

CHAPTER 1

Introduction

Problem and its significance

The complexities of nursing practice require nurses to have analytical and problem-solving skills so that they can make appropriate clinical decisions underpinned by holistic professional competence. The achievement of such competence requires conceptual understanding thus allowing knowledge to be used across a variety of contexts. According to Fish and Twinn (1997) when practice is based on principled understanding the nurse is better able to deal with the realities of patient care. In preparation for the Registered Nurse (RN) role, undergraduate nursing students are expected to develop and integrate knowledge and practice to achieve conceptual understanding so that it is possible to make the necessary clinical decisions required for competent, professional, patient-centred care. According to the World Health Organization [WHO] (2001) nurse preparation courses should therefore facilitate students to learn complex technical skills and develop knowledge and understanding that can be applied to a range of situations. Using an ethical and moral framework, educational programs should also foster appropriate attitudes so that nurses can look after and support those in their care. WHO (2001) suggests that a balance of theory and practice opportunities should be provided where a student-focused approach is taken to help students integrate theory and practice with appropriate clinical supervision.

However, there have been problems. Martin's (1997) investigation into the effectiveness of different models of work-based university education found that employers of graduates of Health Sciences, Social Work, Engineering and Business courses believe that the graduates do not have enough knowledge and are therefore considered to not be ready for work. In relation to preparation of nurses, WHO (2000b) reports that problems exist with the variability of learning outcomes from undergraduate nurse education programs with some graduates not being appropriately prepared to tackle complex health problems. The implication therefore, is that there is variability in nursing students' learning outcomes from their courses. Inadequate preparation of new graduates impacts on their readiness to undertake the

role as a nurse. If new graduates are not adequately prepared, as evidenced by variability of learning outcomes, they will not be able to look after their patients and provide the appropriate care and support that is expected by their employers.

In response to concerns with the variable quality of outcomes from nurse education programs, the 6th meeting of the 49th World Health Assembly developed a set of guidelines for curriculum development for initial nurse education programs (World Health Organization, 2001). In order to meet the challenges that will arise within the context of health care reform, and in consideration of the current emphasis on 'health promotion and disease prevention, community development, multidisciplinary team working, the provision of health services closer to where people live and work, and equity of access' (World Health Organization, 2000a, p.1). World Health Organization (2000b) recommends an evidence-based, research-based and competency-based curriculum, designed with the country's needs in mind. Such a program allows nurses to integrate theory and practice and, as well, prepares them for a professional life aimed firstly at working collaboratively with patient, family and the wider health care team in order to achieve best outcomes. Other aims include preparation of nurses for change: and finally, that they will recognise the need to update knowledge and skills regularly in order to maintain clinical competency.

It is expected, therefore, that academic nursing programs will provide students with theoretical and clinical learning opportunities to develop the required professional knowledge and skills. Heath (2002) asserts that competencies should be used to indicate the requisite learning outcomes in line with WHO guidelines. Preparation programs typically consist of a combination of theory and clinical practice of which the clinical practicum is an important component. Students on clinical practicum require some level of supervision and support and this is provided in a variety of ways. One common way of achieving this is by the employment of a registered nurse, known as a clinical teacher or educator who is appointed by a university to supervise, teach, support and assess a small group of nursing students whilst on clinical placement (Farrell, Pearson & Roberts, 2002; Hunsberger, Baumann & Lappin, 2000). A particular focus of the practicum is on helping the student to make the links between theory and practice (Landmark, Hansen, Jones & Bohler, 2003). More detail in relation to models of clinical support is provided in Chapter 2.

Although the WHO guidelines were announced in 2001, (World Health Organization, 2001) the Australian nursing profession had already developed a range of professional competencies that nurses must possess if they are to practise as RNs. The Australian nursing competency standards, as designed by the Australasian Nurse Registering Authorities Conference (ANRAC) in the late 1980s, are broad, emphasising the intricacy and holistic character of practice (Cheek, Gibson & Gilbertson, 1995). Updated nursing competencies, previously known as Australasian Nursing Council Incorporated (ANCI) competencies and now known as Australian Nursing and Midwifery Council (ANMC) competencies for registered nurses and midwives, show a continuation of this emphasis (Australian Nursing & Midwifery Council, 2005). Nursing competencies serve a number of purposes which include: determining the scope of nursing practice by giving clarity to the role of the nurse, aiding in the development of nursing professionalism and providing a basis for accreditation of courses. Of particular relevance to this discussion is that competency standards are used for determining suitability for practice (Cameron, 1989).

Even though competency standards are in place in Australian nurse preparation programs, problems are nevertheless apparent with the quality of student learning outcomes. Two Australian government inquiries conducted after the establishment of competency standards identified problems with nurse preparation programs. The Australian Nurse Education National Report (Reid, 1994) identified that new graduates lacked competence in their clinical work. The Australian National Review of Nurse Education (Heath, 2002) expressed concerns that current approaches to nursing education will not adequately prepare nurses for the future. Boychuk Duscher (2001) reports on her study aimed at investigating recruitment and retention issues with a particular focus on the transition of new graduates to the workplace. This study identified issues in relation to the gap between theory and practice. Participants in Boychuk Duscher's (2001) study reported that what they had been taught in their preparation programs was not what was actually practised in the clinical setting. Ramritu and Barnard's (2001) study explored new graduates' conceptions of competence. A variety of different ways of conceiving of competence was identified. It is their recommendation that new graduates require support and assistance as they make the transition from student to registered nurse. The Australian National Review of Nurse Education (Heath, 2002) sought feedback from

students themselves regarding clinical placements. Issues such as insufficient clinical time, fragmentation of clinical experience, the lack of a feeling of belonging to the organisation, and travel and/or accommodation costs, were identified. Of particular interest however, is that these students also identified issues with inadequate supervision, feeling a burden to clinical staff and the gap experienced between theory and practice. Given that any of these issues could have a negative impact on learning outcomes it is important to investigate the clinical practicum component of undergraduate nursing course offerings.

Problems experienced with the quality of learning outcomes from nurse education programs could be related to the way in which competencies are being interpreted and used. Cheek, Gibson and Gilbertson (1995) argue that there are different interpretations of the competency standards. If interpreted in the narrowest sense, nursing is reduced to lists of tasks and the higher order skills such as complex decision-making are unacknowledged. Cust (1996) argues that lists of competencies only deal with knowledge and skill in an objective fashion and that the subjective meaning of practice is absent. Nurses' intentions, determined by meaning ascribed to nursing, decide their approaches to patient care. Further to this, the separation of the knowledge and skill components of competence is inadequate because the person performing the skills is not considered (Sandberg, 2000). It would appear then, that even when competency standards are in place, there are limitations in their usefulness for determining readiness for professional practice both currently, and, also, it would seem, into the future.

Professional practice is much more complex than the achievement of competencies viewed from a narrow perspective would indicate. Fish and Twinn (1997) assert that instead of disintegrating professional practice by using competencies, nursing students need to develop a holistic notion of professional competence. They argue that professional practice entails complex decision-making involving judgments founded on moral principles that cannot be reduced to rules and routines. This implies that to work as a professional, behaviour and patient care outcomes are as important as understanding the subjective meaning for the nurse since he/she is held morally and legally accountable for his/her practice. Therefore, it is important to investigate how clinical teachers experience nursing and clinical teaching. This will provide insights as to possible reasons for variability in learning outcomes where

new graduates are not considered capable of providing the care required by their patients. Such an investigation might facilitate understanding for what might be needed to improve the outcomes for learners and subsequently for their future patients.

A research approach that is proving to be useful in the context of teaching and learning in universities is phenomenography (Entwistle, 1997). This research method is based on the belief that a particular phenomenon can be experienced and understood in a limited number of qualitatively different ways (Marton & Booth, 1997). It is usual for phenomenographic research to focus on investigating variation in the learning process, the teaching process or a particular concept that is being learned or taught. Of particular relevance to this study is the phenomenographic research into teaching and learning which has shown that the quality of student learning outcomes depends on a number of factors. Students' conceptions of learning and their learning situation are related to previous learning experiences, approaches to learning and quality of learning outcomes (Ramsden, 2003). At any one time, the student's awareness is focused on one or more of these aspects. Therefore, students experience learning in different ways (Ramsden, 2003). Variation also occurs in teachers' experiences of teaching and learning, in particular their conceptions of the teaching situation and their prior teaching experiences as well as their teaching approaches (Prosser & Trigwell, 1999b).

Relationships have also been identified between teacher approaches to teaching, student approaches to learning and the quality of learning outcomes. According to Prosser and Trigwell (1999a) teacher approaches to teaching are related to their understanding of what is to be taught and learnt, their perceptions of the environment, their prior teaching experiences and intentions and the quality of student learning outcomes. Teachers who intend that their students achieve conceptual change possess complex conceptions of teaching and learning and use student-focused teaching strategies. Students of such teachers are more likely to adopt deep approaches to learning thus affording high quality learning outcomes. Of interest to this study is the question of how clinical teachers conceive of nursing and clinical teaching and how they approach their clinical teaching.

Phenomenographic research has identified that a relationship exists between the way people interpret situations and their subsequent actions (Marton & Booth, 1997). Since phenomenography aims at describing the variation in ways people experience phenomena it is an appropriate research method that can be used to investigate clinical teachers' experiences of nursing and clinical teaching. As there is a relationship between teacher approaches to teaching, student approaches to learning and the quality of learning outcomes, it is important to know what the key variations are in relation to clinical teachers' approaches to clinical teaching. In order to understand how clinical teachers go about clinical teaching, use of phenomenographic research enables identification and description of the qualitatively different ways they conceive of nursing and teaching and how these differences relate to their approaches to clinical teaching. It is argued in this thesis that there is a relationship between nurse teachers' understanding about nursing and clinical teaching and how they go about their teaching. Therefore, the process of nursing students developing professional nursing competence would be better appreciated if the interrelationship of the supervising clinical teacher, their conceptions of nursing and approaches to clinical teaching were understood.

Developing knowledge about conceptions and approaches of clinical teachers of undergraduate nursing students is significant since the focus of phenomenographic research into teaching and learning thus far has been mainly focused on classroom situations. Knowledge about teaching in the clinical setting will therefore provide a means for identifying whether similar relationships exist between teacher conceptions and approaches to teaching in the clinical setting. Since there has hitherto been no phenomenographic research conducted into clinical teachers and their perspectives on nursing and teaching, the research findings from this study will extend knowledge that will assist with preparation and support of these clinical nurse teachers in the future. By understanding the relationship between clinical teachers' conceptions of nursing and their approaches to clinical teaching it is possible to help clinical teachers change their conceptions and approaches. It is reasonable to assume that clinical teachers who want their students to achieve conceptual change will possess complex conceptions of nursing and clinical teaching and use student-focused teaching strategies. As is the case in previous phenomenographic research, it is suggested that nursing students of such teachers are more likely to adopt deep

approaches to learning and, as a consequence, students' learning outcomes will improve.

The findings of this research contribute in a third way, through adding to the body of research that has informed the general understanding of teaching in higher education, and more specifically to teaching in clinical settings. Finally, the findings of this research also contribute to what is already known about conceptions and approaches to teaching from a phenomenographic perspective.

Aim of the study

Because of previously established relationships between teacher conceptions and approaches to teaching and the quality of student learning outcomes, the major aim of this study was to investigate a particular group of clinical teachers who provided clinical supervision and teaching to nursing students whilst on clinical placement. It identifies the conceptions of nursing held by those clinical teachers and their approaches to clinical teaching as it was anticipated that a relationship would exist between their conceptions of nursing and approaches to clinical teaching. It is also identifies the interrelationships between those conceptions and approaches to teaching in the clinical setting because of the known link between teacher conceptions, approaches to teaching and student learning outcomes. This study reports on how clinical nurse teachers experienced teaching undergraduate nursing students on clinical placement and the key variations of those experiences. Their experiences of teaching nursing students include their conceptions about nursing and clinical teaching, and their teaching approaches. Variation in conceptions of nursing and clinical teaching as well as approaches to clinical teaching is therefore identified from a phenomenographic perspective.

The research reported in this thesis investigated clinical nurse teachers' experiences of nursing and clinical teaching of undergraduate nursing students on clinical placement. Many issues related to the preparation of nurses for their professional role are generic, so that although this study has been conducted in Australia, and is therefore particularly relevant to the Australian context, it also has international relevance.

Analytical framework

To understand how clinical teachers experienced nursing and clinical teaching, in particular their conceptions of and approaches to nursing, and their conceptions of and approaches to clinical teaching, knowledge from phenomenographic research on learning and teaching in higher education was investigated as well as that which is known about teaching and learning about nursing. To investigate and describe clinical teachers' experiences of nursing and clinical teaching the research of Marton and Booth (1997) provides an analytical framework. Marton and Booth (1997) assert that experience of a phenomenon involves the 'what', that is the ways in which something is understood, and the 'how', which are the subsequent actions taken. Marton's and Booth's (1997) analytical framework views learning for example, in terms of related 'what' and 'how' aspects. The 'what' aspect concerns conceptions about a phenomenon. The 'what' of learning, therefore includes the ways in which something is understood, and is differentiated in terms of meaning and structure. The 'how' aspect is concerned with the approaches to learning about a phenomenon. Approaches to learning can also be viewed in two ways. The first way, the 'act' (strategies used) of learning, refers to the quality of that act of learning. The second, the 'indirect object' (intention) refers to the type of capabilities being mastered for example, acquiring knowledge or relating facts to a situation. The 'what' and 'how' aspects of learning are seen to be ceaselessly intertwined and related to the intention of the learner (Marton & Booth, 1997).

Even though Marton's and Booth's (1997) analytical framework focuses on analysing and describing student experiences of learning, in this study it was applied to a different context. In this study Marton's and Booth's framework was used to analyse and describe clinical teachers' experiences of nursing (see Figure 1.1) and clinical teaching (see Figure 1.2) in terms of the separate 'what' and 'how' aspects, and understood in terms of the relationship between these aspects.

Research questions

From a phenomenographic perspective on teaching and learning, identifying clinical teachers' experiences of nursing and teaching is an important foundation to improving the clinical teaching of undergraduate nursing students. Knowledge of these conceptions and approaches embedded in their experiences of nursing and clinical teaching will provide the basis for preparing and supporting these teachers in

their roles in the future. Better preparation and more focused support of clinical teachers will lead to change in conceptions and approaches to clinical teaching and subsequent improvement in learning outcomes for students.

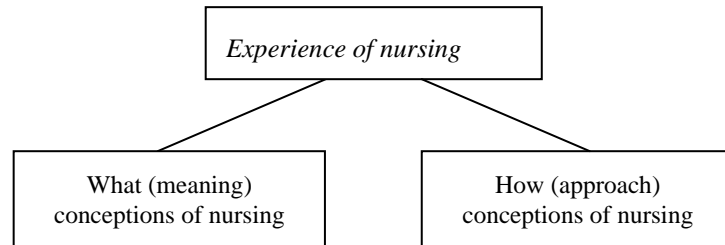


Figure 1.1: *The experience of nursing: an analytic framework (adapted from the Experience of learning, Marton & Booth, 1997)*

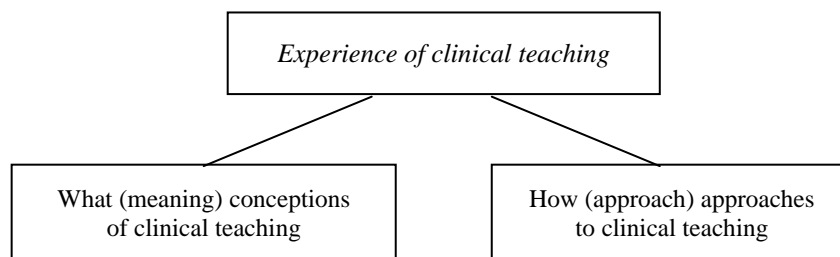


Figure 1.2 *The experience of clinical teaching: an analytic framework (adapted from the Experience of learning, Marton & Booth, 1997)*

The research questions addressed in this thesis were drawn from the current knowledge underpinning the phenomenographic perspective on learning and teaching.

The main research question:

How do clinical nurse teachers experience teaching undergraduate nursing students on clinical placements and how does this relate to their experiences of nursing?

Three subsidiary questions were also addressed. They were:

How do clinical teachers experience nursing? In particular, what are their conceptions of nursing and how do they approach nursing?

How do clinical teachers experience teaching? In particular, what are their conceptions of teaching and how do they approach teaching?

How do clinical teachers' experiences of nursing relate to their experiences of teaching? In particular, do clinical do teachers' conceptions and approaches to nursing relate to their conceptions and approaches to teaching?

Outline and structure of the thesis

In this study clinical teachers were interviewed to identify the key aspects of variation in their experiences of nursing and clinical teaching. In addressing the first subsidiary research question the focus was on identifying the key qualitative differences in the way the clinical teachers experienced nursing. In addressing the second subsidiary research question the focus was on identifying the key qualitative differences in the way the clinical teachers experienced clinical teaching. To address the third subsidiary research question the focus was on identifying the relationship between clinical teachers' experiences of nursing and clinical teaching by examining logical and empirical relationships. Identification of the relationship between clinical teachers' conceptions of nursing and their approaches to clinical teaching has firstly answered the main research question and secondly, provided a basis for discussion about the implications for clinical teaching in nursing and for recommendations.

In Chapter 2, the literature on nursing, learning and teaching is reviewed to provide a context and point of reference for the ways in which the clinical teachers in this study conceived of nursing and teaching and how they approached their teaching. In this chapter a perspective on nursing is provided to facilitate understanding of how clinical nurse teachers experience nursing and why these experiences may vary. A historical background of nursing, followed by an exploration of nursing's place in contemporary health care provides a context for the research. In the second part of this chapter, aspects of pre-registration nurse preparation programs are presented especially in relation to clinical programs and models of support and supervision. In the third part of this chapter various perspectives on how learners gain knowledge are also explored. Perspectives encompass behaviourist and cognitive approaches to learning, including individual and social constructivism. Following this, the phenomenographic perspective on learning is introduced. Comparison of these various perspectives with phenomenography shows the importance of recognising the internal relationship between the learner and the outside world, and the relationship with student learning outcomes. Although this study focuses on teaching

in the clinical setting, attention has also been paid to learning because of the relationships that have been identified between teaching and learning as a consequence of phenomenographic research. Previous research is drawn upon, especially in relation to the qualitative differences identified in learners' experiences of phenomena, their approaches to learning, learning outcomes and the relationships that exist between these areas. Teacher experiences of teaching in higher education, and the literature that surrounds teaching and learning is explored from a phenomenographic perspective especially in relation to student learning outcomes. The relationship of learner, teacher and the learning environment is identified.

In Chapter 3, the general orientation and nature of phenomenographic research approaches are described. Phenomenography was selected as a research approach because of its focus on understanding the different ways individuals experience phenomena. This is consistent with the aim of this study, which was to understand the qualitatively different ways in which clinical teachers experience nursing and clinical teaching. A detailed description of the research process used to investigate clinical teachers' conceptions of nursing and their approaches to teaching undergraduate nursing students on clinical placement follows. This research approach made it possible to answer the main research question as well as the three subsidiary research questions.

The results of the study are reported in chapters 4 and 5. The results are based on interviews with twenty clinical teachers and the analysis of the resulting data. In Chapter 4, a phenomenographic perspective is used to report on clinical teachers' experiences of nursing: in particular, their conceptions and approaches to nursing. Categories of description about these conceptions and approaches to nursing are also included. The results of an analysis of the logical and empirical relationships between the conceptions and approaches to nursing are also reported on. Chapter 5 reports on clinical teachers' experiences of clinical teaching: in particular, their conceptions and approaches to clinical teaching. Categories of description about these conceptions and approaches to clinical teaching are identified and described. The results of analyses of the logical and empirical relationships between conceptions and approaches to clinical teaching will also be reported, as well as the logical and empirical relationships between conceptions and approaches to nursing and clinical teaching.

Chapter 6 forms the discussion of the findings and the conclusion of the study. In this chapter the critically different ways of experiencing nursing and clinical teaching are compared with the desired ways of experiencing nursing and teaching. The significance of the results for nursing and clinical teaching and the applicability to nursing education are discussed. In the latter part of the chapter significance of the study and its results for the phenomenographic research approach, teaching approaches to teaching in higher education in general, and approaches to teaching nursing students on clinical placements is discussed. Finally, identification of future research into aspects of nursing and clinical teaching is proposed.

Summary and conclusion

The research reported in this thesis investigated clinical nurse teachers' experiences of nursing and clinical teaching of undergraduate nursing students on clinical placement. Known relationships between teacher approaches to teaching, student approaches to learning and learning outcomes underpin this study. What is unknown, however, is the relationship between clinical nurse teachers' conceptions of and approaches to nursing, and their conceptions of and approaches to clinical teaching. This introduction chapter sets the scene for the research study by identifying the problem and its significance. Particular attention is paid to nursing graduates' lack of preparedness for their role as Registered Nurses. This detailed discussion therefore justifies the aim of the study. The analytical framework was introduced in this chapter and the research questions, developed on the basis of the knowledge and processes around teaching and learning were presented. Finally, the research study was outlined. Within the outline of the study the structure of the thesis is explained. The explanation of each chapter and its focus indicates how each contributes to the investigation.

CHAPTER 2

Background and literature review

Introduction

In the first chapter the problem addressed by the thesis was outlined. The variability of nursing student learning outcomes is of concern given that graduate nurses are expected to be adequately prepared for the professional nursing role. Existing relationships between teacher approaches to teaching, student approaches to learning and learning outcomes provide a foundation for this study. The relationships between clinical nurse teachers' conceptions of, and approaches to, nursing and their conceptions of and, approaches to, clinical teaching are not known. Yet, knowledge of the interrelationships between clinical teachers' conceptions of and approaches to nursing, and their conceptions of and approaches to clinical teaching will help progress what is already known about teaching and learning, both in higher education generally and specifically in clinical nurse education. This study explored how clinical nurse teachers experienced nursing, and teaching undergraduate nursing students on clinical placement, and the variations in those experiences.

In this thesis it is argued that clinical teachers, who intend that their students will achieve conceptual change, will possess complex conceptions of nursing and clinical teaching and use student-focused teaching strategies. As a consequence, students of such clinical teachers are more likely to adopt deep approaches to learning which therefore lead to high quality learning outcomes.

Since this empirical study has investigated clinical teachers' experiences of nursing, this background and literature review chapter presents a range of perspectives on nursing. Nursing is viewed initially from a historical point of view, and secondly, to show the position of nursing in contemporary health care. These perspectives provide a point of reference in relation to the limited, but qualitatively different, conceptions of nursing held by a particular group of clinical teachers in this study.

Another important focus of this study has been the examination of clinical teachers' experiences of clinical teaching from a phenomenographic perspective. Research on learning and teaching provides a further context and point of reference for the research. In order to understand clinical teachers' conceptions of, and approaches to, clinical teaching, it is important to explore what is known about teaching in higher education, and more specifically, in relation to teaching undergraduate nursing students, particularly in the clinical setting. Review of research knowledge about

student and teacher experiences of learning and teaching in higher education is provided because of the known relationship between teacher approaches to teaching, student approaches to learning and the quality of learning outcomes. It was anticipated that a review of literature related to the clinical education of undergraduate nurses would be inadequate in comparison with what was known about teaching and learning in higher education more generally.

In order to understand how clinical teachers might experience nursing and clinical teaching, it is intended in this chapter to review literature that will:

- provide both historical and contemporary perspectives on nursing as well as to explore how clinical teachers experience nursing:
- provide a range of theoretical perspectives on learning and their influences on nursing education:
- introduce the phenomenographic perspective on learning and teaching:
- identify clinical teachers' experiences of teaching pre-registration nursing students in the clinical setting.

Section 1: Perspectives on nursing

In order to understand how clinical nurse teachers experience nursing it is necessary to identify how nursing is understood by the profession itself. It is difficult, however, to settle on one definition of nursing that has remained consistent over time. A possible explanation is provided by Virginia Henderson, influential American nurse leader when she stated that “Nursing is modified by the era in which it is practiced” (Henderson, cited in Safier, 1977, p. 121). Henderson made this statement when she was interviewed by Safier about the contributions she has made to the development of nursing. The quotation captures the changeable nature of nursing and helps to focus the discussion on contemporary nursing and how it has been and is currently understood. In the following discussion attention is paid to the way in which nursing is defined and the immediate influences and effects on nursing at three points in its evolution.

The influence of Florence Nightingale, who is credited with being the founder of modern nursing in the 19th Century, forms the first part of the discussion; the impact of technology, the second part; and the final part of the discussion focuses on the contemporary health care context. In addition to explaining how nursing is understood, approaches to nursing will also

be described. No research papers were detected that directly investigated how clinical teachers experienced nursing.

Historical perspective on nursing

Through the ages nursing has been persistently beleaguered by conflicting images of compassion and disrepute and it was through the leadership of nurses such as Florence Nightingale that its reputation improved. Florence Nightingale conceived of nursing as a vocation based on religious traditions where nurses provided devoted compassionate care to the sick. Yet nursing work, provided by untrained women of dubious reputation, was also seen as disreputable and lowly where images of dishonesty and drunkenness abounded (Holliday & Parker, 1997; McAllister, 2003). According to Binnie and Titchen (1999), Burchill (1992) and Lumby (2001) it was through Nightingale's commitment to the physical, psychological and spiritual care of the person and adherence to Christian principles such as discipline and self-denial, that nursing began to achieve respectability. This era is described by Bevis (1978) as the ascetic period. A number of nurse leaders, some of whom trained under Nightingale, appreciated the importance of her holistic beliefs and training methods which emphasised character training and the virtues of the nurse. There were expectations of obedience, passivity and unobtrusiveness. Nightingale's influence and training methods spread to other parts of the world including Australia and Canada (Baly, 1997; Herdman, 2001; Lumby, 2001).

The respectability of nursing was further enhanced by professionalisation aimed at improving standards in order to protect the public. According to Pearson (1990) nurse leaders around Nightingale's time believed that nursing should be established and recognised as a profession in order to control recruitment, training and certification. While not altogether in agreement with the professionalisation of nursing (Holliday & Parker, 1997) the provision of training programs was identified by Nightingale as a necessary improvement, with lectures being provided by doctors (Baly, 1997). Additional measures to improve the preparation of nurses included the provision of practical training within a defined timeframe, examination of knowledge and skills and the keeping of a register of trained nurses (Baly, 1997). Professional organisations were also established to oversee regulation of practice, training and registration. While the professionalisation of nursing began in the Nightingale era with the recognition and maintenance of standards, it was not until the late 19th

Century that government controls were first formally legislated for both nursing and medicine (Baly, 1997; Pearson, Fitzgerald, Walsh, & Borbasi, 2002). All professions today, whether they be nursing, medicine, dentistry or architecture have regulatory authorities, legitimised through government legislation, with responsibility to establish and maintain practice standards. These standards relate to admission to the profession to secure registration and continuing competence for continuity of registration. Legislation also empowers these authorities with disciplinary control as part of their role in maintenance of practice standards. In turn, all professionals accept responsibility to provide high quality service in return for appropriate remuneration and status (Pearson, 2002).

While professional controls were seen to be vital in order to protect the public they, along with their alignment with medicine also elevated the status of nursing, though not without consequences. Grehan (2004) asserts that some nurse leaders, such as Nightingale, believed the alliance between medicine and nursing occurred because of a shared scientific knowledge base. However, Baly (1997) argues that the increasing public standing and admiration for the medical profession was also appealing to nursing. Grehan (2004) observes that although nursing efforts were focused on setting and maintaining standards it was implicit that the role of nursing was to support medicine in its endeavours. Luckey (1985) reports the legacy of these early influences meant that the relationship of nursing to medicine was one of subservience, with the physician directing and the nurse providing care. However, according to Baly's (1997) historical account of Florence Nightingale's substantial contribution to the foundation of the nursing profession, she notes Nightingale believed that nursing was more than the acquisition of technical skills and provision of assistance to doctors. She saw nursing instead, as a feminine art, where nurses were "sanitary missioner(s)" (p. 79) as well as health educators. Nightingale's position, according to Holliday and Parker (1997) was that nurses should work with doctors, not for them. The following much cited Nightingale quotation signifies the independence of nursing. Nightingale stated that what nursing has to do is "put the patient in the best condition for nature to act on him" (Nightingale, 1969, p.75). Nightingale (1969) identified that by providing a clean, ventilated environment, nurses were independently contributing to patient healing. It is clear that modern nursing as understood by Florence Nightingale was more than performing tasks.

Instead, in collaboration with medicine, nurses independently provided the necessary care to promote healing.

While the collaborative and independent aspects of the nurse's role had been identified by Nightingale, nursing's subservience to medicine was further strengthened under the influences of technology and the institutionalisation of health care. During the last decade of the 19th Century the increase in surgical procedures and new knowledge, particularly in relation to antisepsis and asepsis, necessitated people being hospitalised instead of being nursed at home Baly, 1997; Grehan, 2004). In Australia, for example, the modern hospital emerged around this time and was the domain of the doctor supported by a staff of female nurses (Nelson & Grehan, 2006). Reverence for the doctor as the leader of the team combined with the long-held value of austerity legitimised nursing at this time. Bevis (1978) describes this as the romantic period. Through the institutionalisation of health care and the increasing importance of technology, nursing's dependence on medicine was heightened (Nelson & Grehan, 2006). In spite of this perceived dependence on medicine, Manthey (1980) provides an example of what American nurses were able to do in the 1920s in relation to their independent role and that of providing individualised nursing care. She stated:

“The nurse took care of the sick person from the time the need for care was identified until it no longer existed: care was personally administered by the nurse according to the assessment she made of the individual needs of the patient. There were no rules or regulations, no routine procedures, no hospital policies, time schedules or supervisors. She practices nursing with a degree of independence unheard of in modern hospital nursing.” (p. 2).

Fitzgerald (2006) points out that this type of care was provided in the community setting and not the hospital. As a consequence of institutionalisation and technological changes in the context of illness care, nursing adopted medicine's values associated with curing of disease. Espousing medicine's values, according to Pearson (1990) was to have a substantial impact on nursing practice in the future. Pearson (1990) asserts that medicine's reductionist approach, where the body is reduced to smaller and smaller parts, gave rise to specialisation in medicine and nursing. Fragmentation of patient care is seen to be a consequence of specialisation (Begun, Tornabeni & White, 2006; Pearson, 1990).

As technology started to impact on the care of the sick, nursing maintained its functional approach to the provision of patient care. With the emphasis on service to medicine, patients were assisted by nurses who were focused on the dutiful completion of practical tasks (Binnie & Titchen, 1999). Nelson and Grehan (2006) report that by the end of the 19th Century nursing work was still domestic in nature with care aimed at airing and improving ventilation and providing a clean environment. Nurse training focused on positioning of patients, bedbathing and provision of comfort techniques (Parker, 2006). Trainee nurses were instilled with a task orientation and the scientific aspect of patient care was seen to be the province of the doctor. According to Binnie and Titchen (1999) this production-line style of work organisation, adopted from industry, and a consequence of bureaucratic and hierarchical organisational structures, continued well into the 1960s, if not later. Garbett and McCormack (2004) and McCormack (2004) assert that this style of work organisation structures the main centre of activity around the completion of practical tasks. Binnie and Titchen (1999) report that the nursing workforce was firmly controlled as it went about getting the work done by performing the bedbaths, giving medications, taking temperatures and performing domestic duties. These main tasks were expected to be performed by nurses in a subservient and timely manner. Castle (1987) also describes a strict division of labour where junior student nurses performed domestic work such as cleaning, serving meals, and making beds. Complex tasks such as administration of medicines, injections, performance of dressings, management of intravenous therapy and weighing of diets were performed by more senior student nurses and registered nurses.

The functional approach to providing nursing care, while seen to be efficient, was problematic because of its focus on tasks rather than people. According to Adams, Bond and Hale (1998) providing task-focused, routinised care means that no one takes responsibility for anything outside the routine tasks. Subsequently, the opportunities for developing caring relationships are limited. Instead, patients are kept at a professional distance where relationships are formal and nurses somewhat removed from patients' suffering and distress. In addition, decision-making is at a minimum with the emphasis being on routine and procedure. Garbett and McCormack (2004) and Binnie and Titchen (1999) argue that while production line organisation of work results in a lack of responsiveness to individual patient needs, it

also inhibits nurses from ‘thinking’. Consequently, personal responsibility is avoided and passed on to more senior staff. A mechanistic approach such as this means many nurses are involved in only performing tasks for the patient. The consequent fragmentation, leads to the focal point being on maintenance of the routine and task completion rather than meeting the needs of individual patients.

Impact of technology on nursing practice

Following World War 2 scientific discoveries and technological developments in health care impacted on hospital culture, work practices and the organisation of health care. Some examples of new technology available since then include new pharmaceuticals, increasingly sophisticated equipment for diagnosing and treating disease and, more recently, the availability of organ transplantation (Lumby, 2001). McConnell (1998) identifies some of the outcomes of new technologies which include improvements in health, effects on quality of life, the need to consider new legal and ethical issues and effects on roles of health professionals. As a consequence of these developments, with the associated improvements and changes, different ways of caring for patients evolved. For example, intensive care and theatre recovery units were introduced in the 1960s and 1970s. With these changes came further nursing specialisation and the need for new roles. Costs also increased hence the need for revision of health care funding (Clifford, 2000; Lumby, 2001).

In order to deal with the impact of technology there is some evidence that nursing began to closely examine its role. It is interesting to consider Henderson’s definition of nursing around the middle of the 20th Century. Henderson recognises the independent and interdependent roles of nursing, as well as the need to work towards patient outcomes of independence, improvement, recovery or support in death.

Henderson states:

“The unique function of the nurse is to assist the individual, sick or well, in the performance of those activities contributing to health or its recovery (or to a peaceful death) that he would perform unaided if he had the necessary strength, will or knowledge. And to do this in such a way as to help him gain independence as rapidly as possible. This aspect of her work, this part of her function, she initiates and controls: of this she is master. In addition, she helps the patient to carry out the therapeutic plan as initiated by the physician. She also, as a member of a medical team, helps other members, as they in turn help her. To plan and carry out the total program whether it be for the improvement of health, or the recovery from illness or support in death.”

(Henderson, cited in Safier, 1977, p. 116)

However, according to Pearson's (1990) reflections on this period, nursing was becoming focused more on medical and technical aspects associated with cure. Less emphasis was placed on the patient's experience of illness. Lumby (2001) concurs, reporting that the focus of nurses moved away from body care and associated activities to the tasks related to technology. While the old values of austerity and romance continued, Bevis (1978) identified pragmatism as the dominant value of the time. Nevertheless, it is evident in the literature that contemporary conceptions of nursing included the recognition that since patients have individual problems requiring distinct answers, as can be seen in Henderson's definition above, nursing practice ought to be seen as a dynamic process focused on addressing patient needs rather than being a fixed set of tasks to be completed (Binnie & Titchen, 1999; Pearson, 1990).

Meeting patients' individual needs has been accepted as a core value of nursing for many years and is commensurate with high quality of care. According to FitzGerald (2006) individualised nursing care "assumes understanding of the biopsychosocial needs of each person, and a service that accommodates as many of these needs as possible" (p. 241). Individualised patient care incorporates activities such as assessment, building relationships and working toward meeting patients' needs. The likely outcome of this approach includes improvement in health status, patient comfort and satisfaction.

In response to the further impact of technology on nursing practice and patient care, nurses, dissatisfied with the dehumanising effects of the hospital system, experimented with new models of care delivery during the 1960s and 1970s. The new models were thought to promote individualising of patient care (Binnie & Titchen, 1999). Examples of these new models of care delivery include team nursing and patient allocation. Both models were designed to reduce the number of patients nurses would come into contact with each day. For example, team nursing involves a small group of nurses, with a range of skills, charged with the responsibility of caring for a group of patients. According to Schweikhart and Smith-Daniels (1996) this model is based on manufacturing principles where operations are streamlined and resources and services are placed closer to the patient.

The patient allocation model, according to Adams, Bond and Hale (1998) involves individual nurses having sole responsibility for providing a wide range of services for a small allocated group of patients. Nurses, in this model, are assigned to patients rather than to tasks. Binnie and Titchen (1999) note that in both models these arrangements can usually only be managed on a shift-by-shift basis because of the limitations involved in rostering staff. Inevitably, it is difficult to achieve continuity between nurse and patient. However, many of the problems dealt with by nurses, such as managing wound healing, for example, cannot be solved in an eight hour shift and these methods of work organisation do not take this into account. Furthermore, team nursing and patient allocation limit the nurse's ability to put a plan into place or to monitor and evaluate outcomes. As a consequence, neither model could be considered as being patient-focused. Providing patient-focused, individualised nursing care relies on continuity between nurse and patient, but neither team nursing nor the patient allocation model of care delivery allows for such continuity.

Around the same time as the introduction of these different models of care delivery the "Nursing Process" was launched in recognition of the need for the nurse to have scientific knowledge and as a further method of individualising patient care. According to Chandler, Gustin, Schmuck and Wilson (2001) the "Nursing Process" is a clinical decision-making framework based on the scientific method. Use of this method involves the nurse assessing the patient in order to diagnose patients' nursing problems, planning and implementing interventions and evaluating outcomes. By structuring nurses' thinking, systematic organisation of nursing practice ensues and patient-focused care is possible. Nursing care plans were also introduced around the same time and were a means of documenting the "Nursing Process" with the aim of further individualising patient care (Mottola & Murphy, 2001). According to O'Connell, Myers, Twigg and Entriken (2000) nursing care plans determine the nurse's focus and how patient care is approached.

Just as there were problems with new care delivery systems, the new approaches to clinical decision-making, thought to help nurses individualise patient care, were also limited. The clinical reasoning process was often routinised in the same way as other nursing activities, therefore, overlooking the uniqueness of the individual (McAllister, 2003; Mottola & Murphy, 2001). According to O'Connell, Myers,

Twigg and Entriken (2000), just as with task-oriented practice, responsibility still did not sit with any particular nurse when different approaches to care delivery were used. Binnie and Titchen (1999) point out that although the intention of individualising patient care is to put the patient's needs at the centre of the nurse's awareness, an underlying problem was that the nurse did not have the authority to tailor standard protocols to individual patients or to expect others to follow the plan. While efforts were made to individualise patient care, Adams et al. (1998) note power relations between the nurse in charge and other nursing staff remained unchanged. They argue that different philosophies and structures were necessary to achieve the changes being sought. Omissions of care were the consequence and the nursing care plan became the focus as opposed to patient needs. Recent research by O'Connell et al. (2000) questions the relevance of nursing care plans. The results of their evaluation study found that plans were out of date, lacked relevant information, did not prioritise care and therefore did not provide information about patients' ongoing needs.

Summary

While Florence Nightingale conceived of nursing as a holistic enterprise, the institutionalisation of health care and the alignment, yet subservience of nursing to medicine have been influential in the fragmentation of patient care. Tension between the holistic aims of nursing and the curative aims of medicine is evident. While individualisation of patient care is considered a core value of nursing, strategies designed to assist nurses to focus on meeting individual patient needs have not met with success. Additionally, other forces within the contemporary health care context impacted on nurses individualising patient care. As technology started to influence the care of the sick, nursing maintained its functional approach to the provision of patient care. The functional approach to providing nursing care, while seen to be efficient, was problematic because of its focus on tasks rather than people.

Contemporary health care context

Contemporary health care continues to experience unceasing change as it attempts to deal with challenges that surround rapid and continuous developments in knowledge and technology and the effects of corporatisation. Polder, Meerding, Bonneux and van der Maas (2005) describe the current health care climate as involving patients

experiencing medical treatments that are highly specialised and technical. Additionally, treatments are becoming standardised and hospital stays are shorter with advanced nursing care being conducted in private homes. While patients these days are usually better informed and demand high quality care for their problems, pressure is also on the health care system to reduce costs. This situation is true for all Western health care systems. While people are acknowledged as having a right to health care services they are also held increasingly accountable for their health. Bjork (1995) and Gallant, Beaulieu and Carnevale (2002) report that to improve efficiency, people are expected to be actively involved in the maintenance of their health, thus avoiding indiscriminate use of health care services. Technological advances and increasing costs of health care provision have seen the focus switch from disease treatment to prevention (Jonsdottir, Litchfield & Pharris, 2004) and more recently to corporatisation of health care services (Jackson & Borbasi, 2006). Health care systems around the world have been revolutionised in answer to ever expanding and demanding technologies and increased competition in response to market forces (Spitzer, 1998).

The current health care climate with its corporate focus presents many challenges for nursing. Jonsdottir, Litchfield and Pharris (2004) argue that the realisation of outcomes is essential to the achievement of efficiency and effectiveness in health service delivery. While no one would argue against efficiency, effectiveness and achievement of related outcomes in an environment of diminishing resources, Hollinger (2003) makes the case that health care professionals struggle with the political and economic structures of the health care system. Hollinger (2003) asserts that these structures frequently appear to work against meeting all the patient's needs. Talerico, O'Brien and Swafford (2003) argue that standardised care involves patient care decisions and goals being determined by providers of health care. Talerico et al. (2003) and Jonsdottir et al. (2004) argue that standardised care is rewarded in the current health care system as opposed to high quality patient-centred care. Stickley and Freshwater (2002) assert that the therapeutic relationship between the nurse and the patient is not valued because in an environment focused on outcomes such a thing is not measurable. FitzGerald (2006) argues that even though individualised patient care is a central value of nursing there is little empirical evidence that it makes any difference to patient outcomes. While she is not

recommending abandoning individualised care, she points out that there are so many variables to consider it is difficult to show why patient improvements occur. Under the current health care system, Jonsdottir et al (2004) affirm that the full expression of nursing is restricted.

In addition to increasing expectations of efficiency and effectiveness the nursing role, in a highly complex and technical illness care environment, continues to be fragmented. The complexities of contemporary nursing practice are such that nurses are expected to be professionally competent in their use of technology (Barnard, 2006). In addition to this they are expected to be competent in their ability to make judgments and clinical decisions underpinned by knowledge and understanding (Heath, 2002; WHO, 2001). Yet, within the current illness care context, nursing continues to depend on medicine, especially in relation to technology where nurses are necessarily directed by physicians (Bernardo, 1998). Jonsdottir, Litchfield and Pharris (2004) refer to the ‘medicalization of nursing’ (p. 242). They argue that nursing continues to be thought of as being about assisting in the provision of medical treatment and duplicating the medical techniques of diagnosis and treatment. Spitzer (1998) stresses that with the continued replication of the medical model there is little opportunity for nurses to make independent decisions. Within this milieu of rapid change Spitzer (1998) and Bernardo (1998) assert that existing understandings of nursing need further revision if it is to survive. Spitzer (1998) believes that instead of being concerned with replicating the medical model, by diagnosing and treating human responses to illness, nursing would be better if it could show that it is less ‘medicine compatible’ (p. 789). Spitzer (1998) maintains that nursing needs to articulate its unique contribution in areas of patient safety, management of elimination, hygiene and nutrition, for example. While Spitzer (1998) and Bernardo (1998) bemoan the dependence of nursing on medicine, McConnell (1998) acknowledges the dependency but argues that nurses also have an independent role where they are not reliant on technology to provide care.

Current definitions of nursing are worth exploring at this time. For example, the International Council of Nurses (2006), a federation of nurses’ organisations that represent nurses in more than 120 countries, states that:

“nursing encompasses autonomous and collaborative care of individuals of all ages, families, groups and communities, sick or well and in all settings. Nursing includes the promotion of health, prevention of illness, and the care of ill, disabled and dying people. Advocacy, promotion of a safe environment research, participation in shaping health policy and in patient and health systems management, and education are also key nursing roles”.

(ICN, www.icn.ch/definition.htm retrieved 2 January, 2006).

Once again the autonomous and collaborative roles of nurses are highlighted as they work to meet the needs of their patients/clients. What is different in this definition is the focus is on, not only illness care, but health promotion as well. Of interest also are the political, health management and education opportunities for nurses which have been identified.

While the impact of technology is wide ranging it is also an essential component of patient care that needs to be managed. McConnell (1998) argues that, while the purpose of technology is to improve health and human function, it is costly, and therefore, in danger of being the central focus. According to Allshouse (1993) technology and associated routines require patients to be dependent and submissive. Yet, Manley (2004) asserts that technology is only one aspect of patient care, not its principal focus. McConnell (1998) further argues that when only one aspect of the person is treated, for example, using technology to improve a person's physical state, then all needs have not been met. Focusing on cure of physical symptoms is not enough. According to Hollinger (2003) care for the whole person should be a central concern since there is a complex relationship between the physical, emotional and spiritual aspects of a person. Relationships and social context are also important to our sense of well-being. Of particular relevance to nursing is Hollinger's (2003) stance that while cure is not always achievable, it is always possible to care. Equally, he states, it is not enough to care and not cure when the latter is likely. Bassett (2002) asserts that while technology provides important tools for nurses to care for their patients efficiently and effectively, it is the manner in which it is used by nurses that is important. McConnell (1998) maintains that obstacles to holistic patient care presented by technology can be balanced by nurses taking a humanistic approach. Humanistic philosophy, she argues, values people, their concern and contribution. This philosophy guides nursing practice, so that not only biological, but psychosocial and spiritual needs are addressed by nurses who are caring, understanding and purposeful.

While technology is an important asset for patient diagnosis and treatment, making improved patient outcomes possible, the independent role of the nurse comes to the fore when combined with humanistic care. Bernardo (1998) asserts that it is the alignment between technology and the independent role of nurses that creates the opportunity to be patient-focused rather than having technology as their focal point. Binnie and Titchen (1999) assert that the nurse-patient relationship is central to patient-centred nursing. Cumbie, Conley and Burman (2004) define patient-centred care as that which is appropriate to the particular patient and family to meet their needs. Talerico, O'Brien and Swafford (2003) argue that a patient-centred approach, informed by insight gained into the individual and responsiveness by the nurse, allows for the provision of holistic care. Such an approach is cohesive, meaningful and empowering for the patient and family: essential for providing quality health care. Binnie and Titchen (1999) maintain that when the patient is at the centre of care, the nurse is present, open, available and non-judgmental. The nurse, using clinical expertise, whether it is for identification of problems or strategies for improvement, listening or performing nursing tasks, and providing support, works with the patient and family to handle whatever needs to be dealt with. They state that this approach overcomes the problems associated with fragmentation of care.

Patient/nurse partnerships

Integration of technology and humanistic care through the establishment of a partnership between patient and nurse to achieve patient-centred care is advocated. According to Tasch (1985) the notion of partnership grew out of the consumer movement in the 1960s in the U.S.A. The focus of the consumer movement was on the need for cost effectiveness of health care services. An additional factor at this time was the emphasis on health promotion. Gallant, Beaulieu and Carnevale (2002) believe, however, that the creation of a patient-nurse partnership, while providing a vehicle for independence and better use of resources, builds on previous values held by nurses and patients about relationships. McCormack (2004) argues that it is this relationship between patients and nurses that is the solution to improved patient outcomes. Tasch (1985) identifies empathy, caring and trust as essential elements of partnership. Gallant et al. (2002) add to this, the values of co-operation, commitment, empowerment, and active inclusion in decision-making as well as recognising the uniqueness and value of the individual. Both Tasch (1985) and Gallant et al (2002)

argue that the aforementioned attributes facilitate sharing of concern, hopes and feelings as well as understanding. Such sharing allows for the achievement of shared goals through the provision of more effective and therapeutic care leading to increased patient and nurse satisfaction. The patient is an active participant whose perceptions and experiences are acknowledged and valued (Binnie & Titchen, 1999). According to McCormack (2004) by having knowledge of what is important to the patient, the nurse can adopt a negotiated style approach towards decision-making.

