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Teaching Nursing Practice at Jordanian Universities

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by

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Dedication

Dedicated to my parents, my brother Dr Yousf,

my husband and to all members of my family.

Acknowledgement

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Summary

This research examined factors affecting the effectiveness of clinical teaching of nursing in Jordan for the first time. Three methods were used, a questionnaire administered to students and teachers, direct observation of ten teachers and critical incidents elicited from students. The technique of critical incidents asked students to give events which were examples of good and bad teaching practice and a large pool of incidents was developed. It was found that the questionnaire method did not give useful results because of a large response bias, suggesting that questionnaires, at least in English, may be inappropriate for use in Jordanian student evaluations.

The critical incidents were classified by the researcher with a jury and the types of effective and ineffective behaviour identified were generally similar to those found in the previous literature. They were also supported both by the researcher's direct observations and by students' and teachers' suggestions for improving teaching, made in the questionnaire. Five categories of issue were identified, the interpersonal abilities of the teacher, summative evaluation, formative evaluation, professional competence and motivational factors. Some special problems were identified which reflected the difficulties of applying nursing practices learned from Anglo-American textbooks to Jordanian society. Other problems included teachers failing to have sufficient interaction with the students or with ward staff, teachers not being involved in clinical procedures themselves and teachers not interacting appropriately with students. There were also problems with evaluation; formative evaluation was often absent or confused with summative evaluation and the criteria for summative evaluation were not clear. These findings are discussed with reference to the previous literature and a number of suggestions are made for improving clinical teaching of nursing in Jordan.

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Chapter ❶

Background to the study

This chapter will describe the reasons for undertaking the research, its purpose and objectives. The main reasons behind the interest of the researcher in conducting this study were as follows:

From the author's experience as a nursing supervisor at Jordan University Hospital it appeared that newly qualified nurse BSc graduates were deficient in clinical skills, their performance was not satisfying the needs of the patients. Many incidents happened in the hospital, caused for example by recent graduates giving medication wrongly, communicating poorly with the patients and lacking basic technical skills in nursing. Also they lacked a professional attitude to nursing. They appeared reluctant to become involved in basic nursing care, only concerned with academic medical knowledge and inexperienced in the provision of basic nursing. They also appeared to feel that their degrees meant that further learning and skill acquisition were unnecessary. Additionally, they appeared to feel that they had a high status which was not compatible with basic nursing tasks needed for patient care.

These issues were discussed in a committee led by the nursing director at Jordan University Hospital in June 1992 with the supervisors of the hospital's units and the Dean of the School of Nursing at Jordan University. Different views were pressed as regards the causes of the general weakness in graduate nurses. Some supervisors blamed the problems on the qualities of the clinical teachers and on the clinical teaching methods adopted in schools of nursing,

some attributed the problems to the limited time devoted to clinical teaching in School of Nursing, some blamed the students themselves claiming that they were not willing to make an effort to learn how to nurse the patients.

Reilly and Oermann (1992) claimed that the major aim of clinical teaching is to develop in the students the confidence and competence in providing patient - centred quality nursing care and prepare them as a future professional nurses for the health care services. Therefore the decision was made to identify how clinical teaching affected students' learning by allowing the students to describe effective and ineffective clinical teaching behaviours as they experienced them.

The second reason behind conducting this study was that recently, in Jordan after the Gulf crisis at 1991, 10 private universities were established. In two of them, two schools of nursing opened. The researcher will act as the Dean of one of them (Applied Science University). The major philosophy of this university is addressed in its name (Applied Science), Nursing being one of the applied sciences. Therefore the decision was made to focus this study on the teaching of the clinical part of the nursing curriculum by investigating factors contributing to clinical teaching effectiveness in nursing.

Effectiveness to be judged by those who already experienced it; senior nursing students and faculty members at Jordanian Universities. Stewer J. (1987) stated that "the wide range of characteristics in setting, students, and faculty makes it essential for educators to evaluate their own programmes before they adopt a popular new curriculum whole sale", p.31.

In addition the fees of the students in the private universities in Jordan are eight times more than the fees for the state universities. So it is quite expensive for the students, therefore one might anticipate that students want to know what they are paying for. In general, most students have a goal in mind

and they are unwilling to be subjected to hours of unrewarding and irrelevant material (Morton 1987). Therefore, to identify the practices of effective clinical teaching as described by student nurses, might be a crucial issue to identify what features should be presented, deleted or modified to be implemented in the new institution.

In Jordan all nursing texts are borrowed from UK or USA and none are Jordanian. These texts were made for USA or UK culture to meet the needs of those cultures. The extent such texts are applicable and fit the needs of Jordanian society is not known. This might be a crucial issue because nursing is considered as an applied science which directly influences human health.

Leininger (1978) discussed the issue of transcultural health care which might arise if for example a nurse from America wants to work in Scotland. This also applies to the issue of bringing an American or British text into Jordan; Sohier (who is Scottish) in Leininger (1978) after she described her traditional values and beliefs, she described her situation. When she went to work in a Jewish community she said "with these values and self - perception, I began working for the first time in my life in a large Jewish community. A few days were essential to recognise my own distress signals and my need to adjust to a new cultural group; the Jewish people. Indeed these people appeared strange and different to me. I did not comprehend their values and behaviour for some time, even when they spoke excellent English. I knew, however, that I was not meeting the needs of the Jewish family. While any nursing school in Scotland had taught me to provide physiological and psychological care to patients, this was not enough. I could not read their family signals, nor distinguish clearly between physiological and psychological needs of the people in relation to their cultural orientation and values. These Jewish people seemed overly solicitous of themselves, fearful,

demanding, and unusually insecure. I could not understand why they did not respond to nursing practices which ordinarily brought favourable results in Scotland. Curiosity and professional idealism combined and began to see the challenge as well as the reasons why this family was not being understood. Thus, the problem of understanding and responding to this new Jewish culture became evident as a real challenge", p.435-436.

The issue of applying theory to practice in nursing is discussed extensively even when the text used is culturally appropriate. The relationship between theory and practice may be even more problematic when "theory" comes from one culture and practice occurs in another.

In Jordan, the annual number of students exceeds places available in the clinical setting, therefore the opportunities available for practical experience are extremely limited. One might question wither this issue affects the quality of clinical teaching provided to the students.

The literature has much to offer in terms of identifying good and bad qualities of clinical teachers in other cultures. None of the previous literature was concerned about the situation of clinical teaching in Jordan. Thus this will be the first study of its kind in Jordan and therefore it is of importance to examine and understand the problem associated with clinical teaching in Jordan and with Jordanian culture.

Echermann (1994) stated that "As teachers we cannot assume that our ways of helping students to learn are the best and the only way as this may not apply to all groups of students nor we cannot adopt other countries methods and apply it to another country. Cultural awareness therefore is urgently addressed", p.361.

❶.1 *Importance of the study*

The increased demand of Jordanian society for health care and the increasing population in need of quality nursing care place a grave responsibility upon those schools of nursing preparing nurses. A major factor that determines the quality of nurses produced is the competence of the teachers of nursing. The projected need for teachers of nursing continues to exceed the current enrolment in graduate programmes, Suliman (1993). Furthermore, this problem of supply and demand has a circular characteristics as more students cannot be enrolled in programs in nursing unless there are adequate numbers of qualified teachers to teach them, and more teachers cannot be produced without an increase in the pool of graduate nurses from which the teachers are drawn. It is therefore essential that current programmes for the preparation of teachers of nursing be able to identify the behaviours that make for the most effective teaching, and that wasteful, ineffective behaviours be avoided.

