts, T., & Gooch, J. (2003). Learning together: Clinical skills teaching for medical and nursing students. *Medical Education, 37(7),* 630-637.

Turner, B.S. (1997). Foreword: From governmentality to risk: Some reflections on Foucault's contribution to medical sociology. In A. Peterson, & R. Bunton (Eds.), *Foucault, Health and Medicine* (pp. ix-xxi). London: Routledge.

Victorian Nursing Council. (1973). *Executive Committee, Minutes of Meetings*, 4th July 1973.

Victorian Nursing Council. (1974a). *Executive Committee, Minutes of Meetings*, 20th March 1974.

Victorian Nursing Council. (1974b). *Executive Committee, Minutes of Meetings*, 20th November 1974.

Victorian Nursing Council. (1976a). *Executive Committee, Minutes of Meetings*, 14th April 1976.

Victorian Nursing Council. (1976b). *Executive Committee, Minutes of Meetings*, 20th October 1976.

Victorian Nursing Council. (1976c). *Executive Committee, Minutes of Meetings*, 14th April 1976.

Victorian Nursing Council (1976d). *Executive Committee, Minutes of Meetings,* 20th October 1976.

Victorian Nursing Council. (1985). *Executive Committee, Minutes of Meetings*, 6th February 1985.

Warelow, P.J. (1997). A nursing journey through discursive praxis. *Journal of Advanced Nursing, 26,* 1020-1027.

Waterworth, S. (2003). Temporal reference frameworks and nurses' work organization. *Time and Society, 12(1),* 41-54.

Weber, J.R. (1993). Collaborative teaching: Preparing for the reality of nursing. *Nursing Management, 24(12),* 47-52.

Weedon, C. (1995). *Feminist Practice and Poststructuralist Theory,* Oxford: Blackwell.

Welch, M., & Polifroni, E.C. (1999). Postmodernism and nursing science. In E.C. Polifroni, & M. Welch (Eds.), *Perspectives on Philosophy of Science in Nursing: An Historical and Contemporary Anthology* (pp. 467-470). Philadelphia: Lippincott, Williams and Wilkins.

Wellard, S., & McKenna, L. (2001). Turning tapes into text: Issues surrounding the transcription of interviews. *Contemporary Nurse, 11(2-3),* 180-186.

Wellard, S., Williams, A., & Bethune, E. (2000). Staffing of undergraduate clinical learning programs in Australia. *Nurse Education Today, 20(7),* 548-554.

While, A.E. (1991). The problem of clinical evaluation – a review. *Nurse Education Today, 11(6),* 448-453.

White, R., & Ewan, C. (1991). *Clinical Teaching in Nursing,* London: Chapman & Hall.

Whittemore, R., Chase, S.K., & Mandle, C.L. (2001). Validity in qualitative research. *Qualitative Health Research, 11(4),* 522-537.

Williams, A., Wellard, S.J., & Bethune, E. (2001). Assessing Australian undergraduate clinical learning. *Collegian, 8(4),* 9-13.

Williams, J. (2001). The clinical notebook: Using student portfolios to enhance clinical teaching learning. *Journal of Nursing Education, 40(3),* 135-137.

Williamson, G.R., & Webb, C. (2001). Supporting students in practice. *Journal of Clinical Nursing, 10(2),* 284-292.

Wilson, A., & Startup, R. (1991). Nurse socialization: Issues and problems. *Journal of Advanced Nursing, 16(12),* 1478-1486.

Wilson, M.E. (1994). Nursing student perspective of learning in a clinical setting. *Journal of Nursing Education, 33(2),* 81-86.

Windsor, A. (1987). Nursing students' perceptions of clinical experience. *Journal of Nursing Education, 26(4),* 150-154.

Wiseman, R.F. (1994). Role model behaviours in the clinical setting. *Journal of Nursing Education, 33(9),* 405-410.

Wolin, S.S. (1988). On the theory and practice of power. In J. Arac (Ed.), *After Foucault: Humanistic Knowledge, Postmodern Challenge* (pp. 179-202). New Brunswick: Rutgers University Press.

Wong, F.K.Y., & Lee, W.M. (2000). A phenomenological study of early nursing experiences in Hong Kong. *Journal of Advanced Nursing, 31(6),* 1509-1517.

Wong, J., & Wong, S. (1987). Towards effective clinical teaching in nursing. *Journal of Advanced Nursing, 12(4),* 505-513.

Yong, V. (1996). 'Doing clinical': The lived experience of nursing students. *Contemporary Nurse, 5(2),* 73-79.

Yonge, O. (1997). Assessing and preparing students for distance preceptorship placements. *Journal of Advanced Nursing, 26(4),* 812-816.

Yonge, O., Krahn, H., Trojan, L., & Reid, D. (1997). Through the eyes of the preceptor. *Canadian Journal of Nursing Administration, 10(4),* 65-85.

Zisberg, A., Bar-Tal, Y., & Krulik, T. (2003). The presence of nursing students and its influence on the quality of care provided by staff nurses. *Nursing Outlook, 51(3),* 102-107.

# Appendix 1:

# Publications and Presentations Arising Out of the Study

**JOURNAL PUBLICATIONS**

McKenna, L.G. & Wellard, S.J. (2004). Discursive influences on clinical teaching in Australian undergraduate nursing programs. *Nurse Education Today*, In press.

Wellard, S.J. & McKenna, L.G. (2001). Turning tapes into text: Issues surrounding the transcription of interviews. *Contemporary Nurse*, 11(2/3), 180-186.

**CONFERENCE PRESENTATIONS**

McKenna, L. & Wellard, S. (2002) A discursive picture of undergraduate clinical education around the transfer of nurse education in Australia. *13th International Nursing Research Congress,* Brisbane, Australia, 24-26 July 2002.