Jonsdottir, Litchfield and Pharris (2004) are of the view that the notion of partnership, an expression of caring, conceptualises the relational aspect of nursing. By dealing with the complexity of the patient as a person through assessing morale and spirit, the nurse individualises care, gains greater recognition of the nursing contribution to health care and improves professional morale. By taking this approach technology and humanism are combined so that the patient receives the best possible technology balanced by a humanistic approach (Cumbie, Conley & Burman, 2004). McCormack (2004) affirms that being person-centred includes knowing the patient and their values and seeing them as more than a set of needs to be met. He further argues that the relationship between the nurse and patient is the means to success in achieving patient outcomes (McCormack, 2003a). According to Pearson (1990) when nursing is based on humanistic and holistic principles, improvement in patient outcomes and cost efficiencies are evident. Cumbie (2001) argues that, when nursing is viewed from a “holistic-relational-contextual perspective”, (p.57) the nurse genuinely participates with the patient in a caring-healing partnership.

Multidisciplinary care

The autonomous role of the nurse has been considered a key component of the nurse's role since the time of Florence Nightingale. Similarly, consideration of the patient as central to the nurse's concerns, and the desire to provide nursing care that is based on a humanist philosophy to achieve particular outcomes, have been with us just as long. Yet, it has already been shown how nurses, in the illness care environment have been consistently been unable to exert their independent role to any great extent, instead choosing to come under the direction of medicine. It has also been seen that institutionalisation of health care and technological imperatives have increased the dependence of the nursing profession on medicine. Furthermore,

it has been argued that combining technology with a humanist approach in today's complex health care environment can improve patient outcomes. However, it is difficult to see how the adoption of a humanistic approach helps nurses to become more independent. What follows is a discussion on how multidisciplinary care may provide the necessary contextual change that may facilitate nurses to participate in the provision of cohesive, patient-centred care, where they are able to be independent and interdependent within a health care team.

Given the complexities of the current health care environment, multidisciplinary health care is an important consideration in terms of meeting patient needs. Multidisciplinary health care is patient-focused and provides cohesive and economical care. If health care is truly patient-centred and, given that no discipline is geared to meeting all patient and family needs, Griffiths and Crookes (2006) and Richardson (1985) argue that a multidisciplinary health team is required. Bjork (1995) and Clifford (2000) believe that under the current health care conditions health team members are required to collaborate, not only with each other but with the patient as well. Griffiths and Crookes (2006) contend that such a team includes "professionals from various health-related disciplines, whose contributions do not overlap, in planning and provision of ever-improving standards of healthcare" (p. 186). An example is provided by Cape (1985) who describes the collaborative practice model as a joint undertaking involving integration and cohesion achieved through shared decision-making. According to Malone and Morath (2001) collaboration, aimed at achievement of patient outcomes involves activities such as advocacy, joint assessment, referral and evaluation.

Multidisciplinary health care relies on effective team functioning and has a number of benefits, including economic gains as well as advantages for the patient and the nurse. According to England (1985b) the collective relationship of the team needs to work on the collaborative relationship, by coming together with an agreed purpose and location. Agreement about roles and communication are also vital to cohesive team functioning. Effective team functioning, according to Richardson (1985), will facilitate the attainment of mutual goals through collaborative activities such as exchange of information, opinions, problem-solving, decision-making and planning, therefore overcoming the myriad of problems associated with fragmentation. England (1985b) states that patients are further advantaged as a consequence of

integrated multidisciplinary team planning and communication. There is a wider range of strategies for improvement available to health team members for the benefit of patients. According to England (1985a) since patients and allied health members are part of the team, there are fewer occurrences of mistakes as a consequence of reduced duplication. Griffiths and Crookes (2006) assert that improved patient outcomes and cost containment through optimal use of resources have been demonstrated by this approach to health care. England (1985a) points out that through collaboration, an increased understanding of patients' experiences of illness is gained and, as well, improved patient and nurse satisfaction. Collaboration, therefore, provides the opportunity for nurses to further enact their interdependent role as an equal member of the health care team focused on providing patient-centred care (Bernardo, 1998).

The primary nursing model of care delivery

Taking a multi-disciplinary approach to patient care can be further enhanced by nursing care being delivered in a different way from what has been described earlier in this chapter. In contrast to the bureaucratic models of care delivery, that is team nursing and patient allocation, the primary nursing model of care delivery is based on humanistic principles. This model facilitates the provision of individualised patient care because it allows for continuity between the patient and the nurse. Manthey, credited with being the founder of primary nursing, states that it is a "delivery system for nursing at the station [ward] level that facilitates professional nursing practice despite the bureaucratic nature of hospitals." (Manthey, 1992, p.1). Within this model, the primary nurse is responsible and accountable for planning, implementing and evaluating nursing care of her patients, 24 hours a day, and seven days a week. The primary nurse has responsibility and authority to expect that planned care will continue to be undertaken by other nurses in her absence. This model relies on decentralised decision-making and nurses who accept responsibility and accountability for their practice (Manthey, 1980). Pontin (1999) reports this model is patient-centred, allowing for patients to be actively involved in their care. For nurses, it provides opportunities to practice professionally, to role model professional nursing practice and to facilitate the professional development of other nurses. Clifford (2000) asserts that primary nursing improves patient care and as a consequence improves patient and nurse satisfaction.

This empirical study has explored whether a relationship exists between clinical teachers' conceptions of nursing and their approaches to clinical teaching undergraduate nursing students on clinical placement. The findings suggest variation in clinical teachers' conceptions and approaches to nursing, however, no research studies on clinical teachers' experiences of nursing were detected in the nursing literature.

Summary

This chapter commenced with the premise that nursing is modified according to the era in which it is practised. The ensuing discussion has shown this to be partially true. Some aspects of nursing have not changed regardless of the era and influences. For example, the focus on the patient, the desire to provide individual care in order to achieve patient outcomes and the independent role of the nurse were explicit in all three definitions of nursing. Other aspects of these definitions did change however, with the nurse's role becoming increasingly sophisticated as health care developed and changed. In Nightingale's era, the availability of technology was limited and thus approaches to nursing were focused on providing important aspects of care such as hygiene. As technology became increasingly complex and demanding, the requirement for nurses to have scientific knowledge in order to understand and be able to competently manage the technology was paramount. As health care changed it became apparent that nursing was practised in increasingly diverse environments with subsequent changes in roles for nurses.

Although change is an unvarying characteristic of the health care context, constants such as political and economic imperatives and technology with the demands for efficiency and effectiveness have impacted on the expression of nursing. While nursing continues to depend on medicine, especially in relation to technology and its application, it is possible for the independent role of the nurse to emerge when combined with a humanistic approach to patient care. The nurse, using a patient-centred approach, provides clinical expertise and works with the patient and family to provide quality care.

The integration of technology and humanistic nursing using a patient-centred approach requires a partnership between patient and nurse. The patient-nurse partnership is based on a trusting relationship between the two parties and has the

potential to facilitate independence for both participants. The nurse empowers patients by including them in care decisions focusing on outcomes, thus meeting their needs. Partnership between the two acknowledges the connection between nurses and their patients which makes the full expression of nursing possible. However, it is not enough to have the nurse and patient in partnership, with the nurse meeting as many of the patient's needs as is possible. The reality is that patients, in today's complex illness care environment, have needs which surpass what nursing can offer on its own. This being the case, the outcomes for patients are further improved if relevant health professionals involved in the patient's care, unify their efforts so that resources are used more effectively, and the patient receives cohesive, coordinated and efficient health care. Adoption of the primary nursing model of care delivery, in combination with a multidisciplinary approach has the potential to further improve patient outcomes and their levels of satisfaction.

Section 2: Relationship between nursing and clinical teaching of nursing

This empirical study explored whether a relationship existed between clinical teachers' conceptions of nursing and their approaches to clinical teaching undergraduate nursing students on clinical placement. The findings suggest variation in clinical teachers' conceptions and approaches to nursing, however, no research studies on clinical teachers' experiences of nursing were detected in the nursing literature. Given the complexity of current perspectives on nursing it is important to this study that knowledge about how clinical teachers conceive of and approach nursing is known. It is anticipated that there is a relationship between these experiences and how they experience teaching nursing students. In addition, since the clinical practice component is an essential part of any undergraduate nurse preparation program, this section outlines some of the key aspects of these programs. For example, the nature of nurse preparation programs, expected nursing students' outcomes and some of the models of clinical support and supervision is discussed. Particular attention is paid to the clinical teacher model of support and supervision since clinical teachers and their experiences of nursing and teaching are the focus of this study.

Pre-registration preparation

Contemporary pre-registration nursing education in Australia is now conducted solely at tertiary level and differs significantly from traditional hospital-based

apprenticeship programs (Russell, 2006). The transfer of nursing education to the tertiary sector has occurred because of technological and social changes affecting the health care setting and the nurse's role as discussed in Section 1 of this chapter. Educational programs for nurses provide opportunities for students to develop the necessary knowledge, skills and attitudes required for beginning level professional practice (Heath, 2002). As discussed in the first chapter, nurse preparation programs consist of a mixture of theory and clinical practice, of which the practice component is very important. A typical approach to preparation of nurses is that theory is taught prior to a practice placement and the student is then expected to apply the theory to real situations. The student is provided with opportunities to learn to think and act like a nurse. This includes being able to deal with abstract as well as concrete situations. It is expected that the student will integrate theory and practice whilst providing patient care (Spouse, 1998). For example, participation in clinical practice provides students with opportunities to develop skills in recognising relevance of information, synthesising formal and informal knowledge and integrating this knowledge into developing frameworks of professional understandings to inform professional judgment. According to Conway and McMillan (2006) the importance of clinical experience should not be underestimated. It is here that the nursing student not only learns to apply theory to practice but also identifies contradictions between theory and practice, learns about nursing values and develops a professional identity as a nurse.

The organisation and management of clinical practice experiences for pre-registration nursing students varies across courses. According to Barnard and Dunn (1994), the relevant professional registration body determines the total number of clinical practice hours in a Bachelor of Nursing program. While decisions about the sequence of clinical practice, student to staff ratio, and number of hours per day and week are usually school-based, the Nurses Board of Victoria (Australia) oversees such decisions as part of their role in accreditation of courses (Nurses Board of Victoria, 2006). Other differences between courses include the type of clinical education model, such as mentorship, preceptorship or the clinical teacher model, used to support student learning in the clinical setting.

Clinical education models

While the organisation and management of clinical placements may vary, all students require support, supervision and teaching to facilitate achievement of learning outcomes. Review of the literature reveals an emphasis on the need for some sort of clinical support to be provided by the health agency/hospital, rather than entirely by the academic institution providing the theoretical component of the program. Authors such as Andrews and Wallis (1999) and Fowler (1996), advocate a collaborative approach to clinical education. They recommend direct clinical supervision, regular support of those in a direct supervisory role, and the necessity for some form of assessment to ensure that all aspects of the clinical experience are covered.

Several models of clinical support, supervision and teaching are referred to in the literature. Some of these models include preceptorship, mentorship and clinical supervision. Andrews and Wallis (1999) and Fowler (1996) acknowledge that there is considerable confusion and overlap of role descriptions surrounding these terms. Differentiation between models of support is therefore necessary. According to Madison, Watson and Knight (1994), preceptorship and mentorship seem to be terms that are used interchangeably at times. In both of these models the student and the supervisor are in a one-to-one relationship. According to Neary (2000), a preceptorship relationship is one where an experienced nurse and a student work side by side for a short period of time so that the learner achieves certain learning outcomes. Yet Myrick and Yonge (2004), state that preceptorship is a short-term arrangement aimed at orientation and socialisation of a novice to a workplace. Activities undertaken by a preceptor include facilitation, guidance and role modelling. Fowler (1996) agrees that preceptorship involves the orientation of a new staff member or student to the work environment, but clarifies that the teaching is related to the routine clinical work of the area. There is less clarity regarding preceptorship when it is used for a peer or supervisory relationship for new employees, or whether an element of assessment is involved.

Mentorship, another model of clinical support, also involves a relationship between two people. According to Fowler (1996) it is often seen as a longer relationship, where an experienced nurse guides, assists and supports students as they learn new skills, behaviours and attitudes. Barnard and Dunn (1994) argue that the aim of the mentor is to provide guidance for the professional development of the less experienced, but nevertheless registered nurse and occurs over a lengthy time period.

On the other hand Kram (1983) asserts that mentorship accomplishes psychosocial and career functions through activities such as sponsoring, coaching, protecting, counselling and role modelling in situations of transition or professional advancement.

Clinical supervision is a model of clinical support that has a variety of meanings. According to Fish and Twinn (1997) the term clinical supervision is used when a senior nurse supervises a lesser qualified nurse in relation to continuing professional development. The other context for clinical supervision is used in reference to the facilitation of learning and the assessment of competence of pre-registration or post-registration students.

The clinical teacher model of teaching and supervision is used when a nurse supports, supervises and teaches a group of nursing students. Clinical teaching is a term used when a clinical teacher teaches and supervises a small group of students during a defined clinical practicum (Nehls, 1997). For the purposes of this study, the term clinical teaching will refer to the teaching and supervision of pre-registration nursing students. According to Conrick, Lucas and Anderson (2001) the registered nurse, in his or her role as a clinical teacher is appointed by a particular university to assist pre-registration students with the development of knowledge and skills. This person may or may not have teaching experience and may or may not be familiar with the health care agency where the students attend their placement. Craddock (1993) reports that the term clinical teacher denotes the registered nurse who has responsibility for negotiating, guiding and supervising a small group of nursing students. Small groups of students are commonly in a 1:8 or even 1:10 ratio. A related model of clinical support identified by Brammer (2006) is one where the registered nurse has responsibility for direct supervision of students on a shift-by-shift basis in conjunction with other clinical responsibilities. This is usually an informal role where the nurse acts as a “buddy” for the student at the bedside, although the student is also being supervised by a clinical teacher. The “buddy” model is therefore complementary to the clinical teacher model of clinical support and supervision.

There is an array of clinical education models described in the literature. These models are all aimed at supporting, supervising and teaching students in the clinical

setting. The common component of models such as mentorship, clinical supervision and preceptorship is the one-to-one relationship between the student and the registered nurse. Given that the clinical teachers being investigated in this study were registered nurses acting as clinical teachers, each with a group of students on clinical placement, the remaining discussion in this section will focus on the clinical teacher model of clinical support and supervision.

According to Nehls (1997) an advantage of the clinical teacher model is that students are exposed to nurses who are committed to research-based practice and higher education. Such clinical teachers are said to be student-centred. Conrick, Lucas and Anderson (2001) argue that this is because these teachers, appointed by universities, are aware of the goals of the course and students' objectives. A disadvantage of this model, according to Conrick et al. (2001) is that these teachers may not be familiar with the particular hospital setting and the details of clinical specialties. According to Nehls (1997) this lack of familiarity means that students may not learn about the realities of nursing. Conrick et al. (2001) also argue, however, that the lack of familiarity with the hospital means clinical teachers, being independent of the hospital, are therefore in a better position to liaise with hospital staff to ensure best experiences for students. When nurses are seconded by universities to teach and supervise student groups in their own hospitals, students may not necessarily benefit either. Conrick et al. (2001) point out that although those clinical teachers are seen to be clinically competent and familiar with, and committed to the hospital, effective student learning may not always be their primary focus.

Undergraduate nursing students need more than clinical exposure if they are to learn to be nurses. However, there is no clear approach to clinical supervision and teaching detected in the literature. Conrick, Lucas and Anderson (2001) point out that there is a failure to recognise the importance of the attributes and skills of those supporting students in clinical practice. Fish and Twinn (1997) assert the teacher is responsible for addressing student learning more broadly than just supervising practice skills. Spouse (1998) believes the nursing student needs opportunities to use formal knowledge in practice. Reilly and Oermann (1992) argue that it is the clinical teacher's responsibility to provide a supportive learning environment and to negotiate learning experiences according to learner need. Other functions of the teacher include provision of guidance (Hermann, 1997) and diagnosis of learning

problems (Greenwood & n'ha Winifreyda, 1995). Packer (1994) is of the view that in order to achieve these aims it is necessary for the teacher to possess knowledge about nursing and have the ability to transmit that knowledge to students.

Additionally, teachers require clinical expertise, teaching skills and enthusiasm in order to successfully teach students on clinical placement (Packer, 1994; Reilly & Oermann, 1992). Interpersonal skills and availability to students are also considered of importance by Reilly and Oermann (1992) who also acknowledge the dynamic interrelationship between the teacher and the learner. More specifically, Craddock (1993) identifies the importance of the interrelationship between teacher and learner by identifying three fundamental elements involved in the role of the clinical teacher. These elements include the skills of the teacher, the task to be learnt and the learner's needs.

Clinical teaching, supervision and support

Student supervision and support are essential given the dynamic and risky nature of the clinical environment. While the learning opportunities offered by the clinical environment are evident, the very nature of the setting can be threatening to the beginner (Paterson, 1998). According to Kleehammer, Hart and Keck (1990) pre-registration students feel anxious about many aspects of clinical experience such as making mistakes, unexpected change in a patient's condition and talking to doctors. Reilly and Oermann (1992) state that doubt, conflict and anxiety are inherent in professional practice. For example, nursing students must be able to manage atypical patient problems when they occur. Such variations in usual responses by patients often require resolution by use of alternative solutions. Challenges such as these require learners to engage in risk-taking behaviour where the best possible outcomes are weighed up against the worst outcomes for their patients. It is in this context that the undergraduate student learns to become a nurse. Spouse (1990) argues that the learner needs to feel safe and valued if learning is to result from the clinical experience. According to Reilly and Oermann (1992) students therefore need assistance to deal with uncertainty in practice.

Summary

The first two sections have established the value, importance and challenges that arise for nursing students and clinical teachers within a context of continual change, increasing complexity and unpredictability. Problems experienced with the quality of

learning outcomes from nurse education programs were described in the introductory chapter of this thesis. In order to develop professional competence, nursing students need exposure to the clinical setting and opportunities to work with patients to develop their task skills and higher-level thinking skills. It has also been established that nursing itself is a complex profession with many possible interpretations. So the question of how clinical teachers understand and teach nursing requires investigation. In order to improve the quality of learning outcomes for undergraduate nursing students this study aimed to understand the interrelationships of supervising clinical teachers' conceptions of nursing and their approaches to clinical teaching. Of interest to this research is the question of what clinical teachers focus on and how they go about their teaching.

Section 3: Perspectives on teaching and learning

This thesis argues that clinical teachers, who intend that their students will achieve conceptual change, possess student-focused conceptions of clinical teaching and use student-focused teaching strategies. As a consequence nursing students are more likely to adopt deep approaches to learning which lead to high quality learning outcomes. In order to understand how clinical nurse teachers teaching undergraduate nursing students on clinical placement and the variations in those experiences, various perspectives on learning and teaching are presented. The two most relevant theories of learning in the nursing context are behaviourism and cognitivism. The perspectives presented in this section specifically focus on cognitivism and its influences on nursing education. The cognitivist perspective includes behaviourism and cognitivism which includes individual constructivism and social constructivism. These perspectives on learning and teaching provide a context and point of reference to compare and contrast with the phenomenographic perspective on learning and teaching. Knowledge of the interrelationships between clinical teachers' conceptions of and approaches to clinical teaching will help progress what is already known about teaching and learning, both in higher education generally and specifically in clinical nurse education.

The behaviourist perspective on learning and teaching

Behaviourism has a special significance to this discussion because nursing has made extensive use of the theory over time as a foundation for training nurses.

Behaviourist theory is based on Pavlov's investigations in 1927 of how animals and

humans learn, and focuses on that which is observable and measurable. According to Bolles (1979) a number of theorists have contributed to the development of behavioural theory and include theorists such as Thorndike (1874-1949), Watson (1878-1958) and Skinner (1904-1990).

The central tenet of behaviourism is that learning is an unconscious response to a stimulus with the resulting performance being able to be measured (Bolles, 1979). Millhollan and Forisha (1972) state:

‘The behaviorist orientation considers man to be a passive organism governed by stimuli supplied by the external environment. Man can be manipulated, that is, his behavior controlled through proper control of environmental stimuli. Furthermore the laws that govern man are primarily the same as the universal laws that govern all natural phenomena. Therefore, the scientific method, as evolved by the physical sciences, is appropriate as well for the study of the human organism’. (p. 13)

Pavlov (cited in Bolles, 1979) argued that all actions are based on reflexes in response to stimuli of some sort. Skinner expanded the theory in 1953 (Bolles, 1979) asserting that actions can be manipulated in response to reinforcement or reward to achieve desired outcomes. This is described as operant conditioning. The theory suggests that all learning is observable and is described in terms of permanent behavioural change.

Behaviourist theory provided a way of focusing the training requirements of nurses, particularly in the early stages of the profession's development. Norton (1998) asserts that the underlying behaviourist principles were incorporated into the work of nurse training leaders such as Tyler and Bevis. Bevis (1989) describes the adoption of the Tyler curriculum model post World War 2 when considerable change was occurring in health care, particularly in the areas of technology and education. Curriculum based on the behavioural, technical Tyler curriculum model included the following features: ‘a philosophy: a conceptual framework...: behaviourally defined, measurable objectives on every level...: the development or selection of learning activities sorted into a program of studies: and the evaluation of learning based on the behavioural objectives’ (Bevis, 1989, pp. 30-31). According to Bevis (1989) the learning environment is highly structured with content being provided, and timeframes for presentation of content and learning being pre-determined. In other words the teacher is dominant and focuses on that which is being performed is done

so correctly by assessing learners for permanent behavioural change (Norton, 1998). Learning experiences are therefore highly structured with the teacher intending to shape learner behaviours. Hence, the learner's role is to follow the direction, cues and positive reinforcement of the teacher in meeting pre-determined behavioural objectives to achieve desired behaviours.

While behaviourism remains useful for the technical aspects of nursing, it is not adequate for contemporary nurse education. Nurses today are expected to have an extensive scientific knowledge base and are required to apply theory to practice. In addition, it is expected that they will solve problems and plan, implement and evaluate nursing care. Nursing has had a long history of being faithful to the medical model which is described by Bevis and Watson (1989) as "dualistic, reductionistic, objective... (and focused on) diagnosis and treatment" (p. 5). Yorks and Sharoff (2001) argue that the emphasis of Tylerian curriculum models was on the transfer of knowledge with little or no emphasis on the professional development of the nurse as a whole person. They further argue that a shift has occurred from the expert model of health care to one which is patient-centred. Instead of treatment focusing on the presenting symptom, the patient and health professional determine the best course of action.

In terms of explaining how learning occurs, behaviourism has some limitations. It does not assist understanding of what is being done, or how it is being done, without referring to the content and structure of the learner's previous experiences. Norton (1998) and Marton and Booth (1997) assert that behaviourism is not concerned with how learners gain knowledge, only with behavioural change. Behaviourism, according to Bevis (1989) does not provide guidance for important aspects of nursing such as measuring understanding, reflection, meaning, or problem-solving. Norton (1998) adds that the mechanistic behaviourist model does not explain how concepts are formed or problems solved. Bevis (1989) points out that adherence in the past to a behaviourist curriculum provided nursing with the necessary tools to raise the standards when the focus was on training rather than education. However, Bevis and Watson (1989) argue that such an approach to teaching is narrow and rigid and therefore limited. Bevis states a behaviourist curriculum 'discounts insights, analysis and patterns' (1989, p.36) thus threatening the necessary development of nursing education essential in a constantly changing world. According to Bevis (1989) since

nursing is a human science rather than a traditional science it requires theories which allow for the multiple realities of learning and teaching about nursing.

It is apparent then, that behaviourism does not explain how learning occurs and views learning from a teacher perspective with its focus on observation of behaviour. Behaviourism does not account for the interrelationships between teacher approaches to teaching, student approaches to learning and the quality of learning outcomes. Traditional teacher roles where the teacher is dominant are no longer relevant in nursing education. Prosser, Martin, Trigwell, Ramsden and Leuckenhause (2005) argue that teacher-focused teachers conceive of and approach their teaching with the aim of transferring information to their students. The teachers' focus is on their own activities rather than on helping their students develop and achieve understanding. Paterson (1998) is concerned that such teaching approaches create a dependency for students on the authority of the teacher. Teacher-focused approaches to teaching, where the teacher decides what must be learnt and the student is a passive recipient has a negative effect on learning outcomes (Norton, 1998).

The cognitivist perspective including individual constructivism and social constructivism

As a consequence of dissatisfaction with behaviourist theory and its focus on environment, individual events, stimuli and demonstrable behaviour, cognitive learning theorists focus on the individual's mental processes as a way of explaining how people learn. Once again a range of theorists have contributed to the development of cognitive learning theory. These theorists include among others, Ausubel, Bruner and Bandura (Bolles, 1979) who developed the theory from the 1950s onwards. Cognitivism is well regarded in nursing education especially in relation to the need for nurses to engage in higher order thinking.

In essence, cognitive learning theory proposes that learning occurs as a consequence of thinking. Jonassen (1991) states that cognitivism is concerned with what learners know and how they acquire their knowledge. Learning is seen to be a process where material is conveyed to the learner and is absorbed via the sensory organs and then internalised. As a consequence of processing, information is stored and meaning is developed. Patterns, memory and perception are key features of this theory. The emphasis is on knowledge acquisition and the development of understanding

(Norton, 1998). Learning from the cognitivist perspective is defined as an “active, constructive and goal-oriented process that is dependent upon the mental activities of the learner” (Schuell, 1986, p. 415). It is expected then that the student will be actively engaged in the learning process and the construction of new knowledge to gain meaning (Norton, 1998). Norton (1998) argues that cognitivist theory provides advantages for the teacher by providing specific direction about teaching approaches. For example, teaching is said to involve more than the delivery of information. According to Schuell (1986) the teacher must know how to motivate learners to engage in learning activities that are liable to lead to the achievement of learning outcomes. Norton (1998) asserts that the teacher needs to relinquish control in favour of learners who are accountable for their learning. Approaches to teaching are focused on enhancing retention of information and the development of understanding so that problem solving and critical thinking abilities of students are improved.

Reilly and Oermann (1992) argue that knowledge and its use is fundamental to professional nursing practice. Schuell (1986) maintains that because learning is considered to be an active process for the learner, what the learner does is more important than what the teacher does in relation to the learner achieving learning outcomes. However, Marton and Booth (1997) maintain that cognitivism does not explain how meaningless information is synthesised into an internal representation of the external world. Nor does cognitivism adequately explain the process of synthesis or how “internal representation” (p. 9) is operationalised. Schuell (1986) also notes that although the emphasis in cognitive theory is on the learner developing meaning, the theory does not explain how meaning is extracted from experience. Lave and Wenger (1991) argue that when absorption of given material and internalisation are provided as an explanation of learning, there is a separation between the learner and the world and the learner is an unproblematic part of the process. Jonassen (1991) agrees that cognitivism is dualistic and argues that learners, their nature, their world and the way learners relate to the world need to be accounted for.

Constructivism is another theory of the psychology of learning belonging to the cognitivist group of theories. This learning theory is seen to be relevant to nursing education, particularly in relation to the construction of knowledge. While there are a number of constructivist viewpoints on learning, the perspective described here is known as individual constructivism and will be distinguished from a social

constructivist perspective which follows. Individual constructivism proposes that knowledge is constructed within the learner and tested by external interactions (von Glaserfeld, 1995). The basic operating processes of learning in this theory include assimilation, accommodation and construction (Norton, 1998). This theory, based on the work of Piaget and Vygotsky, suggests that learning is developmental (Norton, 1998). Constructivism, according to Jonassen (1991) is concerned with how the learner constructs knowledge as a function of beliefs, prior experiences and mental structures. For example, Biggs (1993) uses the “presage, process, product” model to describe how students’ perceptions of their learning context interact with their prior experiences of teaching and learning, and the context in which they are currently being taught and are learning. The approach to learning used by students is related to their perception of the context as well as to their previous experiences. Biggs (1993) argues that the components of the model, while independently constituted, continuously interact with each other and that knowledge is therefore developed when new information is integrated with present understanding.

Constructivism also has a place in nursing education. Common applications of constructivism include solving problems through using Problem-based Learning where learners construct knowledge for themselves through discovery. Use of concept maps (All, Huycke & Fisher, 2003) and reflection on learning are other applications, all of which are said to enhance critical thinking and decision-making, these being important aspects of professional nursing practice. Norton (1998) argues that students are given more responsibility for their learning, with each student being required to interact with content, ask questions and establish relationships between concepts and principles. As a consequence of an approach such as Problem-based Learning, student learning outcomes are said to be improved (Forbes, Duke & Prosser, 2001).

Constructivism also does not explain the process of developing understanding. According to Marton (1998), rather than learning being about replacement of understandings, his research has shown that there is continuity between understandings: that is, further possibilities are added to previous understanding thus increasing the complexity of the way a particular phenomenon is understood. By considering the question of how we gain knowledge about the world, Marton and Booth (1997) cast doubt on the tenets of individual constructivism. They argue that

the theory does not explain what the conditions are for replacing one set of understandings with another. Nor does the theory explain what is involved in the process of choosing to accept a more advanced level of understanding over an inferior one. Finally, explanations are not provided for the state of the individual's construction of the world, or what triggers the search for knowledge. In the same way as other perspectives examined, this viewpoint of learning is dualistic (Prosser & Trigwell, 1999a). Prosser and Trigwell (1999a) argue that constructivism assumes a reality independent of the learner and does not account for the interrelationships between teacher approaches to teaching, student approaches to learning and the quality of learning outcomes. Instead, the individual's interpretation of reality is contained in the learner's mind.

Another currently held view of learning which has influenced nursing education is that of social constructivism, also known as situated cognition. According to Lave and Wenger (1991) learning can be understood from a social practice theory perspective. The work of Vygotsky (1978) provides important theoretical foundations to this perspective on learning. Learning is seen to involve more than a learner trying to make sense of something. Vygotsky (1978) argues that there is a gap between what learners can learn by themselves and what can be learnt with guidance. Lave (1996) asserts therefore, that learning is "an aspect of participation in socially situated practices." (p.150) and is therefore considered to be an integral aspect of activity in and with the world, through participation in communities of practice. Lave and Wenger (1991) argue that increasing participation in practice results in learning where change occurs in people, their identities, knowledge and skills. This change occurs regardless of the form of teaching that precedes it.

The place of the teacher in this perspective on learning is as a participant in the community of practice. Quay (2003) asserts that the role of the teacher is shared with other members of the community and involves creating an environment conducive to learning, structuring learning situations and managing group tensions. The student and teacher are of equal status, and have equal control and responsibility for learning (Chaiklin & Lave, 1993). Associating with practitioners in natural settings allows the novice to become increasingly familiar with the skills and knowledge and ways of thinking. Learning, therefore, becomes more meaningful because ideas, theories and principles are practised. For those involved, whether they are experienced

practitioners or novices, all learning activities are considered to be situated and involve connections between learning and the social contexts in which it occurs. Social constructivism acknowledges the relational nature of knowledge and learning, the negotiated nature of meaning and the involvement and interest in learning activities. Miller and Boud (1996) assert that learning is socially and culturally constructed. They state that learners actively construct their own experience in the context of social and cultural values and economic and political environments. The emphasis of social constructivism is on learning to understand thus involving the whole person and their relations with the world.

Because learning, the world and the learning activity do not exist without each other, it is possible this theory of learning could account for the relationships between teacher approaches to teaching, learner approaches to learning and student learning outcomes. However, social constructivism is concerned with the relations between individuals and situations and also does not provide an adequate explanation of learning. Marton (1998) argues that while social constructivism deals with the conditions and characteristics of learning, the theory does not address how learning occurs or what is learnt. Furthermore, the notion of learning as increasing involvement in the practice world implies the whole person participating in the practice community. In the traditional apprenticeship model of nurse training, for example, student nurses were members of the workforce, learning from peers as well as through trial and error. Yet, Spouse (1998) reports that student nurses found it difficult to connect with the clinical setting in an educational manner or to gain access to the professional knowledge of their colleagues. Moreover, social constructivism, according to Marton (1998) interprets the relations between individuals and individuals and situations from the researcher's perspective. He argues that it is assumed that the participants and the researcher view situations in the same way. Spouse (1998) asserts that the occurrence of learning as a result of experience cannot be guaranteed. From both Hutchins (1993) and Spouse's (1990) points of view it is not always enough for learners to be in the presence of others who are working. Instead, nurse learners need learning experiences to be selected according to individual need. In addition, it is helpful if experienced staff make problem solving and team work overt to the nursing student. Practice therefore

requires integration of learner, world and activities such as knowledge and learning, where the relations and interdependency are emphasised.

The phenomenographic perspective on learning

Given the contrasting theoretical accounts of learning and the implications for teaching previously presented, phenomenography provides an alternative approach to explain learning and teaching (Marton, 1981, 1986; Marton & Booth, 1996 and 1997). It is important to note that phenomenography is not in itself a theory of learning. According to Prosser (1993) phenomenography includes a view of learning and, as such, suggests principles to inform teaching and learning. A precursor, therefore, to understanding the phenomenographic perspective on teaching is an understanding of the phenomenographic or relational perspective on learning. This perspective on learning emerged in the 1970s and developed in the subsequent years as a consequence of qualitative research undertaken by researchers including Ference Marton, Lars Owe Dahlgren, Lennart Svensson and Roger Säljö at the University of Göteborg, Sweden. Their research focused on learning in order to explore why some students are better at learning than others (Marton, 1981; Marton, 1988a; Marton & Booth, 1997; Marton & Säljö, 1976a).

The point of departure of a relational perspective on learning from each of the other learning perspectives is that it is non-dualistic. According to Marton and Booth (1997) the learner and the world are not separate from each other. They state ‘... the learners, we deal with are people experiencing aspects of the world...[The world] is constituted as an internal relation between them...’ (p. 13). They argue that ways of describing experiences are therefore, neither physical nor psychological but are descriptions of a non-dualistic relationship between the person (subject) and the phenomenon (object). “Ways of experiencing a phenomenon” is a term that describes the internal relationship between the individual and a phenomenon in the world (Marton & Booth, 1997). From a phenomenographic perspective, conceptions of phenomena and situations reflect the relationship between an individual, task and context and as such are not characteristics of that individual (Trigwell, Martin, Benjamin & Prosser, 2000). Since phenomena and situations cannot be understood separately from each other, a learning situation is experienced and comprehended in relation to the phenomena involved. Since individuals will experience the phenomena differently, Marton and Booth (1997) propose that distinctive internal

relationships are formed between the person and the world. What is learnt lies in these relationships.

Learning, according to Marton & Booth (1997) is “coming to experience the world, or aspects of the world, in particular ways” (p.vii); it is the change that occurs in the learner’s experience of a phenomenon. Therefore, the way the person experiences the world is strongly tied to the way phenomena, arising from situations are experienced. For example, in a learning situation, phenomena and situations, are noticed and defined by the learner. Parts and sub-parts within are also noticed and defined and related or distinguished from other situations and phenomena (Marton & Booth, 1997). Conversely, the learner’s awareness of phenomena is experienced and understood from the viewpoint of the situation, thus making phenomena, situations and the learner inextricably linked (Marton & Booth, 1997). The situation the learner is involved in thus provides the immediate learning context. The phenomenographic perspective on learning therefore emphasises the internal relationship between the learner and the outside world as evident through the learner’s awareness of the world and the ways meanings differ and change. What is hoped for, in relation to student learning, is the transformation of the way a student thinks about or conceives of key ideas in the field of study, resulting in conceptual understanding. The internal relationship between the learner and the phenomenon changes as a result of new experiences of the phenomenon. The learner now understands the phenomenon in a more complex way than before.

Bowden and Marton (1998) contend that variation is fundamental to learners’ experience of learning. Variation in the quality of learning outcomes is related to the ways in which the learner approaches learning (Prosser & Trigwell, 1999a). Approaches to learning are also referred to in the phenomenographic perspective on learning as the ‘how’ of learning. According to Säljö’s (1979) research those who approach learning taking a deep approach have been shown to have an intention of understanding. Deep learners have been shown to achieve higher quality learning outcomes than those who approach learning by using a surface approach. Learners using a surface approach to learning have been shown to have an intention to reproduce material. Learners using deep learning approaches use strategies to answer their questions. These strategies include; discerning patterns and identifying

principles, evidence and arguments. Aspects of the task are identified as part of the whole. Learners theorise about the task, generate hypotheses and link their understanding to other parts of the subject as well as to other subjects. On the other hand those who approach learning in a surface way are not likely to achieve understanding of the subject. Therefore, deep and surface approaches constitute variation in approaches to learning and the quality of outcomes is related to the approach adopted. For example, Trigwell and Prosser (1991) conducted a study of nursing students' understanding of subject matter in a 'communications' subject. They found that students who approached their study in a deep way achieved high quality learning outcomes. A further example is provided by Davey (1995). She conducted a study of Year 2 nursing students' understanding of asepsis. It was found that a student who reported using a deep approach to learning had a complex understanding of the principles of asepsis. The majority of nursing students in this study who had used a surface approach failed to understand any more than three or four of the relevant principles.

Variation in approaches to learning is related to how the learner conceives of learning. Conceptions of learning are also referred to in the phenomenographic perspective on learning as the 'what' of learning. Säljö's (1979) research, which built on earlier research into conceptions and approaches to learning (Marton & Säljö, 1976a & 1976b) identified five qualitatively different conceptions of learning. The first and least complex conception of learning is that of increasing one's knowledge. In terms of this conception, the focus is on gathering facts and information. The next conception of learning is the acquisition of knowledge. The focus here is on what is to be done. Learning is seen as memorising and reproducing. The next conception sees learning as application. So, in addition to gathering and storing information, knowledge is applied to other contexts. The fourth conception of learning is about achieving understanding. Here, new knowledge is applied but also integrated into the learner's world through comparing and contrasting. Instead of the focus being on the tasks of learning the focus is now on the learner. The fifth conception views learning as seeing something in a different way. The learner, while aiming to understand the real world develops a flexible and dynamic perspective. Later, Marton, Dall'Alba and Beaty (1993) identified a sixth conception of learning. The sixth and most extensive conception is that learning changes the person. Learning is not only

acquiring, retaining and applying, but it is also beneficial to the learner who ultimately is the recipient of its effects. Within these six conceptions, Marton and Booth (1997) identify two groups. The focus of the first group is on the tasks of learning for reproduction: a focus on searching for meaning is the focus of the second group. The more integrated the conception of learning, the more likely the learner is to adopt a deep approach to learning and achieve high quality learning outcomes.

Variation in approaches to learning has also been found to be related to learners' prior learning experiences and their perception of the learning environment (Prosser & Trigwell, 1999a, 1999b; Ramsden, 2003). Eklund-Myrskog (1997) conducted phenomenographic research into nursing students' conceptions of and approaches to learning and whether the context was influential on their experiences of learning. Students (n=60) were interviewed at the beginning of their course and again at the end of their course. The results confirmed a relationship between conceptions and approaches to learning. The results also suggested that the learning context was influential. Beginning nursing students (70%) adopted a quantitative approach whereas by the end of the course 82% of these students were using a qualitative approach. Eklund-Myrskog (1997) reports that students experienced learning differently, relating their learning to their future professional practice.

The learner's previous learning background also influences the approach used by learners by interacting with their perceptions of the learning environment. The environment consists of course design, content, teaching and assessment methods (Trigwell & Prosser, 1991). Therefore, the way students approach learning tasks will depend on their perception of the context and task as well as their prior learning experiences. Trigwell and Prosser (1991) believe that students who are clearly aware of the goals of the subject, who have some autonomy about what is to be learnt and perceive their learning environment to involve high quality teaching are likely to adopt deep approaches to learning. Those who perceive that the workload is too high and that the assessment requires recollection of facts are likely to adopt a surface approach. According to Marton and Booth (1997), these variations are also related to learners being more aware of some aspects of their situation than other aspects. Since the quality of teaching as perceived by the learner is related to the learning approach

adopted by the learner it is important to find out how clinical teachers approach their teaching in the clinical setting.

Summary

The traditions of behaviourism, cognitivism, including individual constructivism and social constructivism, represent diverse and contrasting theoretical explanations of how individuals gain knowledge. What is most apparent with the views about learning held by behavioural and cognitive theorists is that the learner is separate from the outside world. This section has introduced an alternative perspective on learning. The phenomenographic perspective on learning forms part of the theoretical background to this study. In summary, learning, from a phenomenographic perspective occurs through experience, with learners experiencing the learning context in qualitatively different ways. Learning involves a change in the way a phenomenon is experienced through experiencing variation in relation to the phenomenon. In contrast to other learning perspectives, phenomenography takes a non-dualistic view of the relations between individuals and the world. The quality of learning depends on the learner's awareness of the outside world. That is, their perceptions of what is to be learnt, their perceptions of the learning environment, prior learning experiences, quality of teaching, level of workload and level of choice which are all co-existent, are related to student intentions and approaches to learning. The phenomenographic perspective on learning provides an important foundation for understanding the phenomenographic perspective on teaching.

This empirical study has explored whether a relationship exists between clinical teachers' conceptions of nursing and clinical teaching and their approaches to nursing and clinical teaching undergraduate nursing students within a clinical context. Variation in approaches to clinical teaching is evident and related to how teachers conceive of nursing and clinical teaching within this specific context. Variation in clinical teachers' approaches to teaching originates from awareness or lack of awareness of different aspects of nursing and teaching of undergraduate students in the clinical setting, the implications of which will be discussed in this next section.

Phenomenographic perspectives on teaching

It was argued in the previous section that when learners conceive of learning in complex ways, perceive that their learning context consists of high quality teaching

and that the goals of learning are clear, they are more likely to adopt deep approaches to learning. Such learners are more likely to achieve high quality learning outcomes. In this section, how teachers conceive of teaching and learning, how they perceive their teaching context, and how they approach their teaching in that context are shown to be related to the quality of student learning resulting from their teaching. Having an understanding of these relationships makes it possible to develop ways of improving teaching and therefore student learning outcomes. Marton and Booth (1997) describe good teaching as:

“... meetings of awarenesses, which we see as achieved through the experiences that teachers and learners undertake jointly. ...teachers mold experiences for their students with the aim of bringing about learning, and the essential feature is that the teacher takes the part of the learner, sees the experience through the learner’s eyes, becomes aware of the experience through the learner’s awareness.... The teacher focuses on the learner’s experience of the object of learning. Here we have the “thought contact” [with] the teacher molding an object of study to which the learner directs her awareness.” (p. 179)

Just as students experience learning and teaching in different ways, so do teachers. This section reviews research specifically focused on a non-dualist perspective on teachers’ experiences of teaching. These studies focus firstly on teacher conceptions of teaching across groups of university teachers, in a range of disciplines, where phenomenographic research approaches are typically used. These studies also focus on relations between teacher conceptions of teaching and learning, approaches to teaching, student approaches to learning and quality of learning outcomes. Some of this research has gone beyond phenomenographic research approaches and used quantitative analysis to measure degrees of association appropriate for the variables being investigated.

Trigwell and Prosser conducted a series of studies in 1994 which investigated how twenty four, first year university physical sciences teachers experienced teaching and learning. The studies confirmed the relations between teaching contexts, teacher conceptions and approaches to teaching, and learner approaches to learning and learning outcomes. One of these studies (see Prosser, Trigwell & Taylor, 1994) investigated the conceptions of teaching and learning of a group of first year science teachers, and how those conceptions related to their approaches to teaching. Conceptions of teaching were investigated separate to, but in conjunction with,

conceptions of learning because of previous research (Ramsden, 1987) that showed conceptions of the two phenomena to be strongly related. Conceptions of teaching are also referred to in the phenomenographic perspective on teaching as the ‘what’ of teaching. In this phenomenographic study, six related conceptions of teaching were identified in Prosser, Trigwell and Taylor’s study (1994). These conceptions included teaching being viewed as:

- A Transmitting concepts of the syllabus
- B Transmitting the teachers’ knowledge
- C Helping students acquire concepts of the syllabus
- D Helping students to acquire teachers’ knowledge
- E Helping students develop conceptions
- F Helping students change conceptions

Similarities can be seen with Dall’Alba’s (1991) earlier research findings where a range of qualitatively different conceptions of teaching were identified following interviews with twenty university teachers from fields including Medicine, Economics, Physics and English. The conceptions in hierarchical order are as follows:

- A Teaching is viewed as presenting information
- B Teaching is viewed as transmitting information (from teacher to students)
- C Teaching is viewed as illustrating the application of theory to practice
- D Teaching is viewed as developing concepts/principles and their relations
- E Teaching is viewed as developing the capacity to be expert
- F Teaching is viewed as exploring ways of understanding from different perspectives
- G Teaching is viewed as bringing about conceptual change

A logical order is apparent in both sets of conceptions. On the one hand, the focus of teaching is on the teacher and what the teacher does (Conceptions A, B and C). On the other hand, more complex conceptions are held (Conceptions D and beyond). What is apparent is that the focus shifts from the teacher to the content and finally, the focus is on the connection between the teacher, students and material to be learnt. In both studies the more complex categories describe the teacher as having a complex conception of teaching and being aware of many aspects of the conception. Other studies have identified similar conceptions and relationships: for example, Martin and Balla (1991) following interviews of thirteen teachers in the higher education setting. Seven related categories were identified and were clustered in

three major groups which included: presenting information, encouraging active learning and relating teaching to learning.

These three studies (Dall'Alba, 1991; Martin & Balla, 1991; Prosser, Trigwell & Taylor, 1994) show that teachers enter their teaching and learning contexts with limited but qualitatively different conceptions of teaching. In all three studies the categories form a range of conceptions from being teacher-focused to student-focused: terminology introduced by Trigwell, Prosser and Taylor (1994). The categories describing conceptions of teaching in these studies are hierarchically ordered: that is, teachers who adopt the more teacher-focused conceptions lack awareness of more student-focused conceptions in the particular situation they are in. Alternatively, those teachers who have more student-focused conceptions are aware of more teacher-focused perspectives.

Teaching experienced in a teacher-focused way

Conceptions and approaches to teaching that are teacher-focused have been described in two ways. Firstly, teaching is experienced as presenting, transmitting or imparting information to students. The focus of the teachers is on themselves and their information delivery skills (Dall'Alba, 1991; Samuelowicz & Bain, 1992) or pieces of information to be presented to the students (Trigwell, Prosser & Taylor, 1994). Another teacher-focused way of experiencing teaching is where the content is structured so that students find it easier to acquire knowledge. Instead of just providing fragments of information the teacher is focused on making links between concepts. Kember (1997) labels this category as "transmission of structured knowledge" (p. 264). According to Prosser and Trigwell (1999a & 1999b) teachers holding teacher-focused conceptions of teaching lack an awareness of more student-focused perspectives in the circumstances in which they find themselves. Samuelowicz and Bain (2001), Dall'Alba (1991) and Martin and Balla (1991) agree that where a teacher experiences teaching in a teacher-focused way, communication is one-way: that is, it is initiated by the teacher. The teacher is in control of the content which exists in text books, lecture notes or with the teacher. Learning outcomes are either not considered or are thought about only in terms of reproduction of atomised information. According to Trigwell, Martin, Benjamin and Prosser (2000) there is little evidence of reflection by teachers with low level conceptions

and approaches to teaching. If they reflect at all it is on what they do, rather than on how the students experience learning.

Teaching experienced in a student-focused way

Conceptions and approaches to teaching which are student-focused are those that are more complex than teacher-focused conceptions, but include them. When teachers conceive of teaching and learning in student-focused ways they approach their teaching with a focus on the student. The intention is for students to achieve conceptual development and change in their thinking. Although the focus is on the student there are two different conceptions identified in the research. In the first, the teacher helps the student to develop knowledge and understanding (Trigwell, Prosser & Taylor, 1994) or prevents the student from misunderstanding (Samuelowicz & Bain, 2001). The second and more complex conception is focused on the teacher helping the student to change their understanding, for example, from less to more complex or from naïve to professional (Dall'Alba, 1991; Samuelowicz & Bain, 1992, 2001; Trigwell et al., 1994). Knowledge is seen as being developed and transformed by the student rather than being acquired externally. Responsibility for organising or transforming knowledge rests with the student. The student is therefore expected to actively engage in learning so that understanding of the subject matter is developed and changed. Samuelowicz and Bain (2001) describe communication as being two-way as student and teacher negotiate meaning.