Brown (1981) claimed that the teaching of nursing is not greatly different from teaching in other fields; but the teaching of nursing in a complex medical centre and in community agencies does have a critical phase not found in the usual type of laboratory learning where the interpersonal component is not so directly involved. In the clinical situation, the relationship of student to teacher is very important. The learning situation is often one that cannot be repeated, and the clinical learning milieu is not usually tailored specifically for the teaching of the nursing student. Teaching, especially under these circumstances, is unquestionably a complex process, but it is the student who is the recipient of the teacher's effort. The student's response, therefore, is one pertinent measure of the teacher's effectiveness.

The major aims of evaluating the clinical teaching effectiveness in nursing are to enhance learning through the improvement of instruction and to enhance the personal growth of each instructor in the performance of the educational role. Hildebran, (1972), also Gien (1991) argued that the purpose of evaluation of faculty teaching competency are many folds, including collecting data to be used in decisions concerning promotion, tenure, renewal, and merit awards; improving the quality of teaching, assisting faculty members to self evaluate; improving accountability in education; meeting the criteria for the approval of the academic institution; and identifying the content areas for faculty development programme.

To achieve these aims it is necessary to help students and teachers appraise their strengths and weakness, to identify what features should be preserved, to plan future learning and teaching, to make and assess progress towards an ultimate goal of providing high quality care to the patient, (Stewart, 1987).

Brown (1981) stated "if we, as nursing educators, cannot distinguish between effective and non effective teaching behaviour in the clinical nursing setting, how can we expect to know the way to help students achieve desired goals,(p.4)

Nursing students must be able to provide a competent level of care for their patient. In order to do so, they must receive enough teaching; guiding and supervision from their teachers throughout their academic years.

It is not the scope of this research to find out whether the teaching students receive from their clinical teachers is parallel to the care they give to their patient, rather, the aim of this research is to gain an in -depth understanding of the common essences of teaching by exploring the meaning of effective and ineffective teaching behaviours as perceived and experienced by student nurses

in their encounter with their clinical teachers.

Knowing and understanding how Jordanian student nurses conceptualise effective teaching behaviour, what propositions or beliefs they use to explain teaching behaviours, how they try to cope with ineffective teaching behaviours, what values or sentimental them what are effective and ineffective teaching behaviours, and what mechanisms they use for dealing with effective and ineffective teachers, will alert the teacher to use appropriate strategies to help the students learn in the clinical area.

❶.2 *Purpose of the study*

The main goal of the study was:
To identify factors contributing to clinical teaching effectiveness in nursing at Jordanian Universities.

❶.3 *Objectives*

(1) To overview what the clinical teaching activities ought to be as rated by senior nursing students and nursing faculties at Jordanian University.

(2) To describe the social context; the interaction process in the clinical setting as observed by the researcher.

(3) To identify effective and ineffective behaviour of clinical teaching as described by student nurses.

Chapter ❷

Jordan

❷.1 *Introduction*

"Since the 1960s, many changes and developments have taken place in Jordan. These improvements have influenced almost every aspect of life in the country, medical care included" (Khanji et. al. 1989 : 119). Therefore, it might be useful to provide a brief background information about Jordan (i. e. its geography, population, constitution, health care, education, women's role, and nursing education and practice).

❷.2 *Background Information*

The Hashemite Kingdom of Jordan is bounded on the North by Syria, on the East by Iraq and Saudi Arabia, on the South by Saudi Arabia and the Gulf of Aqaba (an arm of the Red Sea), and on the West by Israel. Jordan has an area of 97,740 square kilometres. It is divided by the Jordan River and the Dead Sea into two Banks: the East Bank and the West Bank. The latter has been occupied by Israel since 1967 and is known as Palestine by both the Islamic and Arab world. Most of the East Bank is a flat desert. However, the West Bank is mountainous and contains most of Jordan's cultivated land (Halasey, 1978; Patai, 1957).

Jordan has a population of 3,454,000 (Ministry of Health (MOH, 1990). Amman the capital has been in existence since about 400 BC. and has 41.8% of the total population. Appendix 1 section A, B provides more information about the population in Jordan. The principal every day language is Arabic, and the Principal state religion is Islam. Jordan (East Bank) has eight govern orates Amman, Zarqa, Irbid, Mafraq, Al - Balqa, Alkarak, Tafela, and Ma'an. The currency unit is one Dinar which is equal to 1,000 Fils.

Before 1988 the Jordanian Dinar valued at U.S.$ 2.80, however Jordan experienced a fiscal crises after 1988 where the U.S.$ 1.00 valued at JD. 0.70 (Alrai Newspaper, 1993).

The Kingdom of Jordan went into effect as a constitutional Monarchy since 1952. The Cabinet, which is headed by a prime minister, is responsible for the assembly which consists of two houses. The senate, consisting of 40 members, is appointed by the King, and the house of representatives of 80 members, is elected by citizens over 20 years of age. May 25 is the Independence Day, and the Royal Salute of Jordan is the National Anthem.

Jordan's topography makes the construction of transportation facilities difficult and costly. The Jordan Valley and the Dead Sea form a significant barrier. Most imports come through Lebanon and Syria. Access by sea to the west is through Al-Aqabah, Jordan's only port. There is a good network of primary roads but secondary roads are inadequate. Civil airports have been enlarged with regular services to different countries. Jordan's exports consist of mainly phosphates, vegetables and other agricultural products sold chiefly to neighbouring Arab countries. Imports consist mainly of motor vehicles, machinery and metal products petroleum and textiles (Halasey, 1978).

❷.3 *The Health Care Delivery System*

Health conditions in Jordan have undergone rapid and dramatic changes. The World Bank of 1990 reported that between 1965 and 1988, life expectancy rose from 49 to 68 years for males and from 51 to 68 years for females. Between 1965 and 1987, the crude death rate fell from 21.0 to 6.5 per 1,000 population, and the infant mortality rate fell from 114.0 to 44.0 per 1,000 births. Between 1978 and 1990 (MOH, 1990; the Document of the World Bank 1990), the number of physicians per 10,000 population grew from 6.7 to 16.8, the number of registered nurses and midwives from 3.4 to 8.5, the number of pharmacists from 1.9 to 6.1, and the number of dentists from 1.4 to 3.1.

Jordan has one of the highest population growth rates in the world (3.8%- 4.0% in the 1970s and early 1980s, dropping slightly to 3.4% by 1990), while the crude birth rate fell slightly in the 1980s (from 48 per 1,000 in 1981 to 34.6 in 1990). Jordan continues to have a high birth rate 5.6% in 1990 (Jordan Population and Family Health Survey (JPFHS) 1990). For further information see Appendix 1 which provides general country data, and specific data concerning population, health sector resources, and hospital utilisation, and Appendix 2 provides definitions of health, and population terms.

The major organisations involved in the formal health care sector are:

1- The Ministry of Health (MOH).

2- The Royal Medical Services (RMS).

3- Jordan University Hospital (JUH).