McKenna, L. & Wellard, S. (2001) Issues surrounding the application of philosophical positions in “real” research. *7th Annual Qualitative Health Research Conference*, Seoul, Korea, 27-29 June 2001.

McKenna, L. & Wellard, S. (2000) Evolutionary perspectives on clinical teaching in nursing. *New Century, New Directions: Deakin University School of Nursing International Conference*, Melbourne, Australia, 8-11 August 2000.

# Appendix 2: Plain Language Statements

**PHASE ONE**

**DEAKIN UNIVERSITY ETHICS COMMITTEE**

**PLAIN LANGUAGE STATEMENT**

---

Dear….,

Further to our telephone discussion I am currently a PhD student at the School of Nursing at Deakin University. The research project that I am undertaking seeks to explore clinical teaching roles in undergraduate nurse education including the factors that impact upon, and shape, their development. The study involves examining both historical development of clinical teaching roles from the transfer of nurse education into the tertiary education sector, along with the current context. From searching through available literature, I have found that there are a great many studies about effective clinical teaching from both student and academic perspectives. However, little research has been generated from the perspective of clinical teaching around the time of the transfer of nurse education into the tertiary sector. I am interested in the models that were initially employed for clinical teaching and the factors that shaped the decision to adopt them.

I would like to invite you to participate in the study. If you agree to participate you will be asked to sign a consent form indicating your agreement to participate. Your participation will involve an interview with myself to discuss your views on the clinical teaching role around the move to the tertiary sector. The interview will last between 1 – 1½ hours and will be audiotaped so that it may be transcribed and analysed later. A summary of the interview will be provided for you to check your comments have been accurately interpreted.

During the interview key issues will be explored with you, and the following questions will guide our discussion:

- *Can you describe your recollections of clinical teaching roles as they existed prior to the transfer of nurse education into the tertiary sector?*
- *Can you describe the factors that influenced the initial clinical teaching roles immediately following the transfer of nurse education into the tertiary sector?*
- *What model for clinical teaching was adopted initially?*
- *What was the rationale for adopting that particular model?*

Participation in this study is completely voluntary and your participation will be confidential. You may choose to withdraw at any time. Your name will not be recorded in any information and a pseudonym will be used to refer to your comments. Data will be secured in accordance with Deakin University guidelines and retained for a minimum of 6 years following publication of research findings.

Copies of a summary report will be available to participants in the study upon request. It is expected that the findings will be published in professional journals and conference proceedings.

Thank you for considering this request. Should you have any further questions or wish to discuss the project with me, please contact Lisa McKenna on 03 9904 4352(work) or by email lisa.mckenna@nursing.monash.edu.au or through my supervisor Dr Sally Wellard, Senior Lecturer, Deakin University School of Nursing on 03 92445627 or email: swellard@deakin.edu.au.

---

Should you have any concerns about the conduct of this research project, please contact the Secretary, Ethics Committee, Research Services, Deakin University, 221 Burwood Highway, BURWOOD VIC 3125. Tel (03) 9251 7123 (International +61 3 9251 7123).

**PHASE TWO**

**DEAKIN UNIVERSITY ETHICS COMMITTEE**

**PLAIN LANGUAGE STATEMENT**

---

My name is Lisa McKenna and I am currently a PhD student at Deakin University. The research project that I am undertaking seeks to explore clinical teaching roles in undergraduate nurse education including the factors that impact upon, and shape, their development. The study involves examining both historical development of clinical teaching roles from the transfer of nurse education into the tertiary education sector, along with the current context. From searching through available literature, I have found that there are a great many studies about effective clinical teaching from both student and academic perspectives. However, little research has been generated from the perspective of the person undertaking the clinical teaching, whether it be a sessional clinical teacher employed by a university, clinical teaching associate or preceptor employed by a health care agency. Therefore, I am particularly interested in how you as a clinical teacher perceive your role and the factors that influence the way in which you carry it out.

I would like to invite you to participate in the study. If you agree to participate you will be asked to sign a consent form indicating your agreement to participate. Your participation will involve an interview with myself to discuss your views on the clinical teaching role. The interview will last between 1 –1½ hours and will be audiotaped so that it may be transcribed and analysed later. A summary of the interview will be provided for you to check your comments have been accurately interpreted.

During the interview key issues will be explored with you, and the following questions will guide our discussion:

- *How would you describe your role as a (sessional clinical teacher/clinical teaching associate/preceptor)?*
- *Can you describe the teaching component of your role?*
- *Are there other key components of your role that you are able to identify and describe?*
- *A number of factors may influence the way in which you execute your role. Can you describe the factors that you perceive influence your clinical teaching role?*
- *What difficulties do you experience in carrying out your clinical teaching role?*
- *Do you perceive any means for minimising the difficulties you have identified?*

Participation in this study is completely voluntary and your participation will be confidential. You may choose to withdraw at any time. Your name will not be recorded in any information and a pseudonym will be used to refer to your comments. Data will be secured in accordance with Deakin University guidelines and retained for a minimum of 6 years following publication of research findings.

Copies of a summary report will be available to participants in the study upon request. It is expected that the findings will be published in professional journals and conference proceedings.

Thank you for considering this request. Should you have any further questions or wish to discuss the project with me, please contact Lisa McKenna on 03 9904 4352(work) or email at lisa.mckenna@nursing.monash.edu.au or through my supervisor Dr Sally Wellard, Senior Lecturer, Deakin University School of Nursing on 03 92445627 or email: swellard@deakin.edu.au.

---

Should you have any concerns about the conduct of this research project, please contact the Secretary, Ethics Committee, Research Services, Deakin University, 221 Burwood Highway, BURWOOD VIC 3125. Tel (03) 9251 7123 (International +61 3 9251 7123).