Teacher conceptions of learning were first investigated by Prosser, Trigwell and Taylor (1994) because of the view that such conceptions would underpin teacher conceptions of teaching. A set of logically related categories, describing first year university science teachers' qualitatively different conceptions of learning were identified. These categories, in hierarchical order, show conceptions of learning ranging from less to more complex understandings of learning. The more complex conceptions of learning include the less complex conceptions of learning. Learning, according to Prosser et al. (1994) was viewed by these first year university teachers of physical sciences as:

- A Accumulating more information to satisfy external demands
- B Acquiring concepts to satisfy external demands
- C Acquiring concepts to satisfy internal demands

- D Conceptual development to satisfy internal demands
- E Conceptual change to satisfy internal demands

Logical relationships were also found to exist between conceptions of teaching held by teachers and their conceptions of learning. Prosser et al. (1994) show that science teachers who conceive of teaching as being about transmitting information also conceive of learning as being about students gathering more information. In contrast, those teachers who conceive of teaching as being about students developing understanding, conceive of learning as being about students developing and changing their conceptions and understandings. At a later stage Trigwell and Prosser (1996b) demonstrated a strong empirical relation between these teachers' conceptions of science teaching and their conceptions of science learning.

Just as conceptions and approaches to learning have the potential to limit learning for students they also have the potential to limit teaching. Variation in the quality of learning outcomes is not only related to the ways in which the learner approaches learning, but also to the ways in which teachers approach their teaching (Prosser & Trigwell, 1999b). Approaches to teaching are also referred to in the phenomenographic perspective on teaching as the 'how' of teaching. Studies conducted by Prosser et al. (1994) and Trigwell and Prosser (1996b), show that there is usually coherence between teacher approaches to teaching and their conceptions of teaching and learning. What is apparent is that university science teachers with a teacher-focused approach seem to have characteristics in common with a surface approach to learning. Teachers with a student-focused approach appear to have characteristics in common with students' deep approaches to learning. Once again, Trigwell and Prosser (1996b) demonstrated a strong empirical relation between these teachers' conceptions of science teaching and learning and their approaches to teaching.

Variation in approaches to teaching has been found to be related also to prior teaching and learning experiences and teachers' perceptions of the teaching and learning environment (Prosser & Trigwell, 1999a, 1999b). According to Prosser and Trigwell (1997) both higher education teachers and students enter teaching/learning contexts with a range of previous experiences of learning and teaching. The teaching and learning context elicits particular kinds of former experiences which then

position the teachers in those contexts. Teaching, for example, is then approached by the teacher in certain ways relevant to the situation with the teacher being simultaneously conscious of particular aspects of the situation. Prosser and Trigwell (1997) studied first year university science teachers to identify how they perceived their teaching context and whether or not there was any relationship between their perceptions and their approaches to teaching. The study was conducted in two phases. In the first phase of the study thirteen, first year university teachers were interviewed as to their perceptions of their teaching context. It was found that adoption of student-focused approaches to teaching was associated with perceptions of control over content and how it was taught, class sizes that were not too big and working in a department where teaching was valued. As a consequence, Prosser and Trigwell went on to develop a “Perceptions of Teaching Environment Inventory” (Prosser & Trigwell, 1997). The inventory provides indicators of teachers’ perceptions of their teaching and learning situation.

The second (quantitative) phase of Prosser and Trigwell’s (1997) study was used to investigate the relationship between university science teachers’ approaches to teaching and their perceptions of the teaching context. Data, in this second phase, were collected from forty six, first year university teachers, using the Approaches to Teaching Inventory, previously developed by Prosser and Trigwell (1993) and the Teaching Environment Inventory referred to previously. The findings appear to indicate that variation in the ways university teachers approach their teaching is systematically related to the variation in the ways they perceive their teaching environment. For example, adopting more of a conceptual change/student-focused approach to teaching is related to positive perceptions of the teaching context. Prosser and Trigwell (1997) argue that in order to improve the quality of teaching and learning in higher education, the teachers’ perceptions of their teaching context need to be taken into account.

Relationships have also been found to exist between teacher approaches to teaching, students’ approaches to learning and to the quality of learning outcomes. Trigwell and Prosser (1996a) and Trigwell, Prosser and Waterhouse (1999) have shown that the approaches taken by university teachers to their teaching are related to their conceptions of teaching. These studies have also shown that there is a relationship between university teacher approaches to teaching, their conceptions of their

teaching and the way in which their students experience learning. Relationships have also been found to exist between teacher conceptions of teaching, their approaches to teaching and the quality of student learning outcomes. Trigwell et al. (1999) investigated the relations between a science teacher's approach to teaching and the approaches to learning of students in the class of that teacher. The conclusion of this study was that qualitatively different teaching approaches are associated with qualitatively different learning approaches. For example, teachers who adopt a transmission/teacher-focused approach to their teaching are more likely to have students in their class who report adopting a surface approach to learning in that class. Whereas, teachers who are student-focused and intend for their students to achieve conceptual change are more likely to have students in their class who adopt a deep approach to learning and therefore achieve high quality learning outcomes.

Research conducted by Ironside (2005) shares some similarities with phenomenographic research into teacher approaches to teaching. Ironside (2005) conducted a hermeneutic study of nurse teachers' (n=30) and post-graduate nursing students' (n=15) experiences of teaching and learning. Non-structured interviews were conducted to find out how nurse teachers and students experienced teaching and learning when Narrative Pedagogy was used as a teaching strategy. Findings of the study revealed themes which are similar to phenomenographic categories describing conceptions of teaching and learning. The major theme identified in Ironside's (2005) study is "Teaching thinking and reaching the limits of memorization." (p. 443). Here, the teacher's role is seen to be about giving students information and the student's role is to acquire information to be memorised. The content to be learnt is determined by the teacher. Within this theme two sub-themes were identified. The first sub-theme is identified as "Thinking as memorization and recall." (p. 444). In this sub-theme it is identified that organisation of content is thought to make it easier for students to remember. However, both teachers and students identified that when organising frameworks are used, content is not necessarily understood, nor is it necessarily transferable to other situations. The second sub-theme is "Beyond memorization: Thinking in context." (p. 445). Use of Narrative Pedagogy, where the focus is on students interpreting and sharing nursing practice narratives, was seen to help students develop and change their understandings of nursing. In this theme the focus shifts away from the teacher and

content for memorisation to the student developing and changing their conceptions. The use of this teaching/learning strategy is seen to help students to engage in “multi-perspectival thinking” in the context of nursing (Ironside, 2005, p. 446). The strategy was seen to help students to change their study approaches and question their knowledge base, practice interpreting information and thinking.

While the majority of phenomenographic research in higher education has been conducted in traditional, university-based classroom learning environments similar teacher conceptions of learning and teaching have been found in a study into learning in a work-based university education model. Martin (1997) investigated conceptions of work-based learning held by university teachers who organise and supervise work-based learning experiences for undergraduate students in a range of fields. The fields included: engineering, business studies, health sciences and social sciences.

Variation in conceptions of learning range from: learning occurring because of being in the work-place: learners benefiting because of being involved with the work-place and the university: and learning involving a redefinition of theory by the student who is in a joint arrangement involving the university and the workplace. Martin (1997) identified parallels between the findings of her study and the research findings of Prosser et al. (1994). In Martin’s (1997) study, teachers who viewed work-based learning as unproblematic, thought that exposure to a work environment so that students can pick up skills is all that is required. Similarly, in the study by Prosser et al. (1994), learning was also viewed by some as unproblematic. Information was provided and students were not engaged in issues and problems in the field of study. In both studies, a complex conception of learning is identified as teachers engaging students in developing and changing their conceptions in key areas in the field of study. Martin (1997) states, “learning happens by design not by chance” (p. 203).

Summary

Phenomenographic research has established relationships between teacher approaches to teaching, student approaches to learning and the quality of learning outcomes. Teachers, who intend that their students will achieve conceptual change, possess complex conceptions of teaching and learning, and use student-focused teaching strategies. Teachers who are aware of fewer aspects of teaching and

learning take a teacher-focused approach to their teaching and tend to have students who adopt a reproduction approach to their learning.

Section 4: Clinical nurse supervision research

While there is a range of research surrounding nursing student supervisory issues, the focus has been mainly on the teacher and the student as individuals. A review of the literature did not reveal any research papers directly focusing on clinical teachers' conceptions of clinical teaching. However, a small number of papers indicate a focus on the clinical teacher role and role-related issues. Review of the literature has also revealed papers focusing on various aspects of approaches to clinical teaching. Some of these papers focus on the purpose of clinical teaching and the role of the clinical teacher. Other papers focus on teaching strategies, all of which are considered as separate strategies: and effective clinical teacher behaviours, where attention is given to the characteristics and qualities of the teacher. This section outlines this research.

The first body of literature to be considered is related to the purpose of clinical education. The purpose of clinical education is defined by Wong and Wong (1987) as 'to apply the previously acquired knowledge to patient care situations and to acquire the kinds of professional and personal skills, attitudes and values thought essential for entering the health system' (p. 505). Wong and Wong's (1987) paper focused on reviewing the results of a large number of studies into clinical education at the time of transition from hospital-based training to the higher education sector. Wong and Wong (1987) noted that the focus of clinical learning has changed from doing to knowing and understanding. With the expectation that students will achieve understanding of theoretical aspects underpinning patient care, Wong and Wong (1987) argue that the clinical teacher therefore needs to be concerned with this expectation.

The next body of research relates to the clinical teacher's role as well as role-related issues. Viverais-Dresler and Kutschke (2001) identify that important aspects of the clinical teacher's role include facilitating students to achieve their clinical objectives, evaluating clinical performance and examining written assignments. Research has also focused on role strain (Piscopo, 1994) and experience of clinical teachers as temporary employees (Paterson, 1997). None of this research identifies how the clinical teachers conceive of clinical teaching, or how they help students to

understand nursing or understand theoretical and practical aspects of practice. According to Morton-Cooper and Palmer (1993, 2000) nurse teachers are now expected to facilitate student learning in the clinical setting where they create an appropriate learning environment, act as a resource and offer guidance to the learner. Morton-Cooper and Palmer (2000) argue that the focus should be on the learner. They state that the facilitator “allow(s) their students to be self-directed, but are able to appreciate when their interventions are requested or needed” (p. 166).

The next body of research is focused on clinical teaching strategies. Examples of research include studies focused on teaching activities used by clinical teachers (Morgan, 1991). The use of patient assignment is identified as a method of organising and presenting teaching in the clinical setting to achieve learning (Reilly & Oermann, 1992). However, in this paper, the focus is only on the process of selecting patients rather than showing how learners achieve better outcomes on clinical placement. Research conducted by Bjork (1997) focused on teachers’ understanding of practical skill acquisition. Other papers are focused on student opinions about selection of their own patients (Treece, 1969), multiple student assignment (Van Den Berg, 1976), and pre-planning activities (McCoin, & Jenkins, 1988). Other teaching methods such as written assignments, (Reilly & Oermann, 1992; Sedlak, 1992), clinical conferences (Wink, 1995) use of multi-media (Baldwin, Hill & Hanson, 1991; Gilbert & Kolacz, 1993; Howse, Smith & Perkin, 1994; Oermann, 1990) preceptorship (Nehls, 1997; Pierce, 1991;) and use of questioning (Phillips & Duke, 2001; Selleppah, Hussey, Blackmore, & McMurray, 1998) were found. While not explicitly stated, it is implied in each of these papers that adoption of the investigated strategies would mean that students would learn more effectively. However, none of these papers identifies how clinical teachers help students to understand nursing, or develop and change their understanding of theoretical and practical aspects of practice.

Clinical teachers require certain personal and professional characteristics if they are to be effective in their role. For example clinical teachers are considered to be effective if they are knowledgeable and share their knowledge and expertise in the clinical setting (Bergman & Gaitskill, 1990; Nehring, 1990). Several studies (Kanitsaki & Sellick, 1989; Mogan & Knox, 1987; Sellick & Kanitsaki, 1991) have identified that clinical teachers’ teaching abilities are highly valued by both educators

and students. Clinical competence is another important clinical teacher (Mogan & Knox, 1987; Nahas & Yam, 2001; Nehring, 1990; Sieh & Bell, 1994). Yet according to Tang, Chou and Chiang (2005) clinical teacher attitudes are more important than professional abilities. Clinical teachers have been found to need certain personal characteristics to be effective in their role. These include honesty, co-operation, patience and flexibility (Bergman & Gaitskill, 1990; Mogan & Knox, 1987; Nehring, 1990). Approachability (Viverais-Dresler & Kutschke, 2001) and enthusiasm (Krichbaum, 1994) are other characteristics considered to be important as well as availability to students (Bergman & Gaitskill, 1990). Lee, Cholowski and Williams' (2002) study identified that clinical teachers' ability to manage interpersonal relationships was the mostly highly valued characteristic as determined by clinical teachers and students. However, the phenomenographic research into teaching and learning shows that teachers' approaches to teaching are contextually situated rather than resting on personal characteristics of teachers.

One research paper by Scanlan (2001) studied how clinical teachers learned to be clinical teachers. This qualitative study was conducted using a purposive sample of five novice and five experienced clinical teachers. Data were collected using interviews, journaling and concept mapping and were analysed using content analysis. The findings of this study identified that clinical teaching is learned on the job using a range of cognitive processes such as hypothesising, problem solving and reflection to develop as teachers. Other ways clinical teaching was learned included attending workshops and conferences, reading relevant literature and using indefinable strategies such as "intuition, magic and osmosis." (p. 242). Other findings included the importance of past experiences of learning. For example, it was found that those novice clinical teachers' experiences as learners, both positive and negative, influenced how they approached teaching. Scanlan (2001) identifies, however, that novice clinical teachers were unable to "convey... practices to students." (p.244). Another finding was the differing relationship between experiences of nursing and approaches to clinical teaching of novice and experienced clinical teachers. For example, novice clinical teachers were not able to focus on student learning. Instead they focused on the patient and themselves. Because of their lack of experience and their anxiety to do clinical teaching correctly, novice clinical teachers tested out various teaching strategies and did not seem to be aware of what

students learning needs were. On the other hand, experienced clinical teachers were seen to have complex understandings of nursing and were able to relate these understandings to clinical teaching. These teachers were identified as being able to consider student learning, as well as think about the patient needs.

Phenomenographic research into teaching and learning shows that teachers' approaches to teaching are related to past experiences of teaching and learning. Phenomenographic research also relates teacher approaches to conceptions of teaching and learning but Scanlan's (2001) study does not consider teacher conceptions.

Instruments for measuring clinical teacher effectiveness have been another focus of the research into clinical education. The instruments described in four studies (Fong & McCauley, 1993; Mogan & Warbinek, 1994; Reeve, 1994; Zimmerman & Westfall, 1988) were developed from the literature and prior research: these studies record their validity and reliability. Finally, Viverais-Dresler and Kutshke (2001) investigated nursing students' perceptions of clinical teachers' behaviours and approaches to clinical teaching. In this study evaluation is seen to be the most important aspect of the clinical teacher role. This finding is inconsistent with similar studies where personal characteristics were seen to be more important (Bergman & Gaitskill, 1990; Mogan & Knox, 1987; Nehring, 1990). Viverais-Dresler and Kutshke (2001) point out that the students in their study were at a different level from students in other studies and had had more than two years experience in their course. They argue that that may account for the difference in findings. No research papers were detected where teacher approaches to clinical teaching were linked with quality of student learning outcomes.

While there is a paucity of research in the area of nurse student-teacher relationships, one notable study is worthy of some detailed attention. Gillespie (2002) conducted a qualitative study using interpretive description to identify the nature and importance of the student-teacher relationship in clinical practice. Eight undergraduate nursing students were interviewed in order to find out about their experience of the teacher-student relationship and the effect of this connection on learning. Data were analysed using a constant comparative analysis. While Gillespie (2002) reports that the study was limited by its small sample and the consequential lack of transferability of findings, the results suggest that personal and professional aspects of the clinical

teacher influence the teacher-student relationship and student learning outcomes. Gillespie (2002) identifies that the way the clinical teacher uses knowledge is of great importance. Readiness to share personal and professional knowledge and willingness to get to know the student as a person influences learner outcomes because the student's learning is better focused, knowledge is synthesised and there is cohesion between 'ways of knowing, being and doing that comprise clinical nursing practice' (p. 574). The findings suggest that, by getting to know students, teachers are able to find out their learning needs and possibly help them to develop their knowledge. Phenomenographic research has shown that a relationship exists between the quality of learning outcomes, teacher approaches to teaching and student approaches to learning. These relationships are not identified in Gillespie's (2002) study.

Selection, preparation and continuing support of clinical teachers have been identified as factors contributing to their effectiveness. For example, French and Cross (1992) argue that employing nurses as educators, on the basis of patient care experience and not their academic abilities is not appropriate. They argue for clinical teachers to have academic training. Yet, they state there is a lack of academically prepared nurse educators, According to Clare (1993), these teachers are likely to have been prepared differently from their students. Consequently, their beliefs about what students require will depend on their perceptions of professional knowledge needed by nurses. According to Beach (1995) these perceptions will influence the formal goals of the educational program experienced by nursing students. However, French and Cross (1992) believe that many nurses are not interested in development of the profession but instead focus on "replication" and "preservation". Viverais-Dresler and Kutsche (2001) argue that clinical teachers need to have an understanding of nursing and teaching consistent with the philosophy of the program in which they are teaching. This thesis argues that there is a relationship between how clinical teachers conceive of nursing and the approaches they take to their teaching.

Hermann (1997) conducted a study of the effectiveness of preparation of clinical teachers for clinical teaching. The aim of the study was to find out whether educational theory made any difference to the teaching methods used by clinical teachers in their clinical teaching. The study was a non-experimental survey design

using a convenience sample (n=692). The teachers were divided into two groups; those with, and those without educational theory preparation. The analysis showed no significant differences in teaching strategies between the two groups. It also revealed a need to identify the educational content necessary to prepare nurse teachers for teaching. Hermann (1997) argues that “if transfer of knowledge is as important as the knowledge transferred” (p.321) then the nature of the content needs to be identified by conducting further research. Transmission of knowledge using a “show and tell” format is dismissed by Johnson-Crowley (2004) as being inadequate. Although Johnson-Crowley’s (2004) argument relates to preparation for classroom teaching, she argues that nurses learning to be teachers enter their education programs with sets of beliefs about teaching and learning based on their own experiences of teaching and learning situations. These beliefs, she argues, influence their approaches to teaching. Johnson-Crowley (2004) proposes that teacher preparation courses need to change their focus from transmitting information to discovering underlying beliefs about teaching and learning. Such exposure may help student teachers to broaden their ideas and further develop their own personal theories of teaching nursing.

Conclusion

As shown in Section 1 of this chapter, some aspects of nursing have not changed over time. The literature reviewed in this section has shown that the focus of nursing has always been and still is on the patient as the centre of care. Individualizing patient care to achieve outcomes is a core value of nursing. The impact of technology has challenged nursing, however, and its various responses have not necessarily met with success. The demands of technology and political and economic imperatives have presented further challenges and opportunities. The literature review has shown that a solution for nursing may lie in multidisciplinary team work, where there is an opportunity not only for independence but interdependence as opposed to the dependence created by nursing’s servitude to medicine. By using a multidisciplinary approach to patient care, enhanced by the primary nursing model of care delivery, places the patient at the centre of care. This combination would enable patient outcomes to be better met, by drawing on the improved availability and use of resources, within a patient-centred environment. It is therefore possible for nursing to be understood in a number of ways. In an environment which is becoming

increasingly complex and demanding, professional nursing practice requires nurses to be able to make judgments and decisions, as well as perform technical tasks in a professionally competent way.

The literature reviewed in Section 2 of this chapter shows that nursing students undertake a particular program in preparation for their role as a registered nurse. Expectations include the development of professional competence. The achievement of such professional competence requires conceptual understanding thus allowing knowledge to be used across a variety of contexts. If clinical teachers are to successfully prepare undergraduate nursing students for such an environment then they themselves require complex understandings of nursing. The literature review revealed an absence of any research about how clinical teachers understand nursing.

If clinical teachers are to successfully prepare nursing students for professional nursing practice they also require complex understandings of teaching as well. The literature reviewed in Section 3 of this chapter focused on research on learning and teaching in the higher education sector. It has shown that phenomenographic research has established relationships between teacher approaches to teaching, student approaches to learning and the quality of student learning outcomes. Teachers who intend that their students will achieve conceptual change, possess complex conceptions of teaching and learning and use student-focused teaching strategies. Once again, there is an absence of any research on how clinical teachers experience teaching undergraduate nursing students on clinical placement. The development of professional nursing competence can be better understood by exploring the interrelationship of the clinical teacher, their conception of nursing and approaches to clinical teaching. Knowledge about conceptions and approaches of clinical teachers of undergraduate nursing students is significant since the focus of phenomenographic research into teaching and learning thus far has been mainly focused on classroom situations. Knowledge about teaching in the clinical setting will therefore provide a means for identifying whether similar relationships exist between teacher conceptions and approaches to teaching in the clinical setting.

CHAPTER 3

Methodology

Introduction

In the previous chapter, the importance of researching clinical teaching in nursing was established. A review of the literature highlighted the educationally critical significance of new graduates being adequately prepared for the Division 1 Registered Nurse role. Given the unpredictability of contemporary health care environments and the possibility of various interpretations of nursing, the question of how clinical teachers teach nursing students to be nurses is of concern. Furthermore, phenomenographic research on teaching and learning has established links between high quality teaching and student learning outcomes. Specifically, a relationship exists between teacher approaches to teaching and student approaches to learning. When the student perceives high quality teaching where the teacher has a conceptual change/student-focused approach, a deep approach to learning is likely to be adopted. Given that student learning outcomes from nursing courses are being questioned it is important, therefore, to investigate how clinical teachers conceive of nursing and approach clinical teaching. Knowing how clinical teachers experience nursing and clinical teaching will inform what is currently known about teaching nursing students in the clinical context as well as provide a foundation for better preparation and support of clinical teachers.

The phenomenographic research method is one that investigates how people experience phenomena (Marton, 1986) and, as introduced in Chapter 1 of this thesis, is the method best suited to this study. This chapter describes the phenomenographic research method used to investigate clinical teachers' conceptions of nursing and their approaches to teaching undergraduate nursing students on clinical placement. The study was designed to address the main research question:

How do clinical nurse teachers experience teaching undergraduate nursing students on clinical placements and how does this relate to their experiences of nursing?

Three subsidiary questions were also addressed. They were:

How do clinical teachers experience nursing? In particular, what are their conceptions of nursing and how do they approach nursing?

How do clinical teachers experience clinical teaching? In particular, what are their conceptions of clinical teaching and how do they approach clinical teaching?

How do clinical teachers' experiences of nursing relate to their experiences of clinical teaching? In particular, do clinical teachers' conceptions and approaches to nursing relate to their conceptions and approaches to clinical teaching?

To answer the above questions clinical teachers were asked to describe their experiences of nursing and clinical teaching so that descriptions of the key aspects of variation of those experiences could be identified.

The results of the investigation of the main research question as well as the three subsidiary questions were combined to describe variation in the group of clinical teachers' experiences of nursing and teaching undergraduate nursing students on clinical placement.

The chapter comes in two main sections:

- Section 1: The general orientation and nature of phenomenographic research approaches

In this section the general orientation and nature of phenomenographic research approaches are described. Also included are the object and outcomes of phenomenographic research as well as data collection, techniques of analysis and validity and reliability of results. Contentious methodological issues in relation to data collection, analysis and validity and reliability will also be explored. The approach used in this empirical study is outlined in each section.

- Section 2: Method of the empirical study

In this section a detailed description of the research method used to understand the key variations in how clinical teachers conceived of nursing and approached clinical teaching and the nature of the relationship between the two are presented. A two phase study which includes approaches to selection of participants, data collection and data analysis is described, as are methods to maintain critical awareness and communicability of results.

Section 1: The general orientation and nature of phenomenographic research approaches.

Phenomenography emerged as a qualitative research specialisation during the 1970s at the University of Göteborg, Sweden. Initially the research focus was on learning, the detail of which is described in Section 3 of Chapter 2 of this thesis. Some years later this type of research was named by Ference Marton as phenomenography. According to Marton (1986) ‘phenomenography is a research method for mapping the qualitatively different ways in which people experience, conceptualize, perceive, and understand various aspects of, and phenomena in, the world around them’ (p. 31). Variation in how any given population experiences phenomena, with some explanations being more advanced or complex than others, is related to different ways of experiencing the phenomena in question (Marton, 1981; Marton, 1986; Marton & Booth, 1997).

The focus on conceptions is fundamental to phenomenographic research. Terms such as conception, perception, apprehension or understanding are used synonymously with ways of experiencing a phenomenon (Marton, 1992). According to Säljö (1981) conceptions are the meanings people ascribe to their understanding of a phenomenon. Entwistle, Skinner, Entwistle and Orr (2000) assert that conceptions are constructed from a wide variety of sources, including experiences, images and knowledge and are, therefore, somewhat individual. Marton (1981, 1986) asserts that conceptions do not exist within individuals but rather, are relations between an individual, particular task and context. Therefore, conceptions are not stable entities but instead are dynamic and depend on the context in which the task is being studied. It is through this internal relationship between the individual and the world that meaning is constituted. Entwistle et al. (2000) state that “within phenomenography... the variation between conceptions is explored, with each conception being viewed as relational, activated and potentially altered by the context rather than simply existing in the person’s mind” (p. 9-10).

It is common for researchers to view the world from a first order perspective where statements are made about situations and phenomena; in particular, about how things are and how things are not, from the researcher’s point of view (Marton, 1981). Phenomenography, on the other hand, takes the second order perspective where the world as experienced by the individual is described by the researcher. The method allows the researcher to pick up on key

differences and uncover the meaning embedded in participants' perceptions. Since the key area of interest of phenomenographic research is the variation in the way groups of individuals experience something, this empirical study is aimed at identifying variation, in terms of meaning and structure, in the way clinical nurse teachers experience nursing and how they experienced teaching undergraduate nursing students in a clinical placement. Direct description of these conceptions will be useful to nurse educators involved in teaching nurses.

In recent times Marton and Pang (1999) developed the idea of two faces of variation. The first face is variation in the ways a phenomenon is experienced by others. This is a key principle of classical phenomenography where the researcher discerns and constitutes the variation between the different ways of experiencing something. The second face, is variation as experienced by the experiencers. This characterises new phenomenography (Marton & Pang, 1999) where the researcher sets out to describe the nature of ways of experiencing in terms of the individual's awareness of key aspects and corresponding dimensions of variation. This perspective on variation can be found in the work of McKenzie (2003), and Rovio-Johansson (1999). The focus of this study is on the key aspects of variation in experiences of nursing and clinical teaching across the group of clinical teachers; not how individual nurses experience that variation. This thesis is concerned with the first face of variation and, therefore, corresponds more closely to classical phenomenography.

The object of phenomenographic research

According to Marton and Booth (1997) the unit of phenomenographic research is 'a way of experiencing something.' (p.111). Different ways of experiencing phenomena are related to the internal relationship that exists between a person and the world. According to Marton and Booth (1997) experience of a phenomenon is "an internal relationship between the experiencer and the experienced" (p. 113). As established in the first chapter of this thesis, the different ways of experiencing something can be understood in terms of the related "what" and "how" aspects of the experience. In summary, the "what" aspect of experiencing a phenomenon is understood in terms of meaning and structure whereas the "how" aspect is concerned with intentions (indirect object) and strategies (act). These two aspects are inextricably linked (Marton & Booth, 1997). Experience of a phenomenon can be further understood in terms of the structure of the learner's awareness. Marton and Booth draw on Gurwitsch's ideas about the structure of consciousness. Gurwitsch (1964) identified the structure of awareness, based on the field of consciousness, as a means of understanding the ways of experiencing phenomena. According to Gurwitsch (1964) awareness can be characterised by a general 'figure-ground' configuration. At any time certain things are in the foreground of our awareness, described by Marton (1981) as figural or thematised;

whereas, at other times, these certain things have receded to the background becoming tacit or unthematized. The structure of awareness is described by Gurwitsch (1964) in terms of three overlapping areas; the theme, the thematic field and the margin. For example, the theme is the focus of the person's awareness of the phenomenon in question. The thematic field is a term used to describe that which surrounds the phenomenon and the 'margin' refers to that which is not directly related to the phenomenon.

A structure of awareness has also been described by Marton and Booth (1997) in terms of an external and an internal horizon. The external horizon refers to the context in which the phenomenon is being experienced. Each individual is aware in a less focused sense of other aspects of the world not considered to be related to the phenomenon. Issues that surround the phenomenon or those that are not directly related are transient but co-existent with aspects of the person's awareness. The following example may further clarify the explanation. Consider the example of a nurse who is cleaning and dressing a patient's wound. The external horizon includes features of the room, other rooms in the ward, patients and staff in the ward, the hospital, as well as issues in the nurse's private life, such as worries that he/she has. These non-related aspects of the world make up the external horizon, the 'ground', 'non-figural' or thematic field (Marton & Booth, 1997). For the purposes of this thesis the term external horizon will be used to refer to that which surrounds the phenomenon in question. The phenomena being investigated in this thesis is clinical teachers' experiences of nursing and their experiences of clinical teaching; in particular, their conceptions of nursing and their approaches to clinical teaching.

Marton and Booth (1997) describe the internal horizon, the 'theme' or 'figure' as making up the core of the person's awareness. The internal horizon consists of the aspects of the phenomenon simultaneously present in the theme of awareness, and the relationships between these aspects and between the aspects and the phenomenon as a whole. To continue with the example, the nurse might be aware only of cleaning and dressing the wound, or the internal horizon may also include other aspects such as the patient's physical condition, emotional state, wound response to treatment, level of healing, level of pain and so on. It is possible therefore to identify aspects of clinical teachers' conceptions of nursing, their approaches to clinical teaching and the relationships between these aspects and to the phenomena overall. In this thesis, the term internal horizon will be used to describe what is in the foreground of awareness of clinical teachers in relation to their conceptions of nursing and their approaches to clinical teaching.

The aspects of a phenomenon being focused on will depend on the context in which the individual experiences a particular phenomenon. While these aspects can be considered as a snapshot they are also fluid and dynamic with a different context possibly bringing about a different awareness. Returning to the example of the nurse caring for a patient's wound, once she leaves the patient's room his/her awareness changes. The boundary between the external and internal horizons delimits the theme from its context and is explained by Marton (1994) as "what is focused and what is not" (p. 7). Marton and Booth (1997, p.87) use the example of experiencing a deer in the woods to illustrate internal and external horizons:

"Thus, the external horizon of coming on the deer in the woods extends from the immediate boundary of the experience – the dark forest against which the deer is discerned – through all other contexts in which related occurrences have been experienced (e.g. walks in the forest, deer in the zoo, nursery tales, reports of hunting incidents, etc.). The internal horizon comprises the deer itself, its parts, its stance, its structural presence."

Experiencing a phenomenon therefore has a meaning, referred to as the referential (meaning) aspect and a structural aspect (internal and external horizons). According to Marton and Booth (1997) the meaning given to a phenomenon lies in the structure of awareness of the person experiencing the phenomenon. The referential aspect, or meaning, is derived from the related aspects of the phenomenon in the internal horizon and the aspects making up the external horizon and the relationship between the two horizons. Within the internal horizon there is variation in the ways of experiencing the phenomenon. According to Marton and Pang (1999) structure (internal and external horizons) and meaning (referential aspect) are co-constituted; that is they cannot exist without each other. The learner is aware of aspects of the phenomenon simultaneously with being aware of aspects of the phenomenon previously unknown. As the nurse in the provided example has more experience with caring for patients' wounds it is possible that he/she will become aware of more aspects of the phenomenon of wound care thus expanding awareness. This awareness and what is focused on by the individual leads to the possibility of further meanings being developed. Change in understanding occurs as the individual conceives of the phenomenon in a different way than previously. Variation in ways of experiencing something, therefore, stems from awareness, or lack of awareness, of different aspects of the whole (Marton & Booth, 1997) as the external and internal horizons and the relationship between them.

Experience must therefore be considered from a non-dualistic perspective since the person's experience of something is a relationship that exists between themselves and the phenomena, and yet, encompasses both. Phenomenography, therefore views experience as relational between the person (subject) and something (object). Since phenomenography is concerned with describing the qualitatively different ways people experience phenomena, variation is the object of the research (Marton & Booth, 1997). These descriptions, according to Marton (1986) are "relational, experiential, content-oriented, and qualitative." (p. 33).

Marton and Booth's (1997) analytical framework for describing students' experiences of learning was applied for this study and introduced in Chapter 1 of this thesis. The framework facilitates analysis and description of clinical teachers' experiences of nursing (see Figure 1.1) and clinical teaching (see Figure 1.2). This framework shows not only the separate "what" and "how" aspects but also includes the referential aspects and structural aspects including the internal and external horizons. Figure 3.1 shows the analytical framework used for analysing and describing clinical teachers' experiences of nursing. Figure 3.2 shows the analytical framework used for analysing and describing clinical teachers' experiences of clinical teaching.

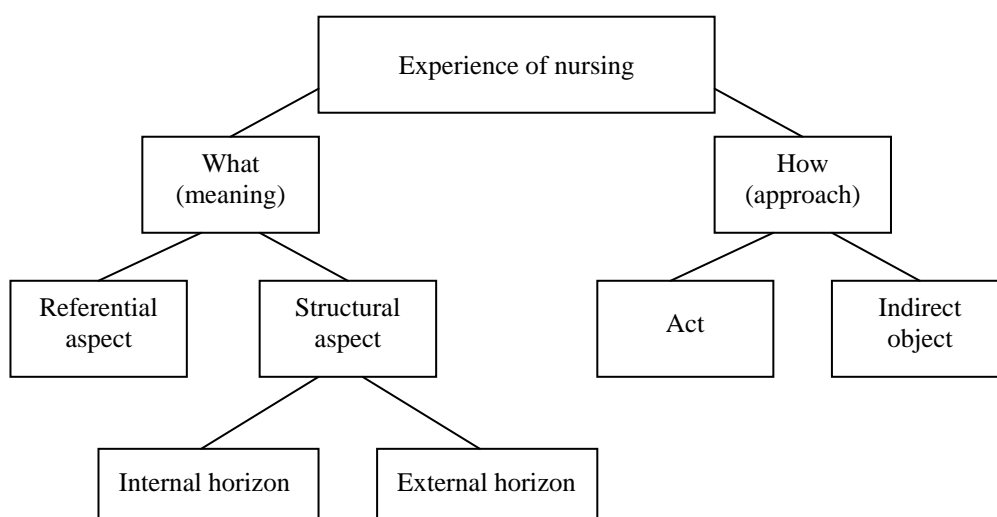


Figure 3.1: The experience of nursing: an analytic framework (adapted from the Experience of learning, Marton and Booth, 1997)

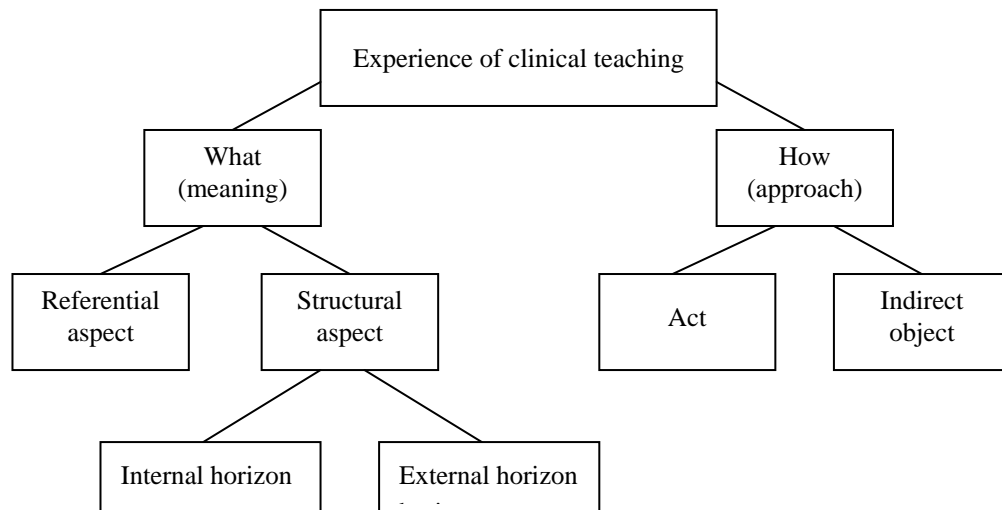


Figure 3.2: The experience of clinical teaching: an analytic framework (adapted from the Experience of learning, Marton and Booth, 1997)

Analysis of participants' approaches to nursing and clinical teaching was limited in this study at the level of Act and Indirect Object only, because of the complex nature of the study. Inclusion of structure, reference, internal and external horizons in relation to approaches to nursing and clinical teaching could be the basis for future study.

Three different lines of research based on variation of the object of research have been identified by Marton (1986). The first line of research focuses on the general aspects of learning. This includes relations between conceptions, approaches to and outcomes of learning. A range of studies investigating student learning, conducted at University of Göteborg, Sweden identified qualitatively different outcomes of learning as well as approaches to learning (Dahlgren, 1975; Marton & Dahlgren, 1975; Marton & Säljö, 1976a). Logical relationships were evident between the different conceptions of learning. The different conceptions were expressed in a hierarchy of categories of description representing different but incomplete understandings of the whole (Marton & Säljö, 1976a). Relationships between conceptions and approaches were also found. Not only did these students in these studies have different understandings of the authors' argument, but two distinctively different approaches to learning (deep and surface approaches) were also identified. Deep and surface approaches to learning have been described in detail in the

previous chapter. Logical relationships were also identified between the different approaches to learning and were expressed in a hierarchy of categories of description representing different understandings of the whole with some conceptions being more complex than others (Marton & Säljö, 1976b). The approaches to learning and quality of outcomes were found to be related; a pattern that has been confirmed by many phenomenographic studies since. For reference to examples of phenomenographic studies into learning and quality of outcomes and other studies see the annotated bibliography by Bruce and Gerber (1995).

Research aimed at identifying relations between conceptions, approaches to and outcomes of learning, according to Bowden (2000) takes place in educational settings. Trigwell, Martin, Benjamin and Prosser (2000) report, that while this qualitative research approach has been used initially to investigate learning, there has been a subsequent interest in exploring teaching from a phenomenographic perspective. Outcomes of phenomenographic research studies into teacher conceptions of teaching and teacher approaches to teaching have been described in the previous chapter.

The second line of phenomenographic research focuses on identifying variation in students' ideas about content and how these ideas change (Bowden, 2000; Marton, 1994; Marton, 1978). This research, according to Bowden (2000) also takes place in educational settings. Finally, the third line of phenomenographic research focuses on identifying the variations in how people conceive of different aspects of their everyday world which Marton (1986) describes as 'pure' phenomenographic research (p. 38).

The empirical study described in this thesis belongs to the first line of phenomenographic research where key aspects of variation of clinical teachers' experiences of nursing and teaching undergraduate nursing students on clinical placement are described. The objects of research were:

- variation in ways of experiencing nursing
- variation in ways of experiencing clinical teaching, and
- the nature of the relationship between ways of experiencing nursing and experiencing clinical teaching.

The outcomes of phenomenographic research

The result of phenomenographic research is an outcome space made up of a set of related categories of description of how the phenomenon in question is experienced by the given population (Booth, 1992; Marton & Dahlgren, 1976). According to Bruce (1997) and Säljö (1988) an outcome space is the structural framework that encompasses categories of description which represent the conceptions of the different ways of experiencing the phenomenon. The framework is presented diagrammatically showing the logical relationships that exist between the different conceptions of the phenomenon of interest. According to Entwistle, Skinner, Entwistle and Orr (2000) the purpose of such a framework is useful for teachers for example who wish to develop their teaching. They state:

“Categorisations offered by researchers provide a conceptual framework through which teachers and lecturers, whatever their experience, can more readily reflect on their experiences of teaching, and become more consciously aware of their own progression through the conceptual hierarchy.” (p. 24)

The categories of description which make up the outcome space depict the key but limited variation of ways of experiencing a phenomenon. Using a second order perspective the researcher portrays the variation in a group of individuals' accounts of experiencing the phenomenon in question. Marton and Booth (1997) point out that the categories of description emerge from the whole data set representing the collective rather than the individual. Criteria are provided by Marton and Booth (1997, p. 125) on which to ground the development of categories of description. These criteria include: firstly that each category stands alone representing a critical aspect of the way the phenomenon is experienced, but is clearly related to the phenomenon in question; secondly, that the categories are logically related to each other and usually form a hierarchy, so that the more complex and inclusive categories include the features of less intricate categories; and finally, that the outcome space consists of as few categories of description as is reasonable.

Marton and Booth (1997) and Säljö (1988) assert each category within the outcome space is internally related to the others. This means that the categories of description are described in terms of the relationships that exist between them and the phenomenon as a whole as well as between them and other relevant phenomena.

Each category should be carefully described so that distinct characteristics are communicated in relation to the group and the phenomenon in question; that is, how the internal and external horizons differ from each other. The terms, internal horizon and external horizon, were introduced earlier in this chapter. Marton and Booth (1997) explain that variation in the way a phenomenon is experienced reflects concurrent awareness of more or fewer aspects of the phenomenon. The more advanced or sophisticated the awareness, the more aspects of the phenomenon is experienced hence a more complex and complete understanding is portrayed. Therefore, an individual category represents one way of experiencing a phenomenon. Each carefully worded category is supported by appropriate quotations from the set of data. These quotations are used to clarify important aspects of each category. The outcome space therefore represents the qualitatively different ways of experiencing the phenomenon. According to Säljö (1988) because categories of description are not meant to represent individuals, quotations are taken from the whole set of transcripts. Key aspects of variation of clinical teachers' experiences of nursing and clinical teaching are described in the empirical study as a consequence of identifying these critical differences between categories of description within each outcome space.

In summary, the outcome space is comprised of a set of categories of description which portray the different aspects of the phenomenon in question and the relationships between them. A hierarchical structure which is increasingly complex is evident within the outcome space. Therefore, each category of description can be seen as a different aspect of the whole. The categories within the outcome space show increasingly complex and inclusive ways that a particular phenomenon is experienced.

Another part of phenomenographic analysis involves mapping conceptions and approaches on to a two-dimensional matrix which represents the way a phenomenon has been experienced. The set of categories of description is the main outcome of the analysis representing the most distinctive characteristics of the variation in the range of ways a phenomenon has been experienced. According to Tempone and Martin (2003) in phenomenographic analysis, it is the range of conceptions articulated by the participants which are mapped on a two dimensional matrix which represents an outcome space. The two dimensions of the matrix represent what it is that is focused

on by interviewees (the referential aspect), and how what is focused on is experienced by the interviewee (the structural aspect). What is mapped onto this space is the relation between different categories identified through analysis of the transcripts. Tempone and Martin (2003) state:

“The mapping exercise typically shows that some participants see a particular phenomenon in less complex ways than others but it also shows how the different responses are related. The responses once analysed and mapped present a hierarchy of understanding of the phenomenon with higher order conceptions incorporating lower order ones.” (p. 233)

Outcome spaces depicting clinical teachers’ conceptions of nursing and clinical teaching as well as their approaches to nursing and clinical teaching undergraduate nursing students on clinical placement are outcomes of this research. Each of the outcome spaces consist of sets of categories of description. Each category of description describes the referential (meaning) and the structural (internal and external horizons) aspects of the different ways clinical teachers conceive of nursing and clinical teaching. Approaches to both nursing and clinical teaching are also presented by identifying variation in the ways nursing and clinical teaching is carried out (Act) and the type of abilities being mastered (Indirect Object).

In this study, variation in the ways nursing and clinical teaching was experienced by clinical teachers was mapped onto two-dimensional matrices. The first matrix represents clinical teachers’ experiences of nursing. In particular, their conceptions and approaches to nursing are mapped. This matrix is presented in Chapter 4 of this thesis. The second matrix represents clinical teachers’ experiences of teaching. In particular, their conceptions and approaches to teaching are mapped. This matrix is presented in Section 3 of Chapter 5 of this thesis. Finally several matrices are presented to represent the relationship between clinical teachers’ experiences of nursing and their experiences of teaching. In particular, the relationships between clinical teachers’ conceptions and approaches to nursing and their conceptions and approaches to teaching are mapped. These matrices are presented in Section 4 of Chapter 5 of this thesis.

Data collection

The purpose of data collection in phenomenographic research is for the researcher to illuminate how a particular population experiences the phenomenon in question. Although there is a range of data collection approaches in phenomenographic studies, for example; drawings, observation and written discourse (Marton & Booth, 1997; Martin & Ramsden, 1988), a typical approach to collecting data is through semi-structured interviews with the researcher interviewing a representative of the particular population of interest and jointly exploring the phenomenon in question from the interviewee's perspective (Booth, 1992). Bowden (2000) specifies that decisions about who to interview should be based on whether the individual is appropriate to the purpose and context of the research. This approach is referred to as a theoretical sample (Glaser & Strauss, 1979). For the purposes of this study nurses engaged by universities specifically to supervise and teach undergraduate nursing students in the clinical setting were invited to participate.

Phenomenographic interviews share some common characteristics with other qualitative research interviews. Kvale (1983) points out that qualitative research interviews take place in an interpersonal situation where the focus is on the interviewee's experience. The interviewer seeks to understand the meaning of the phenomenon in question for the interviewee. The interviews are qualitative and descriptive, without assumptions, and are focused on particular themes. The interviewer seeks clarity and meaning and encourages reflection to facilitate the interviewee to express and change understanding as is appropriate. Such an interview according to Kvale (1983) may be a positive experience for the interviewee.

The distinctive characteristics of the phenomenographic interview, on the other hand, are described by Bruce (1994) as being the aim, the focus, the role of the interviewer and the design and implementation of the interview. Each of these characteristics will be addressed individually. Firstly, the aim of the phenomenographic interview is to fully understand the interviewee's way of experiencing something (what) and ways of experiencing particular acts or approaches (how) (Marton & Booth, 1997). Marton and Booth (1997) and Svensson (1994) identify that the processes of data collection and analysis are inseparable with analysis beginning during the data collection phase. Svensson (1997) points out that phenomenographic interviews are exploratory and interpretive because of the need to ascertain the nature of the participant's

conceptions. Since these conceptions are unknown there is a need to define meaning. In order to find the meaning, the participant must be given a chance to reflect in order to discern their experience of the phenomena from the situation as a whole (Ashworth & Lucas, 1998; Marton & Booth, 1997). Therefore, what makes the aim different from other qualitative research interviews, according to Bruce (1994), is that the researcher is seeking to find the variation in experience. In the case of this research, the aim was to understand fully the different ways in which clinical teachers experienced nursing and teaching undergraduate nursing students on clinical placement, and how those experiences related to each other.

Marton's (1988) description of phenomenography as being about "the relations between human beings and the world around them" (pp.178-9) highlights another distinguishing feature of the phenomenographic interview where the focus is on the relationship of the interviewee and the theme of the interview. The interviewer's role is to attempt to view the phenomenon as it has been experienced by the interviewee. Booth (1992) warns that during the interview, the researcher must be aware of any shift in focus which might mislead the analysis and to also be sensitive to changes in direction which would need to be pursued by the researcher. According to Bruce (1994) the researcher assists the interviewee by questioning, probing and encouraging reflection on experience. Use of this approach helps the interviewer to identify the internal and external horizons of the person's experience so that the different ways of experiencing the phenomenon are evident.