4- The United Nations Relief and Works Agency (UNRWA).

5- Private and Voluntary Hospitals and Private General Practitioners.

The following sections of this part of the chapter will present each health care sector separately:

❷.3.1 *The Ministry of Health (MOH)*

The MOH (1990) provides a complete range of primary preventive and curative services through its 810 health centres. General hospital care is provided in 19 hospitals with a total of 2233 beds located in major population centres in Jordan. More specialised hospital services, out - patient as well as in - patient, are provided at Al - Bashir hospital in Amman with 529 beds. This is a referral hospital which also acts as a general hospital for people living in Amman. Patients requiring sophisticated care e.g. cardiac surgery and neurosurgery are referred to the Jordan University Hospital or the King Hussein Medical Centre.

In 1990 almost 667841 out-patients were seen at MOH units and approximately 145477 patients admitted to MOH hospitals; 44530 were delivery cases and 42681 had operations. The bed occupancy was 64.6%. (MOH, 1990). MOH services are available for all. Free care is only available for government employees who contribute compulsorily by a deduction from their salaries of regular month contributions to the civil insurance fund. Small plastic health insurance cards which record the employee's name, date of birth and photograph are issued to employees and the low - income people. The assessment of whether a particular family is of low income is carried out by the department of social affairs.

Longford (1980) reports that the MOH arranges with the armed forces and UNRWA on the treatment of their patients. Where no army hospital exists, soldiers are charged 30% of the fees in MOH hospitals, and reimbursed by the army. In Aqaba, where there is no MOH hospital, non -army patients are treated in the military hospital on the same basis as in MOH hospitals. The agreement with UNRWA has changed over time and is being re- negotiated. However, during the period of 1977/1979, UNRWA annually paid a lump

sum of 106,000 J.D. to the MOH, to enable refugees to be treated free in MOH hospitals. The agreement laid down that a certain number of beds would be made available to them.

❷.3.2 *Royal Medical Services (RMS)*

The RMS provides health care services to all people serving in the armed forces, intelligence, and public security forces and their dependants, in addition to retired military and reservists. As noted by Longford (1980), these people contribute to the cost of the service by a deduction of 0.5 JD per month from their pay. The RMS provides maternal and child health, preventive, and general practice ambulatory care. The MOH (1990) indicates that the RMS in - patient care is provided by 8 district hospitals, which contains a total of 1507 beds. An outstanding quality care is provided at King Hussein Medical Centre (KHMC) in Amman (Qussos, 1994). Out - patient clinics are held at all hospitals, with more specialised ones at KHMC. During 1990 there were 79190 admissions to the RMS, of which almost two- thirds were to the KHMC. The bed occupancy rate was 68.8% (MOH,1990).

❷.3.3 *Jordan University Hospital (JUH)*

The JUH was opened in 1973. It is a teaching hospital and considered as part of the University of Jordan. It has 507 beds and provides general, specialist and emergency out - patient and in- patient care. It provides a wide range of services including neurosurgery and renal dialysis. The MOH (1990) shows that there were 23583 admissions. The overall occupancy was 65% .

Longford (1980) pointed out that various groups are either eligible for care by insurance contributions or by referral, and others are required to pay fees. For example, the employees at the UOJ and the JUH may choose to have deductions made from their salary in insurance arrangements. The amount deducted depends on the type of accommodation the contributor would want if admitted. There are four classes of accommodation available. Additional payment is required for the wife and children to be eligible for care. The premiums are shared by employer and employee. University students pay a premium to the University which then pays the hospital the fee for services used.

However, Government employees if referred from MOH services pay 20% of the fees and their dependants 30%. If they are not referred then both of these groups pay 40% of fees. Low-income people (as defined by the department of social affairs) if referred from MOH units pay 20% of fees. Carcinoma patients are given free care. Institutional arrangements exist with certain bodies e.g. British Embassy, Jordan Electricity Authority, United Nations Office.

The budget of the JUH is derived from three sources: The government provides about 59% of its expenditure while the remainder is derived from fees revenue and the University subsidy to assist with teaching (Longford, 1980).

❷.3.4 *United Nations Relief and Works Agency (UNRWA)*

UNRWA provides health services for Palestinian refugees living in Jordan. Out-patient preventive and curative services are provided by 48 specialised clinics. UNRWA does not have hospitals of its own but contracts

for beds in seven hospitals (four MOH and three private). In 1990 there were almost 977460 curative out-patient attendance (MOH,1990; Longford,1980).

❷.3.5 *Private and Voluntary Hospitals & General Practitioners*

Everybody who can pay fees can use the private sector. Information available from the MOH department of statistics indicates that in 1990 there were 110880 admissions and 157894 out-patient consultations. The number of private hospitals was 25. The total number of beds was 1506, with an occupancy rate of 42.5%.

❷.4 *The Education System*

Jaradat, Mut'amen, and Samaha (1990:10) state that " Focus on education was one of the main characteristics of development in Jordan. In 1932 the first national conference for teachers was held , and the first Council for Education was formalised. The first Education Act was legislated in 1933".

Enrolment growth and demand for schooling were recognised since the 1950s. The reason was due to the following changes in the schooling system In 1955 the Education Act mandate the provision of educational opportunities for all children. Elementary education became compulsory for six years and free of charge. In 1964 the Education Act expanded the basic compulsory education to nine years and in 1988 to ten years. Secondary education was diversified to provide vocational in addition to general academic programmes. (Jaradat and Abu Sheikha, 1992).

❷.4.1 *Organisation and Structure*

The current formal education system has the following structure in accordance with the provision of the Education Act (1988).

a. Pre - school education
b. Basic education
c. Secondary education

Pre - school education begins at age 4 to 6. Basic education begins at age 6 to 16, and consists of 6 elementary and 4 preparatory years. Secondary education begins at age 16 to 18. It accommodates students who have completed the basic education . It leads to the General Secondary Certificate Examination (G.S.C.E). The G.S.C.E. is:

> *"A bi-annual achievement examination held by the Jordan Ministry of Education. It measures the Twelfth Grade students' knowledge of their syllabuses. The students' admission to higher education is determined by the results of this examination"* (Takruri 1993: 20).

Secondary education consists of two major streams:

a. The academic (i. e. literary and scientific streams).
b. The vocational stream (i.e. industrial, commercial, agricultural, nursing, and hotel education) (Jaradat, Abu Sheikha, 1992).

Non - formal education provides various programmes such as:

a- illiteracy programme which is carried out through evening classes, district campaigns, and special groups of rural areas and women;
b- evening schools which provide opportunities for school - leavers or school - dropouts to continue their schooling in parallel with formal schooling;

c- special studies which provide opportunities for adults to follow self-learning studies, and sit for school examinations and continue their education.

Special education for the handicapped and gifted is provided through institutions financed by private sectors and voluntary organisations.

❷.4.2 *Financing Education*

Public education is funded mainly by the government. Jaradat, & Abu Sheikha (1992) reported that 9% of the national budget and 6% of GNP is allocated for education. Education is financed also by the private sector, for example, Pre-school, Basic and Secondary Education. The UNRWA finances the basic education of the Palestinian refugees. Other public agencies and voluntary organisations finance education for special groups such as the handicapped and children in remote areas.

❷.5 *Women In Jordan*

The status, rights, and role of Jordanian women are changing. This is related to their access to education, health care and to some extent employment opportunities. Jordanian political leaders have adopted the views that improvement in the status of women is both necessary and compatible with Islam. They recognise that the education of women and their increased freedom in family life will not only permit women to enter more productively into national life, but also permit them better to rear and educate their children and thereby enhance the nation's future (Shakatrah, 1992; Prothro and Diab, 1974).

The *Mother and Child in Jordan Newsletter* (1993) showed that the illiteracy rate among females had decreased from 53% in 1972 to 28% in 1990. Women holding school diplomas increased from 6.8% in 1972 to 13.4% in 1990, while those holding higher degrees increased from 1.9% in 1972 to 10.8% in 1990. Women join all fields of education today (i.e. Medicine, Engineering, Agriculture, etc.) and are given the same educational opportunities as males. In spite of this progress in female education, illiteracy remains high in rural areas and a woman's role is often limited to her home and neighbourhood. This is related to several reasons: first, the control of their lives by social traditions and constraints. second: lack of their employment opportunities in rural areas as compared with urban areas. Therefore, several organisations have been established to improve the role of women in rural areas, these are the Noor AL-Hussein Foundation and Queen Alia Fund. Organisations work to extend basic health and education services to women in general. These are: The General Foundation of Jordanian Women, the National Committee for Women, and the Professional Women's Club *(Mother and Child In Jordan NewsLetter,* 1993*).*

Women are still a minority in the public sector workplace, as documented by Shakatrah (1992). The female unemployment rate especially among community college graduates increased from 11.7% in 1979 to 30.6% in 1990. As reported by the *Mother and Child Newsletter (*1993) a study by the Civil Service Commission in collaboration with the Business and Professional Women's Club assessed the status of women in the formal sector by looking at applications to, and employment of women by the Commission. The study indicated that 64% of employment applications were handed in by women, of whom 71% were community college graduates, 20.2% were University graduates, and 8.3% were high school graduates. However, 11.2% of University graduates, and only 2% of female community college

graduates were appointed. The study pointed out that since 1986 the increase in application by community college graduates was five times the increase in university graduates. The same study found that only 32% of government employees were women, and that women were employed in clerical and low - paying positions, with only a few are in middle or upper management. Among medical staff, only 3.4% of specialised physicians are women.

In the Jordanian Constitution there is no discrimination between men and women in terms of rights and responsibilities. However, there is still a gap between the theory and practice of women's rights. Since 1982, women have been allowed to vote and run in municipal and parliamentary elections. Yet there were no woman in the Lower House of Parliament until November 8,1993 when one woman was elected in the new parliament for the coming four years, and two women were appointed to the senate. Three women were appointed as ministers. However, women are also under - represented in national planning committees and there has never been a female judge in Jordan .

Shteiwi and Daghestani conducted a study on the woman's participation in political life in Jordan. Their work indicates that good reputation, trustworthiness, academic strong personality, and self confidence were the most important characteristics of those who enter the political arena should possess. Of the 2050 respondents, 84.8% (among which there was 1018 males and 1032 females) maintained that these characteristics were more prominent among males than females. The study indicated that 67.28% of the female respondents and 59.43% of the male respondents thought that the political, economic, and social situation of Jordanian women to be satisfactory.

❷.6 *Nursing education in Jordan*

❷.6.1 *Historical background*

The first school for nursing was established in 1914 in Palestine. Nursing education were conducted within the hospital of nursing in the private sectors which were under the missionary projects and the government hospitals, (Bandak 1988). The entrance requirement was elementary certificate. Teaching methods focused on disease entities and mainly used rote learning. Lectures were given by doctors and foreign nurses. Clinical supervision was done by the British nurses working in the clinical area. All schools of nursing have a uniform programme and at the end of each year students sat for a general examination prepared by the Board of Examiners. In 1948, as a result of the Arab-Israeli war, the British terminated their mandate and all British national were evacuated. Teaching was completely carried out by the native nurses. In 1952, because of the increasing health problems especially among the refugees of the war, the Ministry of Health in collaboration with the United Nations Relief and Works Agency (UNRWA) established another school of nursing in Jerusalem at the Augusta Victoria Hospital which was run by the Lutheran mission . The teaching facilities at this hospital were good (Kelly, 1974; Musallam, 1958; Noor, 1976).

Also in 1952, a school of Midwifery was established in Ashrafiya Hospital in Jabal Amman. The school was established by British nurses and provided a two year training course in midwifery (Kelly, 1974).

A project for starting a permanent school of nursing on a higher educational level was later established in Amman, in November, 1953 with the technical co-operation of the United States government Point IV program. The nursing curriculum encompassed a wider scope of subjects including biological and social sciences. Native nurses were also employed as members

of the teaching staff at this time although directorship remains under an American. It was not until 1958, that the school of nursing became under the control of a Jordanian. Medical-Surgical subjects were taught by doctors; Pharmacology by chemists; and Bacteriology by laboratory technicians. The school offered a three year training program for nurses to students who completed primary school. The program starts from 8 am to 2 pm Sunday to Thursday and Friday as the holy and week-end rest day. Arabic is the official language in Jordan but English is the medium of instruction used in the nursing schools. Male and female student nurses received allowances from the Ministry of Health in addition to their board and lodging. Male nurses live out of the school's residential quarters but were given living out allowance. However, female nursing students must reside in the nurses' quarters throughout the whole period of their training. This is because females in the Muslim countries are still very much sheltered and protected. To persuade their families to let their daughters enrol in the nursing school, the school must provide the kind of protection their families would be satisfied with (Musallam, 1958). In order to attract women into nursing, the Ministry of Health and military services offered scholarships for all nursing students including free housing and transportation. It was not until 1966 that males were allowed to apply in the nursing school (Al-Ma'aitah, 1994a). At present, nursing students receive JD14 (Jordanian Dinars) per month allowance throughout their training. This is roughly equivalent to $28.00 (American Dollars). Graduates from these colleges have to pay back the Ministry of Health certain number of years service to any government hospitals or community health centres (i.e. for females, one year of service for every year of training and for males, two years of service for every year of training).

Besides the three years general training for nurses, the practical nursing program was established in the hospitals by Ministry of Health in 1963. It started with a six month program until 1966 when it was increased to fifteen

months. Education requirement for entry into this program is completion of primary school and instruction is conducted only in Arabic. The graduates are awarded a Practical Nursing Certificate (Noor, 1976).

The Ministry of Education also provide a program for aid nurses. Students take a nursing speciality Year nine and should pass the nursing Tawjihi (certificate examination) in the final year of schooling which is Year twelve. As a rule by the Ministry of Education, only the first five highest students from this program can proceed to enrol in the diploma or baccalaureate degree in nursing (Al-Ma'aitah, 1994a).

In 1966, the School of Nursing was changed into a College of Nursing. The entry requirement was raised to the high school certificate level (secondary schooling). Later in 1978, the School of Midwifery was joined with the College of Nursing. The first year of the nursing program became the core course for both the midwifery and nursing programs. Students enrolled in Midwifery branches do another year of training while students enrolled in Nursing have to complete another two years of training. Graduates from these two programs were awarded a Diploma in Midwifery or a Diploma in Nursing.