The design and implementation of the phenomenographic interview also differs from other qualitative research interviews. Phenomenographic interviews are typically unstructured or semi-structured. Booth (1992) argues that in unstructured interviews, the interviewee is free to speak openly without interruption with the exception of some prompting from the researcher to maintain the flow of information. Whereas, in a structured interview, used for example in surveys, the interviewer has a list of ready made questions that assume information required from the interviewee. Booth (1992) asserts that the use of the semi-structured interview lies between the two extremes leaving open the possibility that the interviewer can deviate from a small number of prepared questions to probe and seek clarification where necessary. For

this study semi-structured interviews were used to collect data relevant to the research questions.

Implementation of the phenomenographic interview requires the interviewer to consider the aim and the ways in which the data will be examined and how these will influence the interview (Bruce, 1994). Bowden (2000) notes that at the beginning of the semi-structured interview the participant may be asked to reply either to a given situation or some planned questions. He points out that common question types include those to do with a problem in a given field of study or a “what is X?” question. The latter type of question may be less useful than the former question type because of its closed nature. Åkerlind (2005) argues the importance of using open-ended ‘why’ questions to ascertain rationale as being important in enhancing descriptions of interviewee’s experiences. Questions, according to Ashworth and Lucas (1998) are open-ended so that the participant can choose the aspect of the question they want to focus on. Bowden (2000) also notes that questions of clarification such as ‘what do you mean by that?’ Or ‘can you give an example?’ may also be asked. In this study while a set of planned, open-ended questions were used to guide the interviews, some questions seeking clarification were also asked.

Communication issues which could affect the quality of the data are raised as a particular concern. For example, Säljö, (1988) critically questions whether what the interviewee or participant in a phenomenographic interview says, reflects what has really been experienced. He states ‘issues of communication, language and meaning are primary in many respects when deciding on what is meant by what is said’ (p. 177). Säljö (1988) further argues that it is reasonable to assume the comments made by the participant in response to questions could also reflect a desire to answer because of an obligation to do so and that the interviewee may say anything rather than feel uncomfortable when faced with a difficult question. Marton and Booth (1997) acknowledge that certain aspects of the interview can be problematic and therefore require persistence and careful handling by the interviewer. It is suggested that the interviewer should keep focusing the interviewee on the theme of the interview and use alternative questions where appropriate. According to Marton (1981) the interviewer assists the reflective process by not only listening for meaning but also paying attention to how the interviewee is delimiting the phenomenon.

Marton and Booth (1997) further argue that it is the role of the interviewer to work with the interviewee to bring his awareness into being. Svensson (1997) believes that the interviewer needs to be sensitive to the way the participant defines the phenomenon. Furthermore, the way in which questions are asked is also important in this type of research (Marton, 1986). Bearing all of these strategies in mind, Marton (1986) contends that the aspect selected for discussion by the participant provides important data because this is where their understanding or meaning is revealed.

Data analysis

The aim of phenomenographic analysis is to identify ultimately distinctly different ways of experiencing the phenomenon by the group being researched. Bruce (1994) affirms that data analysis is a continuation of the exploration of the relationships between the interviewee and the phenomenon in question that began in the interview. Svensson (1997) refers to the researcher analysing phenomenographic data as trying to 'find the whole qualities of the conception' (p. 18). According to Marton (1986) precision is required by the researcher as a process of iteration between the data and the categories is undertaken in relation to the whole set of data. The initial phase of analysis involves reading all of the transcripts and noting expressions of interest relevant to the question. Next, the researcher, looking for similarities and differences, selects quotations which are used to form a pool of data. According to Booth (1992) within the pool of data lies a 'pool of meaning' (p. 62); that is, the way the phenomenon is understood not only by individuals but by the group being researched. The context of the quotations should be considered since each quotation has meaning in relation to the individual as well as the group (Marton, 1986). Meaning is interpreted by the researcher as a consequence of clustering similar comments. The researcher develops the categories of description based on their similarities with each category representing one of the ways a phenomenon has been experienced. Meanings, quotations and categories are tested against the data and the categories are organised and re-organised over and over until stability is achieved. Categories are also distinguished from each other based on their differences. Finally each category is supported by quotations taken from the data set. This is described as an iterative and dialectical process as the researcher moves back and forth between the data and the categories of description.

Dahlgren and Fallsberg (1991) describe specific steps that may be used to guide analysis. Firstly, familiarisation occurs through listening to the tape recordings of the interviews and reading the transcripts. This ensures accurate transcription and helps the researcher become familiar with the data. Next, answers to certain questions are compiled so that key elements are identified with the answers from each participant. The third step involves condensing significant data to find the most important elements. The next part of the process involves grouping similar answers and comparison of categories follows with the researcher ascertaining the boundaries between the categories. The researcher names the categories and finally they are compared and contrasted.

The process of analysis aimed at identification of an outcome space occurs as a result of the researcher undertaking a rigorous analytical process. The process of analysis is summarised by Booth (1997) as follows:

“It consists of studying the interview transcripts, both individually and alongside one another, studying sets of extracts both in and out of their original contexts, seeking distinct similarities and differences. The researcher immerses himself or herself in the material, trying to see the total meaning in what the research subjects said or did, resolving apparent contradictions, knitting together as whole a picture of the meaning of the phenomenon as possible, not only for individual subjects but also for the group. Eventually a spectrum is seen. As the material is studied further, features of the spectrum might shift, new features might be resolved and others merge, logical links might be seen between features and the phenomenon in question, and spectra might be seen in different dimensions. The set of categories arrived at can be considered to be satisfactory when an internal logical relationship, a hierarchy, is seen to exist between them, which in turn can be related to other descriptions of the phenomenon in question. The whole process may need to be repeated many times before this state is reached..” (p. 138)

While the approaches to analysis between phenomenographers vary in some ways, as described by Booth (1997), Dahlgren and Fallsberg (1991) and Marton (1986) in the previous section, the variation in approaches to phenomenographic analysis should be questioned in relation to the affect on research outcomes. One example is where variation in approach among phenomenographic researchers lies in whether the analysis process involves use of the whole data set versus parts of transcripts (Ashworth & Lucas, 2000). Marton (1986) advocates reading the data set as a whole

followed by selection of quotations of interest. Even though Marton (1986) cautions that the researcher needs to keep the context in mind when considering the selected quotations, Bowden (2000) disagrees with this approach to analysis. He argues that the resulting decontextualisation is at odds with the nature of phenomenographic research. Instead Bowden (2000) strongly recommends that the data set is treated as a whole at all times.

Another aspect of the analysis that has the potential to affect research outcomes is the construction of the outcome space. Hasselgren and Beach (1997) argue that phenomenographic research purports to be about the relationship between a person and a phenomenon, yet through the process of analysis and constructing outcome spaces the individual's voice is lost. Bowden (2005) argues that when the purpose of the research is of an educational nature then it is pragmatic to find the limited but key variations in how the phenomenon is experienced. He further argues that because a person's conceptions are context and time dependent it is not possible to be absolute about individual conceptions.

Walsh (2000) contends that some researchers deem that categories are constructed by the researcher believing that 'categories emerge from the relationship between the data and the researcher' (p. 20). To construct the categories then, the researcher draws on his or her particular perspective to describe the relationship between the interviewee and the phenomenon in question. The researcher's viewpoint influences the categories. If a researcher approaches analysis as a process of construction, there is danger that a logical framework will be imposed when it is not justified. On the other hand, if a 'discovery' view is taken, where categories of description are seen to exist independently of the researcher's method of analysis, there is a danger that the analytical process itself will be bypassed. Bruce (1994) suggests that if both approaches are taken, where analysis involves both construction and discovery, the problem will be overcome. From a relational perspective, however, it can be argued that the categories represent a relationship between the transcripts and the researcher and as such carry aspects of both the transcripts and the researcher. In the empirical study described in this thesis, the categories of description were constituted as a consequence of the relation between the researcher and the data using an open approach to the analysis.

The impact of researcher subjectivity on the results is a related area of concern. Booth (1992) and Säljö (1988) believe that bracketing of the researcher's own experiences and preconceptions is initially important to avoid tainting the analysis. The process of bracketing is seen to begin in the interview where the interviewer consciously puts aside their own views and judgments. Ashworth and Lucas (2000) argue that while it is not possible to suspend some assumptions, for example, the shared topic and the possibility of discussing experiences, care must be taken not to arrive at research findings prematurely and not to assume particular explanations. Both Booth (1992) and Säljö (1988) assert that the researcher, by being reflective, must be able to separate self from the material and think about the relationships between the interviewee and the phenomenon. Eventually, the researcher becomes more focused so that results are achieved. Cope (2002) also agrees that it not possible for the researcher to bracket all of their prior experience but that every effort should be made to maintain a critical awareness of how they may have influenced the research.

In this empirical study, elements of the approaches advocated by Booth (1997), Dahlgren and Fallsberg (1991) and Marton (1986), were followed and include:

- The audio tapes were listened to, initially in conjunction with reading of the transcripts as a whole, to become familiar with the data.
- On subsequent readings, quotations of importance were highlighted and notes written in the margins of the hardcopy of transcripts. These same areas were highlighted on the copies of the transcripts on computer files as well.
- Key themes were identified and questions were developed aimed at finding differences and similarities in order to identify the meaning within the transcripts as a whole.
- Transcripts were also studied individually to find distinct similarities and differences.
- Similar comments and themes and answers to questions were clustered and categories of description were constituted as a consequence of iteration between the data and the categories.
- The data and categories were continually searched for an internal logical relationship between the categories of description and the experiences of nursing and clinical teaching.

The issue of rigor is important and a much more detailed description of the approaches to analysis used in this study will be described in the second part of this chapter.

Scope of phenomenographic research

While the identification of outcome spaces is where phenomenographic research normally concludes, classification of transcripts against the categories of description within the outcome spaces is particularly contentious in phenomenographic research. Phenomenography is clearly qualitative in nature and orientation and to mix the paradigms by including a quantitative component is controversial because of the potential risk of concealing the relationship between person, phenomenon and context (Ekeblad & Bond, 1994). Yet, Ekeblad and Bond (1994) contend that it is sometimes necessary to combine the two methods if application of the research findings in educational settings is desired. Prosser and Trigwell (1999a) argue that while both qualitative and quantitative research methods each have their merits it is possible to use both approaches as long as the results are interpreted in a complementary way in relation to the central concern- the awareness of the relationship between the person and the phenomenon. Bowden (1994) agrees that it is acceptable to include quantitative analysis in a phenomenographic study but it should not be included as part of the phenomenographic analysis. He advises researchers who take the categories of description out of the interpretative paradigm into the quantitative arena, that expected procedures and accepted practices must be followed. Several examples of the use of quantitative analytic techniques to complement phenomenographic research are Pramling (1988), Prosser and Millar (1989) and Prosser and Trigwell (1999a).

In the empirical study reported in this thesis the transcripts were classified in relation to the structured outcome spaces and an analysis of the logical and empirical relationships between the outcome spaces was done. This was done by focusing on using the outcome spaces to describe individual variation using cross-tabulation analyses to show the empirical relationships identified using Marton and Booth's (1997) analytical framework.

Questions of validity, reliability and generalisability of results

Concerns about validity, reliability and generalisability of results are relevant for all research whether it be from a first-order perspective or from a second-order point of view. Validity, reliability and generalisability of results are particularly contentious issues in phenomenographic qualitative research (Lincoln & Guba, 1985). Ekeblad and Bond (1994) note there are differences in power relations between researcher

and participant and as a consequence is an issue for any human and social research. Ekeblad and Bond (1994) argue that regardless of type, there is a moral responsibility for the researcher to be faithful to the people studied in the research since the descriptions are those of the researcher and not the participant. Specific criticism of phenomenographic research, however, is offered by Bowden (1995) who identifies a lack of validity, researcher bias, lack of predictive power and categorisation denying the voice of the individual. All of these issues will be discussed in the following section.

Validity in phenomenographic research

Validity can be defined as a researcher's justification for presenting results and claims based on those results as being credible and trustworthy. Booth (1992) argues that validity in phenomenographic research is achieved in three ways. In the first place, Booth (1992) contends that the research needs to be based on the researcher having a solid understanding of the subject content. Secondly, she argues that the study should be designed and implemented according to phenomenographic principles. Appropriate design and implementation of the study includes matters to do with selection of the population, data collection and a rigorous approach to analysis. For example, Booth argues that the population selected should be relevant to the study; that is, a theoretical sample is selected. Data collected should be relevant to the questions of the study. Since the structure and content of the interview determine the validity of the data, interviews should be conducted as previously described with the context being one of openness and deep discussion between the interviewer and the interviewee. During the analysis the researcher should question the data continuously until categories of description are identified. An open approach should be adopted by the researcher whereby attitudes, biases and judgments are put to one side so that meaning in the data is revealed, yet at the same time holding on to a sense of the whole while investigating particular information.

The third and final way of achieving validity of results, according to Booth (1992), is presentation of, and reporting of results, in such a way as to be understood and recognisable to others in the same field. Results should be communicated to the relevant research community and be open to scrutiny. The categories therefore need full description and should be supported by appropriate quotations from the data (Booth, 1992). Burns (1994) contends that the researcher's background should be

clearly articulated because even though there is an intention to approach data collection and analysis openly, this knowledge would further assist the reader to understand the context in which the research has taken place.

Establishing reliability

The reliability of qualitative research findings is normally demonstrated through the replication of results (Booth, 1992). Yet, Marton (1986) and Säljö (1988) argue that since the constitution of the original set of categories of description is a type of discovery it is not reasonable to expect that another researcher would constitute the same set of categories. Säljö states:

“The categories are the constructions of the researcher and there is always a possibility that another researcher would have arrived at a different categorisation. In fact, to be logical, it follows from a constructivist conception of reality that the possibility of interpreting reality differently applies to the activity of describing conceptions of reality itself.” (p. 45)

Burns (1994) maintains that trustworthiness of results, a term introduced by Lincoln and Guba (1985) is important, however. Burns (1994) asserts that truthful representation can be established in phenomenographic research when there is evidence of the researcher’s familiarity with the phenomenon in question and application of phenomenographic principles throughout the process of discovery and description. Despite the problems related to validity, reliability and generalisability of phenomenographic research results, Marton (1986) argues that the constituted categories should be recognisable to other researchers. This confirmation can be achieved as suggested by Booth (1992) through the scrutiny of outcomes in terms of credibility and truthfulness by the research community.

Phenomenographers have traditionally argued that the use of clear communication is a way of ensuring that the categories are understood by other researchers. Säljö (1988) introduced the idea of communicability of categories meaning that the researcher describes them in such a way as to clearly communicate to others what they are about. One version of communicability is to base it on interjudge reliability as proposed by Bowden (2005) where a team of researchers establishes the categories. The process involves researchers independently establishing the categories of description using the same set of data. These researchers come together to compare the categorisations, argue for and against categories, check and re-check

the categories against the data and with each other until such time as there is agreement about the categories of description (Trigwell, 2000). Säljö (1988), whilst in agreement with this strategy, provides additional ways of ensuring reliability of results. Säljö's (1988) strategies include comparison of results with other research and reviewing the internal logic of each category and how they relate to the phenomenon of interest. Another strategy for ensuring reliability of results is recommended by Booth (1992). She reports the outcome space, containing the categories of description with supportive quotations from the data, can be presented to a co-judge to see if agreement on results is possible. The supportive comments are then classified against the outcome space. The higher the agreement, the more reliable are the categories. The co-judge's conclusions are checked against the researcher's and then the degree of agreement is determined. Säljö (1988) asserts that 80-90% agreement is appropriate. If agreement is not achieved then the categories need refining. According to Cope (2002) this process has been renamed and is now known as interjudge communicability which in summary describes the process of asking other researchers to classify transcripts or quotations against an outcome space either as a team or individually. Säljö (1988) suggests that the communicability of categories "gives the researcher information that someone else can see the same differences in the material as he or she has done" (p.45). In phenomenographic studies, then, reliability is commonly replaced by communicability.

Communicability of categories of description and interjudge reliability are seen to be very similar. Sandberg (1997) argues that the quality of the interview data and detection of researcher influence is problematic. Sandberg (1997) contends it would be very difficult if not impossible for the co-judge to detect if the researcher has influenced the categories. He further argues that with the focus being on validation of the categories, attention is diverted away from the research process itself. Booth (1992) adds that interjudge communicability is problematic because statements from individuals may contain more than one conception. Since an outcome space usually consists of a hierarchy of categories of description where the more complex categories include those that are less so, the problem arises when the co-judge might classify an individual's conception as conveying a less complex conception than they actually have because of a lack of familiarity with the data. To circumvent these difficulties Sandberg (1997) proposes interpretive awareness as an alternative.

Interpretative awareness, according to Sandberg (1997) is a means “to acknowledge and to explicitly deal with our subjectivity throughout the research process instead of overlooking it” (p.209).

Several suggestions are provided by Sandberg (1997) to assist the researcher to maintain interpretive awareness. For example, suspension of the researcher’s theories and biases so as to allow full attention to the individual and their conceptions under exploration is one strategy. Interpretive awareness also involves accurate description of the individual’s conception rather than providing explanation; equal importance being paid to all aspects of the individual’s experience; and, searching for the structure of meaning by focusing on the relationship between the ‘what’ and ‘how’ aspects of the experience. According to Cope (2002) identification of the structure of awareness as described by Marton and Booth (1997) and previously described in this chapter will strengthen phenomenographic data analysis and hence validity of results. The structure of awareness should include two aspects. Firstly, a structural aspect, incorporating the internal and external horizons and secondly, a referential aspect showing the meaning in the structure. In this empirical study trustworthiness of results was established in the following ways:

- Familiarity of the researcher with the area under study.
As a consequence of my lengthy nursing (more than 30 years), and teaching (approximately 20 years) experience, I am very familiar with the area under study. I teach undergraduate nursing students in their theoretical and practice programs at various levels. I also prepare and support clinical teachers as they supervise and teach undergraduate nursing students on clinical placement.
- Application of phenomenographic theory throughout the research process.
This is well described throughout this thesis. In particular, the application of phenomenographic theory is described in detail in Section 2 of this chapter. In addition, frequent interactions with supervisors, Dr Michael Prosser and Dr Angela Brew, both experts in the field of phenomenography, provided guidance for the development of the thesis. Dr Chris Cope, another phenomenographic expert, also provided guidance through regular discussions.
- Identification of the structure of awareness of clinical teachers about nursing and clinical teaching.
Analysis of data in the empirical study includes description of a structural aspect consisting of the internal and external horizons, and a referential aspect which refers to the meaning inherent in the structure for both nursing and clinical teaching. The structural aspect comprises the scope of variation simultaneously present in the internal horizon, the existence and nature of relationships between the dimensions of variation, and the characteristics of the boundary between the

internal and external horizons. The structure of awareness is used as described by Marton and Booth (1997).

- Scrutiny of results by the nursing and phenomenography community through conference and other presentations.

Several opportunities were taken to present results to relevant communities for feedback. A detailed account of the study is provided in Section 2 of this chapter entitled: The empirical study.

- Interjudge communicability.

Communicative validity was sought in several ways. Firstly, professional discussion was held regularly with PhD supervisors, fellow PhD student Lynne Leveson and colleague Dr Chris Cope. Three co-judges (Dr Maxine Duke, Ms Elizabeth Watt and Ms Rosalie Strother) were used at various points of the development of categories of description and classification of transcripts against the outcome spaces. Further detail is provided in Section 2 of this chapter.

Section 2: The empirical study

In this section an overview of the method of the empirical research is provided.

Following the overview, a detailed account of the approach to the study is then provided. The aim of the study was to consider the main research question as well as three subsidiary questions. These questions were presented at the beginning of this chapter. Specifically, the study investigated:

What variation exists in the way clinical nurse teachers experience nursing?

What variation exists in the way clinical nurse teachers experience clinical teaching?

What is the nature of the relationship between clinical teachers' experiences of nursing and their approaches to clinical teaching?

Overview of the study

The research was designed in order to understand how clinical teachers conceived of nursing and how they approached their teaching in the clinical setting. Understanding these experiences relies on identification of the variation that exists in the way these teachers experience nursing and teaching. It is also necessary to identify the nature of the relationship between clinical teachers' experiences of nursing and their approaches to clinical teaching. It was believed that by having this understanding, insight would be gained into the kind of support clinical teachers require in order to further improve the quality of their teaching. Enhancement of student learning and quality of learning outcomes would be a flow on effect.

The study was designed to give insight into clinical teachers' experiences of nursing and clinical teaching. In particular, the study investigated clinical teachers' conceptions of nursing and their approaches to teaching of undergraduate nursing students on clinical placement. An intensive two-phase study was conducted that used semi-structured interviews of a group of twenty clinical teachers. For the first phase of the research a pilot study was conducted. In the pilot study, six clinical teachers were interviewed. Whilst this group was initially considered as a pilot group the data were of sufficient quality to include in the overall group. In the second phase a further fourteen clinical teachers were interviewed. The interview transcripts for the whole group provided data about the "what" and "how" aspects of the experiences of these clinical teachers. The data were analysed using phenomenographic techniques resulting in four outcome spaces. The outcome spaces represented the variations in the ways nursing was conceived and approached as well as the ways clinical teaching was conceived and approached. The results of the investigation, included the "what" and "how" aspects and the relationships between them which were combined to describe variation in clinical teachers' experiences of nursing and their approaches to clinical teaching. For a fuller exploration of the logical relationships between conceptions and approaches to nursing and clinical teaching the transcripts were classified against the outcome spaces. All of the results were combined and describe the variation in the experience of nursing and clinical teaching and the relationship between the two.

Participants of the study

To ensure the sample selected represented the maximum range of variation in conceptions, the following approach was taken to selecting participants for the study. Clinical teachers are nurses employed on a sessional basis, specifically by universities to accompany small groups of undergraduate nursing students on clinical placement. Their role is to supervise, support, guide, teach and assess their students during the clinical placement. The participants of this study were recruited from a range of Victorian universities in Australia. For the pilot study, the Clinical Co-ordinator of the Bachelor of Nursing course at one particular metropolitan university was contacted by telephone to request access to sessional clinical teachers employed by that particular university to teach undergraduate nursing students whilst on clinical placement. Because of concern about competition in relation to access to

experienced nurses interested in and available for clinical teaching, that was perceived to exist between Schools of Nursing, this particular Co-ordinator agreed to facilitate my request only if he could act as an intermediary and send out my letters of invitation himself. Letters of invitation, the plain language statements, consent forms and stamped addressed envelopes were sent to him. This Co-ordinator then sent this material to the sessional teachers on my behalf. Clinical teachers were asked to reply to this person. As a consequence of this process the Co-ordinator provided me with nine names and contact numbers of clinical teachers who had responded to him following receipt of the letter of invitation. Of the nine clinical teachers who expressed interest in participating in the study, six were selected for interview based on availability.

In the second phase of the study, recruitment was managed similarly to the pilot study with the exception of the arrangements for returning consent forms. Clinical Co-ordinators at five different Victorian universities were approached, by telephone, for permission to access their sessional clinical teachers. The metropolitan campus of my employing university was excluded from the study because of the likelihood of a conflict of interest, given that I co-ordinated a clinical subject at the time where sessional clinical teachers were employed to teach undergraduate students. A rural campus of my employing university was included in the study since I did not have any prior or current contact with sessional clinical teachers employed by that School of Nursing. A total of sixty letters of invitation, plain language statements, consent forms and stamped addressed envelopes were provided to the five Clinical Co-ordinators to be circulated to the clinical teachers employed specifically to teach undergraduates in their Bachelor of Nursing courses. Clinical teachers interested in participating in the study returned their consent forms to me at my home address. Of the sixty letters sent out twenty five replies were received. Of the twenty five clinical teachers who expressed interest in participating in the study fourteen were selected based on availability. This brought the total number of study participants to twenty.

Although each of the twenty participants were nurses employed specifically to supervise, teach and assess undergraduate nursing students whilst on clinical placement, variation in terms of nursing and teaching experience, terms of employment, sex, age, type of health care setting in which the nurse usually practised

as a nurse, type of health care setting in which clinical teaching was conducted, year level of students, length of recent clinical placement and student group size were evident. Each of these differences will be addressed separately in this section.

The first difference between the participants was in terms of experience both as nurses and as clinical teachers. The range of nursing experience varied from three years to thirty five years. One clinical teacher had recently finished her first clinical teaching experience whereas at the other extreme, others had been teaching for several years. Eighteen of the twenty participants had been employed sessionally, that is, they were casual employees of the university employed for the specific purpose of teaching the students on clinical placement. Two of the participants from the group of twenty had been seconded from their roles in their employing hospitals to teach the undergraduate students whilst on placement in their hospital. Eighteen participants were female and two were male. Although the percentage of male participants in this study was small (10%), this is equivalent to the percentage of male representation in nursing in Australia (Australian Institute of Health and Welfare, 2003). Eighteen participants were female and 2 participants were male. The ages of the clinical teachers varied from mid-twenties to mid-fifties. Nine participants usually worked in acute care facilities when employed as a nurse; seven of these in metropolitan Melbourne and the other two, in rural Victoria. Three participants usually worked as a nurse in critical care in metropolitan Melbourne. One participant usually worked as a midwife, another in a rehabilitation hospital and yet another in a psychiatric hospital. Five of the participants no longer want to work as nurses, focusing instead on clinical teaching. The type of health care setting in which clinical placements took place also varied; some clinical teachers were teaching students in aged care settings; others were in acute care and others were in rural health settings where there was a mixed focus of aged and acute care. Some clinical teachers were teaching Year 1 students, whilst others were teaching Year 2 or Year 3 students. Other variations included the length of clinical placement. Some clinical placements were only two days in length, whilst other placements extended for between two and four weeks. The final variation was the size of the group of students for which each teacher was responsible. Group size varied between six and eight students. The method of participant selection was based on theoretical sampling; the main criteria of which, were the selection of individuals who are

appropriate to the purpose and context of the research and who would enable the researcher to maximise the variation that might exist in the data collection and analysis (Glaser & Strauss, 1979; Strauss & Corbin, 1990).

Pilot study

Initially, it was decided to run a small pilot study following the usual ethical guidelines to test the research questions and processes. The questions on experiences of nursing and clinical teaching were aimed at identifying the conceptions held about nursing and teaching and the teaching approaches used in the clinical setting. The empirical study was aimed at studying whether similar relationships existed between clinical teachers' conceptions of nursing, clinical teaching and their approaches to clinical teaching. If a relationship was apparent, the nature of that relationship was also of interest. The questions for the pilot study, aimed at identifying conceptions of nursing and clinical teaching and approaches to clinical teaching were:

Describe a situation you have been involved in which you think depicts what nursing is about at this hospital.

After this question, the discussion then focused on clinical teaching with the following question:

Why was it important in terms of clinical teaching?

The questions for the pilot study aimed at identifying clinical teacher intentions were:

What were you trying to achieve in the clinical teaching experience?

Why is that?

How did the university help you to achieve your teaching goals?

How did the hospital help you to achieve your teaching goals?

Pilot study questions aimed at identifying clinical teacher strategies were:

What were you trying to achieve in the clinical teaching experience?

What teaching strategies did you use to achieve your goals? Why?

Following selection of the participants for the pilot study as described previously, arrangements were made to meet at a time and place to suit each participant. Five out of the six participants in the pilot study were interviewed in their own home. One participant chose to meet with me in my office at La Trobe University, Bundoora as this was more convenient for her. The study was explained to each participant and

consent forms checked at the beginning of the interview. Any questions were then answered in relation to the study. In-depth semi-structured interviews of approximately forty five minutes in length were conducted to collect qualitative data from these participants. The nine interview questions were used to guide the pilot interviews, and to help the participants to reflect on their experiences of nursing and clinical teaching. Responses to these questions were probed when required. The processes of the pilot study and the data were used to inform the second phase of the study. The data from the pilot study formed part of the larger pool of data. The interviews were tape-recorded to ensure fidelity.

The six interviews from the pilot study were transcribed by me into a set of Word files. There was one file for each interview and each file was titled with a participant number allocated according to the order in which each person was interviewed. A hard copy of each transcript was printed and kept in a folder to allow ease of reading during the analysis phase.

Following transcription of the tapes, each transcript was read through at the same time as listening to the tapes, to identify and correct any transcription errors. On subsequent readings, quotations of importance relevant to the research questions were highlighted and notes written in the margins of the hardcopy of the transcripts. These same quotations were also highlighted on the copies of the transcripts on the computer files as well. At this stage of the analysis the transcripts were studied individually to find distinct similarities and differences. Key themes were identified and questions were developed aimed at finding differences and similarities in order to identify the meaning. Examples of questions related to the themes are provided below. See Table 3.1: *Themes: Pilot Study: Nursing* and Table 3.2: *Themes: Pilot Study: Clinical Teaching*. Examination of the two tables will reveal early identification of themes related to nursing and clinical teaching. Also evident in Tables 3.1 and Table 3.2 is an early attempt to organize the nursing and clinical teaching themes hierarchically. Each table shows supportive quotations from the transcripts.

Table 3.1: Pilot Study: Themes: Nursing

| Nursing themes | Quotations from transcripts |
|---|---|
| Being involved in patient concerns and meeting relevant physical, emotional and cultural needs | “ culturally, appropriate care for him surrounded that medallion and I think that’s what nursing is about in terms of providing care that is really appropriate to that person. Whereas at a whole lot of other levels, technical levels like check lists and urinalysis and making up a post op. bed, all those things that you might say are nursing...” (P2) |
| Being involved in patient concerns and meeting relevant physical, emotional, cultural and spiritual needs | “ it’s the day to day getting everything done, ... It’s all areas of care, physical, psychological, spiritual, greater emphasis on social..”(P4) |
| Being involved in patient concerns and meeting relevant physical, emotional and cultural needs which help pts. to feel more human | “I think nursing is taking care of everything, like physical things, the person like making sure their finger nails are clean, ...because if you are sick, that makes you feel more human and cared about .. that’s what makes a person feel well, clean and comfortable, all those things that are constant ... We really try and take care of the whole person. (P1) |
| Being involved in real people’s concerns and building genuine relationships with them while meeting relevant physical, emotional, cultural and spiritual needs | “You are there to make them feel at home to be part of a family and not ‘you’re here, we’re going to make you better, and send you home’. Visitors come less frequently in aged care than they do in the acute setting so people need to know that they (nurses) actually care” (P6) |
| A mutual arrangement between health team members and patient which involves meeting physical, emotional cultural and spiritual needs of the patient aimed at achieving independence and resumption of a normal life | “And the spinal unit is different to most other units cos it is so hands on all the time. You’re the hands and the feet for most patients, it’s more hands on than any other unit”... care is 24 hour physical, mental care preparing people to go home back to work, rehabilitation, that starts the day they have their injury. So, care is not just the physical aspects it’s everything ..the most important part of nursing is getting people back to work, back to home, back to a relatively normal way of life. So ultimately that’s what my aim is to educate them in rehabilitation nursing...independence. (P3) |
| A mutual arrangement between patient and nurse in meeting the comfort needs of the patient | “total care, to the comfort, the palliative care, the good nursing techniques like good aseptic technique... The professionalism, ... there was a total commitment (to the pt.) ...She had a good knowledge base, she had very good interpersonal skills both with the patient and ... the relatives. She included the patient in all the things she was doing, talking to the patient and asking questions and saying to the patient ‘we do this don’t we because of this, don’t we?’. The patient seemed to know because the patient had been there for a long time and knew about her treatment. The empathy that went with it, it wasn’t just sterile care...” (P5) |

Table 3.2: Pilot Study: Themes: Clinical Teaching

| Clinical teaching themes | Quotations from transcripts |
|---|---|
| Theme: Clinical teaching is getting the importance of care across to the student by getting them to change their perceptions about nursing and learning | ... it's fine and good to be into the action but basic nursing care is pretty important too. And there is so many opportunities to do basic things with people. And getting the students to see that cos they just follow the nurses, what they see, dealing with the drugs and the dressings, not talk to the patient. It was really hard to get that across to them, trying to role model that because they weren't seeing that being done. ..I've seen a lot of younger nurses just get caught up in the technical side and I really wanted to role model caring and that was my main goal. And it was really hard cos I always had to fight with the students to get them to be interested in that aspect. The attitude was I'll learn it for the exam and then I'll forget it. I was a bit worried when I saw this attitude. I suppose that's what happens when they are at school, things are disconnected with the next year, so you'll learn a subject and then you don't have to apply it later..." (P1) |
| Theme: Clinical teaching is about helping each student to build individual knowledge independently | So if we come from the point of view that every day we can learn something then you are always building on your knowledge. So from that point of view the clinical experience is a learning process... I try to talk to them ... and say 'it's not just a matter of putting a few tasks together, you can always learn something'... Some will sit back and say 'well I know how to do that, I can care for two patients, I can make their beds, whatever' and they never see beyond that and so they are missing part of the process... when it comes to putting it together, linking it with theory, looking for extra information...All these extra things are what you actually need to learn because it's not a task'. (P2) |
| Theme: Clinical teaching is helping students to change their theoretical perceptions into practical knowledge | Teaching is broadening their horizons from what they are learning in the classroom. Broadening their horizons from what is actually in a book to what reality is, ... that's part of my job as a clinical teacher ... teaching the reality on the unit compared to what they are taught in the class room. I feel like they don't have an understanding of what they are being taught in the classroom until they get the practical experience and the knowledge from people who are doing it all the time. (P3) |
| Theme: Clinical teaching is helping the student to put theory into practice | I look at myself as a continuum of the university teaching. I like to think that I keep very close contact with the co-ordinator of the subject during the time the students are at the hospital. I look at myself as the person that facilitates their ability to put theory into practice (P5) |
| Theme: Clinical teaching is about responding to student needs for support, information and practice opportunities | I ask them what their expectations are of me. I spend a lot of time reassuring that I will be there.. I expect them to ask questions. A lot of the teaching I do, comes from the students themselves. I don't set out with re lessons I'll teach the students every clinical because everyone's experience is different, different places have different amounts of lab time... I let them drive most of the learning . (P6) |

During the analysis phase for the entire study, which extended over a lengthy period due to my part-time student status, keeping reflective notes in a journal was useful. The journal functioned as a tool to facilitate reflection, especially in relation to subjectivity. The journal was also a place to document emerging questions that were then used to guide the analysis of data. An example from my journal of a reflective comment is as follows:

“My selection of categories is problematic... if I allow my values to influence ie. Participant 5”. (Learning Journal, 13 September, 2002, p.13).

This statement reflects awareness of imposing my own views and judgments on the data.

Examples of questions documented in my journal were as follows:

“Approaches to clinical teaching are constituted in terms of intentions and strategies. What is the variation in the way they approach their teaching? What is the variation in the way they understand teaching? Where is the focus? ie facts, skills or ? relationships between them. Is the student thought to have prior knowledge? Is the student thought of as an active learner? Is the clinical teacher telling the student what to do?” (Learning Journal, 28 February, 2004, p. 144).

These sorts of questions guided my reading of the transcripts as I sought out the different ways clinical teaching had been experienced. Similar questions were raised about how nursing was experienced and were also used to guide the reading of the transcripts.

Modification to research processes following the pilot study.

The pilot study interview process helped to identify issues in relation to the focus of the study and the usefulness of the questions. It was initially intended to focus on clinical teachers who were teaching nursing students in Year 1 of their course. This proved to be difficult to adhere to as clinical teachers who had had previous experience as a teacher frequently referred to previous clinical teaching situations where students might have been at a different year level. It was also noted in the pilot study that if a clinical teacher had had a recent teaching experience of only two days in length, they invariably drew on other experiences to answer the questions. It was decided that by relaxing the restriction whereby participants were only questioned about Year 1 clinical placements the problem would be resolved.

As a consequence of the pilot study some of the questions were modified. One problem encountered was in relation to a clinical teacher (Participant 3), who worked for the same hospital in a full-time capacity as a nurse where she also taught nursing students during the time of their clinical placement. The arrangement was that she was released from her normal duties to act as clinical teacher for a group of eight students when they attended the hospital for a clinical placement. This person found it difficult to answer the question “Describe a situation you have been involved in which you think depicts what nursing is about at this hospital.” I rephrased the question to “Can you tell me what you think nursing means to you?” to ascertain her conception of nursing. For phase two of the study, the question “How does this relate to your personally held beliefs about nursing?” was added to the list of questions. It was anticipated that should any clinical teacher have similar issues, then this question could be modified to ensure that this specific area about conceptions of nursing was covered. The following questions, “What are you trying to achieve in the clinical teaching experience?”, “How does the university help you to achieve your teaching goals?” and “How does the hospital help you to achieve your teaching goals?” were refocused to become, “What do you understand teaching to be about?”, “What does the university want your students to learn on this placement?” and “What does the hospital want your students to learn on this placement?” when it was realised that the original (pilot study) questions were eliciting limited information. The refocused questions were much more specific and facilitated fuller responses.

The third aspect of the research process that changed following the completion of the pilot study was in relation to transcription of the interview tapes. A decision was made, in the interests of improving the timeframes, to employ a person specifically to type up the taped interviews from Phase 2 of the study. This person was an experienced transcriber and would be able to complete transcription of fourteen, forty five minute tapes more quickly than I could. The transcriber was requested to establish and label a further set of Word files in the same manner as was done in the pilot study. She was requested to indicate in the transcript where she experienced any difficulty with terminology by highlighting such areas on the computer file. At the end of the transcription process I met with the transcriber to discuss the difficulties experienced. She indicated that the process had been straightforward though she had experienced some problems with terminology. She had, as requested, highlighted

those places on the transcript. Word files (on floppy disc) as well as hard copies were handed to me at the conclusion of our discussion.

Phase 2 of the study

In Section 1 of this chapter the question of validity and reliability of results of phenomenographic research studies was discussed. The conclusion drawn was that an open and detailed account of the method used in a phenomenographic study was a means of establishing validity and reliability of the results. To counter the concern that research processes, in particular those related to management of interviews and data and method of analysis could threaten validity and reliability of results, a detailed description of the processes involved in the research method follows.

In the second phase of the study, semi-structured interviews of approximately forty five minutes in length using the modified interview schedule were conducted to collect qualitative data from these participants. Thirteen of the fourteen participants were interviewed in their own home and one participant chose to be interviewed in my home because it was more convenient for him. Just as it was in the pilot study, the aim of each interview was to fully understand the interviewee's way of experiencing nursing and clinical teaching, specifically finding out the meaning (what) and the approaches used (how) of those experiences. The interviews allowed such examination, because I was aware that analysis begins during the data collection phase and, since the conceptions of these clinical teachers were unknown, there was a need to define meaning by discerning variation. The internal and external horizons, acts and indirect objects, which make up the 'What' and "How" of nursing and clinical teaching, form the framework of the structure of awareness (Marton & Booth, 1997) which was used to guide the process of analysis that began in the interview. During the interview each participant was given opportunities to reflect, in order to discern their experience of the phenomena from the situation as a whole. During the course of each interview, I attempted to view nursing and clinical teaching as it had been experienced by the interviewee. Attention was paid toward any shift in focus or changes in direction which might mislead the analysis and were pursued as necessary. The planned questions were asked and in addition, probing questions such as "Can you tell me more about that?" and those that clarified, such as "What do you mean by help?" Use of this approach helped me to identify the internal and external horizons of the person's experience so that the different ways of

experiencing nursing and clinical teaching were evident. The interviews were also tape-recorded in Phase 2 of the study to ensure fidelity. The fourteen interviews were transcribed resulting in computer files and hard copies as previously described.

In the same way as in the pilot study, each transcript was read through initially at the same time as listening to the tapes. The intention of this activity was to identify and correct any transcription errors, and to get a general sense of the data. The transcription errors requiring correction were minimal. On subsequent readings, quotations of importance were highlighted and notes written in the margins of the hardcopy of the transcripts. These same areas were highlighted on the copies of the transcripts on the computer files as well. The transcripts were initially examined as a whole with the aim of finding key differences and similarities in how nursing and teaching were experienced using the themes and questions identified in the pilot study as a guide so meaning could be ascertained. An iterative process which involved focusing on the general set of data (including data from the pilot study) and considering the collective set of transcripts as well as focusing on individual transcripts was undertaken. Similar comments and themes and answers to questions were clustered. These specific data were extracted and stored separately in files titled Nursing, and Clinical teaching. Each chunk of data was marked with the participant's number. As a consequence of iteration, initially between the data and the themes, draft categories of description were constituted for conceptions of nursing and clinical teaching and approaches to clinical teaching. The draft categories of description can be viewed in tables 3.3 and 3.4. These tables are included to increase the transparency of the analysis. Table 3.3: *Draft categories: Conceptions of nursing*, shows the draft categories for clinical teachers' conceptions of nursing. These categories were developed following completion of all interviews. Table 3.4: *Draft categories: Conceptions of clinical teaching*, shows the draft categories for clinical teachers' conceptions of clinical teaching. These categories were developed following completion of all interviews. Within each outcome space there are five draft categories of description with internal and external horizons detailed.

When the empirical study was designed, the approach to nursing was not anticipated to be part of the research, but during early analysis, approaches to nursing appeared to be implied within the data. The decision was made to go back through the data to

see if inferences had been made by the participants. Whilst clinical teachers were not specifically questioned about their approaches to nursing it was possible to glean such information from the data in addition to their conceptions of nursing.

The data and the categories were continually searched for an internal logical relationship, between the categories of description and the experiences of nursing and clinical teaching. As the constitution of the categories progressed, refinement of the categories was guided by considering what information was not in a particular category that was in the next one, thereby distinguishing the categories from each other based on their differences. This assisted the identification of critical differences between categories. As a consequence, the categories of description within the outcome space: Conceptions of Nursing were reduced from five categories to four. An outcome space for Approaches to Nursing was constituted consisting of four categories of description. In the outcome spaces: Conceptions of Clinical Teaching and Approaches to Clinical Teaching the number of categories of description were reduced from five categories to three.

In addition to the iterative process, another strategy used to assist with the refinement of the categories of description was the writing of short summary statements about the categories in preparation for writing the results chapters. An excerpt from the written summary of categories from my notes follows:

Table 3.3: Draft categories: Conceptions of nursing (following completion of all interviews)

| Category/Referential/Meaning | Structural/Internal horizon | Structural/External horizon |
|---|--|--|
| <p>A Nursing is about performing technical skills and/or routine physical care</p> | <p>Technical skills and/or routine physical care</p> | <p>Individualised care including technical skills, physical care, and emotional care Situation improvement Individual objectives Collaboration</p> |
| <p>B Nursing is a process Nursing is about performing individualised care which includes technical skills, physical and emotional care How it's done is important</p> | <p>Individualised care including technical skills, physical care, emotional care (includes rights dignity respect, privacy)</p> | <p>Situation improvement Individual objectives Collaboration</p> |
| <p>C Nursing is about performing individualised care which includes technical skills, physical and emotional care in order to improve the person's situation (comfort) (process with outcomes)</p> | <p>Individualised care including technical skills, physical care, emotional care Situation improvement</p> | <p>Individual objectives Collaboration</p> |
| <p>D Nursing is about performing individualised care which includes technical skills, physical and emotional care in order to improve patient situation (comfort) and meet individual objectives (process with outcomes)</p> | <p>Individualised care including technical skills, physical care, emotional care Situation improvement Individual objectives</p> | <p>Collaboration</p> |
| <p>E Nursing is about performing individualised care which includes technical skills, physical and emotional care in collaboration with other health team members in order to improve the person's situation</p> | <p>Individualised care including technical skills, physical care, emotional care Situation improvement Individual objectives Collaboration</p> | |

Table 3.4: Draft categories: Conceptions of Clinical Teaching (following completion of all interviews)

| Categories | Internal horizon | External horizon |
|--|--|--|
| <p>A Clinical teaching is about exposing students to clinical practice and includes establishing learning environment, negotiating with students' ward staff for learning opportunities, buddying Supporting students Up to the staff to teach/supervise Student dependent on staff</p> | <p>Exposure to clinical practice</p> | <p>Information transmission Linking theory to practice Metacognition Perceptual development</p> |
| <p>B Clinical teaching is about information transmission, giving information, showing how, reinforcing rules, policies and procedures of the organisation, assessment, emphasis on facts and skills More hands on than A Teacher makes links</p> | <p>Exposure to clinical practice Information transmission</p> | <p>Linking theory to practice Metacognition Perceptual development</p> |
| <p>C Clinical teaching is about helping student to link theory to practice to understand the patient</p> | <p>Exposure to clinical practice Information transmission Linking theory to practice</p> | <p>Metacognition Perceptual development</p> |
| <p>D Clinical teaching is about helping the student to monitor their learning in the clinical setting</p> | <p>Exposure to clinical practice Information transmission Linking theory to practice Metacognition</p> | <p>Perceptual development</p> |
| <p>E Clinical teaching is about helping students to develop their perception of the nurse's role</p> | <p>Exposure to clinical practice Information transmission Linking theory to practice Perceptual development</p> | |

“Categories A & B of nursing represent perceptions that nursing is a process involving elements such as the administration of technology, provision of routine physical care and the individualising of care by providing technological, physical and emotional care in such a way as to protect the person’s dignity and privacy. The context in which clinical teachers are teaching students appears to have influenced the focus of their awareness about their perceptions of nursing. For example, those teaching in nursing homes, where technological intervention is not as overt as it is in acute care facilities, perceived that nursing was about the provision of routine physical care. Those teaching in acute care facilities were more aware of technological interventions.

Perceptions of clinical teaching are focused on the teacher rather than the student. The perception is that exposure of students to experienced nurses in practice is important for nursing students to learn the practical skills of nursing. A common strategy is to buddy the student with the ward nurses. The clinical teacher’s role is then to circulate a list of skills that the student needs to practise and then to assess the students performance. In addition to this perception students are helped to acquire facts and skills for safe practice by the clinical teacher providing information and demonstrating skills. This is achieved by providing information to students, asking questions to test knowledge, demonstration of technical skills, reinforcement of policies and procedures and asking staff for feedback about the student’s progress. Approaches to teaching are not only constituted by the teachers’ perceptions but also by their intentions. The clinical teachers’ goals revolved around assessing students’ knowledge and skills.”

(Learning Journal, March 3, 2003, p. 27).

A by-product of the written summary statements was that the categories continued to evolve and became more tightly focused, in terms of similarities and differences between categories. It should be noted, particularly in the first paragraph of this excerpt, that the issue of context in which teaching takes place is raised. Four outcome spaces were now clearly evident. The outcome spaces for clinical teachers’ experiences of nursing and clinical teaching were as follows:

- Variation in conceptions of nursing
- Variation in approaches to nursing
- Variation in conceptions of clinical teaching
- Variations in approaches to clinical teaching

These outcome spaces along with four transcripts were then sent to Dr Chris Cope, an expert in phenomenography at La Trobe University, Bendigo Campus, to ensure communicability of the categories. Four transcripts were included to give Dr. Cope a sense of the data. His task was to read the categories of description and the transcripts and provide comments on the categories themselves and the issue of context. Chris prompted the need to keep looking for the differences between conceptions as well as the questions; in particular those relating to the focus of the teacher. In response to my concern about the different clinical environments, it was suggested that I review the transcripts of those clinical teachers who were currently, or had recently taught, in aged care settings to see if their conceptions of nursing across this smaller group were different from the categories of description developed from the general set of data. I reread transcripts for participants 4, 6, 7, 12, 17, 18, 19, 20 who were all either currently teaching students in aged care settings or had done so recently. I selected participant quotations of interest in relation to the question, “Does teaching in an aged care setting influence clinical teachers’ conceptions of nursing?” and pasted them into the categories of description that they best supported. The conclusion drawn was that the categories of description as they were at the time did not change because of teaching taking place in the aged care context.