In 1984, two other colleges of Nursing and Midwifery were established, one in Zarqa and the other in Irbid. In 1990, the Irbid College of Nursing was named Nusaiba Al-Mazenieh College of Nursing and at the same year, the two nursing colleges in Amman and Zarqa were amalgamated, transferred to its new location in Yajouz and was named Rufaida Al-Islamia College of Nursing and Midwifery. The medical model of education had been the focus of the nursing curriculum since the beginning. However, when the curriculum was changed to 153 credit hours, incorporation of an expanded primary health component became the focus of both the nursing and the midwifery programs. This change has been in line with the World Health Organisation's policy on

Health for All by the Year 2000 through the primary health care approach which was adopted by the Ministry of Health in Jordan.

The 153 credit hours has to be completed in three years consisting of two semesters and a summer session per one academic year. Practical training (clinical practicum) is conducted two days per week throughout each semester. The rest of the week is spent in the classroom. During the last three months of their training, the students spend their time fully in the clinical area. This gives them the opportunity to carry out increasing amount of responsibility as a staff nurse. They were also allowed to do their clinical training in their own home town as majority of students will be posted there upon completion of the course or wherever nurses are needed.

In 1960, the Royal Medical Services opened a school to train male students as assistant nurses to work mainly in clinic. Later in 1962, a diploma in nursing program was also established at the Royal Medical Services, Princess Muna College of Nursing under the directorship of a British nurse. This is mainly for women and men enlisted in the Armed Forces. Nursing students were given a military rank as cadet officers and upon graduation as second lieutenant rank. Their practical experience is mainly conducted in the military hospitals. Graduate from this college were eligible to acquire the British nurses licensure (Noor, 1976). The school also offers a one year post basic diploma in Midwifery.

❷.6.2 *Degree programs*

The need for preparing professional nurses was also realised in Jordan. The first bachelor of science degree program in nursing (BSN) in Jordan commenced in 1973, one year after the Faculty of Nursing at the University of

Jordan (UOJ) was established under the Royal Decree. The admission criteria for the BSN program was based on passing the science branch in secondary school. The course is of four year duration consisting of 144 credit hours of theory and practicum. The academic year consists of two semesters and a summer. Clinical education is conducted two days per week throughout each semester. In 1981, the Faculty of Nursing started offering a bridging course for registered nurses wishing to upgrade their diploma to a degree. This course consists of 63 credit hours. In 1986, a Master degree program by course work consisting of 40 credit hours was offered. The students are required to pass a comprehensive examination to complete the program. This is the only university which offers a Master degree program for nurses in Jordan.

A second Faculty of Nursing was established subsequent to a Royal decree in 1983 at Yarmouk University in Irbid. In 1986, this faculty together with seven other faculties from Yarmouk University were transferred to its new location in Ramtah and named Jordan University of Science and Technology (JUST). The Faculty of Nursing at this university offers 148 credit hours. This university also offers a bridging course for diploma in Nursing graduates which commenced in 1993.

The students enrolled at the government universities pay 6 JD per credit hour. Their academic year consists of two sixteen weeks semesters and one eight weeks summer courses. Credit hours are calculated as one credit hour per one contact hour of theory and one credit hour per 3 contact hours for clinical practicum.

Private universities also started to offer a degree program for nurses in the beginning of 1992. However, nursing in these universities is under the Faculty of Health Science or the Faculty of Science. Students enrolled at these universities pay 40 JD per semester.

Accreditation of nursing courses in the universities is under the control of the Ministry of Higher Education. The nursing cirrculum and philosophy was based on the American nursing programs. This may due to the fact that majority of nurse teachers are graduates from the American schools of nursing.

All degree courses offered in these universities are of four years duration. Clinical practicum does not commence until the students are in the second year of the program and continues till the fourth year. The registered nurse conversion program is between three to four semesters and the Master degree program for four semesters.

Recruitment into the nursing programs remains a challenge in Jordan. Local perceptions and customs hamper attempts to recruit nurses and educate them. Besides, in a society wherein women have been traditionally kept sheltered under the care of men, in congruency between their traditional roles and roles ascribed to the professional nurses was found to interfere with the socialisation into nursing (Abu Gharbieh and Suliman, 1992). On the other hand, more and more women are graduating from high schools and more educational options were opened at the university level. Contributing to this challenge is the fact that the negative nursing image is still predominant in Jordan and the fact that teaching remains the most desirable career for Jordanian women (Al-Ma'aitah, 1994a). Patients also do not recognise nurses as knowledgeable professionals and do not reveal information or confide in nurses about their problems. Even practising nurses constantly ask university nursing students why they chose nursing when they have the chance to enrol in a more challenging course. Such behaviours showed how much lack of esteem for the nursing profession and for themselves has been internalised on job satisfaction, and job satisfaction was marginally met, results showed that dissatisfaction resulted from unmet psychological needs especially from

their superiors and patients on a study conducted by Zuraikat and Mc Closkey, (1986). However, in spite of the negative public image nursing has suffered over the past years and low level of job satisfaction, applicants to the nursing program has dramatically increased mainly because of the employment opportunities open to nursing graduates.

❷.6.3 *Laboratory sessions*

Laboratory sessions are mainly independent sessions or student directed learning. During the first year of the program, students spend four hours per week per semester in the nursing laboratory as part of the Fundamentals of Nursing subjects. The students do not go to the clinical setting during their first year. During these sessions, students are given face to face instructions and demonstrations of specific nursing procedures. The students are also assigned specific clinical skill topics to present and demonstrate to the class. A list of all procedures that students need to master is given to the students at the beginning of each semester. It is the responsibility of each student to learn these procedures either from the textbook or from viewing the videotapes that are available in the nursing laboratory. It is also the responsibility of each student to make an appointment to the nursing laboratory teaching assistant for practice and demonstrations or whenever they need help in learning a procedure. The number of visits to the laboratory are recorded and these visits are included in their final assessment. Competency testing is usually arranged formally at a present day and time by the students primary instructor.

In the second, third and fourth year, students spend the first two weeks of each semester in the nursing laboratory in order to learn and practice the necessary skills for that clinical practicum. If any student is found to be

incompetent in the clinical area, the student will be sent back to the nursing laboratory for further instruction and to practice the skill until mastery is achieved.

❷.6.4 *Clinical education*

The total number of hours allocated for both the laboratory sessions and clinical education is 1458 hours.

Clinical education is conducted concurrently with the students' theoretical components of the subjects on a two days per week basis. A group of 15 students is usually under the supervision of a teaching assistant. A primary instructor usually co-ordinates the activities of a group of teaching assistants on a clinical subject basis such as Medical-Surgical Nursing or Maternal and Infant Care Nursing.

Maternity Nursing practicum involves a variety of experiences for the students. Time was spent in the Maternal and Child Health centres where students gain experiences in prenatal care, immunisations, postnatal care and infant care. Health education has been an important part in the nursing curriculum because of its emphasis on Primary Health Care. Students are involved in giving health education in the health centres as well an in the school health programs where students prepare health education information materials such as posters and give health education information to school children. They are also involved in health and physical examination of school children.