Following feedback and further iteration between the data and the categories of description, the next part of the process involved adding participant quotations from the data to support the categories, in much the same way as had been done when investigating the issue of the teaching context. Participant quotations were selected which were deemed to best support the different categories of description and the relationships between them. Selecting appropriate participant comments to support each category resulted in some further revision of the categories. The iterative process therefore involved finding meanings in the transcripts through the process of reading transcripts, writing summary statements and professional discussion and feedback, to constitute categories of description which were deemed to represent the different ways nursing and clinical teaching were experienced. These categories were tested against the data and were organised and re-organised over and over until stability was achieved. The final result of the analysis, that is, the variation in ways

in which nursing and clinical teaching were experienced, can be found by reading the results chapters (Chapter 4 and Chapter 5).

Communicability of categories

To further ensure the communicability of the categories, three professional colleagues were asked to participate in the study at different times. The first colleague (known as Co-judge 1) was provided with four outcome spaces containing a total of sixteen categories of description and sets of participant quotations selected from the data set which I thought supported the categories of description as they were at the time. Co-judge 1 was asked to match the comments to the most appropriate category. The purpose of this activity was twofold; firstly to substantiate the categories of description, and, secondly, to begin the process of classifying the transcripts against the outcome spaces. The following table (Table 3.5:

Communicability of categories: Co-judge 1) shows four categories within each of the four outcome spaces, and whether or not Co-judge 1 agreed with my categories of description, and the classification of the participant quotation to the relevant category. Also provided in this table are any comments from Co-judge 1 and the action taken as a consequence.

There was 69% agreement that the provided supportive statements matched the relevant categories of description as they were at the time. In summary, the areas of disagreement were related to:

- Outcome space: Variation in conceptions of nursing: Category C
- Outcome space: Variation in approaches to nursing : Category D
- Outcome space: Variation in conceptions of clinical teaching: Categories C & D
- Outcome space: Variation in approaches to clinical teaching: Category D

The majority of issues were related to the suitability of the selected comments matching the categories of description. In those cases more suitable comments were selected. In the case of Outcome space: Variation in conceptions of clinical teaching: Category D. “Clinical Teaching is about helping students to develop their conceptions of nursing”, Co-judge 1 questioned the relevance of the category. See comments in Table 3.5 below. In response, the transcripts were re-read in total. The decision reached was that there was indeed such a category evident in the data. Attention was then turned to the way in which it was described. The category was

Table 3.5: Communicability of categories: Co-judge 1

| Outcome space | Category | Co-judge 1 | Comment from Co-judge 1 | Action taken |
|---|-----------------|--|--|---|
| Variation in conceptions of nursing | A | agreed | | |
| | B | agreed | | |
| | C | Classified comment as Category B | | Selected a different quotation* |
| | D | agreed | “Does this include collaboration with the patient?” | Transcripts re-read Collaboration with patient evident Selected a different quotation* |
| Variation in approaches to nursing | A | agreed | | |
| | B | agreed | | |
| | C | Agreed | | |
| | D | Classified comment as Category B | | Selected a different quotation* |
| Variation in conceptions of clinical teaching | A | Agreed | | |
| | B | Agreed | | |
| | C | Classified comment as Category B | | Selected a different quotation* |
| | D | Disagreed with the category of description | “This comment seems to be about nursing not teaching. I know that means (Category) D but it doesn’t seem to fit. I need the context I don’t know why it is the highest level to consider that clinical teaching is about helping students to develop conception. I guess this is my opinion and I think it doesn’t stand well alone as a satisfactory way of conceiving of clinical teaching.” | Reviewed transcripts Description of the category reworded Selected a different quotation* |
| Variation in approaches to clinical teaching | A | Agreed | | |
| | B | Agreed | | |
| | C | Agreed | | |
| | D | Classified comment as Category C | | Selected a different quotation* |

*Co-judge 2 was then provided with the changed quotations and revised categories for matching

reworded as follows; “Clinical teaching is about going beyond managing the clinical placement and making the links between theory and practice, and helping students to link theory and practice for understanding, to helping students to change their conceptions of nursing.” By doing this, the inclusiveness of the previous categories is pronounced and the complexity and inclusiveness of the conception is better described.

Revision of categories of description occurred as a consequence of feedback from Co-Judge 1, particularly in relation to Outcome space: Variation in conceptions of clinical teaching: Category D as described above, as well as continual iteration between the data and the categories of description. Revisions included:

- All four categories within the Outcome space: Variation in conceptions of clinical teaching
- Categories A, within the Outcome space: Variation in approaches to clinical teaching

More suitable participant comments were selected for:

- Categories C and D: Outcome space: Variations in conceptions of nursing
- Category D: Outcome space: Variations in approaches to nursing
- Categories C and D: Outcome space: Variations in conceptions of clinical teaching
- Category D: Outcome space: Variations in approaches to clinical teaching

At a later stage, a second professional colleague (known as Co-judge 2) was provided with four outcome spaces containing a total of sixteen categories of description and sets of participant quotations as discussed above. Some of the categories were revised based on feedback from Co-judge 1. Co-judge 2 was also asked to match the supportive comments to the categories. The purpose of this activity was the same as it was for the first co-judge. There was 95% agreement that the provided supportive statements matched the relevant categories of description as they were at the time. In summary, the one area of disagreement was related to:

- Category D, Outcome space: Variation in approaches to clinical teaching

The supportive comment provided was matched to Category C rather than Category D. In response to this feedback the transcripts were read again in total and a more refined group of supportive comments was selected.

Given that Category D: Outcome space: Variation in approaches to clinical teaching continued to be problematic; a third co-judge was enlisted to check communicative validity of this category of description. Co-judge 3, a professional colleague, was provided with the categories of description for Outcome spaces: Variation in conceptions of clinical teaching and Variation in approaches to clinical teaching with supportive comments. Co-judge 3 agreed that the comments provided matched the description of Category D in these two outcome spaces.

Since discussion of the process and the details of the findings of this study are merged and therefore not easily separated, mapping of the structure of awareness of clinical teachers and their experiences of nursing and clinical teaching are presented in Section 5 of Chapter 5 of this thesis.

A number of opportunities were taken in the form of professional presentations of categories of description to professional colleagues. For example:

Presentations at conferences were as follows:

- Clinical teachers' perceptions of nursing and their approaches to teaching undergraduate nursing students. *11th National Nurse Education Conference*, Daylesford, Victoria, 24-26 September, 2004.
- Nurse teachers' conceptions of nursing and their approaches to teaching undergraduate nursing students, *The 13th Improving Student Learning Symposium*, Imperial College, London, U.K. 5-7 September, 2005
- Clinical teachers' conceptions of nursing and approaches to clinical teaching, *Phenomenography Symposium*, University of Sydney, 6-7 December, 2005.

Presentations within La Trobe University, Melbourne were as follows:

- Nurse teachers' conceptions of nursing and their approaches to teaching undergraduate nursing students, Staff Forum School of Nursing & Midwifery, La Trobe University, November 14, 2005.
- Clinical teachers' conceptions of nursing and clinical teaching and approaches to teaching. Guest Speaker, Research School, Gerontic Nursing Clinical School, School of Nursing & Midwifery, La Trobe University, 16 November 2005.
- Clinical teachers' conceptions of nursing and approaches to teaching undergraduate nursing students. Learning and Teaching Week, La Trobe University, November 22, 2006.

Classification of transcripts

The data required to investigate the third subsidiary question:

How do clinical teachers' experiences of nursing relate to their experiences of teaching? In particular, do clinical teachers' conceptions and approaches to nursing relate to their conceptions and approaches to teaching?

were obtained by classifying each interview transcript against the outcome spaces. Each transcript was read to determine how the participant experienced nursing and clinical teaching. In several transcripts a number of ways of experiencing nursing and clinical teaching was found. In such cases the transcript was classified at the highest level.

Once the classification of the transcripts had been completed, the relationship between the 'what' and 'how' aspects of nursing and clinical teaching were investigated by using a detailed statistical analysis of the interview transcript classifications. Analysis of the distributions of the classifications in terms of the categories and the analysis of the empirical and logical relationships between the four sets of categories was done. The procedure for the statistical analysis was that firstly, transcripts were classified according to the highest category of description they represented in each outcome space as previously described. Using SPSS, the degree of association between ways of experiencing nursing with ways of experiencing teaching, were calculated. A non-parametric statistical test was selected since no conditions about the parameters of the population from which the sample group was selected were specified. The Kendall rank correlation coefficient (tau-b) was used to measure the degree of association appropriate for the ordinal variables being investigated. Since any association between variables could be due to chance, a p value is also included with the measure. Statistical results are reported in chapters 4 and 5.

Summary

This chapter has described the phenomenographic research method used to investigate clinical teachers' conceptions of nursing and their approaches to teaching undergraduate nursing students on clinical placement. It was shown in this chapter how the study was designed to address the main research question and associated questions. In Section 1 of the chapter, the general orientation and nature of phenomenographic research approaches were discussed in detail. In addition, contentious methodological issues in relation to data collection, analysis and validity and reliability were explored. Throughout Section 1 of this chapter the approach used

in this empirical study was situated where appropriate within the discussion on methodological issues. In the Section 2, a detailed description of the research method was described so that it was possible to see how the research outcomes were reached.

The approach to phenomenographic research is a second order perspective used to understand the key variations in ways of experiencing phenomena; in this case, clinical teachers' conceptions of nursing and their approaches to clinical teaching. Data were collected in two phases, through the use of semi-structured interviews in accordance with phenomenographic principles from twenty clinical teachers so the key, but different, ways nursing and clinical teaching were experienced could be illuminated. In order to understand the relationships between clinical teachers' experiences of nursing and teaching, and the distinctly different ways these phenomena were experienced, data were analysed through the use of an iterative process between the pool of data and the categories of description.

The result of phenomenographic research is an outcome space made up of a set of hierarchically related categories of description of how the phenomenon in question is experienced. The outcome space represents the key but limited variations of the experience in a group of clinical teachers' accounts of ways of experiencing nursing and clinical teaching. Outcome spaces depicting clinical teacher's conceptions of nursing and teaching as well as their approaches to nursing and teaching undergraduate nursing students on clinical placement are outcomes of this research. The variation in the ways nursing and clinical teaching were experienced were identified as a consequence of the relation between the researcher and the data. An open approach to the analysis was used resulting in the identification of four outcome spaces with the categories within each space representing the critical differences in the ways nursing and clinical teaching were experienced. The outcome spaces containing the categories of description were mapped on to two-dimensional matrices representing clinical teachers' conceptions and approaches to nursing and conceptions and approaches to clinical teaching.

While contentious methodological issues related to phenomenographic research were discussed, the position taken in this study was emphasised. The particular issues include: the variable approaches to analysis, the processes used to develop outcome spaces, the impact of researcher subjectivity on results and the extent of

phenomenographic research. The latter issue is of particular interest since establishment of an outcome space(s) is the usual result of this type of research. This study has also considered the individual clinical teacher's way of experiencing nursing and clinical teaching. To do this, each transcript was classified in relation to the structured outcome spaces and an analysis of the logical and empirical relationships between the outcome spaces was done, thus considering the individual's experiences of nursing and clinical teaching. Further analysis, using cross-tabulations to show the empirical relationships between the phenomena was also done. Issues related to the establishment of validity and reliability of results in phenomenographic studies were identified as being particularly contentious. In this study, a full and open account of the approach, using interpretive awareness, where individual's conceptions are accurately described along with the identification of the structure of meaning was used to strengthen phenomenographic data analysis and hence validity and communicability of results.

It was argued in this chapter that while reliability of results was not appropriate in phenomenographic research, categories of description should be understood by other researchers. Interjudge reliability, based on communicability of categories of description was used to ensure that the categories of description were clearly communicated. The ways of achieving validity and communicability of results included: the researcher having a solid understanding of nursing and clinical teaching; design and implementation of the study based on phenomenographic principles; and presentation and reporting of results at conferences and staff meetings as well as full description of the results in Chapters 4 and 5 of this thesis. In addition to these approaches, careful application of phenomenographic theory was demonstrated throughout the research process; identification of the structure of clinical teachers' awareness about nursing and clinical teaching; and the use of interjudge communicability with four professional colleagues being involved in reading and giving feedback on the categories of description at various stages.

The empirical study was designed to understand how a particular group of clinical teachers conceived of nursing and approached clinical teaching. Limited but qualitatively different ways of conceiving of nursing and approaching clinical teaching have been identified. Logical and empirical relationships have been shown to exist between the clinical teachers' experiences of nursing and their approaches to

clinical teaching. In Chapter 4 of this thesis, the detailed results in relation to how clinical teachers' experience nursing are provided. The results specifically identify the key variations of how nursing is conceived and approached and the relations between the conceptions and approaches. In Chapter 5 of this thesis detailed results in relation to how clinical teachers' experience clinical teaching is provided. The results specifically identify the key variations of how clinical teaching is conceived and approached and the relations between the conceptions and approaches. In addition, the results in Chapter 5 also identify and describe the logical and empirical relationships that exist between clinical teachers' experiences of nursing and clinical teaching.

CHAPTER 4

Clinical teachers' experiences of nursing

The study is designed to address the main research question:

How do clinical nurse teachers experience teaching undergraduate nursing students on clinical placements and how does this relate to their experiences of nursing?

Chapter 3 of this thesis detailed the method of the empirical study. The purpose of this chapter is to present the results that show the variation that exists in the way clinical nurse teachers experience nursing. Clinical nurse teachers' experiences of nursing include their conceptions of, and approaches to nursing. The results are relevant to the first subsidiary

research question:

How do clinical teachers experience nursing? In particular, what are their conceptions of nursing and how do they approach nursing?

The chapter is divided into three sections. The first section presents the empirical results that show the variation that exists in the ways clinical teachers conceive of nursing. The second section presents the results that show how clinical teachers approach nursing. In each of these sections, the categories of description are described and then supported by comments from the data. It should be noted that each supportive comment represents a fragment of the category and is not meant to represent an individual clinical teacher. Finally, results are presented to show the relationship between clinical teachers' conceptions and approaches; that is, how they experience nursing.

Section 1: Clinical teachers' conceptions of nursing

The purpose of this section is to present the results that show the variation that exists in the way nurse clinical teachers conceive of nursing. This section addresses the 'what' or meaning aspect of clinical teachers' experiences of nursing. Marton and Booth's (1997) model, presented and described in chapter 1, is used to analyse and describe clinical teachers' conceptions of nursing. The shaded area in Figure 4.1 depicts the part of the study addressed by the presented results. Next, an outcome

space is presented. This is then followed by the categories of description making up the outcome space that are described in detail.

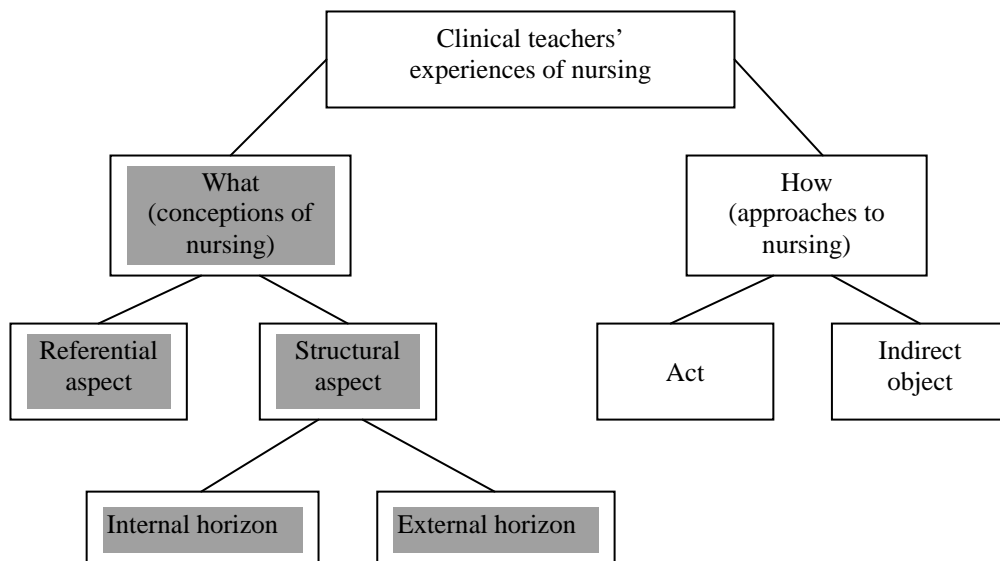


Figure 4.1: Clinical teachers' experiences of nursing, in particular their conceptions of nursing

Outcome space: Variation in clinical teachers' conceptions of nursing

The outcome space, *Variation in clinical teachers' conceptions of nursing* held by clinical nurse teachers was found to consist of four categories of description which are presented in Table 4.1. The four categories describe clinical teachers' conceptions of nursing. The first category (A) shows that clinical teachers conceive that nursing is about performing tasks. The second category (B) shows that nursing is about providing appropriate care of which completion of tasks is an element. The third category (C) shows that nursing is about the provision of individualised patient care aimed at achieving individual outcomes. Finally, in the fourth category (D), nursing is conceived of as being about the nurse collaborating with the health care team members to provide appropriate, individualised patient care aimed at achieving individual patient outcomes. The four categories of description are displayed in Table 4.1 below.

Table 4.1: Outcome space: Variation in clinical teachers' conceptions of nursing

| Category | Referential aspects | Structural aspects | |
|----------|---|--|---|
| | Meaning | Internal horizon | External horizon |
| A | Nursing is performing tasks | Tasks | Appropriate care of patients Patient outcomes Collaboration with health care team |
| B | Nursing is more than performing tasks, it is providing appropriate patient care required at the time | Appropriate patient care Tasks | Patient outcomes Collaboration with health care team |
| C | Nursing is providing appropriate patient care aimed at achieving individual patient outcomes | Patient outcomes Appropriate patient care Tasks | Collaboration with health care team |
| D | Nursing is collaborating to provide appropriate patient care aimed at achieving individual patient outcomes | Collaboration with health care team Patient outcomes Appropriate patient care Tasks | |

Category A: Nursing is performing tasks

Referential aspect

In the first category of description, nursing is viewed as being about the performance of tasks. The variation that exists in this category is related to the context in which nursing is being conducted. In the aged care setting, tasks are identified as those involved in the management of the physical care of residents: for example, showering or offering fluid. Participant 4 believes that nursing in this context is:

“...the day to day getting everything done... effectively and quickly...”

In the acute care setting, tasks to be performed also include those involved in the physical care of patients, as well as the technical tasks related to patient treatment. Participant 10 discusses nursing in the intensive care unit as being:

“...technology orientated. We’re into physiology and pathophysiology in ICU and relating things, looking...if someone’s tachycardic, is this related to blood pressure? Is this related to one of the drugs we’ve started? Is this related to how dry they are? We look at the whole thing from a physiological point of view.”

Structural aspect

The internal horizon of this category consists of tasks to be performed. The context determines the nature of the tasks. For example, in aged care the tasks are concerned with physical care activities, whereas, in acute care the tasks are technical in nature but also include physical care activities. While tasks are the major focus of the nurse's awareness, at times the technical tasks may be given priority over physical care activities. Participant 1 reports on her observation of nurses in the hospital where she was teaching undergraduate nursing students.

“Sometimes the physical needs, basic things ... were forgotten, over the pumps, the dramas and the action. That makes it look exciting and I think it gave the wrong impression of what nursing is about.”

Whatever the nature of the tasks, the patient is not part of the internal horizon of the nurse.

The dominance of the task focus is commented on by Participant 8, who states:

“There is a lot of routine procedures which take a lot of time and they actually take away the one- to-one relationship.”

The absence of the whole person in the internal horizon of the nurse, except as a recipient of routine physical care and technological intervention, delimits nursing to the performance of tasks. Participant 12 argues that she does not believe:

“...that anyone wants to be seen as a number, just a body in a bed. There's been a lot of discussion about, is the mind separate from the body? Is the body separate from the mind?...I think ...they're all integrated together...I think that's probably what most nurses think. However, I can see though that on the acute ward, things are so pressed, that often we have to neglect perhaps some really important areas (that) maybe even equally as important as what's actually going on physically for that person, because I believe that they all interact together.”

Summary of category

Category A represents conceptions that nursing is a process involving elements such as the administration of technology and/or provision of routine physical care. The clinical context appears to influence how nursing is conceived. For example, in nursing homes where technological intervention is not overt, as it is in acute care facilities, nursing is conceived of as the provision of routine physical care. Nursing in acute care facilities is also conceived of as being about performing tasks that can include those related to physical and/or technological care. Regardless of the context, the patient as a physical entity is the recipient of nurse-determined tasks.

Category B: Nursing is more than performing tasks, it is providing appropriate patient care required at the time

Referential aspect

In this category, nursing is conceived of as being more than performing physical and technical tasks. These tasks are part of patient care but are not the only element of care. Little or no variation within this category was identified in the two different nursing contexts. Two statements are provided to support this category of description. Firstly, Participant 3 states:

“...practical tasks are only a small thing. Even though they take up a lot of time, they are a very small component of the rest of the nursing and physical and mental care. There’s so much more to it than tasks.”

Secondly, further confirmation is provided by Participant 4 who asserts that nursing is:

“...all areas of care, physical, psychological, spiritual,... social.”

The elements of appropriate care, therefore, include the provision of emotional, spiritual and psychological support, as well as physical and technical care. Appropriate care is also identified as that which is required by the patient at the time, and varies from person to person, depending on their needs. Participant 7 explains:

“It’s more than just being skill based and technically correct to be a nurse ... (it’s) whatever the person needs at that time. For some patients they need the IVs, the medication, the whatever. For other people they might just need a joke, hold the hand and a bit of a smile.”

Structural aspect

The internal horizon of this category consists not only of tasks to be performed for a patient but also includes appropriate care to be provided as required. These two aspects relate to each other in that tasks are either technical interventions required as part of the patient’s treatment or physical care activities such as washing or feeding. However, there are other aspects included in the notion of care in this category. These aspects include the psychological, emotional and spiritual care of people that may be required some of the time. Participant 2 provides an example of a situation involving a patient with a specific need in addition to technical care.

“Now for this man, culturally appropriate care for him surrounded that medallion ...nursing is ... providing care that is really appropriate to that person. Whereas at a whole lot of other levels, technical levels like check lists and urinalysis and making up a post op. bed, all those things that you might say are nursing, all those things were done, but the minute he came round, he wanted that medallion...”

In this category, the nurse responds to an expressed patient need and therefore meets the specific needs of that patient at that time. It is in this category that the patient as a whole

person enters the internal horizon of the nurse. The patient is a recipient of care in relation to expressed needs. Individualised patient care does not include reference to patient outcomes or who else is involved in caring for the patient, such as the wider health care team. The external horizon, therefore, delimits nursing to appropriate care.

Relationship with previous category

This category is similar to the previous one in that both categories have a focus on tasks to be performed but in this particular category the tasks are only a part of patient care. Other aspects of patient care that separate Category B from Category A are those related to the psychological, emotional and spiritual needs of specific patients. These aspects are seen to be important for some patients and are provided by the nurse as required.

Summary of category

Category B represents conceptions that nursing is a process involving elements such as the provision of appropriate patient care that includes technical, physical, emotional and spiritual care as required by the person. The nurse responds to the patient's needs and determines the care that will be provided and the patient is the recipient of those interventions.

Category C: Nursing is providing appropriate patient care aimed at achieving individual outcomes

Referential aspect

In this category, nursing is conceived of as being about providing appropriate care aimed at achieving patient outcomes. Variation within this category is described in terms of patient outcomes. Participant 10 informs us that for patients receiving intensive care, the nature of the outcomes varies according to the patient. She asserts that each critically ill patient has individual outcomes to be achieved. For some, she states:

"...we're trying to achieve a stability. We're trying to keep these people stable so that we can treat the condition if it's possible to treat it. So that we can keep them stable enough so they can be operated on so that we can get them up to the wards. Usually keep them stable try to keep all their body systems viable is what we're mainly concerned with....We're trying to save these people if we can...every patient's got a different set of objectives. Some people we're trying to keep them alive till we can take them for organ donation, for harvest ...

(For others)

we're trying to keep them stable until they get their heart transplant or we've got their heart transplant in and we're trying to keep their blood pressure low so they don't blow their grafts. Then we get them up to the wards and then they start moving. Every patient's different..."

The previous statements highlight the individuality of each patient and the subsequent identification of specific goals according to the medical diagnosis. While some patient goals can be technically complex as referred to in the previous statement, for others improvement can also be understood in terms of patients achieving independence in daily living activities and returning to their homes. Nursing, according to Participant 20 is:

“...helping people get back to a level of wellness of where they were, where they can function independently, where they don’t need any medical intervention or treatment.”

Structural aspect

The internal horizon of this category consists not only of appropriate care but also care that is outcome-based. These aspects relate to each other, in that care consists of technical intervention or physical care activities as well as emotional and spiritual care, required as part of the patient’s treatment, of which goals are the important aim. While patient care is guided by patient outcomes there is no reference in this category as to who else is involved in caring for the patient, such as the wider health care team. The external horizon therefore delimits nursing to appropriate care to achieve patient outcomes.

Relationship to previous categories

This category is similar to the Category B, in that both categories have a focus on appropriate patient care, but in this particular category the fact that care is based on goals is apparent, thus differentiating Category B from Category C. Category C is similar to Category A in that they both include technical and/or physical aspects of care. Category C differs from Category A in that Category C is outcome-based whereas the former is focused on tasks. The outcomes determine which elements of care are required to achieve patient outcomes.

Summary of category

Category C represents conceptions that nursing is a process driven by the achievement of certain patient outcomes. The outcomes are generally aimed at achieving improvement in the patient’s condition. The general goals of improvement guide the selection of appropriate individualised patient care activities.

Category D: Nursing is collaborating to provide appropriate patient care aimed at achieving individual patient outcomes

Referential aspect

In this fourth category, nursing is conceived of as providing appropriate patient care in collaboration with other members of the health care team in order to achieve individual patient outcomes. Little or no variation in conceptions of nursing within this category across different contexts was identified. The health care team works together to assist the patient to

achieve certain outcomes. The following statement from Participant 3 highlights particular aspects of this category. These aspects include members of the health care team providing appropriate care based on achieving outcomes of independence, whereby the patient will return home, and to work, and to as normal a life as possible. Participant 3 states:

“Rehabilitation is the most important part of nursing. (It) is getting people back to work, back to home, back to a relatively normal way of life...”

[Rehabilitation nursing is]

an aspect of patient care, and all patients need rehabilitation, and cos it’s such a general term, even the lady who has delivered a baby needs rehabilitation back into going home, getting ready to go home, that’s rehabilitation so everyone is rehabilitated, whether it’s through physio or occupational health, social worker, dietitians, it’s all part of rehab, not just nursing it’s the whole spectrum...”

Structural aspect

The internal horizon of this category includes collaboration between nurses and other members of the health care team to provide appropriate patient care so that certain outcomes can be achieved. The elements of appropriate care are included in this category. Some, or all of these elements, are required by some patients some of the time. The elements of appropriate care, achievement of individual outcomes and collaboration relate to each other in the following ways. The elements of appropriate care are what are required by the patient in order to improve. The goals of care and collaboration relate to each, in that the members of the health care team work together to identify the goals of care, and assist the patient to improve.

Relationship to previous categories

This category is similar to Category C, in that both categories have a focus on appropriate care based on the achievement of outcomes. The important element that separates Category D from Category C is the notion of collaboration between health care team members in assisting the patient to improve. Category D shares similarities with Categories A and B in that they both describe the use of technical and physical care. Category D is similar to Category C in that they both include the elements of appropriate care as well as the achievement of patient outcomes. Category D differs from Category C in that the latter category identifies appropriate care as that which is provided as required by the patient at the time. However, there is no mention of collaboration with the health care team. Category D differs from Categories A and B in that neither of these latter categories includes outcomes of care. Category D describes the integration of all the previous categories.

Summary of category

Category D represents conceptions that nursing is a process driven by the identification of certain patient outcomes in collaboration with the health care team. The outcomes are generally aimed at achieving improvement in the patient's condition. The general goals of improvement guide the selection of appropriate individualised patient care activities.

Summary of Section 1

The purpose of this first section was to present results that show the variation which exists in the way clinical teachers conceive of nursing. This section addressed the 'what' aspects of the experience of nursing. Initially, an outcome space was presented which was then followed by the categories of description making up that outcome space. Four categories of description were identified describing clinical teachers' conceptions of nursing which were then detailed. The first category showed that clinical teachers conceive that nursing is about performing tasks. The second category showed that nursing is conceived of as being about providing appropriate care, of which completion of tasks is an element. The third category showed that nursing is conceived of as being about the provision of individualised patient care aimed at achieving individual outcomes. Finally, in the fourth category, nursing is conceived of as being about the nurse collaborating with the health care team members to provide appropriate, individualised patient care aimed at achieving individual patient outcomes.

Section 2: Clinical teachers' approaches to nursing

In describing the methodological aspects of the study (see Chapter 3) it was identified that the participants were not directly questioned about their approaches to nursing. The approaches to nursing were inferred from the data. From the clinical teachers' statements about nursing it was inferred how they would themselves approach nursing.

The purpose of this second section is to present the results that show the variation in the way clinical teachers experienced how nurses approach nursing. This section addresses the 'how' aspect of the experience of nursing. The 'how' aspect, or approach to nursing, includes the act which refers to the nursing strategies used, and the individual object, which refers to the intentions of the nurse. Marton and Booth's (1997) analytical framework (presented and described in Chapter 1) is used to analyse and describe clinical teachers' approaches to nursing. The shaded area in Figure 4.2 depicts the part of the study addressed by the results. Next, an outcome space is presented. This is then followed by the categories of description, making up the outcome space, which are described in detail.

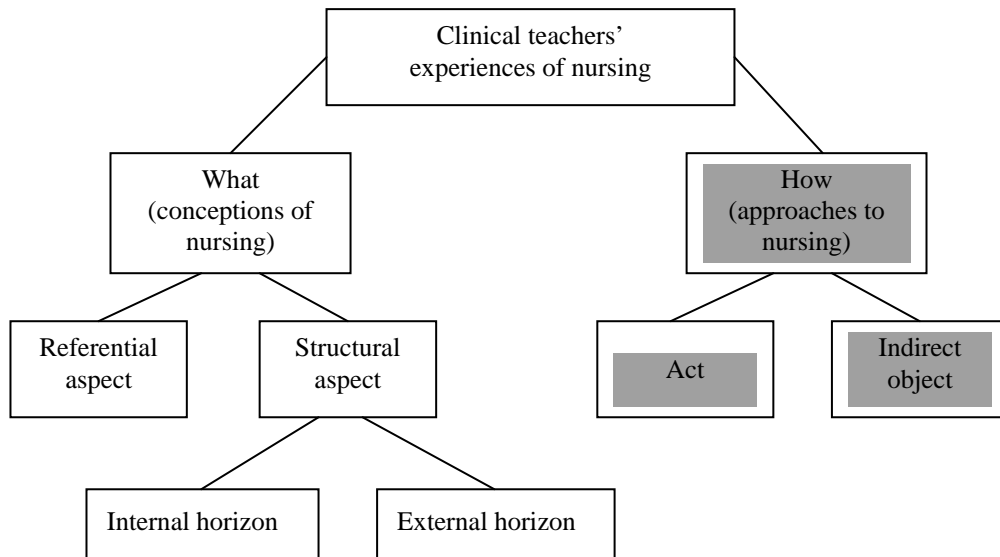


Figure 4.2: Clinical teachers' experiences of nursing, in particular their approaches to nursing.

Outcome space: Variation in clinical teachers' approaches to nursing

The outcome space, *Variation in clinical teachers' approaches to nursing* consists of four categories of description which are presented in Table 4.2. The four categories describe how clinical nurse teachers go about nursing. The first category shows the clinical nurse teachers' focus is on self rather than the patient, with strategies aimed at task orientation. The second category shows the focus is still on the nurse, with strategies aimed at providing appropriate care. In the third category, the focus is on the use of patient-focused strategies aimed at achieving individual patient outcomes. The final category demonstrates the focus as also on the patient, with strategies aimed once again at achieving individual patient outcomes but this time through the collaboration of health care professionals.

Table 4.2: Outcome space: Variation in clinical teachers' approaches to nursing

| Category | Approaches to nursing | Act | Indirect object |
|----------|--|----------------------------------|---------------------------------------|
| A | Using nurse-focused strategies aimed at performing tasks | Using nurse-focused strategies | Task orientation |
| B | Using nurse-focused strategies aimed at providing patient care | Using nurse-focused strategies | Appropriate care |
| C | Using nurse-focused strategies aimed at achieving individual patient outcomes | Using patient-focused strategies | Achieving individual patient outcomes |
| D | Collaborating to use patient-focused strategies aimed at achieving individual patient outcomes | Using patient-focused strategies | Collaboration |

Category A: Nursing is approached as using nurse-focused strategies aimed at performing tasks

In this first category of description, the approach to nursing is experienced as using nurse-focused strategies aimed at performing tasks. The nurse decides on, and performs, particular technical skills and/or physical care activities. The patient is seen only as a passive recipient of the technical or physical care interventions.

Act of nursing

The act of nursing, in this category of description, involves the use of nurse-focused strategies associated with the management regime required by the patient. The act of nursing is expressed as doing things to people. The nurse decides on what is to be done, and performs the tasks. The patient is the recipient of these tasks. A typical quotation comes from

Participant 1 who states:

“There was one particular patient who had had a stroke ... and I noticed that no one had turned her throughout the whole shift and I thought well it’s fine and good (for other nurses) to be into the action but basic nursing care is pretty important too. And there is (sic) so many opportunities to do basic things with people...”

What is striking about this category is the impersonal nature of how nursing is approached. There is no acknowledgement of the relationship that exists between nurse and patient. Nor, is there any recognition that the patient is anything more than a physical being requiring physical care. Furthermore, there is variation in the way the act of nursing is experienced. While the focus remains on the nurse, this can be extreme, as can be seen when patients’ physical needs are neglected. Participant 10 observed that in one acute care agency:

“Patient care was probably not the best I’ve seen around ... They would not blink at leaving people lying in a bed full of poo while they do other little things.”

This participant further explained that one particular nurse wanted to leave an unconscious patient in this state because:

“he’s not even going to notice...”

Cleaning him up meant:

“making more work for ourselves. The linen budget is already stretched to the max...”

This incident emphasises the separation of the nurse from the patient. The patient in this situation is vulnerable when the nurse’s perceived needs override those of the patient.

Indirect object

The indirect object of nursing in this category is that of task orientation. When teaching students in a nursing home, Participant 6 observed that the work of the residents’ Activities Officer was not regarded as important by nursing staff:

“... they (nurses) would often walk in the middle of one her (the activities officer) activities and just take the residents out for a dressing or something...”

Participant 7 confirmed the task orientation-focus of nurses working in the nursing home where she was teaching and supervising nursing students. Participant 7 witnessed residents being told:

“... you’ve got to do this now, so sit down and do it so I can get my job done.”

Furthermore, physical care activities are routinised. According to Participant 7, in the aged care setting:

“... you’ve got 8, 10 residents to wash... it’s very tasky.”

She also commented that nurses in acute care settings were focused on performing nursing tasks. She stated that these nurses:

“...tend to be skill based...This is how we do it, get the work done.”

Participant 14 provides an explanation for acute care nurses being task orientated:

“... whatever we say about this holistic care of looking after a patient, and not seeing them as a task ... like an IMED pump or a nasogastric tube or whatever. Things are not quite like that in the hospitals because of the rapid patient turnover because of the nature of the way nurses work... I think that the repetitiveness which patients are turned over these days doesn’t often allow a nurse-patient relationship to develop, and so the skills come to the fore...So the way things operate in...the private hospital, where the assumption is made that the surgeon has already spoken to the patient...The nurse’s role is fuzzy, and yet they are still required to check off things and to make sure that ...the patient has of course fasted, and is prepared for theatre...The whole mental preparation, the informing...to feel confident before they go to theatre sometimes is not always able to be fulfilled... You think ‘look, this is the way it ought to be, but this is the ...pragmatic way that we have to deal with things’...”

This explanation indicates that the task orientation of nurses has come about in response to high workloads and the subsequent associated pressures. While high patient turnover is a dominant characteristic of acute-care nursing it is not necessarily true for nursing homes, however People in aged-care settings receive extended care on a continuing basis, but still with this approach, the performance of tasks appears to be the priority of nurses, rather than what the resident’s experience is of the situation, or their changing needs.

Summary of category

One way of approaching nursing, as described in this category, is to take a nurse-focused approach aimed at performing tasks. Patients require particular physical assistance and/or the performance of certain technical tasks which are necessary parts of their treatment. The tasks

are the priority of the nurse rather than the patient, and how they, and their family experience the episode of care. Approaching patient care in a task-focused way excludes the patient.

Category B: Nursing is approached using nurse-focused strategies aimed at providing appropriate patient care

In this second category of description, the approach to nursing is experienced as using nurse-focused strategies once again, but this time the aim is to provide appropriate patient care.

There is recognition in this category that patients may have needs in addition to their physical or technical needs. The nurse assesses the patient to determine problems to which she responds.

Act of nursing

In the second category, the act of nursing also describes a nurse-focused approach. Variation exists in this category as to how the act of nursing is described. Patient assessment is an element of this category where information is gathered about the patient to inform kind of what care is required. For example, Participant 9 believes that as a nurse:

“You’ve got to be assessing, you’ve got to be astute to actually pick up in the first place that something’s not right. You’ve got to respond appropriately and to care for the patient.”

Assessment is an important aspect of how nursing is conducted so that patient needs may be determined. Participant 15 observed in acute care that:

“...each nurse’s way of nursing was different so with some it was here’s the task, tick the box when you’ve done it. Some of it was...you’re dealing with the person, ask them questions... It’s not a blackboard where you tick the job when you get it done, you’ve got to deal with the person and do the task and assess their needs and assess their level of wellness and illness.”

The patient is seen as an important source of information, so nurses ask questions. The implication is that patient problems might be identified as a consequence and the nurse then responds by identifying patient needs and initiating relevant interventions.

While assessing patients is part of what some nurses do, there continues to be a lack of acknowledgement in this category of the nurse-patient relationship. The patient is still someone who has things done to them. Participant 9 describes a crisis situation and how she responded to it:

“It had all happened so quickly the family had come to visit and she’d been improving and all of a sudden she had deteriorated. You know, the sit down, explain what’s happening, the cup of tea, the sit there, the pat on the shoulder, real caring...”

A comment from Participant 14 confirms the distance between patient and nurse. She points out that:

“Nurses have this amazing ability to, I guess in a colloquial way to sort of jolly people along. I think a lot of people don’t like being treated like that, but people who are ill and sometimes worried, particularly if they’ve had cardiac surgery or something like that. I think that because nurses approach them in this really practical way and are cheerful, reassuring, confident, mobilising them, getting them moving again, they think they can’t do things but with nurses and the way they are, are liable to get back to their old ways. I think they are amazed at the way that they can manage, and they don’t get much of a chance these days to remain in a patient role for very long.”

Indirect object

The indirect object of nursing in this category is aimed at providing appropriate patient care.

Little or no variation within this category was identified in the two different nursing contexts. Participant 9 provides a description of her nursing intentions. She states:

“Nurses are there to care for the patient’s emotional, everything, all their needs, not just their physical needs ...they won’t get better if you don’t. You can have a patient that physically you are doing all the right things, but if they are depressed or feeling isolated or worried, worry is probably one of the biggest things...”

Relationship with previous category

Similar to the previous category, the approach to nursing is described as using nurse-focused strategies. The patient remains a passive recipient of care. In this second category the focus of the strategies has changed, however, and is directed to the patient by way of the patient receiving appropriate care. Once again the nurse determines what needs to be done based on assessment of the patient.

Summary of category

This category consists of the nurse doing things to the patient which is perceived to constitute appropriate care. The nurse recognises that in some situations patients need more than technical and/or physical care and uses assessment to help identify those additional needs.

Category C: Nursing is approached using patient-focused strategies aimed at achieving individual patient outcomes

In the third category of description, the approach to nursing is experienced as using patient-focused strategies aimed at achieving individual patient outcomes. The patient as an individual is recognised, as is the patient in relationship to the nurse. The nurse in this

category takes care of the patient by providing appropriate care required to help the patient get better.

Act of nursing

Category C describes the act of nursing as being patient-focused. Variation in the way patient-focused nursing is conducted is evident in this category. Individuality and ways of working with patients and families are elements of this category. The importance of treating the patient as an individual is identified by Participant 19. When she was teaching students on clinical placement in a nursing home, she observed nurses, treating the residents as individuals. She states:

“It’s so terribly easy for people in nursing homes to be just treated as one of the seventy or eighty people ... instead of just being deemed that everyone has the same care, it now seems to be more individualised.”

Nurses who take a patient-focused approach recognise that the patient is an individual who is usually capable of making decisions about aspects of their care. Participant 2 comments on the individuality of patients:

“Each person is an individual... it’s up to them to determine what significance they place on different aspects of their life.”

Another feature of this category is the way patient individuality is understood and managed. For example, Participant 10 provides an illustration of what the act of nursing involves when caring for a dying, unconscious patient. She states:

“Every patient’s different... I talk to people the whole way through as though they were still with us. I refuse to say that unconsciousness means they can’t hear us. So I usually would be talking to the person the whole way through. I’d say ‘it’s alright I’m just cleaning you up’ ... To treat people with dignity in their dying hours... I think being rough with people as well, we need to be very careful especially at this end of the spectrum where the skin is more fragile and so forth. They might have heightened sensation of touch as you’re rolling them over You do need to be gentle and calm with people like that. ... You’re quiet, you’re talking to them, don’t ignore them...”

Another element in this category is the consideration shown to the patient’s family as described by Participant 11, who observed nurses caring for a terminally ill patient:

“They paid particular attention to this lady’s hygiene, pressure care that sort of thing. She wasn’t communicating verbally so they would spend the time trying to understand what she was saying, how she was feeling... And then just liaising with the family, they had the family’s feelings in mind... maintaining rights and dignity, that sort of thing, that was foremost in their minds. Another thing was pain relief too, they were very conscious of that...”

(Empathy is)

putting yourself in their shoes, trying to understand how they feel. I always say would I like this done to me if that was me, as the patient. Respect, I think it's respect, treating that person as an individual."

Participant 11 also describes the place of family in the context of patient care as she portrays her approach to nursing in her specialty area of neonatal intensive care. She states:

"... in our unit...you're looking after the baby but you're also looking after the family as well. It's not just the patient you're looking after, so we are definitely family-centred care. That's what we base our nursing on."

Families are also considered to be an important element of patient care in intensive care nursing. Participant 10 states:

"I ...deal with death every day in ICU, you know young people all the time and from my own perspective you ... don't treat families like that. You don't make them see things that upset them unnecessarily....We like to keep them up to date but we find that the way we speak amongst ourselves about a patient and what's happening would be completely different to how we would speak to a family member. We're very technical and then we have to put it in layman's terms..."

Indirect object

The indirect object of nursing in this category is aimed at achieving individual patient outcomes. Little or no variation of intentions within this category was identified in different nursing contexts. A patient-focused approach, therefore, includes recognition that the patient is an individual. Individuality includes recognition that the person has rights, may be able to make decisions about aspects of their own care, and should be treated with dignity and respect. Participant 12 describes the intention of nursing in a large aged care facility where she was teaching students:

"...they all had their own special little hand knitted knee rugs and doona covers, so they personalised it as much as they could, obviously their own clothing etc...it is important to respect the privacy of others, their dignity, and their rights to be treated as an individual. And for me as a nurse I think that's very important.... You don't want to talk about the old bloke with the bald head in bed 2, I think that's really inappropriate. And I suppose for me that was a sign that the staff had really made an effort to recognise their individuality. It is important ... to recognise that everyone has their own story and their own way of looking at things, their own perceptions, and that can lead off to all sorts of avenues. Their treatment, their pain management, whether they can have meals at certain times, what they choose to eat..."

Inclusion of the family is an important aspect of patient care as the nurse works towards helping the patient improve and thereby achieve their specific outcomes, such as getting better and going home. Participant 15 states that patients admitted to hospital are:

“... unwell and they get sick and they’re compromised and they come to hospital, we help them get better... we have to try and make that as comfortable as possible for them. When I say making them better I suppose it’s to a level of wellness as well as we can make them, like a chronic angina patient, heart disease or a diabetic, we can’t take those illnesses away but we can stabilise them enough so that they can manage, and I suppose it’s making them as well as possible and to a level that they can then go home with supports if it’s needed... Like an angry patient may be angry not because they don’t like you, they’re anxious or have other issues that relate to that so they might need some reassurance or it may be explaining what’s happening or maybe getting a family member in and things like that. People placed in a strange environment, they will behave strangely, because it’s not always their normal behaviour. I suppose, I don’t always take things at face value but try and gather all the information and then assess what’s actually going on, that the person in the bed is your best resource, what’s going on in the family, what’s normal, what’s not normal, how are they feeling and why are they feeling like that? All the other things that are peripheral may not be important but what’s relating to the patient and what they need to know about what’s happening, is important. So when they come in, it’s often to relieve their anxiety just to give them an indication of what’s going to be happening over the next few days”.

Relationship with previous categories

In this category the focus is on the patient. The difference in what nurses do in this category in comparison with Categories A and B is the inclusion of the patient and the family in their approach to nursing. Family involvement is seen as an important aspect of this approach to patient care. Another difference between this category and Categories A and B is in the aim of the strategies. In Category C the aim is to achieve patient improvement whereas in Category B nurse-focused strategies are used to provide appropriate care for patients. In Category A the focus is on the nurse completing nursing tasks. What separates Category C from Category B is that, in this third category, the patient is seen as a self-determining individual with rights, who should be treated with dignity and respect in the partnership of patient care. The critical difference between Category C and Category A is that in the latter category things are done to patients by the nurse and in the former, the patient and family are included in care.

Summary of category

This category consists of the nurse, the patient and the family in relationship with each other. The nurse recognises the patient as someone who is experiencing an illness and needs to be treated with dignity and respect. Since illness affects people differently, the nurse’s awareness of the impact is an important foundation to individualising patient care. The

family is integral to the patient's world and need to be appropriately included in patient management. These patient-focused strategies are, therefore, instrumental in individualising patient care.

Category D: Nursing is approached through collaborating to use patient-focused strategies aimed at achieving individual patient objectives

In the fourth category of description, the approach to nursing is experienced as collaboration with other health team members. Collaboration underpins the use of patient-focused strategies as the goals of the multidisciplinary health team guide patient management toward the achievement of individual outcomes. The nurse continues to work with the patient and family. The integration of the nurse, patient, family and health care team provide an important network of resources to facilitate this process.

Act of nursing

The fourth category describes the act of nursing as also being patient-focused. Variation in the way nursing is conducted is evident in this category. Collaboration with the multidisciplinary health care team and family are features of this category. Participant 3 describes the importance of collaboration and some of the processes involved in collaborating in rehabilitation nursing. She states:

“You can make individual decisions within your own faculty but you should get together every week, which we do and you discuss how that patient is going and make major decisions as a team...This is when the discharge date is, let's go on this outing. Is he ready? Let's go into a double bed. All those sorts of decisions are made by the team rather than by a single person...”

The above statement shows that identifying key indicators of patient progress informs the planning and progress discussions at meetings of the health care team. The concept of collaboration between members of the health care team is confirmed by Participant 11, who describes how one registered nurse, caring for a terminally ill patient, helped one of her students become involved in the patient's care. In this particular case, patient care included family involvement through meetings and discussions. In addition to family involvement was the inclusion of the health care team through team meetings. She states the nurse:

“... included the student in all situations...this student really got involved in family discussions, family meetings, team meetings...”

Indirect object

The indirect object of nursing in this category is also aimed at achieving individual patient outcomes. However, the addition, in this category is the notion of collaboration. Little or no variation of intentions was identified within this category. While nurses have areas of independence in patient care, the perspective of the wider health care team is fundamental to

patient management. Participant 11 describes an overview of the nurse's intention when caring for a terminally ill patient. She states that care involves:

“Looking at that patient clinically, what was wrong with that patient, and then looking at the psychological aspect for that patient, how is she feeling, maintaining comfort, dignity, privacy, that sort of thing, and then looking at, on another level, the RNs, and the doctors and medical team, the multi-disciplinary team and how they treat that situation.”