Community health nursing practicum involves a variety of experiences for the students. Home visiting is also an important aspect in their training. Students are expected to perform a community assessment, family assessment

as well as follow-up "risk" cases referred to by the health centres. Student visit homes of their clients in groups of three's or four's. A community health bag is prepared for each use containing basic necessities such as sphygmomanometer, stethoscope, thermometer, dressing solutions and dressing packs, weighing machine for infants, urine testing kit, and others. The students perform this visit on their own, however, spot checks by their clinical supervisor on home visits are often a form of assessment.

Public/government hospitals, health centres and schools are mainly used for clinical placement of students. Overcrowding in the hospitals is a common problems as students from other schools of nursing, medicine and other para-medical schools utilised these facilities, not counting the number of relatives or visitors the patient may have at one time.

Student assessments utilised for the clinical education components varies between clinical log, case conference, ward rounds, and case studies in the form of a nursing care plan.

Comprehensive clinical training during the summer session involves a continuous clinical placement where students choose their facility and speciality of clinical practice. Public and private facilities are utilised by the students. Speciality choice varies between Accident and Emergency Ward, Critical Care Units, Operating Room, Paediatric Wards, Oncology Unit, Renal Dialysis or the general medical or surgical wards. The major purpose of this practicum is to expose the students to the full shift working environment where he or she can demonstrate a fairly independent and safe nursing practice, working with other staff nurses and also to practice administrative abilities.

Chapter ❸

Literature Review

❸.1 *Introduction*

There have been a number of discussions of clinical teaching, both in general and specific to nursing (e.g., Bradshaw, 1989; Watts, 1990; Reilly & Oermann, 1992). There has also been considerable research on the effectiveness of the clinical teaching of nursing, recently reviewed by Oermann (1995) and Nahas (1995). The general principles of effectiveness prescribed in discussions of effectiveness and suggested by the research literature vary somewhat, but are broadly similar. This makes reference to all the different accounts of clinical teaching somewhat redundant. Here, the approach will be to draw on the writing of key commentators, including Greaves (1979), Reilly and Oermann, 1992) and Jacobson (1966), without implying that other accounts are necessarily inferior. Thanks to the recent thorough reviews (Oermann, 1995; Nahas, 1995), the literature review here will be restricted to the issues most relevant to the research conducted, particularly studies using the critical incident technique.

Schweer & Gebbie (1976) defined clinical teaching as "The vehicle that provides students with the opportunity to translate basic theoretical knowledge to the learning of a variety of intellectual and psychomotor skills needed to provide patient-centred quality nursing care (p.43).

❸.2 *Objectives of clinical teaching*

The concept of clinical teaching as described by many prominent nurse educators, includes many basic elements; it constitutes the heart of the nursing curriculum, it involves planning, organising, supervising and evaluating students learning, "it provides students with an opportunity to apply background knowledge to the solving a patient-centred problems" (Schweer and Gebbie, 1976). Wiedenbach (1969) clearly identifies teaching as an extension of academic teaching. She differentiates clinical teaching from academic instruction in that the former enables the students to apply learned knowledge to the clinical areas, whereas the latter process enables the students to assimilate, understand and store the essentials of the subject matter for future use.

However, Oermann (1992) maintained that clinical practice provides students with more than the opportunity to develop the ability to use professional knowledge and skills within a circumscribed practice mode. It also facilitates the ability of the students to learn how to learn, handle ambiguity, think like professionals, develop a notion of personal causation, and evolve their own theory of practice.

Perry (1968) sees the aim of clinical teaching as helping students to approach and handle patients and perform nursing techniques. Also knowledge can be increased, and understanding deepened by observation of the patient and their response to the treatment they are receiving. Furthermore, the British Royal College of General Practice (1972) identified 4 goals of clinical teaching, (1) to help students integrate and assimilate factual information in problem solving, (2) to teach manual skills performance, (3) to demonstrate interpersonal skills, and (4) to provide students with the opportunity for self understanding. These four goals address most of the

objectives discussed by the other authors. Therefore, they will be used in the evaluation of clinical teaching in Jordan.

In addition, as mentioned by Oermann (1995) clinical teaching must lead to students acquiring a professional attitude to nursing. This will be regarded as a fifth objective of clinical teaching. As mentioned in Chapter (1), this objective seemed particularly important in Jordanian nursing schools because one of the perceived problems is that graduate nurses lack a professional attitude.

❸.3 *Greaves' view of clinical teaching*

Greaves (1979) has raised a number of relevant issues about the development of skills and attitudes. He argued that the ideal person to teach the practical skills of nursing is the practitioner of nursing who is constantly working with patients and performing these skills to a high level. One might first believe the ideal that the registered nurse is expert in a wide range of practical nursing skills, and that to maintain a high level of skill she must be a continuous practitioner of these skills. If one accepts this ideal, then logically the teacher of practical nursing skills must be the trained nurse who is involved in patient care from day to day. This logic, however, becomes suspect unless the trained nurse also has some basic knowledge of how to teach.

Secondly, Greaves (1979) proposed that one should attempt to create a situation whereby confidence and ability comes to the students when they have seen the experts working, worked with them, been guided by them, received explanations and descriptions while working with them, practised under their supervision and developed an understanding of why things are done and how they affect the patient.

This situation is basically the teaching method known as "on-going instruction" and is one of the most valuable methods that can be used where the physical care of patients is concerned. This on-going instruction needs to be developed to an almost subconscious level in the clinical teachers, so that it becomes an inherent part of their role. Thus, the clinical teacher in large part should provide a good model for the students to imitate.

❸.3.1 *Major issues to be considered for students attainment in clinical practice*

Greaves (1979) also suggests that before teaching practical skills in clinical setting, the clinical teacher should know what the student can already do and how well they can do it. It is pointless asking students if they can do a particular technique or method or nursing procedure, without making some checks on their ability.

In order to find out what the students can do and to what level they can do it, by observing them and evaluating using a check list similar to the following one:

(1) Do the students demonstrate correct procedure in the care they are doing?

(2) Because students can complete a piece of nursing care do(es) not necessarily mean they are skilled at doing it. Are their physical movements smooth, fluent and sufficiently refined?

(3) Do they carry out a logical sequence of events?

(4) Do they have faults in technique?. Can the teacher identify the serious faults and minor faults?

(5) Are the students safe to work with patients?. If not, at what point is the patient at risk?

(6) Do they give the patients maximum comfort within the circumstances of the care being given?

(7) Do they communicate effectively with the patients?

(8) Do they understand the reasons underlying the procedure and what the benefits are to the patients?

❸.3.2 *Developing correct attitudes*

Greaves (1979) argued that students will always learn more effectively if they possess a positive attitude which can be directed towards their learning outcomes. The impression the trained clinical teachers give the students in terms of skills mastery, in adapting procedure and methods, and meeting individual patients' needs create a positive desire in the students to accomplish the same level of proficiency. This positive attitude is more easily developed in the student if the clinical teachers have maintained their "expertise" in the skill they hope to teach, project enthusiasm in their approach to teaching and are sympathetic to the learning difficulties of the student.

Furthermore, it is essential for the teacher to look for errors and correct these quickly, teacher and the student working through together. Sympathetic but firm handling of the student is required and good natured humour will help soften the student's concern about errors. When students make mistakes (and they will) they must learn from these mistakes and the teacher might provide support by ensuring students do not simply fail without learning. This means allowing students to develop skills at the rate they are capable of and not pushing them too far, too quickly.