Participant 3 confirms the importance and shared responsibility of the health care team for helping patients get better.

“.....rehab is a team effort. Just as in a general hospital getting someone better is not just a nursing responsibility it's the whole team and decisions should be made by the team rather than by individuals.”

Relationship to previous categories

As in the previous category, the focus is also on the patient and includes the family. The difference in what nurses do in this category in comparison with Category C is the inclusion of collaboration with members of the health care team through team meetings, for example.

In Category D, the aim is also to achieve patient improvement by means of achieving particular patient outcomes just as it is in Category C. The critical difference between this category and Categories A and B is that in Category D the focus of the nurse is on the patient whereas in both Categories A and B the focus is on the nurse.

Summary of category

This category consists of the nurse, the patient, the family and the health care team in relationship with each other. There is continued recognition of the importance of treating the patient with dignity and respect and the need to provide individualised care. The family is integral to the patient's experience, recovery and rehabilitation just as is the multidisciplinary health care team. Integration of all of these elements is fundamental to the achievement of patient improvement.

Summary of Section 2

The second section of this chapter has identified four categories that describe clinical teachers' approaches to nursing. The first category shows that one way approach to nursing is in a nurse-focused way, aimed at performing tasks. The second category shows that nursing is also approached in a nurse-focused way, but this time the intention is to provide appropriate care. The third category shows that nursing is approached by clinical teachers in a patient-focused way with the intention of achieving individual outcomes. Finally, in the fourth category, nursing is approached in collaboration with the health care team, also in a patient-focused way aimed at achieving patient outcomes.

Section 3: Relationship between clinical teachers' conceptions of nursing and approaches to nursing

This section presents the results of an investigation to see if a relationship exists between clinical teachers' conceptions of nursing (what) and their approaches to nursing (how). Two outcome spaces were identified each containing four categories of description. The relationship between the categories of description, for outcome spaces, Variation in clinical teachers' conceptions of nursing, and Variation in clinical teachers' approaches to nursing was investigated by analysing the distributions of the transcript classifications in terms of the categories and the empirical and logical relationships between the two sets of categories.

This process is detailed in Chapter 3. The results of the statistical investigation of the relationship between conceptions and approaches to nursing are presented in Table 4.3.

Table 4.3: Relations between conceptions of nursing and approaches to nursing

| Approaches to nursing | Conceptions of nursing | | | | Total |
|-----------------------|------------------------|---|---|---|-------|
| | A | B | C | D | |
| A | 1 | 3 | 1 | | 5 |
| B | | 4 | 1 | 1 | 6 |
| C | | | 4 | 2 | 6 |
| D | | | | 3 | 3 |
| Total | 1 | 7 | 6 | 6 | 20 |

Kendall's tau-b = 0.69, p = <0.01

Categories A and B, in both outcome spaces, represent conceptions and approaches to nursing which are nurse-focused. In comparison, Categories C and D, in both outcome spaces, represent conceptions and approaches to nursing which are patient-focused. The results of the statistical investigation of the relationship between clinical teachers' conceptions of nursing and their approaches to learning are presented in Table 4.3. A statistically significant association was found between clinical teachers' conceptions of

nursing and approaches to nursing

(Kendall's tau-b =0.69, p = <0.001).

Coherence between clinical teacher conceptions and approaches to nursing is suggested in the results of this study. However, not all clinical teachers' approaches to nursing match their conceptions of nursing. Dissonance between conceptions and approaches to nursing in three interview transcripts are presented in Table 4.4.

Table 4.4 : Dissonance between clinical teachers' conceptions and approaches to nursing

| Participants | Conceptions of nursing | Approaches to nursing |
|-----------------------|---|---|
| Participant number 18 | Nursing is providing appropriate patient care aimed at achieving individual patient outcomes (Category C) | Using nurse-focused strategies aimed at performing tasks (Category A) |

| | | |
|--------------------------|---|--|
| Participant number 7 | Nursing is providing appropriate patient care aimed at achieving individual patient outcomes (Category C) | Using nurse-focused strategies aimed at providing appropriate care (Category B) |
| Participant number 20 | Nursing is collaborating to provide appropriate patient care aimed at achieving individual patient outcomes (Category D) | Using nurse-focused strategies aimed at providing appropriate care (Category B) |

Results presented in Table 4.3 suggest that a nurse cannot take a patient-centred approach to nursing unless the nurse has conceived of nursing in a patient-focused way. However, Table 4.4 shows that three out of twelve participants, classified as having patient-focused conceptions of nursing take a nurse-focused approach to nursing. All three participants (numbers 7, 18 and 20) normally work as nurses in acute-care settings when they are not teaching. A possible explanation for dissonance between conceptions and approaches to nursing may be related to the nature of nursing in acute care settings. The acute-care environment is one of high pressure where an aim is to discharge patients as quickly as possible. Because patients are usually only in hospital for relatively short periods, there is little time for nurses to build relationships with patients while they receive their treatment. It is possible therefore that, for these clinical teachers the environment in which they work as nurses is perceived to be one that is not conducive to patient-focused care.

The nine clinical teachers categorised as having both a patient-focused conception and a patient-focused approach to nursing were participants number 2, 3, 4, 5, 10, 11, 12, 15, and 17. These clinical teachers normally worked as nurses in a range of environments, and were teaching in environments such as acute care, rehabilitation and aged care. This group of clinical teachers showed an awareness of the impact of illness on patients and their families.

Respect for the privacy, beliefs, values and dignity of patients was seen to be important. What was also common to clinical teachers in this group was the need to be sensitive to their patients and their individuality by showing empathy. To gain a fuller understanding, research needs to be conducted into the effect of the environment on nurses' approaches to patient care.

Summary of Section 3

In this third section of the chapter it has been identified that a relationship exists between clinical teachers' conceptions and approaches to nursing. The results of the statistical analysis show that clinical teachers, who adopted a patient-centred approach to nursing, conceived of nursing in complex ways. The results also suggest that clinical teachers who approached nursing from a nurse-focused perspective conceived of nursing in less complex

ways. While these results show a statistically significant association between clinical teachers' conceptions and approaches to nursing, for three clinical teachers there was dissonance between conceptions of nursing and approaches to nursing. Where dissonance between conceptions and approaches to nursing was identified, in each case the approach adopted was classified in a lower category than the conception.

Conclusion

Results presented in this chapter show that variation exists in the way clinical teachers experience nursing. In the first section, results were presented that show the variation that exists in the ways clinical teachers conceive of nursing. An outcome space, *Variation in clinical teachers' conceptions of nursing*, containing four categories of description was presented. The first category within this outcome space shows that clinical teachers conceive that nursing is about performing tasks. The second category shows that nursing is about providing appropriate care of which completion of tasks is an element. The third category shows that nursing is about the provision of individualised patient care aimed at achieving individual patient outcomes. Finally, in the fourth category, nursing is conceived of as being about the nurse collaborating with the health care team members, to provide appropriate, individualised patient care, aimed at achieving individual patient outcomes.

In the second section, results were presented that show that variation exists in the way clinical teachers approach nursing. An outcome space, *Variation in clinical teachers' approaches to nursing*, containing four categories of description was presented. The first category within this outcome space shows that clinical teachers approach nursing in a nurse-focused way, with the intention of performing tasks. The second category shows that nursing is also approached in a nurse-focused way, but this time the aim is to provide appropriate care. The third category shows that nursing is approached by clinical teachers in a patient-focused way with the intention of achieving individual patient outcomes. In the fourth category, nursing is also approached in a patient-focused way aimed at collaboration, with the intention of achieving individual patient outcomes.

Finally, empirical results were presented in Section 3 that show that there is a relationship between clinical teachers' conceptions of nursing and their approaches to nursing. Although for some clinical teachers there was dissonance between their conceptions and approaches to nursing, results of the statistical analysis suggest that in order to approach nursing in a patient-focused way clinical teachers need to have a complex conception of nursing. A complex conception of nursing includes the understanding that nursing is goal-oriented and/or is about collaborating with the health care team to meet patient outcomes. If the

conception of nursing is less complex than this, then patient care is approached in a nurse-focused way.

CHAPTER 5

Clinical teachers' experiences of clinical teaching

The previous chapter presented the results that show the key aspects of variation that exists in the ways clinical teachers experience nursing: that is their conceptions and approaches and the relationship between their conceptions and approaches. These results were relevant to the first subsidiary research question:

How do clinical teachers experience nursing? In particular, what are their conceptions of nursing and how do they approach nursing?

The purpose of this chapter is to present the results that show the variation that exists in the way clinical teachers experience clinical teaching, that is their conceptions of and approaches to clinical teaching. The results are relevant to the second subsidiary research question:

How do clinical teachers experience clinical teaching? In particular, what are their conceptions of clinical teaching and how do they approach clinical teaching?

Results are also presented to show the relationship that exists between clinical teachers' experiences of nursing and clinical teaching. These results are related to the third subsidiary research question:

How do clinical teachers' experiences of nursing relate to their experiences of clinical teaching? In particular, do conceptions and approaches to nursing relate to their conceptions and approaches to clinical teaching?

The chapter is divided into five sections. The first section presents the results that show the variation that exists in the ways clinical teachers conceive of clinical teaching. The second section presents the results that show how clinical teachers approach clinical teaching. In each of these sections the categories of description are described and supported by comments from the data. It should be noted that each supportive comment represents a fragment of the category and is not meant to represent an individual clinical teacher. In the third section empirical results will be presented to show how clinical teachers experience teaching students about nursing and the relationship between their conceptions of clinical teaching and their approaches to clinical teaching.

The fourth part of this chapter brings all of the results together to address the central question of the thesis:

How do clinical teachers experience teaching undergraduate nursing students on clinical placement and how does this relate to their experience of nursing?

The fifth and final part of this chapter presents maps showing the structure of awareness of clinical teachers' experiences of nursing and clinical teaching.

Section 1: Clinical teachers' conceptions of clinical teaching

The first section addresses the 'what' or meaning aspect of clinical teachers' experiences of clinical teaching undergraduate nursing students on clinical placement. Marton and Booth's (1997) model, (presented and described in Chapter 1) is used once again to analyse and describe clinical teachers' conceptions of clinical teaching. The shaded area in Figure 5.1 depicts the part of the study addressed by the presented results. Next, an outcome space is presented (see Table 5.1). This is then followed by the categories of description making up the outcome space that are described in detail. The purpose of this section is to present the results that show the key aspects of variation that exist in the way nurse clinical teachers conceive of clinical teaching.

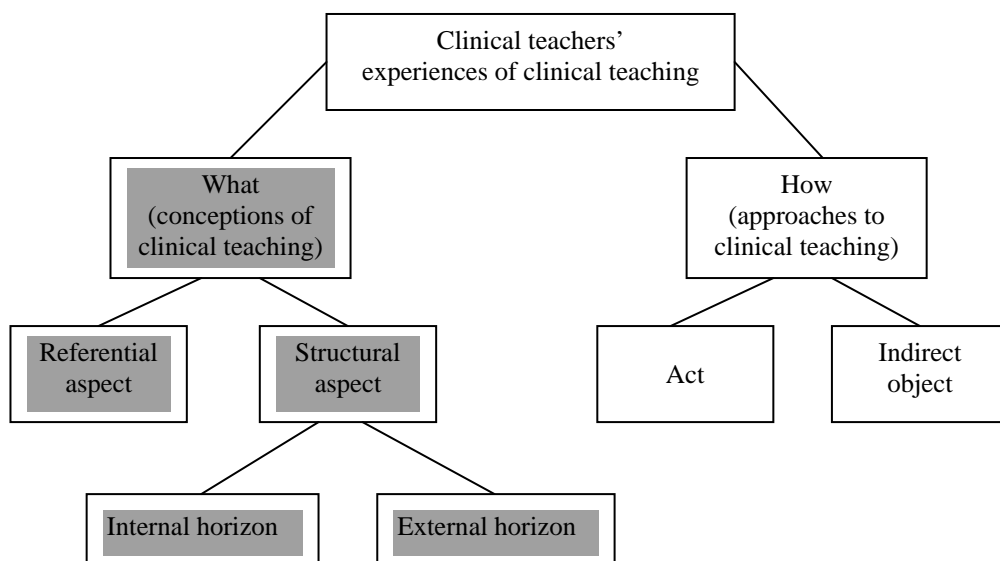


Figure 5.1: Clinical teachers' experiences of clinical teaching, in particular their conceptions of clinical teaching

Outcome space: Variation in clinical teachers' conceptions of clinical teaching in nursing

Four categories have been identified that describe nurse clinical teachers' conceptions of clinical teaching. The first category shows that clinical teachers conceive of clinical teaching as being about managing nursing students' clinical placement. The second category shows that clinical teaching is conceived of as being about not only managing the clinical placement but also making the links for students between theory and practice. The third category shows that clinical teaching is about helping students in their clinical placement to link theory and practice for understanding. Finally, in the fourth category, clinical teaching is

conceived of as being about helping students to develop and change their conceptions of nursing.

Table 5.1: *Outcome space: Variation in clinical teachers' conceptions of clinical teaching in nursing*

| Category | Referential aspects | Structural aspects | |
|----------|--|--|--|
| | Meaning | Internal horizon | External horizon |
| A | Clinical teaching is managing the clinical placement | Managing the clinical placement | Reproduction of facts Developing understanding Conceptual change |
| B | Clinical teaching is going beyond managing the clinical placement and making the links between theory and practice | Reproduction of routine tasks and facts Managing the clinical placement | Developing understanding Conceptual change |
| C | Clinical teaching is going beyond managing the clinical placement and making the links between theory and practice to helping students to link theory and practice for understanding | Developing understanding by linking theory and practice Reproduction of routine tasks and facts Managing students' clinical placement | Conceptual change |
| D | Clinical teaching is about going beyond managing the clinical placement and making the links between theory and practice and helping students to link theory and practice for understanding to helping students to change their conceptions of nursing | Helping students to change their conceptions of nursing Developing understanding by linking theory and practice Reproduction of routine tasks and facts Managing students' clinical placement | |

Category A: Clinical teaching is managing the clinical placement

Referential aspect

In the first category of description, clinical teaching is experienced as the management of nursing students' clinical placements. There is variation in the way clinical teaching is experienced in this category. One way of experiencing clinical teaching is to liaise with ward staff, arrange supervision and assess students doing procedures. Participant 16 explains his conception of clinical teaching and his various roles. He argues:

“Clinical supervisor is more appropriate. Sure there’s the opportunity there for formal teaching but I think the vital thing about the placements and about us being there is to try and ensure that the students get as much clinical practice as they can and because the expectation is that they are all buddied individually with an RN, they’re the guys that they are basically working with and to a large extent learning off as well ...and basically my role, the way I see it as a clinical teacher or supervisor, is to ensure that they are sufficiently buddied...I think it’s a vital opportunity for me to assess my students, I mean I hope that their buddies would be assessing them on an ongoing basis anyway, but because they might only see their buddy for one day during the placement, it doesn’t allow for much continuity that’s why it’s very important for me to eyeball them doing certain procedures...I think a vital part of my role is effective liaison, negotiation and diplomacy with all the staff and the NUMs (Nurse Unit Managers) etc. By having good ward staff who are keen teachers, and by having a good rapport with them I can achieve a lot, because if you’ve got good staff you can lean on them which you need to do if you really want to get a good outcome for your students.”

The preceding statement indicates that responsibility for student teaching rests primarily with the “buddy” nurse. The clinical teacher focuses on arranging staff to buddy up with students and liaising with staff to ensure that students are looked after. The issue of assessment of students is poorly differentiated. In the preceding statement, assessment appears to be shared by the buddy nurse and the clinical teacher. The clinical teacher and student relate through what the clinical teacher arranges for the student to see as well as through assessment. Arranging appropriate learning opportunities for students is another feature of this category.

Observation of nurses at work is one example of a learning opportunity. Exposure to the clinical environment and observation of nurses going about their work helps nursing students develop a more realistic idea of the nurse's role. For example, Participant 10 understands clinical teaching to be about:

“...giving them as much opportunity to learn as is possible... it’s really letting them experience what is a hospital environment. Some of them have never been in (a hospital). For this first placement let them see what the nurse’s role is. A lot of them watch All Saints and ER and have a very warped perspective

on it ...So let's watch what you actually do and give them opportunities to learn what they're able to. Watch this person and see how you actually roll the person over. Watch how they set up an IV, and how they take blood."

Structural aspect

The internal horizon of this category consists of managing the clinical placement by arranging learning opportunities and supervision of students that occurs by liaising with hospital nursing staff. Supervision of students might be provided by hospital staff or the clinical teacher. The awareness of the clinical teacher is on managing the placement rather than on the student's learning. There is no recognition that there is any more to the clinical placement than learning about the role of the nurse and the associated skills. There is no consideration of student conceptions of nursing, the learning experience or clinical placement in this category. Links between theory and practice or the relationships between them are not part of the conception. The absence of the student in the internal horizon of the clinical teacher delimits clinical teaching to management of the clinical placement.

Summary of category

The student is not part of the clinical teacher's conception beyond management of the clinical placement. The clinical teacher and the student are not in a teaching-learning relationship: instead the hospital nursing staff who work directly with the student are mainly responsible for teaching the student. The focus of this category is on the context with students being in the clinical placement to learn about the realities of the role of the nurse and to perform nursing tasks.

Category B: Clinical teaching is going beyond managing the clinical placement and making the links between theory and practice

Referential aspect

In the second category of description, clinical teaching is experienced as going beyond managing the clinical placement and making the links for students between theory and practice. There is variation in the way clinical teaching is experienced in this category. There is recognition of a link between theory and practice: that is, nurses need to have a theoretical rationale for everything they do to patients. Participant 13 understands that clinical teaching is:

"to help the students ...supervise and advise the students... introducing the students to proper nursing management and nursing techniques, but at the same time...reinforcing that, if you don't have a logical explanation for what you are doing, why are you doing it? I'm very much for evidence-based practice, because I find that a lot of nurses will do things blindly."

In this category the need for the student to have knowledge and to be able to safely perform nursing skills is recognised and the best person to provide the knowledge and the skills is the

clinical teacher. In this category the clinical teacher becomes part of the conception and a range of roles are identified in relation to providing the student with the required knowledge and skill. Participant 20 understands clinical teaching to be about:

“...supervising, a resource person, a counsellor, a mentor, just someone they can follow, and look up to and get knowledge from...Standing back, and not letting them make mistakes that are going to be dangerous but making sure you go through things with them and try not to dive in.”

There is recognition in this category that students bring knowledge to the clinical placement but they lack understanding of what they have been taught at university. Clinical teachers can help these students by showing them how and telling them why things are done. The focus is on the clinical teacher in this category. Participant 3 understands clinical teaching to be about:

“... broadening their horizons from what they are learning in the classroom. Broadening their horizons from what is actually in a book to what reality is, is I find my biggest challenge with the teaching...I feel like they don't have an understanding of what they are being taught in the classroom until they get the practical experience and the knowledge from people who are doing it all the time.”

Structural aspect

The internal horizon of this category consists of, not only the management of the clinical placement, but also making the links between theory and practice. Treatments for patients have a theoretical rationale and must be given to students if patients are to receive safe care.

The clinical teacher and other health professionals provide students with information and advice about technique, and so on. The clinical teacher makes the links for students. Whether or not the link between theory and practice is understood is not a consideration in this category. The absence of the student in the internal horizon of the clinical teacher delimits clinical teaching to managing the clinical placement and making links between theory and practice so that the patient is safe and that the nursing student acquires the knowledge and skills of nursing.

Relationship to previous category

This category is similar to the previous one in that management of the clinical placement is a feature in both categories. The clinical teacher's focus is on self rather than on their students. In Category B, however, there is recognition that there is a link between theory and practice thus differentiating this category from the previous one. The clinical teacher is the source of information for the students and makes the links between theory and practice.

Summary of category

Category B represents conceptions that knowing why particular procedures are conducted for safe patient care is important for nursing students to learn. Also, there is a correct way of seeing the knowledge and the clinical teacher is the source of that knowledge. The clinical teacher is the authority and provides relevant information to students as well as showing them how to perform skills. Students may request, or the clinical teacher may perceive the need for direction, information, advice or emotional support. The focus is on facts and skills and not on the relationship between them. The links between theory and practice belong to the clinical teacher rather than the student and therefore, may mean that these links are not relevant to the student.

Category C: Clinical teaching is going beyond managing the clinical placement and making the links between theory and practice to helping students to link theory and practice for understanding

Referential aspect

In the third category of description, clinical teaching is conceived of as helping students to link theory and practice. In this category there is a shift from being teacher-focused to now being student-focused. There is recognition in this category that there are specific university requirements to be achieved: among them applying theory to practice. The student will learn how to do this whilst caring for a patient. There is a shift in this category from the focus being on the teacher and what they are doing to the clinical teacher focusing on the student. The clinical teacher sees him or herself as helping the student to develop understanding so that the patient receives the required care and the student understands the rationale for patient care. Participant 5 conceives of clinical teaching in the following way:

“...I look at myself as the person that facilitates their ability to put theory into practice... Unless they understand what’s wrong with the patient they can’t provide the necessary care.”

Structural aspect

The internal horizon of this category consists of conceptions that include, not only the management of the clinical placement, but that theory and practice are linked. It is assumed in this category that the student should learn about those links with help from the clinical teacher and subsequently achieve understanding if they are to provide appropriate patient care. The student is therefore part of the clinical teacher’s internal horizon. There is no recognition of the student’s understanding of nursing or that their conceptions might change with clinical experience. Clinical teaching is therefore delimited to helping students to develop understanding.

Relationship to previous category

This category is similar to the previous one in that both categories recognise the need for linking theory to practice. In Category B, the clinical teacher demonstrates nursing skills and provides facts to the student: whereas, in Category C, the clinical teacher recognises the student's ability to make their own links with assistance. Content to be learned is identified in relation to the patient being cared for as well as meeting university requirements. This category is similar to Category A and B in that management of the clinical placement is fundamental. Category C differs from Category A in that the former category identifies the student as an active participant in the learning process, whereas, in the latter, the student is a passive recipient. It is in Category C that the focus changes to being student-focused whereas in the previous two categories the clinical teacher's focus is on themselves.

Summary of category

In this third category of description, clinical teaching is conceived of as helping the student to understand. The content to be learnt and understood is related to the patient and the reason for hospitalisation and the treatment regime. The focus, in this category is now on the student as a learner.

Category D: Clinical teaching is going beyond managing the clinical placement and making the links between theory and practice to helping students to link theory and practice for understanding to helping students to develop and change their conceptions of nursing

Referential aspect

In the fourth category of description, clinical teaching is conceived of as teachers having a student-focus and helping students to develop and change their conceptions of nursing.

Participant 3 comments that in her experience her students were:

"...seeing the patients as achievements of tasks rather than seeing the patients as people wanting to get home. There is so much more happening within the patients than task orientated rituals."

The focus of the teacher in this category is on the students' views rather than on their own personal conceptions. Having identified students' conceptions the clinical teacher works with the student to develop and change their conception of nursing. Little or no variation within this category was identified. Participant 15 explains his conception of clinical teaching as follows:

"It's at two levels, the first level is what the student's perceptions are and understanding, and what their values are, what's their level of knowledge, what's their level of experience what do they think nursing is? Cause I don't really think there's sort of one common view of nursing, this is what nursing is, we've all got our own values so its virtually finding out what the student's understanding of what they think nursing is, what they value within that

...caring system, why are they doing it and why they value it, and then try and hone in on the main areas...whether you're working in ICU looking after an intubated patient or whether you're working in a nursing home, you're still caring for people, it's the people we're caring for, it's not the machines...my role I see as trying to work out what they value with their nursing, and I try not to make a value judgment...I try to find out what they value within nursing, what they'd like to direct themselves in nursing, and just try and obviously feed that interest but also try and direct them in other directions as well, like 'how about we look at this as well?'...role model comes into it as well... how I interact with the students and how I interact with the patients, and how I interact with other staff...they see me doing it."

Structural aspect

The internal horizon of this category consists of helping students to develop and change their conceptions of nursing. This is in addition to previous conceptions that include, not only the management of the clinical placement, but that theory and practice are linked and that understanding of those links are fundamental to providing appropriate patient care. The student is once again part of the clinical teacher's internal horizon, but in this category their conceptions are considered to be important. Helping students to change and develop their conceptions of nursing can only be achieved if existing views are known.

Relationship to previous category

This category is similar to the previous one in that both categories recognise the need for understanding the links between theory and practice if appropriate patient care is to be provided. This category is also similar to Category C in that the student is in the forefront of the clinical teacher's awareness and is seen to be an active participant in the learning process. Category D is similar to previous categories in that management of the student placement and linking theory and practice are important. The difference between this category and previous categories is the nature of the relationship between clinical teaching and nursing and their co-constituted nature.

Summary of category

In this fourth category of description, clinical teaching is conceived of as helping the student to develop and change their conceptions of nursing. The clinical teacher acknowledges the views held by the student and works to achieve change. An internal relationship exists between teaching and nursing. It is recognised that conceptions can change as a consequence of students being actively involved in their learning and the clinical teacher being aware of student views and values. This conception also shares elements of Categories B and C that include a focus on linking theory to practice. The critical difference between Category B and

Category C is that in the latter category the clinical teacher recognises the student's ability to make their own links between theory and practice with assistance from the teacher. A common element in all categories is the conception that clinical teaching includes management of the clinical placement.

Summary of Section 1

The purpose of this first section was to present the results that show the key aspects of variation that exist in the way clinical teachers conceive of clinical teaching. This section addressed the 'what' aspect of the experience of clinical teaching. An outcome space was presented first which was then followed by the categories of description making up the outcome space which were then described in detail. Four categories were identified to describe how clinical teachers conceive of clinical teaching. The first category (Category A) shows that clinical teaching is conceived to be about managing the placement so that the students learn about the realities of the role of the nurse and to perform nursing tasks. The second category (Category B) shows that clinical teaching is conceived of as being about linking theory and practice. The clinical teacher is the source of information for the students and makes the links between theory and practice. Category C, the third category of description, shows that clinical teaching is conceived of as being more than linking theory and practice: instead helping the student to understand those links is the critical difference.

The focus, in this category is now on the student as a learner. In the last category of description, Category D, clinical teaching is conceived to be more than helping the student to link theory and practice. Clinical teaching in this category is conceived of as helping the student to develop and change their conceptions of nursing: the focus is also on the student as a learner.

Section 2: Clinical teachers' approaches to clinical teaching

The purpose of this second section is to present the results that show the key aspects of variation that exist in the way clinical teachers approach clinical teaching. This section addresses the 'how' aspect of the experience of clinical teaching. The 'how' aspect or approach to clinical teaching includes the act, which refers to the quality of the approach and the individual object, which refers to the clinical teachers' intentions. Once again Marton and Booth's (1997) model (presented and described in Chapter 1) is used to analyse and describe clinical teachers' approaches to nursing in this thesis where clinical nurse teachers' experiences of nursing and teaching were investigated. The model is presented in Figure 5.2 with the shaded area of the figure depicting the part of the study addressed by the presented results. Next, an outcome space is presented. This is then followed by the categories of description making up the outcome space that are described in detail.

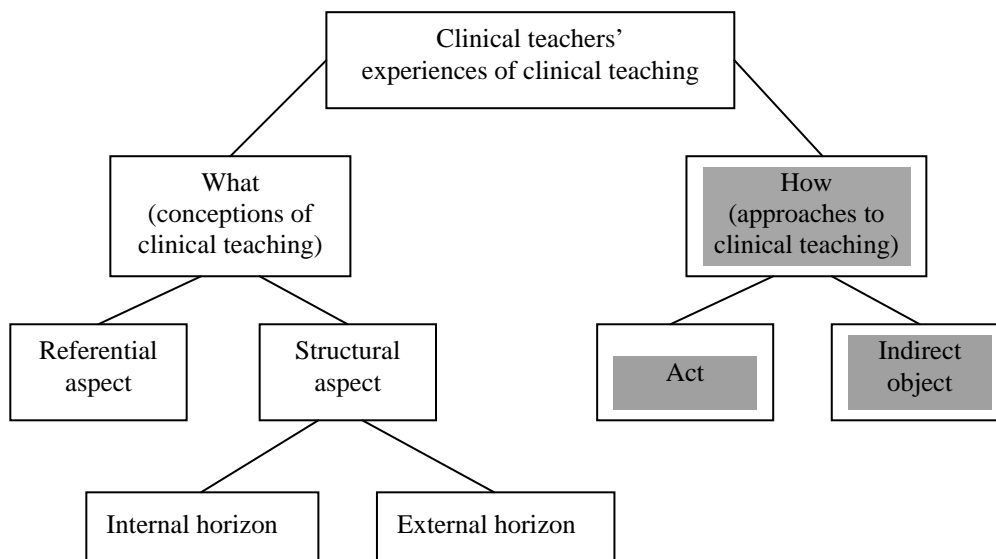


Figure 5.2: *Clinical teachers' experiences of clinical teaching, in particular their approaches to clinical teaching*

Outcome space: Variation in clinical teachers' approaches to clinical teaching in nursing

The outcome space, *Variation in clinical teacher approaches to clinical teaching in nursing* consists of four categories of description which are presented in Table 5.2. The four categories describe how clinical teachers go about clinical teaching in nursing. The first category shows that the clinical teacher's focus is on the clinical teacher rather than the student, with strategies aimed at reproduction of routine tasks. The second category shows that the focus is still on the clinical teacher with strategies aimed at reproduction of routine tasks and facts. In the third category the focus is on the student with the clinical teacher using student-focused strategies aimed at developing understanding. The final category describes the focus as being on the student with strategies aimed at the student achieving conceptual change about nursing.

Table 5.2: *Outcome space: Variation in clinical teachers' approaches to clinical teaching in nursing*

| Category | Approaches to clinical teaching | |
|----------|---|-----------------|
| | Act | Indirect object |
| A | Using teacher-focused strategies, with little interaction between teacher and student, aimed at | Reproduction |

| | | |
|----------|---|-------------------|
| | reproduction of routine tasks | |
| B | Using teacher-focused strategies, with interaction between teacher and student, aimed at reproduction of facts and routine tasks | Reproduction |
| C | Using student-focused strategies, with interaction between teacher and student, aimed at linking theory and practice for understanding | Understanding |
| D | Using student-focused strategies, with interaction between teacher and student, aimed at helping to develop and change their conceptions of nursing | Conceptual change |

Category A: Clinical teaching is experienced as using teacher-focused strategies with little interaction between teacher and student, aimed at reproduction of routine tasks

In this first category of description, the approach to teaching nursing is experienced as clinical teachers using teacher-focused strategies aimed at reproduction of the nursing routine and associated nursing tasks. There is little interaction between the student and the clinical teacher.

Act of clinical teaching

The act of clinical teaching in nursing associated with this first category of description is the use of teacher-focused strategies aimed at students reproducing the nursing routine and tasks associated with patient care. These strategies were variously experienced. Quotations from some of the clinical teachers follow and are indicative of the strategies used in relation to students learning about the role of the nurse and routine nursing skills.

Teacher-focused strategies that make up this category of description include informing students of teacher expectations. Participant 18 tells her students on the first day of the clinical placement:

“... ‘this is how you’ll be marked, this is what I’ll be writing and this is what I expect ...’. I expect them to become competent in basic skills ... Documentation is done properly.”

Liaison and negotiation with ward staff is another strategy used by the clinical teacher as they arrange supervision and appropriate learning opportunities. Participant 16 states:

“I like to make sure that I meet with all the NUMs [Nurse Unit Managers] on all the wards that I’ve got students before I go on, just to outline what level they are on, and what they’re there to achieve...”

Communicating expectations to ward nursing staff working with the students is necessary. Participant 16 provided staff with a list of tasks that students could practice. He stated that he put a:

“... skills list around the ward to let them know what they were mostly there to practice... basic care as in vital signs, patient’s hygiene needs, the real basics like bed making etc...”

Demonstration of nursing tasks is another teacher-focused strategy that comprises this category of description. Participant 20 states that she:

“...show(s) them the way, hopefully the way things should be done, without taking any shortcuts. Working to a certain standard.”

Performing nursing skills in the correct manner is another feature of this category.

Participant 20 explains that there is a:

“...need to follow the venue’s policies and procedures, which is not always the way they were taught at school. And is not always the way the clinical educator or the nurses with them were taught either, so it’s really important to get them to adhere to the place where they are at ...”

Assessment of students is also part of this category of description. Participant 16 states that he:

“...assess(es) their aseptic technique, their wound care and their ability to be able to fulfill the drugs policy. I give them simple medications that they know. Obviously I want to make sure that they’re doing observations...”

Indirect object

The indirect object of teaching in this category is that of reproduction. For example, providing feedback to students on their ability to perform tasks correctly is commented on by

Participant 9. She states that feedback is important:

“...for their confidence. They need to know they’re doing it the right way that ...they are trying to please. There is this element in all of us, that just wants to please. They also want to know they are going to pass.”

The variation that occurs in this category is in relation to the goals of clinical teachers, universities and clinical staff. A typical clinical teacher goal is provided by Participant 20.

She states that she aims to:

“...produce safe and competent nurses.”

The goals of universities in this category are perceived by clinical teachers to be either skill-based or unknown altogether. The following quotation is from Participant 3 who states:

‘The students come in, ... with their booklets of the practical tasks that they have to achieve and the students aim more at me having to tick those off in their books than actually doing the stuff on the ward... they are more focused on what else is happening than getting into the practicalities of being in the one place at the one time and getting to know their patients. Because they are only on the units for such a short time, two weeks, they are more focused on... ‘I’ve taken a blood pressure’, ‘I’ve taken a temperature’ and they are so more

focused on the tick sheet than their patient care that they lose their focus. At the end of the day they go ... ' I haven't checked off this, I've got to achieve this tomorrow.'

Participant 18 also described tasks as being the objective of the university. She states that students were expected to learn:

"ANCI competencies...management of basic care was basically all they wanted them to learn...basic skills...shaving, showering, things like that".

Participant 16 on the other hand provides an example of a clinical teacher not knowing what the university wanted the students to learn while on the placement.

"Oh, good question. Well, I would hope very much the same, but because my contact with the university is often so limited and so sporadic ...so that's a hard one."

There was also variation in the goals of the hospital nurses allocated to work with the students, according to the clinical teachers. Some nurses did not appear to have any goals for the students allocated to them, others thought they were there to help with workload, others would only let students observe. Participant 16 responded that he thought the ward nurses wanted the students

"...to practice their basic skills..."

Additionally, other ward nurses were perceived not to be interested in the students.

Participant 1 commented:

"Sometimes the staff said that they were just too busy to allocate students to patients,(saying) ' its better if we just take care of them.' So I had to move a student to another ward because she wasn't getting any exposure, like she wasn't getting the opportunity to take on a patient."

Summary of category

The focus in this category is on correct performance of nursing routine and associated tasks. The teacher focuses on what needs to be learnt and does not attend to the prior knowledge and ability of the student. There is no recognition of scientific rationale underpinning nursing practice. The clinical teacher, student and what is to be learnt on the placement are not in relationship but are isolated from each other. Teaching is seen from the clinical teacher's perspective with a focus on reproduction of role and associated tasks so that patients are safe and students pass their assessment. The goals of the clinical teacher, the universities and ward staff are not in alignment.

Category B: Clinical teaching is experienced as using teacher -focused strategies, with interaction between teacher and student, aimed at reproduction of facts and routine tasks

Act of clinical teaching

In this second category of description, the approach to clinical teaching in nursing is experienced as using teacher-focused strategies aimed at reproduction of facts as well as routine tasks. There is a link between theory and practice in this category. For example, theory is represented by clinical teachers wanting students to know certain facts about patient treatments. Practice is represented by students being able to safely perform nursing tasks that are part of the patient's treatment regime. Participant 7 found it necessary to show students how to use equipment, how to perform certain nursing skills as well as to provide information about the underlying principles. She explains that she showed her students:

"...how to prime a line, how to set up for a post-op patient, how to do an IM injection, ... I spoke to them a little bit about, as a group, about some of the big principles. We got from the uni, their module book which went through the steps they were meant to do. Which was good because you actually knew what they'd been told and the language that they'd been told it in. To know what to look for. ..."

Questions are a strategy used by some clinical teachers to determine a student's knowledge.

Participant 2 states that she:

"ask(s) questions about what they are doing. I might ask them at any time where the fire exits are or what the codes are, trick questions, but also "why did you give that drug" or "what would you be looking for in that drug". So I'm not just seeing them display the five R's I'm also linking it back to theory..."

Participant 13 provided her students with information once she discovered there were gaps in their knowledge. She states that she:

"... gauge(s) their knowledge just so I know where I need to fill in a blank spot..."

Participant 9 believes that students should rote learn material in order to remember it. She states:

"I'm big, big on knowledge base. I try in that two weeks to instill as much knowledge into them as I can stuff in, that they don't learn at the uni...I trained in the hospital. We saw things over and over again and one of the basic premises of teaching is repetition. There are certain things you just have to rote learn...They've got so much to learn in such a short space of time that they really, in order to get their drugs, they just have to do it time and time and time again until it sinks in."

Referring students to textbooks was identified as another strategy used by one clinical teacher. Participant 12 states that:

“... if they don't know that question, I'm not necessarily going to give them the answer. I want them to go home and read about it...”

Indirect object

The indirect object of teaching in this category is that of reproduction of tasks and facts. There is variation in this category. The variation that occurs is in relation to the goals of clinical teachers, universities and clinical staff. Participant 11 provides a typical clinical teacher goal. Her goal is that her students can apply theory to practice. She states that she wants her students to:

“... practice safely, on a clinical level, task wise, I wanted them to be able to complete the task, such as vital signs, whatever it was, and to do that safely, but to also have a rationale behind it, why are they doing it?”

A single clinical teacher quotation in relation to university goals comes from Participant 8, who states that her students were expected to:

“...apply theory into practice... to be able to manage one patient total care by the end of the week. Hopefully, two by the end of the placement...”

Yet, her perception of the staff goals from the hospital where she was teaching was as follows. She thought they wanted her students to:

“...be able to relate to the area they are working in, to the staff and to be able to familiarise themselves to the equipment and be able to do some procedures in a helpful way. Never independent.”

Relationship with previous category

This category is similar to the previous one in that in both categories the focus of the clinical teacher is on the teacher as opposed to the student. Category B differs from category A in that, in this category students are expected to be able to reproduce facts and tasks whereas in Category A they were only expected to be able to safely perform nursing tasks. Another difference between these two categories is that in Category A there is little interaction between the student and clinical teacher, whereas in Category B there is more communication. Category B further differs from Category A in that in this category there is recognition of a link between theory and practice.

Summary of category

The focus in this second category is on reproduction of facts and tasks. There is recognition of theoretical underpinnings of nursing practice. The clinical teacher focuses on self as a transmitter of information as opposed to focusing on the student and their current knowledge. The clinical teacher and student are in relationship with each other: however, it is the clinical teacher who identifies the content that is to be remembered by the student. The

assumption is that by the teacher giving information the student gains knowledge. The clinical teacher is the authority and the student is the passive recipient of the teacher's knowledge.

Category C: Clinical teaching is experienced as using student-focused strategies with interaction between teacher and student, aimed at linking theory and practice for understanding

Act of clinical teaching

In this third category of description, the approach to teaching nursing is experienced as using student-focused strategies aimed at students achieving understanding. Understanding the links between theory and practice is vital to providing appropriate patient care. What follows are some of the strategies that are perceived to help the students to construct their understanding of the nursing care required for patients for whom they are providing care.

Participant 5 helps to set the scene for the student. This involves students identifying learning objectives:

“... they do write their own objectives at the beginning of the placement and I get them to write more as they go along that are specific to the ward.”

According to Participant 5, the writing of objectives is done because:

“...I talk about it with them and (I) say ‘these are the strategies we are going to use to help you achieve these objectives.’ It’s getting them to identify their needs with me, coming to agreement about the strategies we are going to use for them to meet those objectives...”

In addition to identifying learning objectives Participant 14's students are expected to continually revise them because:

“They’ve got to take responsibility for their own learning. So when they set their objectives, they have to revise them or reset them according to what’s available...”

Variation of rationale and approaches for managing the student's clinical experience also form part of this category. For example, Participant 5 asks her students to care for one patient only in the early stages of the placement because:

“... any more than one is a bit overwhelming. Each one learns at their own pace and it takes them a day or two to know where to be able to look for information, how to deal with things, how to find things out. It gives them a bit more time to talk to the patient, to find out about the patient...”

Participant 17 also arranges for her student to care for small numbers of patients because:

“I think that they start running wild with lots of pieces of information, and it just becomes too difficult for them to collate into a sensible logical format that they’re going to be able to remember and understand and then apply to their next setting. It’s too broad because you just cannot take in that amount of information... sometimes the student will take one piece of that information and think they’re quite competent because, “oh that’s a good bit of (information), I know how to do that, I know how to put the oxygen on, I know how to do this and that. But once again, if you don’t start asking “why am I doing it” and “who is this resident, how old are they, why am I applying it, who ordered it, what standards am I operating under here? what’s normal, what’s not normal...””

The student is expected to orientate themselves to the patient they will be caring for by reviewing patient notes, charts, care plan, results and reports. In addition to this, students are also assisted to identify relevant learning resources such as procedure manuals, text books, dictionary, as well as on-line learning resources. Participant 5 states this is important so the student:

“...can fully understand what’s going on with the patient.”

By checking out the student’s understanding of the patient:

“...I can help them if not. I say ‘I think maybe this isn’t so’ (tell them) why and we go and get the history and we go through it and I help them correct anything they misunderstood.” (Participant 5)

Another strategy to assist students to develop understanding is provided by Participant 11, who states that she asks her students to:

“...seek out the literature ...I say to them, ‘look, there’s a very good library down here... do you want to go and find a journal article relating to this topic?’ ...the neuro ward, they didn’t know much about neurological things, so I sent them down, gave them time out, to go and research stroke...and then they came back and did a presentation to the group. So therefore they’ve got rationale behind why that patient is acting that way.”

Indirect object

The indirect object of teaching in this category changes from reproduction of tasks and facts to that of understanding of the nursing care required for patients. In this category there is cohesion between the goals of the clinical teacher, the university and the ward nurses.

Participant 5 states that her goals for students include that they:

“... fulfill the objectives they set out with at the beginning of their placement which hopefully coincides with what they did at the university. By the end of those two weeks my objective is to get them to be able to look after two patients providing total care, understanding the diagnosis...link it to the pathophysiology...I want them to be able to understand the signs and

symptoms and why that patient was having them and link it to the diagnosis. I like them to link the medications to the signs and symptoms and the diagnoses. I like them to be able to take care of two patients and at the same time develop an understanding of the diseases, the pathophysiology and the medications.”

Participant 17 stated that the university for whom she was teaching expected that the students would understand:

“... what was this resident’s particular health needs and problems at the time, and what we were doing for them, and how to access the care plan.... they also expected them to have an understanding of one of the main disease processes, that was going on, and how that impacted on their care plan.”

Helping ward nurses to develop goals for students under their care was identified as coming about through the building of collegial relationships. Participant 5 raised the importance of the relationship between the clinical teacher, ward nurses and the students. She states:

“There has to be a good rapport between the clinical teacher and the hospital staff for the students to achieve their objectives. If there is any kind of conflict the students tend to suffer and I’ve watched this happen...If there’s anything happening on the ward that is very rare, they will always page me and say ‘do you want your students to watch?’ The stomal therapist rings me up and says ‘I’ve got a very good example of such and such on the ward, would you like your students to have a look?’”

Relationship with previous category

This category differs from both Categories A and B in that, this category shows the student to be the focus of teaching and learning. The focus is on what the student is doing rather than on what the teacher does. Category C is similar to Category B in that both recognise the link between theory and practice. In Category C, however, it is acknowledged that the student should understand the links and construct understanding with assistance from the teacher as necessary. Cohesion between the goals of the clinical teacher, the student, the ward nurses and the university is another important feature of Category C. In previous categories there is a distinct lack of cohesion between the goals of the clinical teacher, student, university and ward nurses.

Summary of category

The focus in this category is on students achieving understanding of the theory underpinning the specific care of their allocated patient(s). The focus in this category is on the student rather than the clinical teacher. Students’ acceptance of responsibility for their own learning is emphasised with the expectation they will identify and refine their individual learning objectives. This information also assists the clinical teacher to identify appropriate learning opportunities for the student. In addition, the clinical teacher assists student learning by helping them to identify available learning resources and ways of orientating themselves to

all of the relevant patient information prior to caring for them. By focusing the student's learning on a small number of patients, the student has an opportunity to develop a cohesive understanding of each patient and their needs. Group presentations are also seen to be another important strategy for assisting students to achieve understanding of the patient. The student is therefore, an active participant in the development of understanding. The alignment of goals between the clinical teacher, student, ward nurses and university are also seen to help the student to achieve understanding.

Category D: Clinical teaching is experienced as using student-focused strategies with interaction between teacher and student, aimed at helping to develop and change their conceptions of nursing

Act of clinical teaching

In the fourth category of description, the approach to teaching nursing is experienced as using student-focused strategies. Participant 15 states that it is important that students:

"...experience it themselves, because I can tell them my experience but it means nothing to them. But once they experience it... get them to experience as much as possible, which is ideally what the university would like them to do...I also say, 'look at a person and how do they look to you?' rather than just using the equipment...trying to give them that encouragement, that experience of the reality of what nursing is. It's not just looking after an illness or taking a blood pressure or analysing what their symptoms are, it's also talking to a person and seeing what they're about."

By getting to know the patient as a person the student has the opportunity to learn how the illness is experienced by that person.

Students being involved in ward rounds and asking questions of the health care team are strategies that help with the development and change of conceptual understanding of nursing.

Participant 11 tells her students:

"... 'You're in a learning environment so just ask'(they need to) see themselves as a professional and that they are on equal par with the medical (staff), they're building a team, they're collating their information...That their feedback is worthy. They often think 'I'm just a nurse, whatever I say doesn't really matter.' So I try and really get that thought out of their minds, and they really are a part of that patient's care and what they have to say is important..."

Seeing the clinical environment as a place of learning and participating in ward activities, the student has the opportunity to learn that nurses are part of the health care team and that their various contributions are as valuable as any other team member.

Appropriate allocation of patients to students is another strategy that assists students to develop an understanding of their professional responsibilities. Participant 15 deals with allocation of patients in a particular way. He states:

“I always try and get the students two patients to look after so that’s their sole responsibility...it’s not just their role to do the blood pressures and the showering, and the wiping of the bottom and things like that, it’s more than just that....Those two people are their responsibility and if there’s anything that those patients need that are outside their level of skill, then they have to ask someone else to do it for them or to help them do it. So it initiates them to, I suppose, approach other people and plan their work, they can’t just follow someone and do something when they’re asked to do it, they have to initiate it... it makes them think about what’s important, or what does this person need? And usually we’ll go through the history and discuss what the main issues are and the potential health problems...”

For Participant 15, this approach is important because the students:

“... have that need, and sometimes it may be an interest, sometimes a skill that they haven’t really harnessed, so it’s something they want to learn. It’s something they had in class but they didn’t really understand it so they want to go over it again. In a classroom it doesn’t make much sense, but when you can see it in actual real life. When you can look at someone’s feet and see the poor circulation, or you know what a ...patient’s chest sounds like, or how they breathe, and things like that, so you get the idea, and so, whatever their interests are I try and pick up on, and I follow through.”