The clinical teacher should create successful experiences for the students by helping them accomplish skills mastery within the type of care that

is right for their level of training, experience and speed of learning. The clinical teacher should give praise for good performance and correct methods. If the students are doing well, or not very well, let them know. They must have knowledge of the results of their learning and it is the duty of the teacher to provide that information to the students.

❸.4 *The General Teaching - Learning Process*

❸.4.1 *Adult learning principles (Application to clinical teaching process)*

It is out of the scope of this thesis to review all theories of adult learning. Most are of limited relevance as they have been developed for classroom use (see Joyce (1992) for review). Kathline (1987) reviewed adult learning principles and tried to apply them to the teaching of operation room nurses. This article the most relevant found to clinical teaching of student nurses. She was proposed the following framework:

(a) Learning is a normal adult activity

Adult learning takes place by the teacher removing or reducing obstacles to learning and enhancing the process after it has begun.

For clinical teaching, one way a clinical teacher may help the student nurse learn is to create an environment with few obstacles (e.g. anxiety conflicts between work and learning responsibility). It may also be helpful to let students learn at their own pace, reduce threats in the learning environment, and to help them focus on learning as well as on hospital procedures.

(b) Adults with a positive self concept and high self-esteem are more responsive to learning.

An environment which threatens self-concept or esteem should therefore be avoided. For nursing this often involves allowing the practice of procedures without having to simultaneously nurse a real patient. For example, learning to position a patient with a fractured spine on the bed should not be done during the actual event. It should be practised first in a simulated lab or classroom setting where mistakes can be made and corrected without harm to the patient or to the learner's self-esteem.

(c) Adults learn best when they value the role of adult learner and possess skills for managing their own learning.

Adult learning is an active, self directed process. After being reoriented to learning, adults can take responsibility for their own learning as they have done with other facets of their lives.

This suggests that clinical teachers should be willing to learn about the student nurses whom they teach and to be responsive to individual needs and learning styles. In clinical teaching process, the student nurse might be made responsible for sharing in planning, implementing and evaluating his or her learning. This collaborative approach between student and teacher can help the student become a collaborative learner.

(d) Immediate, descriptive feedback is essential if adult learners are to modify their behaviour.

As adult learners practice new skills, they need feedback about how they are progressing. According to Kathline (1987) the timing of feedback is important: immediate feedback affects learning the most. The longer the interval between performance and feedback, the less likely it is that feedback

will have a positive effect on learning.

Feedback about outcome also requires that both student and teacher have a clear idea of the behaviour to be learned. Objectives that describe nursing skill and how they are to be demonstrated will be important. Then, feedback can be descriptive rather than judgmental. For example, in order to teach the student about violating aseptic technique, the first time a violation would be pointed out immediately after it occurs, and the correct method then explained: "You are holding the sterile water container too far over the sterile field. Only the lip of the bottle should be held over the edge of that basin". This type of feedback conveys exactly what corrections are needed, and gives the student a chance to practice it immediately.

(e) Success reinforces changes already made and provides a motive for further learning.

For the adult learner, meeting established objectives reinforces the newly acquired skill and motivates more learning. Thus, the earlier satisfaction and success occur in the clinical experience the more likely it is that further learning will take place. The clinical teacher might consider the strategy of reverse changing, i.e. list steps involved in a new skill and demonstrate all of them except the last one. The student then finishes the procedure and has the satisfaction of completing the entire skill thus motivating him/her to learn all the steps.

(f) Adults tend to begin learning programs with some anxiety, and further stress can interfere with learning.

One might say that teaching in clinical setting requires a supportive learning environment., and the initial activities in the clinical teaching process should be planned to minimise anxiety. A clinical teacher might consider the

following points to relieve the anxiety of students, i.e.

(1) Reducing threatening situations in the learning environment.

(2) Creating an environment of acceptance and support for learning.

(3) Providing time for learning and opportunities to practice new behaviour.

(4) Providing opportunities to talk through anxieties related to learning as they occur.

By applying these principles of adult learning clinical teacher can be responsive to the needs of adult learners, ensuring that they will become orientated to the clinical practice quickly , effectively and in a way that is satisfying to them and to their clinical teachers.

❸.4.2 *General Guide lines for the facilitation of learning*

Rogers (1969) states that characteristics of teachers which facilitate student learning include prizing realness or genuineness, acceptance and trust of the learner, and empathic understanding and sensitive awareness of the student. When teacher's behaviours are viewed as open, clarifying, stimulating, accepting and facilitating, the students tend to be productive, by discovering, exploring, experimenting, synthesising & deriving implications. Instructors who manifest these attributes, facilitate students' learning at higher cognitive and effective level Rogers (1969) also presents some guidelines for facilitating of learning which are in essence as follows. The facilitate of learning

(1) is first concerned with establishing a climate of trust.

(2) seeks clarification of the students' aims and tolerates a diversity of goals within the group.

(3) relies on the motivation of each student to pursue his own aims, which are significant only to him.

(4) makes available, or ensures access to the widest range of resources for learning.

(5) acts in a flexible way as a resource to the group.

(6) recognises and accepts both students thoughts and feelings giving due weight to each.

(7) becomes a participant student as the group develops.

(8) shares his own thoughts and feelings with the students.

(9) is alert to tensions and conflicts in the group which are utilised as learning resources.

(10) is aware of and accept his strengths and weaknesses as a facilitator and as a resource.

Similar qualities have been suggested by others (e.g. Watts, 1990; etc).

❸.4.3 *Qualities of clinical teacher in the clinical setting*

Brown (1950) wrote of the qualities needed by the clinical teacher wherever she is. She should be trained in the skill and art of teaching and she should thoroughly understand what clinical teaching means, she must also be an effective practitioner. She should belong to the ward, that is she should work in it with the students daily, she should know the patients and nurses. She should be really familiar with the details of patients' treatments and progress, being present at the morning and evening reports whenever possible.

According to Brown (1980), for effective clinical teaching the instructor must know as much about the patient's condition as do the nurses, otherwise

she will be at a serious disadvantage. However, well trained she might be, "without a real working knowledge of the ward, of patients and students, she will have a very difficult and rather unpleasant task".

More recently Oermann (1992) argued that characteristics of an effective clinical teacher may be grouped into four areas:

a) Knowledge and competence.

b) Teaching skills.

c) Relationship with students.

d) Personal characteristics.

(a) *Knowledge and competence*

In regard to the first area Oermann and Reilly (1992) admitted that knowledge of the subject matter pertains to the teacher's breadth and depth of understanding as it relates to the topic at hand, but also to a larger sphere where that knowledge interfaces with other knowledge. The teacher also requires an ability to analyse theories and synthesise from multiple sources, emphasis on promoting a conceptual understanding among learners, and willingness to examine different points of view.

In Bergman and Gaitskill's (1990) study of effective clinical teachers, both faculty and students identified knowledge as an important characteristic. Windsor (1987) interviewed 19 senior nursing students at a large Mid Western University in the USA. Students expressed the need for knowledgeable clinical instructors who were willing to share their knowledge and expertise. The teacher's theoretical and clinical knowledge used in the practice of nursing and attitude toward the profession influenced teaching effectiveness.