Giving responsibility for patient care through appropriate allocation provides the student with opportunities to learn about nursing, its role in patient care and its relationship with other health care team members. By taking care of patients whilst on clinical placement students have the opportunity to learn that nurses are accountable and responsible for more than performing tasks. Involvement in patient care will allow students to see that nurses assess their patients, identify patient problems, plan and implement patient-centred care in collaboration with other team members. Apart from learning more about the nursing role within the health care team, providing nursing care for specific patients also provides students with the opportunity to further develop specific knowledge and skills.

The use of a regular group debriefing is another strategy that some teachers believe helps students change their conceptions of nursing. Participant 12 states:

“...I get them to talk about the positives and the negatives of their day, what they identify. And usually within the negatives, oh sometimes even the positives as well, the other students will see a different perspective.”

Opportunities for discussion provide students with the opportunity to identify patient care issues as well as issues in relation to nurses and their role within the health care team. As a consequence different conceptions of nursing may develop.

Indirect object

The indirect object of clinical teaching in this category is that of conceptual development and change. There is cohesion between the goals of the clinical teacher, the goals of the university and the goals of the ward nurses. The intention of the clinical teachers appears to be aimed at trying to develop and change students' conceptions of nursing. Participant 15 states that the goals for his students were as follows:

“to start a different way of thinking, and start a new journey...dealing with people and their illness, and helping them...”

Participant 17 understands that the university she works for wants students to have a:

“...stable, sound first experience with nursing, but one that didn't send them into a tail spin, that they just did not know if they were Arthur or Martha, but one that they ... could know their resident each day, they would become familiar with the same residents for at least a week, before they had a change, and that occurred. That they would be able to, at the end of their placement, be able to, whoever asked them what was this resident's particular health needs and problems at the time, and what we were doing for them, and how to access the care plan, and if it wasn't up to date, how they would implement a change with that.”

Participant 3 is employed as a registered nurse in the hospital where she also teaches students. Her teaching experiences are intermittent. She provides an example of a hospital that supports students in their quest for developing and changing their conceptions of nursing. She states:

‘They give me time off and they are very supportive. All staff members are supportive of students. It's like scratch my back I'll scratch yours. We then get the physio students who want to come in and see what happens on the ward. The physios have let my students go round there and help out with a physio session then they'll come around to the ward and the same with the dieticians and the speech pathologists. It's a small little hospital and that helps. I find the whole staff from Nursing Admin. all the way down are very supportive. Especially other nursing staff are very, very supportive of students and that's one thing 99% of students say 'the nursing staff are just so good.' They just get these students in there doing things, give them confidence to do things, it's a big thing. They don't just say 'you're only a student and stand back and watch.' I tell my students 'you have to get in, you have to ask to participate.’ “

It is perceived that clinical teachers' intentions to assist students to think differently about nursing and patient care are made possible when goals between universities, hospital staff

and clinical teachers are cohesive, and students are actively supported by hospital staff and appropriate learning opportunities are provided.

Relationship with previous category

This category is similar to Category C in that both categories show the student to be the focus of teaching and learning. The focus here is also on what the student is doing rather than on what the teacher does. Category D is similar to Category C in that understanding what is going on for the patient is important and that the student is the one to construct their knowledge by working out the links for themselves with assistance from the clinical teacher as necessary. Just as in Category C, cohesion between the goals of the clinical teacher, the student, the ward nurses and the university is important. In Category D, however, it is recognised that the student needs opportunities to develop and change their conceptions of nursing and this is achieved by selection of specific strategies in line with a cohesive set of goals aimed at conceptual change.

Summary of category

The focus in this category is once again on the student rather than the clinical teacher. The student and the clinical teacher are engaged in certain activities that are seen to assist in developing and changing their conceptions of nursing. Participating in total patient care, learning how to assess patients and getting to know patients as people is seen to assist in this development. Taking responsibility for patient care is identified as one strategy that assists the student to develop their conceptions of nursing. Being involved with the health care team through participation in ward rounds, asking questions and contributing patient information further assists the student to develop their conceptions of nursing as well as their clinical knowledge. Analysis of learning activities in group debriefing sessions also assists the process of students developing and changing their conceptions of nursing and developing their knowledge. The clinical teacher, student, ward nurses and university are in relationship with each other through the strategic alignment of goals. As a consequence, it is assumed that the student will reconstruct their conceptions to override existing understanding and produce a new world view.

Summary of Section 2

The purpose of this second section was to present the results that show the key aspects of variation that exists in the way clinical teachers approach clinical teaching. This section addressed the 'how' aspect of the experience of clinical teaching. An outcome space was presented first which was then followed by the categories of description making up the outcome space that were then described in detail. Four categories have been identified to describe how clinical teachers go about clinical teaching. The first category showed that the clinical teacher's focus is on the clinical teacher rather than the student, with strategies aimed

at reproduction of routine tasks. The second category showed that the focus is still on the clinical teacher with strategies aimed at reproduction of routine tasks and facts. In the third category the focus is on the student with the clinical teacher using student-focused strategies aimed at developing understanding. The final category described the focus as being on the student with strategies aimed at the student developing and changing their conceptions of nursing.

Section 3: Relationship between clinical teachers' conceptions of clinical teaching and approaches to clinical teaching

This section presents the results of an investigation to see if a relationship exists between clinical teachers' conceptions of clinical teaching (what) and their approaches to teaching (how). Two outcome spaces were identified each containing four categories of description. The relationship between the categories of description for the outcome space, *Variation in clinical teachers' conceptions of clinical teaching in nursing*, and a second outcome space, *Variation in clinical teacher approaches to clinical teaching in nursing* was investigated by analysing the distributions of the transcript classifications in terms of the categories and the empirical and logical relationships between the two sets of categories. This process is detailed in Chapter 3. The results of the statistical investigation of the relationship between clinical teacher conceptions and approaches to clinical teaching are presented in Table 5.3.

Categories A and B, in both outcome spaces, represent conceptions and approaches to clinical teaching which are teacher-focused. In comparison, Categories C and D in both of these outcome spaces represent conceptions and approaches to clinical teaching which are student-focused. The results of the statistical investigation of the relationship between clinical teachers' conceptions of clinical teaching and their approaches to clinical teaching are presented in Table 5.3. A statistically significant association was found between clinical teachers' conceptions of clinical teaching and approaches to clinical teaching (Kendall's tau-b = 0.89, $p < 0.001$). It would appear that for a clinical teacher to take a student-focused approach to clinical teaching a complex conception of clinical teaching may be required.

Table 5.3: *Empirical relationship between clinical teachers' conceptions of clinical teaching and approaches to clinical teaching*

| Approaches to clinical teaching | Conceptions of clinical teaching | | | | Total |
|---------------------------------|----------------------------------|----|---|---|-------|
| | A | B | C | D | |
| A | 3 | 3 | | | 6 |
| B | | 7 | | | 7 |
| C | | | 4 | | 4 |
| D | | | | 3 | 3 |
| Total | 3 | 10 | 4 | 3 | 20 |

Kendalls tau-b =0.89, p=<0.001

Summary of Section 3

The third section of this chapter identifies that a relationship exists between clinical teachers' conceptions and approaches to clinical teaching. Results of the statistical analysis show that clinical teachers who adopted a student-centred approach to clinical teaching conceive of clinical teaching in ways that are student-focused. Clinical teachers who approached clinical teaching from a teacher-focused perspective conceived of clinical teaching in teacher-focused ways. It would appear that a student-focused conception of clinical teaching is required for a clinical teacher to take a student-focused approach to teaching.

Section 4: Relationship between clinical teachers' conceptions of nursing and approaches to clinical teaching in nursing

This final section presents the results which answer the central question of this thesis, How do clinical nurse teachers experience teaching undergraduate nursing students on clinical placements and how does this relate to their experiences of nursing? This section will be presented in two parts.

Part 1:

This first part summarises the relationships between clinical teacher conceptions and approaches to nursing and their conceptions and approaches to clinical teaching.

- i. The relations between all four outcome spaces:

Variation in clinical teachers' conceptions of nursing

Variation in clinical teachers' approaches to nursing

Variation in clinical teachers' conceptions of clinical teaching in nursing

Variation in clinical teachers' approaches to clinical teaching in nursing

are investigated by analysing the distributions of the transcript classifications in terms of the outcome spaces and the empirical and logical relationships between the outcome spaces. The results of the statistical investigation of the relationship between conceptions and approaches to nursing and conceptions and approaches to clinical teaching are presented in Table 5.4.

Part 2:

In this part the relations between a number of categories of description in the four outcome spaces are examined in more detail. There are four components to this second part and are presented as follows.

- i. The relationship between the categories of description for outcome spaces
*Variation in clinical teachers' **conceptions of nursing**: and*
*Variation in clinical teachers' **conceptions of clinical teaching in nursing***

is investigated by analysing the distributions of the transcript classifications in terms of the categories and the empirical and logical relationships between the two sets of categories. The results of the statistical investigation of the relationship between conceptions of nursing and conceptions of clinical teaching are presented in Table 5.5. Some dissonance between clinical teachers' conceptions of nursing and conceptions of clinical teaching is identified and presented in Table 5.6.

ii. The relationship between the categories of description for outcome spaces

Variation in clinical teachers' approaches to nursing: and
Variation in clinical teachers' conceptions of clinical teaching in nursing

is investigated by analysing the distributions of the transcript classifications in terms of the categories and the empirical and logical relationships between the two sets of categories. The results of the statistical investigation of the relationship between approaches to nursing and conceptions of clinical teaching in nursing are presented in Table 5.7. Some dissonance between clinical teachers' approaches to nursing and conceptions of clinical teaching is identified and presented in Table 5.8.

iii. The relationship between the categories of description for outcome spaces

Variation in clinical teachers' approaches to nursing: and
Variation in clinical teachers' approaches to clinical teaching in nursing

is investigated by analysing the distributions of the transcript classifications in terms of the categories and the empirical and logical relationships between the two sets of categories. The results of the statistical investigation of the relationship between approaches to nursing and approaches to clinical teaching in nursing are presented in Table 5.9. Some dissonance between clinical teachers' approaches to nursing and approaches to clinical teaching is identified and presented in Table 5.10.

iv. The relationship between the categories of description for outcome spaces

Variation in clinical teachers' conceptions of nursing: and
Variation in clinical teachers' approaches to clinical teaching in nursing

is investigated by analysing the distributions of the transcript classifications in terms of the categories and the empirical and logical relationships between the two sets of categories. The results of the statistical investigation of the relationship between conceptions of nursing and approaches to clinical teaching in nursing are presented in Table 5.11. Some dissonance between clinical teachers' conceptions of nursing and approaches to clinical teaching is identified and presented in Table 5.12.

Part 1:

Relationships between clinical teachers' conceptions and approaches to nursing and conceptions and approaches to clinical teaching

The results of the statistical investigation of the relationship between clinical teachers' conceptions of nursing, conceptions of clinical teaching, approaches to nursing, and approaches to clinical teaching are presented in Table 5.4.

Table 5.4: *Empirical correlations between clinical teachers' conceptions and approaches to nursing and conceptions and approaches to clinical teaching*

| | Nursing conception (what) | Nursing approach (how) |
|-------------------------------------|---------------------------|------------------------|
| Clinical teaching conception (what) | 0.60 | 0.68 |
| Clinical teaching approach (how) | 0.50 | 0.74 |

A statistically significant association was found between clinical teachers' conceptions of nursing and their conceptions of clinical teaching (Kendall's tau-b =0.60, p= <.01): approaches to nursing and conceptions of clinical teaching (Kendall's tau-b =0.68, p=<0.01): and approaches to nursing and approaches to clinical teaching (Kendall's tau-b =0.74, p=<0.01). An association between clinical teachers' conceptions of nursing and approaches to clinical teaching was also demonstrated (Kendall's tau-b =0.50, p= <0.01).

The statistical results indicate that there is a strong relationship between clinical teachers' conceptions of nursing and their conceptions of clinical teaching, their approaches to nursing and their conceptions of clinical teaching and their approaches to nursing and their approaches to clinical teaching. While not as strong, the results also indicate a close relationship between clinical teachers' conceptions of nursing and their approaches to clinical teaching. This may imply that for a clinical teacher to conceive of clinical teaching in a student-focused way a patient-focused conception and approach to nursing may be required. It would also seem that to approach clinical teaching in a student-focused way a patient-centred approach to nursing may be required. Finally, it would appear that in order to approach clinical teaching in a student-focused way a student-focused conception of nursing may be required.

Part 2:

Relations between the categories of description in four outcome spaces

Having summarised the relationships between clinical teacher conceptions and approaches to nursing, and their conceptions and approaches to clinical teaching the relations between a number of categories of description in four outcome spaces are now examined in detail.

i. The results of the statistical investigation of the relationship between clinical teachers' conceptions of nursing and their conceptions of clinical teaching are presented in Table 5.5.

Variation in clinical teachers' conceptions of nursing and *Variation in clinical teachers' conceptions of clinical teaching in nursing* were investigated by analysing the distributions of the transcript classifications in terms of the outcome spaces and the empirical and logical relationships between the outcome spaces as described in Chapter 3, Section 2.

Table 5.5: Empirical relationship between clinical teachers' conceptions of nursing and conceptions of clinical teaching

| Conceptions of clinical teaching | Conceptions of nursing | | | | Total |
|----------------------------------|------------------------|---|---|---|-------|
| | A | B | C | D | |
| A | 1 | 2 | | | 3 |
| B | | 5 | 2 | 3 | 10 |
| C | | | 4 | | 4 |
| D | | | | 3 | 3 |
| Total | 1 | 7 | 6 | 6 | 20 |

Kendalls tau-b =0.60, p<0.01

A statistically significant association was found between clinical teachers' conceptions of nursing and their conceptions of clinical teaching (Kendall's tau-b = 0.60. p = <0.01).

Categories A and B in the outcome space, *Variation in clinical teachers' conceptions of nursing* represent conceptions which are nurse-focused (see Table 5.5). In comparison, Categories C and D in this outcome space represent conceptions that are patient-focused.

Categories A and B in the outcome space, *Variation in clinical teachers' conceptions of clinical teaching in nursing*, represent conceptions that are teacher-focused. In comparison, Categories C and D of this outcome space represent conceptions of clinical teaching which are student-focused.

Coherence between clinical teacher conceptions of nursing and their conceptions of clinical teaching is suggested in the results of this study. However, not all clinical teachers' conceptions of teaching match their conceptions of nursing. Dissonance in the responses of five participants between conceptions of nursing and clinical teaching is presented in Table 5.6.

Table 5.6: Dissonance between clinical teachers' conceptions of nursing and conceptions of clinical teaching

| Participants | Conceptions of nursing | Conceptions of clinical teaching |
|-------------------------------------|---|--|
| Participant numbers 7 and 18 | Nursing is providing appropriate patient care aimed at achieving individual patient outcomes (Category C) | Clinical teaching is more than managing the clinical placement, it is making the links between theory and practice (Category B) |
| Participant numbers 3, 10 and 20 | Nursing is collaborating to provide appropriate patient care aimed at achieving individual patient outcomes (Category D) | Clinical teaching is more than managing the clinical placement, it is making the links between theory and practice (Category B) |

Results presented in Table 5.5 suggest that for a clinical teacher to conceive of clinical teaching in a student-focused way a patient-focused conception of nursing may be required. However, Table 5.6 shows that although five out of twelve participants conceive of nursing in a complex way their conceptions of clinical teaching are less complex. That is, these participants conceived of nursing in a patient-focused way but conceived of clinical teaching in a teacher-focused way. One possible explanation for dissonance between clinical teacher conceptions of nursing and conceptions of clinical teaching may be related to the fact that these participants were not aware of student-focused conceptions of clinical teaching.

However, a more compelling explanation for dissonance between clinical teacher conceptions of nursing and conceptions of clinical teaching may be related to perceptions that nursing in particular clinical environments is task and routine focused or that that was all that was expected by universities and clinical staff. For example, participants 7 and 18 both reflected on clinical teaching in aged care settings. They both indicated dislike for this type of nursing because of the task and routine focus of nurses in that type of setting. Both clinical teachers also expressed concern that they were not teaching in their area of expertise.

The other three participants (3, 10 and 20), categorised as having a patient-focused conception of nursing but a teacher-focused conception of clinical teaching were teaching students in different environments (rehabilitation, acute care and mixed aged and acute care) from each other. These three clinical teachers reported that nurses in these environments wanted students to focus on learning particular tasks. Although these three clinical teachers were employed by different universities there was a shared perception that student learning goals of their employing university were either unclear or focused on students learning tasks.

Those clinical teachers who were categorised as having both a patient focus and a student focus (participants 2, 4, 5, 11, 12, 15 and 17) were also employed by different universities, and taught in a range of different clinical environments. In addition, several of these clinical teachers were teaching in clinical settings which were not their area of expertise. Some of these clinical teachers perceived that the university goals were unclear, though the majority of this group identified that the universities expected students to learn more than tasks. One

of these clinical teachers thought the nursing staff in the hospital where she was teaching expected students to learn more than tasks: another two thought staff expectations were unclear: and the other four clinical teachers thought staff expected students to focus only on tasks. The one area that was common to all of these clinical teachers was that each one identified that their teaching goals were focused on students needing to achieve more than tasks. Some examples of clinical teacher goals from this group of teachers follow. The goals were focused on helping the student to:

- achieve their learning goals by finding out students' different learning needs to help link theory and practice:
- challenge what they see:
- feel empowered and to see aged-care as complex:
- develop a positive view of aged care:
- look after two patients by providing total care:
- understand medical diagnosis by linking it to the pathophysiology:
- understand the signs and symptoms of the medical diagnosis and link to the diagnosis:
- link the medications to the signs and symptoms and the diagnosis:
- be able to give a rationale as to why they're doing things:
- mix with the health care team members and develop team skills: and
- know how to go about changing care if they need to do so.

It would appear then that for some clinical teachers the context in which they are teaching nursing students may have some influence on how they conceive of clinical teaching. Even though clinical teachers conceive of nursing in a patient-focused way, when the context in which they teach is perceived to be focused on the achievement of tasks some teachers may conceive of clinical teaching in a teacher-focused way. For others, it would seem that in spite of the context, having teaching goals that go beyond the achievement of tasks may help clinical teachers to have cohesion between their conceptions of nursing and conceptions of clinical teaching.

ii. The results of the statistical investigation of the relationship between clinical teachers' approaches to nursing, and their conceptions of clinical teaching in nursing are presented in Table 5.7. *Variation in clinical teachers' approaches to nursing* and *Variation in clinical teachers' conceptions of clinical teaching in nursing* were investigated by analysing the distributions of the transcript classifications in terms of the outcome spaces and the empirical and logical relationships between the outcome spaces.

Table 5.7: *Empirical relationship between approaches to nursing and conceptions of clinical teaching in nursing*

| Conceptions of clinical teaching | Approaches to nursing | | | | Total |
|----------------------------------|-----------------------|---|---|---|-------|
| | A | B | C | D | |
| | | | | | |

| | | | | | |
|--------------|---|---|---|---|----|
| A | 2 | 1 | | | 3 |
| B | 3 | 5 | 1 | 1 | 10 |
| C | | | 4 | | 4 |
| D | | | 1 | 2 | 3 |
| Total | 5 | 6 | 6 | 3 | 20 |

Kendalls tau-b =0.68, p=<0.01

A statistically significant association was found between clinical teachers' approaches to nursing and their conceptions of clinical teaching (Kendall's tau-b =0.68, p =<0.01).

Categories A and B in the outcome space, *Variation in clinical teachers' approaches to nursing*, represent approaches that are nurse-focused.

In comparison, Categories C and D of this outcome space represent approaches to nursing which are patient-focused. Categories A and B in the outcome space, *Variation in clinical teachers' conceptions of clinical teaching in nursing* represent conceptions which are teacher-focused. In comparison, Categories C and D in this outcome space represent conceptions of clinical teaching that are student-focused. Coherence between clinical teacher approaches to nursing and their conceptions of clinical teaching is suggested in the results of this study. However, not all clinical teachers' approaches to nursing match their conceptions of clinical teaching. Dissonance in responses of two participants between approaches to nursing and conceptions of clinical teaching is presented in Table 5.8.

Table 5.8: Dissonance between clinical teachers' approaches to nursing and conceptions of clinical teaching

| Participants | Conceptions of nursing | Conceptions of clinical teaching |
|-----------------------|--|--|
| Participant number 10 | Using patient-focused strategies aimed at achieving individual patient outcomes (Category C) | Clinical teaching is more than managing the clinical placement, it is making the links between theory and practice (Category B) |
| Participant number 3 | Collaborating to use patient-focused strategies aimed at achieving individual patient outcomes (Category D) | Clinical teaching is more than managing the clinical placement, it is making the links between theory and practice (Category B) |

Results presented in Table 5.7 suggest a strong statistical relationship between the way clinical teachers approach nursing and their conceptions of clinical teaching. The results imply that for a clinical teacher to conceive of clinical teaching in a student-focused way a patient-focused approach to nursing may be required. However, Table 5.8 shows that although two out of nine participants approach nursing in a patient-focused way their

conceptions of clinical teaching are teacher-focused. One possible explanation for dissonance between clinical teacher approaches to nursing and their conceptions of clinical teaching may be related to the fact that these participants were not aware of student-focused conceptions of clinical teaching. Other possible reasons for this dissonance may be related to perceptions of the quality of student preparation for the placement or the length of the placement. Participant number 3, for example, found that the students came to the placements without any knowledge of rehabilitation nursing. She identified that they also had limited understanding of what they had been taught at university about some aspects of nursing care. These students had also been provided with lists of tasks to be achieved by their university. This teacher felt compelled to give them as much information about rehabilitation nursing as possible partially in response to the students' perceived task focus and partially in response to their lack of understanding of this type of nursing. Similarly, participant number 10 felt that her students had not been well prepared for the placement and had very little understanding of the role of the nurse. She therefore felt it necessary to give the students information about the routine and the nursing role. It is worth noting that for this particular teacher the length of clinical placement for students from this particular university was only two days. It is therefore quite possible that a short placement such as this could influence the clinical teacher's conception of clinical teaching in such a situation. It is also important to note that not only was there dissonance between participants 3 and 10's approaches to nursing and their conceptions of clinical teaching but also between their conceptions of nursing and conceptions of clinical teaching (see Table 5.6).

The seven clinical teachers categorised as having both a patient-focused approach to nursing and a student-focused conception of clinical teaching were participants 2, 4, 5, 11, 12, 15 and 17. Discussion about this group was detailed in a previous paragraph relating to Table 5.6.

Regardless of the expectations of the university and the clinical staff these clinical teachers were able to maintain cohesion between their patient-focused approaches to nursing and their student-focused conceptions of clinical teaching. It is possible that having a strong belief in the individuality of patients is also coherent with a belief in the individuality of students.

iii. The results of the statistical investigation of the relationship between clinical teachers' approaches to nursing and their approaches to clinical teaching are presented in Table 5.9.

Variation in clinical teachers' approaches to nursing and *Variation in clinical teachers' approaches to clinical teaching in nursing* are investigated by analysing the distributions of the transcript classifications in terms of the outcome spaces and the empirical and logical relationships between the outcome spaces.

Table 5.9: Empirical relationship between approaches to nursing and approaches to clinical teaching in nursing

| Approaches to nursing |
|-----------------------|
|-----------------------|

| Approaches to clinical teaching | A | B | C | D | Total |
|--|----------|----------|----------|----------|--------------|
| A | 4 | 2 | | | 6 |
| B | 1 | 4 | 1 | 1 | 7 |
| C | | | 4 | | 4 |
| D | | | 1 | 2 | 3 |
| Total | 5 | 6 | 6 | 3 | 20 |

Kendalls tau-b = 0.74, p = <0.01

A statistically significant association was found between clinical teachers' approaches to nursing and their approaches to clinical teaching (Kendall's tau-b = 0.74, p = <0.01).

Categories A and B in the outcome space, *Variation in clinical teachers' approaches to nursing*, represent approaches that are nurse-focused. In comparison, Categories C and D of this outcome space represent approaches to nursing which are patient-focused. Categories A and B in the outcome space, *Variation in clinical teachers' approaches to clinical teaching in nursing* represent approaches which are teacher-focused. In comparison, Categories C and D in this outcome space represent approaches to clinical teaching that are student-focused.

Coherence between clinical teacher approaches to nursing and their approaches to clinical teaching is suggested in the results of this study. However, not all clinical teachers' approaches to nursing match their approaches to clinical teaching. Dissonance between approaches to nursing and approaches to clinical teaching is presented in Table 5.10.

Table 5.10: Dissonance between clinical teachers' approaches to nursing and approaches to clinical teaching in nursing

| Participants | Conceptions of nursing | Conceptions of clinical teaching |
|-----------------------|---|---|
| Participant number 10 | Using patient-focused strategies aimed at achieving individual patient outcomes (Category C) | Using teacher-focused strategies with interaction between teacher and student aimed at reproduction of facts and routine tasks (Category B) |
| Participant number 3 | Collaborating to use patient-focused strategies aimed at achieving individual patient outcomes (Category D) | Using teacher-focused strategies with interaction between teacher and student aimed at reproduction of facts and routine tasks (Category B) |

Results presented in Table 5.9 suggest that to approach clinical teaching in nursing in a student-focused way a patient-focused approach to nursing may be required. However, Table 5.10 shows that two out of nine participants classified as having a patient-focused approach to nursing approached their clinical teaching in a teacher-focused way. Once again there is disparity for participants 3 and 10. This time the disparity is between their approaches to nursing and their approaches to clinical teaching. Both clinical teachers are experienced clinical teachers and nurses and were teaching in different clinical settings from each other.

As before, a possible explanation for disparity between approaches to nursing and

approaches to clinical teaching may be related to a lack of awareness of student-focused strategies and approaches to clinical teaching in nursing. Or, the disparity may also be related to the perceptions of the quality of student preparation and the length of the placement. However, the most compelling argument could be that both of these clinical teachers may have adopted a teacher-focused approach to their clinical teaching because they had a teacher-focused conception of clinical teaching.

The seven clinical teachers categorised as having both a patient-focused approach to nursing and a student-focused approach to clinical teaching were participants 2, 4, 5, 11, 12, 15 and 17. Discussion about this group was detailed in previous paragraphs relating to tables 5.6 and 5.8. It has been shown that these clinical teachers were able to maintain cohesion between their conceptions of nursing and their conceptions of clinical teaching, their approaches to nursing and their conceptions of clinical teaching, and their approaches to nursing and their approaches to clinical teaching. Each clinical teacher in this group was classified as having a student-focused conception of clinical teaching. Their approaches to nursing and approaches to clinical teaching were not focused on themselves. Instead they looked for ways to help their patients and to empathise with their situation. As teachers they looked for ways to help their students achieve understanding and independence as learners so that they built on the knowledge they already had.

iv. The results of the statistical investigation of the relationship between clinical teachers' conceptions of nursing and their approaches to clinical teaching are presented in Table 5.11. *Variation in clinical teachers' conceptions of nursing* and *Variation in clinical teachers' approaches to clinical teaching in nursing* are investigated by analysing the distributions of the transcript classifications in terms of the outcome spaces and the empirical and logical relationships between the outcome spaces.

Table 5.11: Empirical relationship between conceptions of nursing and approaches to clinical teaching in nursing

| Approaches to clinical teaching | Conceptions of nursing | | | | Total |
|---------------------------------|------------------------|---|---|---|-------|
| | A | B | C | D | |
| A | 1 | 3 | 1 | 1 | 6 |
| B | | 4 | 1 | 2 | 7 |
| C | | | 4 | | 4 |
| D | | | | 3 | 3 |
| Total | 1 | 7 | 6 | 6 | 20 |

Kendalls tau-b = 0.50, p = <0.01

A statistically significant association was found between clinical teachers' conceptions of nursing and their approaches to clinical teaching (Kendall's tau-b = 0.50 p = <0.01).

Categories A and B in the outcome space *Variation in clinical teachers' conceptions of*

nursing, represent conceptions which are nurse-focused. In comparison, Categories C and D represent conceptions of nursing which are patient-focused. Categories A and B in the outcome space, Variation in clinical teachers' approaches to clinical teaching in nursing represent approaches which are teacher-focused. In comparison, Categories C and D represent approaches to clinical teaching which are student-focused. Coherence between clinical teacher conceptions of nursing and their approaches to clinical teaching is also suggested in the results of this study. However, not all clinical teachers' approaches to teaching match their conceptions of nursing. Dissonance between conceptions and approaches to clinical teaching are presented in Table 5.12.

Results presented in Table 5.11 suggest that to approach clinical teaching in a student-focused way clinical teachers may need a patient-focused conception of nursing. However, Table 5.12 shows that five out of twelve participants who conceived of nursing as being patient-focused approached their clinical teaching in a teacher-focused way. Once again dissonance is apparent for participants 3 and 10. This time there is dissonance between their conceptions of nursing and approaches to clinical teaching. Once again the quality of student preparation and length of clinical placement is possibly relevant to the dissonance that is shown to exist where the conception of nursing is patient-focused but the approach to teaching is teacher-focused. Participants 3, 7, 10, 18 and 20 were previously identified as having a lack of coherence between their conceptions of nursing and their conceptions of clinical teaching, (see Table 5.6). Dissonance between these particular clinical teachers' conceptions of nursing and approaches to clinical teaching may be related to their teacher-focused conceptions of clinical teaching. This further strengthens the argument that a relationship exists between clinical teacher conceptions of clinical teaching and their approaches to clinical teaching in nursing.

Table 5.12: Dissonance between clinical teachers' conceptions of nursing and approaches to clinical teaching in nursing

| Participants | Conceptions of nursing | Conceptions of clinical teaching |
|-----------------------|---|--|
| Participant number 18 | Nursing is providing appropriate patient care aimed at achieving individual patient outcomes (Category C) | Clinical teaching is about using teacher-focused strategies, with little interaction between teacher and student, aimed at reproduction of routine tasks (Category A) |
| Participant number 7 | Nursing is providing appropriate patient care aimed at achieving individual patient outcomes (Category C) | Clinical teaching is about using teacher-focused strategies, with interaction between teacher and student, aimed at reproduction of facts and routine tasks (Category B) |
| Participant number 20 | Nursing is collaborating to provide appropriate patient care aimed at achieving individual patient | Clinical teaching is about using teacher-focused strategies, with little interaction between teacher and |

| | | |
|---------------------------------|---|---|
| | outcomes (Category D) | student, aimed at reproduction of routine tasks (Category A) |
| Participant numbers 3 and 10 | Nursing is collaborating to provide appropriate patient care aimed at achieving individual patient outcomes (Category D) | Clinical teaching is about using teacher-focused strategies, with interaction between teacher and student, aimed at reproduction of facts and routine tasks (Category B) |

Also of interest is that participants 2, 4, 5, 11, 12, 15, and 17 conceived of nursing in a patient- focused way and approached their teaching in a student-focused way. These same participants have shown cohesion between their patient-focused conceptions and approaches to nursing and their student-focused conceptions and approaches to clinical teaching.

Summary of Section 4

Section 4 of this chapter has identified that relationships exist between clinical teachers' conceptions and approaches to nursing and their conceptions and approaches to clinical teaching. The results of the statistical analyses suggest that clinical teachers who adopted a student-centred approach to clinical teaching conceived of nursing and clinical teaching in complex ways. Clinical teachers who approached clinical teaching from a teacher-focused perspective conceived of teaching and nursing in less complex ways. It would appear then, that for a clinical teacher to have a student-focused conception of clinical teaching a patient-focused conception of nursing may be required and, for a clinical teacher to have a student-focused approach to clinical teaching they may also require a complex conception of nursing and clinical teaching.

While the statistical analyses show strong associations between clinical teacher conceptions of nursing and conceptions of clinical teaching, approaches to nursing and conceptions of clinical teaching, approaches to nursing and approaches to clinical teaching and conceptions of nursing and approaches to clinical teaching, some dissonances have been identified.

Clinical teachers who have a patient-focused conception of nursing may adopt a teacher-focused conception of clinical teaching if required to teach in an area that is not related to her area of expertise, or if it is perceived that the students are expected to only focus on learning tasks. Clinical teachers who have a patient-focused approach to nursing may adopt a teacher-focused conception of clinical teaching if it is perceived that students are poorly prepared for the clinical placement, or if the length of the placement is very short. As a consequence a teacher-focused approach to clinical teaching may be adopted. Finally, clinical teachers who

have a patient-focused conception of nursing may adopt a teacher-focused approach to clinical teaching because they have a teacher-focused conception of clinical teaching.

Section 5: Mapping the structure of awareness

Achievement of stability of the categories of description means that each category stands alone and represents a critical aspect of the way nursing and clinical teaching have been experienced. The categories of description are clearly internally related to each other and are arranged hierarchically so that the more complex and inclusive categories include the features of the less intricate categories. The most distinctive characteristics of the variation in the range of ways clinical teachers experienced nursing and clinical teaching and the relationship between these two were consequently mapped on to a matrix, called an outcome space. What was mapped onto this space was the relation between different ways of experiencing nursing and clinical teaching identified through analysis of the transcripts as described in Chapter 3 of this thesis. The outcome space provides insight into the structural overview of different categories of experience. That is:

- the meaning (what) of the experience. This aspect is referred to as the referential aspect and includes the structural (internal and external horizons) aspects, and the
- the approach used (how) which includes, the act (strategies used) and the indirect object (intention) and the,
- related “what” and “how” aspects of the experience.

In summary, the “what” aspect of experiencing a phenomenon is understood in terms of meaning and structure, whereas the “how” aspect is concerned with intentions (indirect object) and strategies (act).

The structure of awareness of clinical teachers’ experiences of nursing and clinical teaching was mapped. This section presents two maps representing the relationship between clinical teachers’ conceptions of nursing (what) and approaches to nursing (how) and clinical teachers’ conceptions of clinical teaching (what) and their approaches to teaching (how).

Figure 5.3 maps the structure of clinical teachers’ awareness of nursing. Figure 5.4 maps the structure of clinical teachers’ awareness of clinical teaching in nursing. These two maps present the final outcome spaces and categories of description and show the logical relationships between all components. On the maps, the dimensions of variation are divided into those concerning the conceptions (what) and approaches (how) to nursing and teaching.

Referential (meaning) and structural (internal and external horizons) aspects have been mapped for the ‘what’ aspects of nursing and teaching. The ‘how’ aspect, that includes the act and indirect object, have also been mapped for both nursing and teaching. Each of these aspects of the structure of awareness is located on the two maps in individual boxes with a title, for example, What, Referential, Structure (Internal Horizon and External Horizon),

Approach (Act and Indirect Object) for both nursing and clinical teaching. Under each of these boxes is a set of boxes representing the outcome spaces for conceptions of nursing (What), approaches to nursing (How) (Figure 5.4) and conceptions of clinical teaching (What) and approaches to clinical teaching (How) (Figure 5.5). For each outcome space, there are four categories of description represented by a box for each category of description. Vertical lines show relationships between the vertically positioned boxes. The categories of description are displayed in an inverted hierarchy. Category A represents the simplest conception and approach and Category D represents the most complex or sophisticated conception and approach, thus depicting the qualitative variation in conceptions and approaches to nursing and clinical teaching. The categories of description are inclusive: that is that the more sophisticated categories include the elements of the least complex categories. What is evident by viewing the two maps and the data presented in chapters 4 and 5 is the key but limited and qualitatively different ways nursing and clinical teaching have been experienced, through identification of the structural (internal and external horizons) and referential (meaning) aspects of those experiences. Additionally, the approach (How), in terms of indirect object and act, are shown for both nursing and clinical teaching. The variation in experiences of nursing and clinical teaching represents the collective rather than individual experiences. The maps showing the structure of awareness of both nursing and clinical teaching shows the holistic nature of how both nursing and clinical teaching was experienced.

Conclusion

Results presented in this chapter show that variation exists in the ways clinical teaching is experienced by clinical teachers and that there is a relationship between clinical teachers' experiences of nursing and their experiences of clinical teaching.

Sections 1 and 2 answered the second subsidiary question:

How do clinical teachers experience teaching? In particular, what are their conceptions of teaching and how do they approach teaching?

The results show that variation exists in the ways clinical teachers experience clinical teaching. In particular, clinical teachers conceive of clinical teaching in limited but qualitatively different ways. In Section 1, an outcome space, *Variation in clinical*

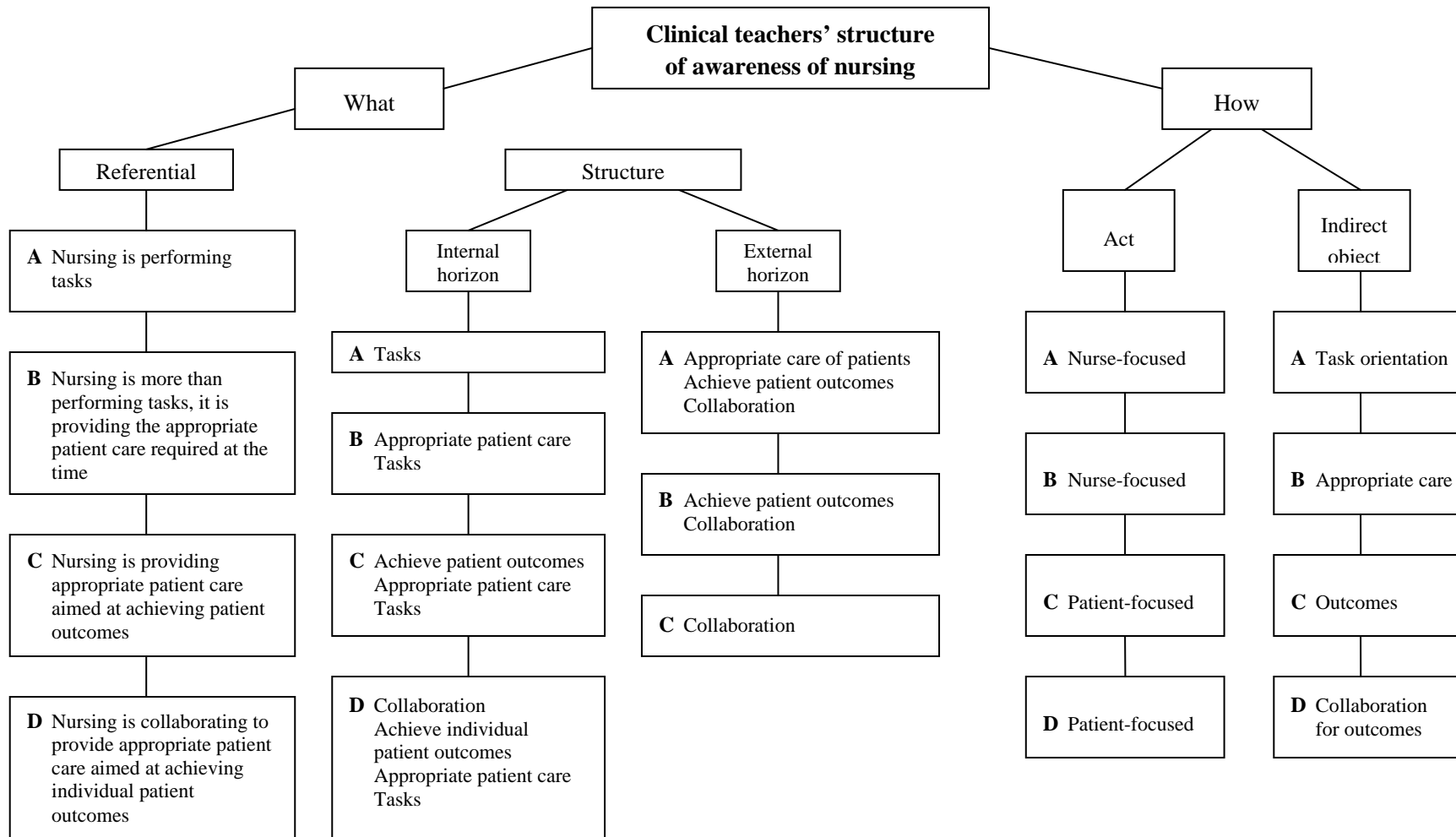


Figure 5.3: Clinical teachers' structure of awareness of nursing

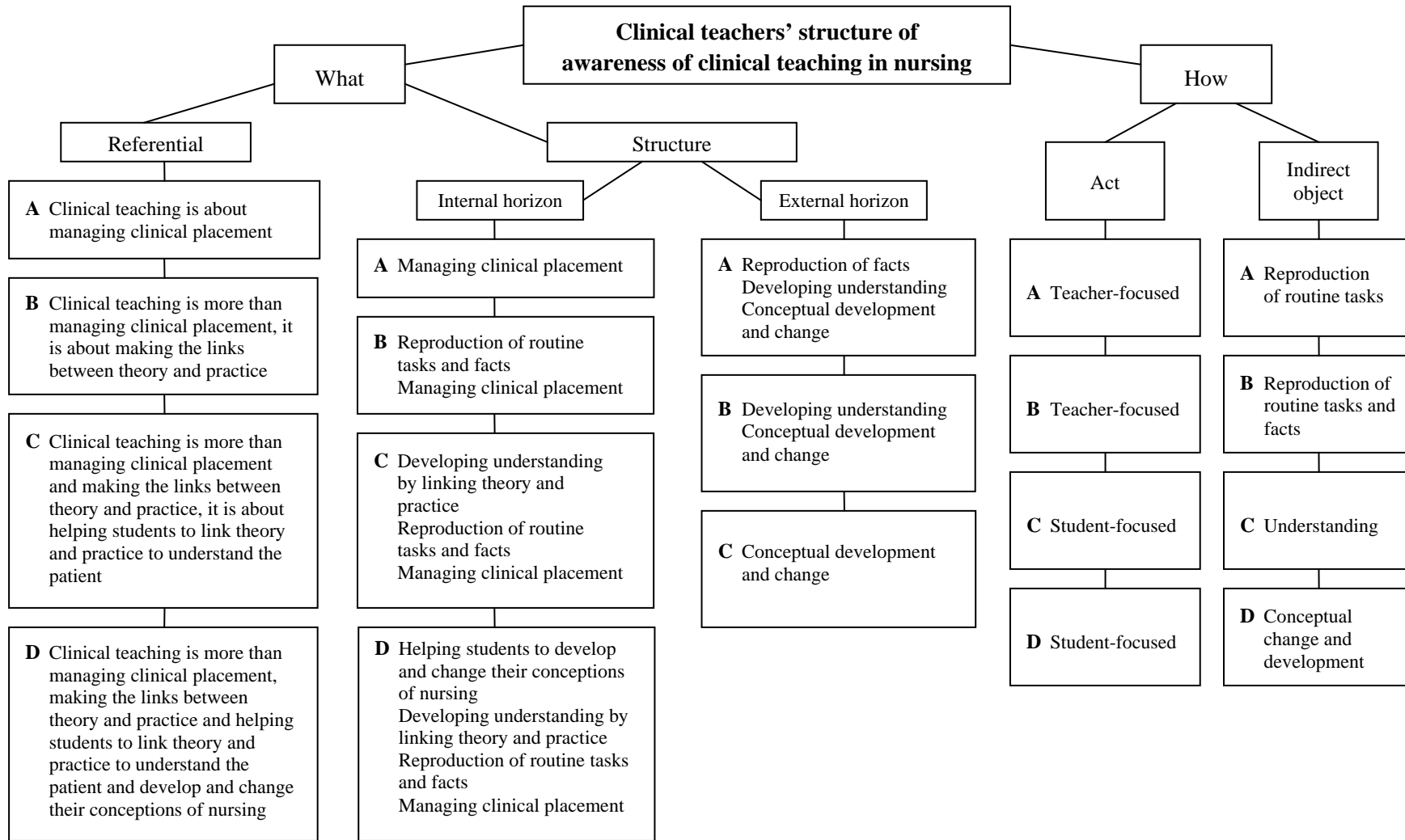


Figure 5.4: Clinical teachers' structure of awareness of clinical teaching in nursing

teachers' conceptions of clinical teaching in nursing, containing four categories of description was presented.

The first two categories within this outcome space reflect teacher-focused conceptions. The first category shows that clinical teachers conceive that clinical teaching is about managing the clinical placement. The second category shows that clinical teaching is about helping students make the links between theory and practice, of which managing the clinical placement is an element. The third and fourth categories within this outcome space reflect a student-focus.

The third category shows that clinical teaching is more than managing the clinical placement and helping the student to link theory and practice, it is also about helping the student to make the links between theory and practice for understanding.

Finally, in the fourth category, clinical teaching is conceived of as being about helping the student to change their conceptions of nursing. This category also includes management of the placement, helping students to link theory and practice and helping students to link theory and practice for understanding

In the second section, results were presented that show that variation exists in the ways clinical teachers approach clinical teaching. An outcome space, *Variation in clinical teachers' approaches to clinical teaching in nursing*, containing four categories of description was presented. The first two categories within this outcome space reflect a teacher-focused approach. The first category shows that clinical teachers use teacher-focused strategies with little interaction between teacher and student, aimed at reproduction of routine tasks. The second category shows that clinical teachers' aim for reproduction of facts in addition to routine tasks. The third category shows that clinical teaching is approached by clinical teachers in a student-focused way. Student-focused strategies are used with the intention of helping students to link theory and practice for understanding. Finally, in the fourth category, clinical teaching is also approached in a student-focused way. The aim of the student-focused strategies is to help students to develop and change their conceptions of nursing. Empirical results were presented in Section 3 that show a relationship between clinical teachers' conceptions of clinical teaching and the ways they approach clinical teaching. A statistically significant association between conceptions and approaches to clinical teaching was demonstrated. The results suggest that for a clinical teacher to take a student-focused approach to teaching a student-focused conception of clinical teaching may be required.

The central question of the thesis, *How do clinical nurse teachers experience teaching undergraduate nursing students on clinical placements and how does this relate to their experiences of nursing* was answered in the final section of this chapter. In Section 4 empirical results show in part 1 of this section that there is a relationship between clinical

teachers' experiences of nursing and their experiences of clinical teaching. In the second part of Section 4 more detailed analyses suggest strong relationships between clinical teachers' conceptions of nursing and their conceptions of clinical teaching, their approaches to nursing and their conceptions of clinical teaching and their approaches to nursing and their approaches to clinical teaching. The results also suggest a close relationship between clinical teachers' conceptions of nursing and their approaches to clinical teaching. The findings imply that in order to conceive of and approach clinical teaching in a student-focused way a patient-focused conception of nursing and a patient-focused approach to nursing may be required. Two maps are presented in Section 5 showing the structure of awareness of clinical teachers' experiences of nursing and clinical teaching.

While the results show statistically significant associations between the ways clinical teachers experience nursing and clinical teaching some dissonance is apparent. A close relationship has been identified between the way clinical teachers' conceive of nursing and approach their clinical teaching. However, perceptions that students are expected to learn specific nursing tasks only may impact on some clinical teachers' conceptions and approaches to clinical teaching. Regardless of whether the task focus is a university, clinical staff, student or clinical teacher expectation, some teachers may focus on themselves and what they think students should learn to do rather than on the student's learning needs. For some clinical teachers the quality of student preparation and the length of the placement might also impact on the clinical teachers' conceptions and approaches to clinical teaching.

Teacher-focused conceptions of clinical teaching are also likely to account for the dissonance that exists between clinical teacher conceptions of nursing and their approaches to clinical teaching. Where dissonance exists it is in the direction of less complex conceptions and approaches to clinical teaching, with the exception of one case. The suggestion is that the way in which clinical teachers experience nursing is structurally more complex than the way they experience clinical teaching.

CHAPTER 6

Discussion and conclusion

Introduction

In order to adequately prepare undergraduate nursing students for contemporary nursing practice it has been important to investigate how clinical teachers' conceive of nursing and how they approach their clinical teaching. Known links between teacher approaches to teaching, student approaches to learning and quality of student learning outcomes has provided an important foundation for this study. This is the first study of its type to investigate clinical teachers' experiences of nursing and clinical teaching and to show relations between their conceptions of nursing and approaches to clinical teaching.

The aim of the study was to investigate a particular group of clinical teachers who provided clinical supervision and teaching to nursing students whilst on clinical placement. This study aimed to understand the interrelationship of supervising clinical teachers' conceptions of nursing and approaches to clinical teaching in order to improve the quality of learning outcomes for undergraduate nursing students. It is argued that understanding clinical teacher conceptions of nursing and approaches to clinical teaching offers an insight into how clinical teachers can be better prepared and supported in their roles.

The aim of this final chapter is to relate the empirical study and its findings to the literature.

In so doing, it will be shown how the main research question and the three subsidiary questions have been addressed by the research outcomes described in chapters 4 and 5. The main research question identified in Chapter 1 of this thesis was:

How do clinical nurse teachers experience teaching undergraduate nursing students on clinical placements and how does this relate to their experiences of nursing?

The three subsidiary questions were:

How do clinical teachers experience nursing? In particular, what are their conceptions of nursing and how do they approach nursing?

How do clinical teachers experience clinical teaching? In particular, what are their conceptions of clinical teaching and how do they approach clinical teaching?

How do clinical teachers' experiences of nursing relate to their experiences of teaching? In particular, do clinical teachers' conceptions and approaches to nursing relate to their conceptions and approaches to clinical teaching?

To achieve the aim, the chapter is divided into 5 sections:

- Section 1: Ways of experiencing nursing and clinical teaching

In this section the findings of this study are compared with what is known about desired ways of experiencing nursing and clinical teaching. This will be done by comparing the critically different aspects of the 'what' and 'how' aspects of nursing and clinical teaching with the literature. The significance of the comparison for the ways in which nursing and clinical teaching are experienced is proposed.

- Section 2: Phenomenographic research method

The phenomenographic method used in the empirical study has been carefully documented in Chapter 3 of this thesis. Some aspects of the methodological approach are further discussed in terms of problems and effectiveness.

- Section 3: Implications for nursing and clinical teaching

The implications for nursing and clinical teaching are presented in this section. The importance of the critically different aspects identified between clinical teachers' experiences of nursing and clinical teaching is presented.

- Section 4: Clinical teaching in nursing

This section considers the contribution of the empirical study to the body of knowledge about teaching in higher education and clinical teaching in nursing.

- Section 5: Further research

The contributions to the relevant knowledge in each of the three research areas have suggested ideas for further research. These ideas are described in this section.

- Conclusion to the thesis.

Section 1: Ways of experiencing nursing and clinical teaching

The central question of how clinical nurse teachers experience teaching undergraduate nursing students on clinical placements and how this experience relates to their experiences of nursing has been answered as a consequence of this study. The results of the study suggest a close internal relationship between the ways in which nursing was experienced and the ways in which clinical teaching was experienced. Strong relationships have been found to exist between clinical teachers' conceptions and approaches to nursing and their conceptions and approaches to clinical teaching. The results of the study suggest that the adoption of a

student-focused approach to clinical teaching is related to a complex conception of nursing and clinical teaching. Teacher-focused approaches to clinical teaching are related to less complex conceptions of clinical teaching. Although it is not possible to draw definite conclusions because of a lack of randomisation of the participants in this study, the results suggest that in order to approach clinical teaching in a student-focused way a complex conception of nursing and clinical teaching may be required.

Research outcomes in terms of conceptions (what) and approaches (how) to clinical teaching and nursing and the relationships between conceptions and approaches are compared to literature described in Chapter 2. Since there is no research into clinical teacher experiences of nursing detected in the literature, the contribution of the findings from this study will be related to the non-empirical literature about desired ways of experiencing nursing in the current health care climate. Relating the findings of this study to the extant literature is important since it may have broad and practical impacts on how nursing is currently understood and approached. In addition, there is a paucity of research into clinical teachers' experiences of clinical teaching detected in the literature, as argued in earlier chapters of this thesis. The findings of this study are therefore compared with what is known about teacher experiences of teaching in higher education.

Logical and empirical results presented in Chapter 4 and Chapter 5 of this thesis show that there was variation in the way clinical teachers experienced nursing and clinical teaching.

Both nursing and clinical teaching were experienced in limited but qualitatively different ways. This study has identified key aspects of variation in those experiences. As explained in Chapter 3 of this thesis, categories of description developed in phenomenographic studies represent critical variation in ways of experiencing a phenomenon. The differences between categories of description are, therefore, important ones and contribute toward a thorough understanding of the phenomena in question.

The dimensions of variation in the ways nursing and clinical teaching were experienced, in which critical differences were found, are illustrated in Table 6.1. The columns in Table 6.1 represent the outcome spaces for nursing and clinical teaching. These outcomes spaces include 'What of nursing', 'How of nursing', 'What of clinical teaching' and 'How of clinical teaching'. The rows represent relevant dimensions of variation of experiences of nursing and clinical teaching. Inverse hierarchies of qualitatively different ways of experiencing nursing and clinical teaching are shown. The more complex categories are lower in the table (Categories C & D) and less complex categories are placed higher in the table (Categories A & B). Each cell represents a dimension of variation for a particular way of experiencing the phenomenon in question. The dark line across the table separating categories B and C represent the location of a critical difference in the dimension of variation represented in the column. The nature of the relationships that exist between clinical

teachers' experiences of nursing and their experiences of clinical teaching can be further understood by addressing the findings related to the three subsidiary research questions for this study.

The structure of the remainder of Section 1 centres on Table 6.1. This section is divided into two parts. The first part is focused on ways of experiencing nursing and the second part is focused on ways of experiencing clinical teaching. In Part 1 of Section 1, the desired way of experiencing nursing is reviewed. Then, the critical differences between categories are highlighted by examining the dimensions of variation between the desired ways of experiencing nursing and the findings of this study. In Part 2 of Section 1 the desired ways of experiencing teaching are reviewed from the perspective of research outcomes in teaching and learning in the higher education sector. Next, the critical differences between categories are highlighted by examining the dimensions of variation between the desired ways of experiencing teaching and the findings of this study.

Table 6.1: Various ways of experiencing nursing and clinical teaching

| Category | WHAT OF NURSING | HOW OF NURSING | WHAT OF CLINICAL TEACHING | HOW OF CLINICAL TEACHING |
|-----------------|---|---|--|---|
| A | Nursing is about performing tasks | Nursing is about using nurse-focused strategies aimed at performing tasks | A Clinical teaching is about managing the clinical placement | Clinical teaching is about using teacher focused strategies, with little interaction between teacher and student, aimed at reproduction of routine tasks |
| B | Nursing is more than performing tasks, it is providing appropriate patient care required at the time | Nursing is about using nurse-focused strategies aimed at providing appropriate patient care | B Clinical teaching is about making the links between theory and practice | Clinical teaching is about using teacher focused strategies, with interaction between teacher and student, aimed at reproduction of facts and routine tasks |
| C | Nursing is providing appropriate patient care aimed at achieving individual patient outcomes | Nursing is about using patient-focused strategies aimed at achieving individual patient outcomes | C Clinical teaching is about students developing understanding by helping them to link theory and practice | Clinical teaching is about using student focused strategies aimed at linking theory and practice for understanding |
| D | Nursing is collaborating to provide appropriate patient care aimed at achieving individual patient outcomes | Nursing is about collaborating to use patient-focused strategies aimed at achieving individual patient outcomes | D Clinical teaching is about helping students to develop and change their conceptions of nursing | Clinical teaching is about using student focused strategies aimed at helping students develop and change their conceptions of nursing. |

Part 1: Clinical teachers' experiences of nursing

Review of the desired ways of experiencing nursing

It was argued in Chapter 2 of this thesis that through the influence of Florence Nightingale, nursing has traditionally been thought of as a holistic endeavour aimed at individualising patient care. The institutionalisation of health care, the subservience of nursing to medicine and the impact of technology in its various forms, have resulted in fragmentation of patient care. In response to these forces nursing has tended to take a functional approach to providing patient care. As was also established in Chapter 2 of this thesis, contemporary health care is exceptionally complex and highly changeable. While technology offers a multitude of benefits for patients it is up to nurses to find a way to manage and still provide patient-centred care. Since continuing and increasing demands for effectiveness and efficiency dominate the landscape, the integration of patient-centred, humanistic nursing care in this technology-driven environment has the potential to make the illness experience more bearable for the patient. It was also argued that contemporary health care, with all of its complexities requires health care team members to work collaboratively, so that desired patient outcomes are achieved. The notion of partnership is an important component of collaboration and includes the patient and family. Integration of the efforts of the health care team and patient and family is more likely to lead to cohesive, co-ordinated and efficient health care. Collaborative partnerships in combination with the primary nursing model of care delivery offer nursing its best opportunity of providing patient-centred nursing care focused on achieving patient outcomes.

Critical differences between the categories of description for clinical teacher experiences of nursing and the desired way of experiencing nursing

A number of critical dimensions of variation of the desired way of experiencing nursing were identified by considering the differences between the various categories of description.

The important differences in clinical teachers' conceptions (what) of nursing and their approaches to nursing (how) are in the perspectives taken by this group of clinical teachers. Key differences in the ways of experiencing nursing include either a task-focused conception or collaboration for outcomes-focused perspective and adoption of either a nurse-focused or patient-focused approach to nursing (See Table 6.1). A nurse-focused, task-oriented conception and approach is less complex than a patient-focused, collaboration for outcomes conception and approach.

The dimensions of variation in how nursing is approached (how) by clinical teachers

The key differences in the 'how' of nursing, that is clinical teachers' approaches to nursing, are identified in the intentions (indirect object) and strategies (act). The quality of the nursing strategies is apparent in the clinical teachers' intentions, which are either aimed at

performing nursing tasks or collaborating for achievement of patient outcomes. Either patient-focused or nurse-focused strategies (act) were used, depending on the intentions (indirect object). A patient-focused approach to nursing involves the adoption of patient-focused nursing strategies aimed at collaboration with the health care team to achieve particular patient outcomes. A nurse-focused approach involves the use of nurse-focused strategies aimed at the performance of nursing tasks.

Despite the recommendations in the non-empirical literature, one way of approaching nursing was to adopt a nurse-focused approach to patient care. When such an approach to nursing is adopted it is seen to be less than desirable. According to McConnell (1998) taking a technical approach means that tasks are the focus of care rather than the patient. Bernardo (1998), Binnie and Titchen (1999) and Pearson (2003), assert that taking a technical approach to nursing highlights nursing's dependence on medicine. Importantly, a nurse-focused approach contradicts the professional commitment of nursing to provide holistic patient care (Spitzer, 1998).

Having a task orientation implies that the nurse's focus is on providing what is routinely done for patients. For example, physical and/or technical care which is considered to be a necessary part of the patient's treatment is performed and may be extended to include emotional or spiritual care as required. When practice is organised in such a way, fragmentation occurs. Begun, Tornabeni and White (2006) argue that fragmentation is a feature of contemporary health care where increasing specialisation has led to discipline-centred care rather than patient-centred care. As a consequence, the patient is cast into a submissive role and the relationship between patient, nurse and task is lost (Allshouse, 1993). Begun et al. (2006) and O'Connell and Warelow (2001) argue that inefficiencies and errors are likely consequences of such an approach. The results of this study indicate that when nursing is approached in a nurse-focused way the patient is not part of the nurse's awareness. The question of why nurse-focused approaches to nursing are adopted may be answered by further examining the key variations in clinical teachers' conceptions of nursing.

The dimensions of variation in how nursing is conceived (what) by clinical teachers

The key differences in clinical teachers' conceptions of nursing include either a task-focused conception or collaboration for outcomes-focused perspective. Although specific research focused on clinical teachers' conceptions of nursing was not detected in the literature, the findings of this study are consistent with documented professional opinions. As established in Chapter 2 of this thesis since the time of Florence Nightingale, nursing has espoused the ideals of patient-focused care. This view appears to be supported in this study as it is one of the key ways in which nursing is understood by this group of clinical teachers.

Understanding that nursing is about providing patient-centred care means that patients should be better positioned to receive cohesive, meaningful, holistic nursing care (Talerico et al., 2003).

Relationship between clinical teacher conceptions and approaches to nursing

As was argued in Chapter 3 of this thesis, the use of quantitative analysis was appropriate to complement phenomenographic analysis by showing the relationships between individuals and the various ways of conceiving and approaching a phenomenon. The analysis of the logical relationship between conceptions and approaches to nursing suggests that there is a strong internal relationship between the two. The results suggest that clinical teachers, who adopted a patient-centred approach to nursing, conceived of nursing in complex ways. That is, they were aware of the need to work collaboratively with the health care team to optimise patient outcomes. A proportion of clinical (60%) teachers were classified as having a patient-focused conception of nursing. The results also suggest that clinical teachers who approached nursing from a nurse-focused perspective conceived of nursing in less complex ways. That is, the focus of some clinical teachers was on performing tasks and getting the work done.

The results of this study suggest coherence between conceptions of nursing and approaches to nursing for these clinical teachers. That is, in order that a patient-focused approach to nursing is taken, a complex conception of nursing may be required. What is noteworthy, however, is that whilst the majority of clinical teachers in this study were classified as holding complex understandings of nursing, some modified their approach to nursing so that a nurse-focused approach was adopted. A proportion of clinical teachers (55%) were classified as having a nurse-focused approach to nursing.

Modification of approaches to nursing might occur as a consequence of the demands of the environment in which nursing care is being provided. According to Jonsdottir, Litchfield and Pharris (2004) highly regulated, technology-driven, contemporary health care environments impact on the caring and relational aspects of nursing practice. Brockhaus and Richardson (1985) and Spitzer (1998) argue that organisational systems that involve rigid routines, rules and standardised procedures mitigate against personal contact with patients, independence as professionals and development of relationships with other disciplines, in particular, medicine. O'Connell and Warelow (2001) argue that changes in work conditions for nurses in acute-care settings which have occurred as a result of rationalisation of resources, have impacted in a variety of ways. They cite examples such as increased patient acuity, decreased length of stay for patients, problems with recruitment and retention of staff and shorter shift lengths amongst others. They assert that under such conditions any nurse would have difficulty maintaining a patient-focus.

Adjustment to approaches to nursing might also occur as a consequence of the nursing culture or the model of nursing care delivery being employed. While nurses strive to provide holistic, patient-centred care, Tonuma and Winbolt (2000) report that the way nurses work is influenced by traditional nursing culture. They explain this as “task orientation, rigid structures and resultant disempowerment of staff” (p. 24). Another possible explanation for why nurses might change their approach to nursing is related to the nursing care delivery system. Adams, Bond and Hale (1998) propose that when a functional care delivery system is in place the focus of nurses is on completion of tasks. The resulting problems include fragmentation of patient care, lack of continuity between nurse and patient and lack of individual nurse responsibility. As was established in Chapter 2 of this thesis a functional approach to nursing, where the nurse is task-oriented, reduces the likelihood of forming caring patient-nurse relationships and individualising patient care. Other problems associated with this limited approach to nursing is that responsibility is devolved to more senior staff and nurses are not likely to be involved in decision-making. It is possible therefore, that when some nurses perceive the context to be task-orientated, the approach to nursing is modified. The nurse-focused approach to nursing is then inconsistent with the nurses’ conceptions. It is therefore conceivable, and concerning, that clinical teachers who approach nursing in a nurse-focused way may focus on this aspect when teaching and supervising undergraduate nurses on clinical placement.

Part 2: Clinical teachers’ experiences of clinical teaching

Review of the desired way of experiencing clinical teaching

It was argued in Chapter 2 of this thesis that it is important that teachers experience teaching in a complex, student-focused way so that students are more likely to achieve high quality learning outcomes. Conceptions and approaches to teaching which are student-focused are those that are more complex than teacher-focused conceptions and approaches but include them. A complex way of experiencing teaching includes a number of important aspects. When teaching and learning is conceived of in student-focused ways approaches to teaching are focused on the student. When the intention is for students to achieve conceptual change, student-focused teaching strategies are adopted. However, if teaching is approached in teacher-focused ways then students are likely to adopt surface approaches to teaching and are less likely to achieve high quality learning outcomes.

Critical differences between the categories of description for clinical teacher experiences of clinical teaching and the desired way of experiencing teaching

A number of critical dimensions of variation of the desired way of experiencing teaching were identified by considering the differences between the various categories describing the variation in the experience of clinical teaching. The important differences in clinical teachers’ conceptions (what) of clinical teaching and their approaches to clinical teaching

(how) are in the perspectives taken by the group of clinical teachers. Key differences in the ways of experiencing clinical teaching include either a transmission-focused conception or conceptual development and change-focused perspective and adoption of either a teacher-focused or student-focused approach to clinical teaching (See Table 6.1). These key aspects of variation are consistent with and confirm research outcomes documented in the higher education literature. A teacher-focused, content-oriented conception and approach is less complex than a student-focused, conceptual development and change conception and approach.

The dimensions of variation in how clinical teaching is approached (how) by clinical teachers

The key differences in the ‘how’ of clinical teaching: that is clinical teachers’ approaches to clinical teaching, are identified in the intentions (indirect object) and strategies (act) used by the clinical teacher. The quality of the teaching strategies is apparent in teachers’ intentions, which were either aimed at reproduction of tasks or facts or conceptual development or change. A student-focused approach to clinical teaching involves the adoption of student-focused teaching strategies aimed at conceptual development and change. A teacher-focused approach involves the use of teacher-focused strategies aimed at the reproduction of facts and tasks. Either student-focused or teacher-focused strategies (act) were used in this study, depending on the clinical teachers’ intentions (indirect object). The findings of this study are consistent with other studies where variation in approaches to teaching was found.

The descriptions of approaches to clinical teaching in this empirical study have elements similar to findings from studies conducted by Prosser, Trigwell and Taylor (1994) and Trigwell, Prosser and Waterhouse (1999). In those two studies and this particular study, teachers adopted either a teacher-focus or a student-focus aiming for either reproduction or conceptual development and change. When clinical teaching is approached in a sophisticated and complex way the student, the teacher and learning tasks are in relationship with each other.

If one way of approaching clinical teaching is to aim for reproduction of facts and skills then, according to the research findings of Trigwell, Prosser and Waterhouse (1999) students of such classroom teachers are more likely to adopt a surface approach to learning. Such an approach is described by Trigwell et al. (1999) as a less effective approach to teaching. Furthermore, if the student perceives that the clinical context is one where reproduction of knowledge and routine tasks is all that is required, it is more than likely that a surface approach to learning will be adopted. Surface approaches to learning, as previously described in Chapter 2 of this thesis, have been shown to be related to poor quality learning outcomes (Marton & Säljö, 1976a; Prosser, Trigwell and Taylor (1994); Ramsden, 2003; Trigwell & Prosser, 1991; van Rossum & Schenk, 1984). The question of why teacher-

focused approaches to clinical teaching were adopted may be answered by further examining the key variations in clinical teachers' conceptions of clinical teaching.

The dimensions of variation in how clinical teaching is conceived (what) by clinical teachers

The findings of this study are consistent with other studies where variation in conceptions of teaching was found. Dall'Alba (1991) and Trigwell and Prosser's (1996b) research into how teachers in higher education conceive of teaching and their students' learning identified variation in conceptions, where some conceptions were found to be complex and others less so. A hierarchical relationship between conceptions was apparent. Similar results have been found in studies by Martin and Balla (1991), Prosser, Trigwell and Taylor (1994) and Samuelowicz and Bain (1992). In this particular study, the more complex clinical teacher conceptions are focused on conceptual development and change and the less complex conceptions are focused on transmitting facts and skills as is the case in studies cited above.

Relationship between clinical teachers' conceptions of clinical teaching and approaches to clinical teaching

Analysis of the logical relationship, as opposed to the empirical relationship, between conceptions and approaches to clinical teaching suggests that there is an internal relationship between the two. These findings are consistent with the findings of numerous other studies where qualitatively different ways of experiencing teaching in the higher education context have been identified. Trigwell and Prosser (1996a) and Trigwell, Prosser and Waterhouse (1999) have shown that there is a relationship between the approaches university teachers take to their teaching and their conceptions of teaching. That is, teachers who conceive of teaching in student-focused ways approach their teaching in student-focused ways.

Relationships between approaches to teaching, conceptions of teaching and learning and teacher perceptions of the teaching context have been empirically identified in other studies as well (Martin & Balla, 1991; Prosser & Trigwell, 1997, 1999a, 1999b; Trigwell, Prosser & Taylor, 1994). In these studies it was found that there is usually coherence between teacher approaches to teaching and their conceptions of teaching and learning. Results of this study showed similar coherence between conceptions and approaches to clinical teaching.

Therefore, it is unlikely that clinical teachers will adopt a student-focused approach if they do not conceive of clinical teaching in a transformative, student-focused way.

This study has identified that a proportion of clinical teachers (35%) approached clinical teaching in a student-focused way. Adoption of a student-focused approach involves teachers trying to help students to transform their thinking. Teachers in this study with a student-focused approach showed awareness of the nature of not only their own understanding, but also student understanding of nursing. Teaching strategies were used that would appear to help students develop a deep understanding and develop and change their conceptions of

nursing. While this approach to teaching in classrooms is described by Trigwell, Prosser and Waterhouse (1999) as an effective approach to teaching, it also appears to be an effective approach to teaching in the clinical setting. There is evidence in this study that a proportion (65%) of clinical teachers approached clinical teaching in a less than desirable way. Given the limitations of this study, the size of the proportions will require further study in the future using a random sample.

As was established in Chapter 2 of this thesis conceptions and approaches to teaching are related. Marton and Booth (1997) assert that amongst other things, a complex conception of teaching is related to the teacher's depth of understanding about the subject matter being taught. In this study a relationship is apparent between conceptions of teaching and approaches to nursing. If approaches to nursing are modified in response to the environment it may be difficult to hold a complex conception of clinical teaching in that environment. In this study a relationship is apparent between conceptions of clinical teaching and approaches to nursing. The results show that for clinical teaching to be understood in a complex way a patient-focused approach to nursing may be required.

Section 2: Research approaches

While there is no clear approach to phenomenographic research, the detailed approach used in this study follows the majority of other reported phenomenographic studies and is provided in Chapter 3 of this thesis. What follows is a reflection on aspects of the method used. In particular, discussion will focus on problematic aspects (selection of participants and data collection) and recommendations are made. Since phenomenographic research methods are constantly evolving it is anticipated that any variations used in this study will assist with the development of the methodology. In particular, variations in data analysis and verification of communicability of results are reflected on in this section.

Selection of participants

The theoretical sampling technique was used to select the sample of twenty clinical teachers.

In preparation for the pilot study one particular university was contacted for access to clinical teachers who were sessionally employed by that university. These clinical teachers were engaged specifically to supervise and teach undergraduate nursing students in the clinical setting. A problem was encountered when the clinical co-ordinator from this particular university perceived different researcher motivation. Since clinical teachers are difficult to recruit because of the nature of the terms of employment, it was perceived that since I was employed by a nearby university that poaching of teachers might occur. Instead of relying on individual university clinical co-ordinators to provide access it may have been more time efficient and less complicated to advertise in newspapers and nursing journals inviting participation in the study.

Data collection

In order to fulfill the aim of this study, semi-structured interviews were used to fully understand the different ways in which a particular group of clinical teachers experienced nursing and clinical teaching of undergraduate nursing students on clinical placement and how those experiences related to each other. Semi-structured interviews are described as a typical data collection method in phenomenographic studies (Booth, 1992). The focus of each interview was on how the teacher experienced nursing and clinical teaching in order to determine the meaning (What) of nursing and clinical teaching and the approaches (How) to clinical teaching that were adopted in order to identify the variation of the experience. The interview experience appeared to be a positive experience for the participants. Some sought further discussion about issues they were experiencing in their roles as clinical teachers. During some interviews I detected a shift in the participant's focus when requests were made for me to give more information about clinical teaching. I was careful to redirect the focus back to the relevant questions of the study. I was also careful to ensure in each of the interviews that I had collected adequate information to inform my study. Requests for more information were taken as partial evidence that I had established a positive rapport with each of the participants and had understood the ways in which they experienced the phenomena. The desire for further information demonstrated that there was either inadequate preparation for the role and/or not enough ongoing support. One participant, in particular, lacked understanding of the tool that she was required to use to assess her students. Conducting a small pilot study provided the opportunity to test the research questions and processes. As a consequence of the pilot study it was identified that some of the questions were flawed and adjustments were made as discussed in Chapter 3 of this thesis. For example, a common way to beginning an interview according to Bowden (2000) is to ask the participant to reply to a given situation. The question "Describe a situation you have been involved in, which you think depicts what nursing is about at this hospital" provided difficulties for some participants. The reason for this difficulty was unclear, however the question was adjusted as described in Chapter 3 of this thesis. Similarly, the question relating to the participants' conceptions of clinical teaching could not be confined to the particular environment they were currently teaching in. It was originally envisaged that clinical teachers would be asked to reflect on their current teaching. This proved to be problematic because not all clinical teachers were teaching at the time of the interview. In addition, all of the teachers referred to various teaching experiences with the exception of one person who was teaching for the first time.

Piloting the processes of the study was particularly useful for me to practice my interview technique. During the early interviews of the pilot study it became evident that I needed to appreciate the value of participant silence and to allow time for pauses. Furthermore, Säljö, (1988) expresses concern that participants in interviews might provide any answers to

questions out of a sense of obligation rather than feel uncomfortable when being asked a difficult question. In several interviews some participants, sought clarification at various times during their interview. One in particular, when asked to “Describe a situation you have been involved in which you think depicts what nursing is about at this hospital” asked me what I was getting at. This question required careful handling and rephrasing of the question.

Semi-structured interviews, according to Booth (1992) allow for this contingency.

Another important advantage of conducting a pilot study is that early data analysis assists with improvement to later data collection. Through early analysis, themes relating to how nursing and clinical teaching were experienced were identified as described in Chapter 3 of this thesis. This assisted with the development of probing questions used in subsequent interviews as I tried to identify the internal and external horizons of the ways of experiencing nursing and clinical teaching. The use of the framework of a structure of awareness allowed effective structuring of interviews.

Data analysis

Since there is some variation in the way phenomenographic analysis is approached, it has therefore been important to clearly document the approach taken in this study. This approach has been documented in detail in Chapter 3 of this thesis. The provision of a clear and open account has assisted in the identification of the distinctly different ways of experiencing nursing and clinical teaching by a particular group of clinical teachers. The process of analysis as advocated by Booth (1997), Dahlgren and Fallsberg (1991) and Marton (1986), was followed. The process undertaken enabled the identification of key themes and the development of questions which were aimed at identifying differences and similarities in order to discover the meaning within the whole data set. Following on from the “whole of transcript” approach, transcripts were also explored individually to further identify similarities and differences. Categories of description emerged as a consequence of iteration between the data and the categories. The data and categories were continually searched for an internal logical relationship between the categories of description and the experiences of nursing and clinical teaching. Finally the categories were named, supported by direct quotations from specific transcripts and compared and contrasted with each other. Meaning was therefore identified as a consequence of the relationship between me, as the researcher, and the data.

What has also been done in this study which has not been commonly done in other phenomenographic studies is the description of how the categories of description evolved. In Chapter 3 of this thesis the process of category development is provided in detail. Various examples of the categories of description are provided at various stages of the analysis.

It was argued in Chapter 3 of this thesis that the use of quantitative analysis can be complementary to phenomenographic analysis. In this thesis both phenomenographic

analysis and quantitative analysis were used. Results have been interpreted in a complementary way in relation to the central concern: the relationship between how clinical teachers experience nursing and clinical teaching. In this study quantitative analysis is clearly separate from phenomenographic analysis. Development of categories of description that comprise the four outcome spaces is clearly described as part of the phenomenographic analysis. Use of quantitative analysis successfully enabled investigation of the relationships between how nursing was experienced and how clinical teaching was experienced.

Verifying communicability of the results

To counter problems related to validity, reliability and generalisability of the results of this study, the categories of description and a number of individual quotations from the data were provided to other nurse educators at different times. These nurses were asked to match the comments to the most appropriate category so that categories of description could be substantiated and to begin the process of classifying the transcripts against the outcome spaces. This approach differed from many phenomenographic studies where transcripts, in their entirety, were used to check the communicability of the categories of description.

In some recent phenomenographic studies a structure of awareness has been used for describing variation in ways of experiencing a phenomenon (Marton & Booth, 1997). Use of this framework to consider ways of experiencing nursing and clinical teaching assisted analysis considerably. In this study a structure of awareness helped to illuminate the way nursing and clinical teaching were experienced and the ways in which the internal horizon and the nature of the boundary of the external horizon delimited each phenomenon from its context.

In summary, the techniques of phenomenographic research approaches are continually developing. Some variations from the general approach described in the literature were used in this study. The variations found to be beneficial included analysis at the individual quotation level as well as the whole transcript level; the use of a structure of awareness as an analytical tool during data collection and analysis; and the use of individual quotations rather than whole transcripts in the process of verifying the communicability of the categories of description. Separate from the phenomenographic analysis, use of quantitative analysis to investigate the relationships between the phenomena was found to be effective.

Section 3: Implications of this study for nursing and clinical teaching

The variability of nursing student learning outcomes is of concern given that graduate nurses are expected to be adequately prepared for the professional nursing role. This concern has been the subject of two Australian government enquiries in the past twelve years, referred to in Chapter 1 of this thesis. As a consequence, a variety of solutions are identified in the literature (for example, see Farrell, Pearson & Roberts, 2002). This section considers the significance of the critically different aspects identified between clinical teachers'

experiences of nursing and clinical teaching. The findings of the study confirm what is already known about teachers' experiences of teaching in classrooms in the higher education sector, but has identified new knowledge to inform clinical teaching in nursing. Furthermore, what is noteworthy about the results of this study is the identification of a hierarchical structure for how nursing was experienced by the group of clinical teachers in this study. The non-empirical literature has not previously identified this hierarchical structure of nursing. The new knowledge generated by this study will help progress what is already known about nursing and clinical teaching in nursing, as well as teaching in the higher education sector. A problem identified in this study was the impact of the environment on nurses' approaches to nursing. For some nurses, the effect of the environment can be related to modification of their approach to nursing. That is, the approach adopted is altered by some nurses if the clinical environment is perceived to be task and routine focused. The appeal in the literature for nurses to adopt humanistic approaches to nursing is evident. McCormack (2004) argues for nurses to adopt genuine humanistic approaches to their practice by moving away from a technical focus. Humanistic nursing practice, according to McCormack "embrace(s) all forms of knowing and acting, in order to promote choice and partnership in care and decision-making" (2004, p. 36). Despite advocating for a humanistic approach to nursing, McCormack (2004) acknowledges that the context is influential in either limiting or enhancing the provision of care that is focused on the patient.

In order to move beyond routine and ritual-based care associated with the demands of technology, nurses need to adopt sophisticated, patient-centred approaches to patient care. As argued in Chapter 2 of this thesis, an outcome-focused approach to caring for patients allows for the identification of patient strengths, in addition to patient problems. According to McAllister (2003) such an approach is efficient and effective and moves beyond technical knowledge to emancipation of both the patient and the nurse. McAllister (2003) states the nurse moves from doing to the patient to "working with and for the patient" (p. 533). Furthermore, patient outcomes are further improved if relevant health professionals involved in the patient's care unify their efforts so that resources are used more effectively and the patient receives cohesive, co-ordinated and efficient health care (Degeling, Hill, Kennedy, Coyle & Maxwell 2000; Kitson, 2002). By taking a multidisciplinary approach resources are used more effectively and the patient receives cohesive, co-ordinated and efficient health care (Degeling et al., 2000; Kitson, 2002). A comprehensive approach to patient care such as this assists the development of mutual patient goals. This is consistent with the writings of Florence Nightingale who conceived of nursing as being about more than performing tasks. In reporting on the writings of Florence Nightingale, Holliday and Parker (1997) state that it was Nightingale's opinion that rather than work for doctors, nurses need to work collaboratively with doctors.

The identification of a hierarchical structure to demonstrate how nursing was experienced by the group of clinical teachers shows that nursing can be understood in a number of different ways. This structure will assist with helping clinical teachers be more aware of different aspects of how nursing is understood and approached. As was established earlier on in this thesis it is likely that clinical teachers who approach nursing in a nurse-focused way may also focus on this aspect when teaching and supervising undergraduate nurses on clinical placement. Therefore, focusing on clinical teacher conceptions and approaches to nursing is as important as focusing on conceptions and approaches to clinical teaching. Identifying the key but different ways nursing can be understood and approached is fundamental to helping clinical teachers see more aspects of how nursing might be experienced. By experiencing nursing in a more complex way it is likely that clinical teachers can also experience clinical teaching in more sophisticated ways.

Furthermore, the structure of how nursing was experienced by the group of clinical teachers in this study might also prove to be useful in aspects of undergraduate nursing curricula. It is recommended that identification of the impact of the environment on nurses' approaches to nursing and use of this structure of how nursing may be experienced could help nursing students better appreciate the realities of the practice world. Illumination of the critically different aspects of the experience of nursing: that is the "What" and "How" of nursing, presents a structure for helping, not only nursing students but clinical teachers as well, to be aware of more aspects of nursing and how it may be experienced.

The clinical teachers in this study were responsible for teaching and supervising undergraduate nursing students as they learnt how to be nurses. However, clinical teacher experiences of clinical teaching were found to be inadequate in comparison with the desired way of teaching in classrooms. With the adoption of low level conceptions and approaches to clinical teaching, the focus was on quantitative differences in students' learning. Teachers with such a transmission conception were more concerned with what they were doing than with what the student was doing. The focus was on the teacher providing what they thought the student needed in terms of facts and skills. Given that studies by Trigwell and Prosser (1996a) and Trigwell, Prosser and Waterhouse (1999) have also shown that there is a relationship between the ways teachers experience teaching and the ways in which their students experience learning, the implications for preparation and support of clinical teachers is important if quality of learning outcomes of nursing students is to change.

It was established earlier on in this thesis that for teaching to be considered successful, adoption of a student-focused approach to teaching is important if students are to achieve high quality learning outcomes. However, another problem identified in this thesis is that it is unlikely that clinical teachers will adopt a student-focused approach if they do not conceive of clinical teaching in a transformative, student-focused way. Given the

significance of the findings of this study, appropriate preparation of clinical teachers is therefore important. A significant proportion of the clinical teaching literature is focused on clinical teaching strategies as outlined in Chapter 2 of this thesis. However, the assumption is that adoption of such strategies will assist students to learn. Forbes and Prosser (2005), although reporting on assessment in clinical nurse teaching, caution that regardless of the method used it is the teachers' conceptions and intentions that are important. Strategies, it is argued, are likely to be used in accordance with clinical teacher conceptions and approaches to clinical teaching. Therefore, if a teacher conceives of clinical teaching in an unsophisticated way and aims for the student to reproduce required knowledge and nursing tasks then it does not matter what clinical teaching method is used.

For a successful teaching experience, clinical teachers need to be helped to be aware of more aspects of nursing and clinical teaching and how each might be experienced. According to

Bowden and Marton (1998)

“the capability of discernment and focusing on critical aspects of situations and seeing the patterns of characteristics in those situations is a far more holistic capability than those commonly defined in competency-based approaches. These holistic capabilities represent the links between disciplinary knowledge and professional skills. They are the results of the transformation of the eyes through which the professional world is seen, brought about in, and by, the scholarly world.” (pp. 8, 11-12).

It is possible, that when nursing competencies are viewed through a narrow and objective lens, where the focus is on students developing their abilities to perform nursing tasks, this may contribute to clinical teaching being interpreted in a low level, teacher-focused way.

Through surveying the literature it was not possible to establish any detailed information about clinical teacher preparation beyond the fact that it is thought to be important. As identified in Chapter 2 of this thesis French and Cross (1992) argued for clinical teachers to have academic training. Without it, they assert that teaching approaches would depend on teacher perceptions of what is required to be a nurse. This study has shown that clinical teachers' conceptions of nursing are related to how clinical teaching is approached. Until now, research in nursing education has not identified the relationship between clinical teacher conceptions of nursing, approaches to nursing, conceptions of clinical teaching and approaches to clinical teaching. It is feasible, despite the limitations of this study, to argue that adoption of a student-focused approach to clinical teaching may require a complex conception of nursing, a patient-focused approach to nursing and a complex conception of clinical teaching.

As part of their preparation and ongoing development, clinical teachers need to become aware, not only of the way they experience nursing but also how they conceive of teaching

and learning within the clinical setting. Preparation and support of clinical teachers needs to focus on expanding the awareness of clinical teachers, not only about the discipline of nursing, but also the teaching of nursing and how students learn. Encouragement of clinical teachers to examine the context in which they are teaching may help increase their awareness of how that context relates to or affects the way they teach. By encouraging more sophisticated conceptions of nursing, teaching and learning, the clinical teacher may change their approach to teaching to incorporate a wider range of teaching strategies (Bowden & Marton, 1998).

The critically different aspects of the outcomes of this study can be used to logically show that a patient-focused approach to nursing and a student-focused approach to clinical teaching are needed if students are to adopt more effective approaches to learning and therefore develop a deep understanding of nursing. For example, critical aspects of the outcomes of this study show that a student-focused approach to teaching is concerned with helping students to link theory and practice for understanding and helping them to develop and change their conceptions of nursing. By illuminating these critically different aspects of the experience of clinical teaching; that is the “What” and “How” of clinical teaching, a structure for clinical teacher preparation and support is provided.

Descriptions and analyses of clinical teachers’ experiences are central to trying to understand teaching in clinical settings and subsequently to work towards the continued improvement of teaching in this area. Knowledge about the critically different aspects of nursing and clinical teaching in clinical teacher preparation and support programs has the potential to position clinical teachers to develop a depth of understanding of nursing and teaching that is required for their work in supervising and teaching undergraduate nursing students. Nursing students stand to benefit from having clinical teachers who have complex understandings of nursing and clinical teaching and who adopt a student-focused approach to their teaching. Use of such an approach is likely to lead to nursing students becoming actively engaged in their learning, leading to knowledge development and transformation of thinking. Undergraduate nursing students will be better positioned to develop the required depth of understanding as they transfer into their new professional roles. For this reason the critical different aspects identified in the study represent an important contribution to the literature. These critically different aspects of nursing and clinical teaching provide an opportunity to improve clinical teacher preparation and support, curriculum design and consequently student learning about nursing.

Section 4: Clinical teaching in nursing

This study belongs to a group of phenomenographic and related studies which have investigated teachers’ experiences of teaching in the higher education sector. These studies have contributed to knowledge about teaching in higher education. The contribution of this

study to this body of knowledge is considered in this section. The findings of this research also contribute to the body of knowledge related to conceptions of, and approaches to, teaching from a phenomenographic perspective. In addition, the findings of this research contribute to the body of research that has informed the general understanding of teaching in higher education and more specifically to teaching in clinical settings.

Clinical teaching in nursing has not been studied previously using phenomenographic techniques. Researching clinical teaching from a phenomenographic perspective is particularly significant to the body of knowledge about teaching in higher education. It has been established through a number of phenomenographic and related studies that when teachers experience teaching in a complex, student-focused way their students are more likely to achieve high quality learning outcomes. These studies have identified that conceptions and approaches to teaching, which are student-focused, are those that are more complex than teacher-focused conceptions and approaches but include them. This study has focused on clinical teachers' experiences of clinical teaching only. Therefore, the relationship to student learning outcomes can only be surmised.

Despite the limitations of this study, the findings of previous phenomenographic and related studies have been confirmed. A complex way of experiencing clinical teaching in nursing includes a number of important aspects. When clinical teachers conceive of clinical teaching and learning in student-focused ways they approach their clinical teaching with a focus on the student. When clinical teachers aim for their students to achieve conceptual change they use student-focused teaching strategies. It is therefore reasonable to assume that if clinical teaching is approached in teacher-focused ways then students are likely to adopt surface approaches to teaching and are less likely to achieve high quality learning outcomes. Given this significance, it is important that the findings of this study support what is known about teaching in higher education developed from phenomenographic and related studies. These insights were described in detail in Chapter 2. The insights are reviewed here and the contribution of this study highlighted.

As was established earlier in this thesis, the phenomenographic research method is based on the view that a particular phenomenon can be experienced and understood in a limited number of qualitatively different ways (Marton & Booth, 1997). Further, that different ways of experiencing the phenomenon can be expressed in a hierarchy of categories of description representing different but incomplete understandings of the whole (Marton & Säljö, 1976a).

Both nursing and clinical teaching were found to be experienced in a limited number of qualitatively different ways. The different ways of experiencing both of these phenomena were related in hierarchies of inclusiveness and increasing complexity.

It was recognised in Chapter 2 of this thesis that teachers conceive of teaching in a limited number of qualitatively different ways (Dall'Alba, 1991; Martin & Balla, 1991; Prosser,

Trigwell & Taylor, 1994). Four qualitatively different conceptions of clinical teaching were identified in this study. The different clinical teaching conceptions were related in a hierarchy, based on logical complexity. Of the four different conceptions of clinical teaching, two key variations were apparent. The key differences of transmission or transformation were equivalent to conceptions of teaching described in other studies.

As was established in Chapter 2 of this thesis, teachers approach teaching in a limited number of qualitatively different ways (Prosser & Trigwell, 1999a; Trigwell, Prosser & Taylor, 1994). Four qualitatively different approaches to clinical teaching were identified in this study. The different teaching approaches were also related in a hierarchy based on logical complexity. Of the four different approaches, two key variations in clinical teaching approaches were apparent. The key differences were equivalent to the teacher-focused and student-focused approaches to teaching described in other studies (Dall'Alba, 1991; Martin & Balla, 1991; Prosser & Trigwell, 1999a; Samuelowicz & Bain, 2001; Trigwell, Prosser & Taylor, 1994).

It was recognised in Chapter 2 of this thesis that variation in approaches to teaching is related to prior teaching and learning experiences and teachers' perceptions of the teaching and learning environment (Prosser & Trigwell, 1997; Prosser & Trigwell, 1999a). It was argued that in the higher education setting, teachers enter teaching contexts with a range of previous experiences of learning and teaching. In this study, clinical teachers' former experiences of nursing are related to the ways in which they experience clinical teaching. Student-focused approaches to clinical teaching were related to complex conceptions of nursing and patient-focused approaches to nursing.

Finally, it was established in Chapter 2 of this thesis that the approach to teaching is related to the teacher's conception of teaching (Trigwell, Prosser & Taylor, 1994; Trigwell & Prosser, 1996b). Both logical and statistically significant empirical relationships were identified between approaches to clinical teaching and complexity of the way of conceiving of clinical teaching. Only the student-focused approach to clinical teaching identified was associated with the more complex ways of conceiving of clinical teaching. In addition, the consistencies of the findings in many other phenomenographic studies which have led to specific knowledge about teaching in higher education provide validity to the findings of this study.

In summary, the findings of this study support previous phenomenographic and related research findings into teaching in higher education. This study also adds to the body of knowledge about the influence of context on approaches to teaching. In circumstances where the context is perceived to be task and routine focused the conceptions of teaching may be influenced. Clinical teachers' conceptions and approaches need to be adjusted to promote

factors known to encourage deep learning approaches other than emphasising reproduction of tasks and/or facts.

Section 5: Further research

Having considered the implications of the research reported in the thesis for nursing, clinical teaching in nursing and higher education and the development of phenomenographic research approaches in general, some suggestions for future research are presented.

If approaches to patient care are truly multidisciplinary then professional roles in health care could be more flexible. Advantages of such an approach, as described by Cameron and Thompson (2005), include the potential to increase the availability of health care workers, reduce health care costs and improve job satisfaction. Cameron and Thompson (2005) contend, however, that currently, any notions of collaboration between health care professionals is informal and adhoc at best. They argue that both nursing and medicine, as the two major professional groups within the health care system, are dogged by lengthy histories of power struggles within, and between the two disciplines, as they fight to protect their professional boundaries. They further argue that a dysfunctional health care system is the result of this introspection. Shortages and mal-distribution of health care professionals with required skills have resulted in patients having poor access to services and high levels of job dissatisfaction among health care professionals.

According to McCormack (2004) nurses need to balance a range of competing demands, amongst them the organisational and professional requirements and are not well prepared for this. To be collaborative, requires the professional ability to contribute to the decision-making of the health care team. Taking a task approach to nursing is therefore no longer appropriate. Knowledge about nurses' experiences of collaboration with the multidisciplinary health care team is an area of importance and therefore requires further definition and exploration through research. The focus of this research needs to uncover the key, but limited ways in which nurses conceive of, and approach collaboration. Knowledge of the different ways in which collaboration with the multidisciplinary health care team is experienced by nurses would lay the foundation for future developmental activities to improve patient care, nursing and subsequently clinical teaching of nursing students.

There were some limitations to the study reported in this thesis. Clinical teachers' experiences were investigated using only a small number of clinical teachers. It is likely that only some of the possible variations in the experience of clinical teaching in nursing were identified. Hence there is no guarantee that all of the educationally critical aspects of the teaching experience became evident. Investigating the teaching experiences of a wider range of nurses who provide clinical supervision for nursing students would therefore be an interesting and worthwhile research project.

Research in the higher education sector has identified relationships between teacher approaches to teaching, student approaches to learning and the quality of student learning outcomes. Investigating nursing student experiences of learning in the clinical setting and identifying whether a relationship exists between clinical teacher approaches to teaching and student learning outcomes would be an important and worthwhile research project.

Section 6: Thesis conclusion

Clinical teachers are an important conduit between universities and hospitals where nursing students experience a theoretical and skill development program for application in the clinical setting. This study has been concerned with experiences of nursing and clinical teaching from the perspective of a group of those clinical teachers in nurse/patient and teacher/student situations. This study, with its logical and empirical evidence has shown the holistic entities of nursing and clinical teaching.

While there is a desired way of experiencing nursing that has been well documented over time, this study has identified differences in the way nursing is experienced by examining the experiences of a particular group of nurses from a phenomenographic perspective. Although varying approaches to nursing have been identified, problems arise for patients, nurses and the nursing profession when a nurse-focused approach is taken. A proportion of clinical teachers in this study have taken a nurse-focused approach to nursing. This is in direct contradiction to the ideals of nursing. While there was variation in their conceptions, the majority of clinical teachers held complex understandings of nursing. The reasons for nurses taking a nurse-focused approach to nursing are not particularly apparent when their conceptions of nursing were examined. A possible explanation for why clinical teachers, holding complex conceptions of nursing but adopting nurse-focused approaches to nursing, may lie in the nature of the environment in which these nurses work. It would appear that highly regulated, technology-driven, environments which are focused on achieving efficiency and effectiveness have impacted on nursing and the way it is conducted. While there is a desired way of experiencing teaching that has been well researched and documented, this study has identified similar differences in the way clinical teaching is experienced. Limited, but qualitatively different conceptions and approaches to clinical teaching have been identified. Furthermore, a strong relationship was demonstrated between conceptions of clinical teaching and approaches to clinical teaching. A proportion of clinical teachers in this study have taken a teacher-focused approach to clinical teaching. The reasons for clinical teachers taking a teacher-focused approach to teaching are apparent when their conceptions of clinical teaching were examined. While there was variation in their conceptions, a proportion of clinical teachers held low level, transmission conceptions of clinical teaching.

It has been argued previously in this thesis that from a phenomenographic perspective conceptions of a phenomenon are not inherent characteristics of the individual but are the relationship between the person, the particular phenomenon in question and the context in which both are situated (Marton, 1981, 1986). Marton (1981, 1986) further argues that the resulting conceptions are context dependent and are therefore changeable. The experience of nursing in this thesis was seen as a relation between the clinical teacher working as a nurse

and the health care context. The clinical teacher's experience of nursing is therefore a function of previous nursing experiences and the context in which they are employed. The findings of this study provide important insights into how nursing and clinical teaching are understood. This new knowledge about nursing and clinical teaching and the relationship between them, provide a useful structure for clinical teacher preparation and support, and undergraduate nurse preparation in the future, with the potential for improving the quality of student learning outcomes.

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