Nehring (1990) and Knox and Mogan (1987) referred to this theoretical and clinical knowledge as nursing competence. Findings by them indicated

that the best clinical teachers possessed nursing competence and the worst did not. The best clinical teachers were ones who enjoyed nursing, were good role models, demonstrated clinical skills and judgement, assumed responsibility for their own actions and demonstrated a breadth of knowledge in nursing.

In Bergman and Gaitskill's (1990) study, findings suggested that important dimensions of clinical teaching included ability to relate underlying theory to nursing practice, being well-informed, and possessing the ability to communicate knowledge to students. Bergman and Gaitskill (1990) recommended that "special attention should be given to developing a functional body of knowledge in the area of instruction and in communicating that knowledge to students", (p.14).

Maintenance of clinical competence is essential in assisting students in development of knowledge and skill and providing expert supervision in the clinical setting. Nehring (1990) found similar to an earlier study by Knox and Mogan (1987), that the best teachers were ones who demonstrated expert clinical skills and judgement. Ability to demonstrate the skills, attitudes, and values that are to be developed by the student in the clinical area and ability to stimulate the student to want to learn behaviours associated with professional competence also have been reported as important characteristics of an effective clinical teacher (Bergman and Gaitskill, 1990).

(b) *Teaching skills*

In an early study by Rauen (1974) of role characteristics of clinical nurse teachers, one of the highest ranking characteristics was the teacher's skill in demonstrating how to function in a real nursing situation. This skill is dependent upon maintaining clinical competence. Pugh (1988) also reported

that the teacher's ability to demonstrate nursing care in a real situation was an important behaviour in clinical teaching identified by students.

The second area of the quality of the clinical teacher as identified by Reilly and Oermann (1992) was teaching skill. Teaching skill involves the ability to diagnose learning needs, plan instruction in terms of learner characteristics and goals to be achieved, supervise students and evaluate learning. An effective teacher presents information in an organised manner, gives clear explanations and directions to students, answers questions clearly, and demonstrates procedures and other care practices effectively. According to Eble (1988), good teachers are masters of a subject, well organised, emphasise important points during teaching, clarify ideas and point out significant relationships, motivate students through their teaching practices, and pose and elicit useful questions.

According to Reilly and Oermann (1992), teaching in this respect is showing, explaining, describing, supporting and supervising students. It involves setting good skills levels by example, listening to students problems, helping them derive meaning from what they do, making sure they develop at the very least an acceptable minimum standard of competence. It also means helping the students look at and solve nursing problems and giving them an experience in the value, worth and effectiveness of providing individualised nursing care. It also involves inspiring the students to inquire, to question practices and search for meaning.

In Puph's (1988) study on clinical teaching effectiveness, many of the teaching behaviours rated by students as important pertained to teaching skill: ability of the teacher to correct and comment on written assignments; make specific suggestions for improvement of performance; plan assignments which assist in the transfer of theory to clinical and are based on course objectives;

give encouragement and praise; suggest resources for learning; assist the learner in preparing for difficult and new situations and analyse patient's file data. Nehring (1990) found that the best clinical teachers enjoyed teaching and were well prepared for teaching in the clinical setting.

The ability and practices of the teacher in evaluating learning in the clinical setting are important aspects of teaching effectiveness. Qualities in this area are ability of the teacher to provide useful feedback on student progress, exhibit fairness in the evaluation process (Bergman and Gaitskill, 1990), promote student independence through evaluative practices, correct student mistakes without belittling, and communicate clear expectations to students (Nehring, 1990). Flager, Loper-Powers, and Spitzer (1988) found that giving positive feedback was most valuable in helping students develop self-confidence as a nurse; giving mostly negative feedback hindered students' development of self confidence in clinical practice. Greer (1990) believes that honest praise generously given early in the semester "bolsters students' self-confidence", (p.38).

(c) *Relationship with students*

The third area of teacher's quality as grouped by Reilly and Oermann (1992) was relationship with students. They argued that the ability of the teacher to interact with students is another important teacher behaviour. This skill involves interacting with the group of students as a whole and on a one - to - one basis and includes developing mutual respect and rapport between teacher and learner. Clayton and Murray (1989) emphasise the importance of this relationship in the teaching of nursing; this relationship represents a caring experience between teacher and student.

Bergman and Gaitskill (1990) in their research found that relationships with students were ranked as the most important characteristic of effective clinical teachers. Also other studies have confirmed the importance of the relationships established between teacher and students (Brown, 1981; Knox and Mogan, 1987; Nehring, 1990; Puph, 1988).

Nehring (1990) and Edwards (1991) recommend using a variety of listening skills and techniques to facilitate communication, enhance the student-teachers relationship, reduce stress experienced by students, and improve teaching and learning. Diekelmann (1990) believes that conversations with students "need to be dialogues in which we hold mirrors up which reflect and call one another forth. Dialogue is engaged listening, seeking to understand, and being open to all possibilities", (p.301).

An important element in developing positive relationships with students is the teacher's commitments to conduct teaching in caring way. Faculty attitudes toward learners are characterised by a "deep respect for them as human beings and a concerted effort to deal with them at their level of understanding" (Hedin, 1989, p.79). In establishing interpersonal relationships with students, the teacher is warm and open, highly student centred, and predictable (Lowman, 1985).

Lowman (1985) believes the quality of instruction results from the teacher's skill at creating intellectual excitement and positive rapport with learners. "A teacher who is accomplished at both is most likely to be outstanding for all students and in any setting", Lowman, 1985, p.10). The teacher's interpersonal rapport with students is critical in motivating them to learn. This dimension of teaching deals with the faculty's awareness of the interpersonal processes within the teaching situation and their skill in communicating with students in ways that foster motivation, enjoyment,

excitement about learning, and independence in learning. The teacher "respects the students as individuals and sees them as capable of performing well", (Lowman, 1985, p.16).

Carl Rogers (1983) identified certain qualities of this relationship that facilitate learning. These qualities, similar to those necessary for any therapeutic encounter, include realness or genuineness, trust and respect for the learner, and empathetic understanding.

The teacher who exhibits realness or genuineness in a relationship is honest and open with students and willing to express his or her own feelings. Genuineness implies an ability to admit mistakes and acknowledge limitations.

Other qualities of this relationship include trust (important in promoting risk-taking behaviours in the clinical setting), and respect, i.e. accepting learners as they are. Trust communicates confidence in student ability to achieve in clinical practice; and in a trusting relationship with faculty, learners are more inclined to discover and seek out new experiences.

Empathetic understanding is also a significant attribute of a strong teacher-student relationship. Empathy means the teacher can view a situation from the learner's perspective. The development of a helping relationship requires teacher responsiveness to the feelings of students and an ability to communicate that understanding to them.

Rogers (1983) writes, "when the teacher has the ability to understand the student's reactions from the inside, has a sensitive awareness of the way the process of education and learning seems to the student, then again the likelihood of significant learning is increased", (p.125).

(d) *Personal characteristics of teacher*

In regard to the fourth area of qualities of teacher as identified by Oermann and Reilly (1992) was personal characteristics. The emphasis in this area is on the personal attributes of the teacher, which in many ways are associated with the dynamism of the faculty and enthusiasm for teaching in the clinical setting. This flair and enthusiasm for teaching come with enjoyment in working with students and confidence in one's own teaching ability and clinical skills. One of the benefits of self-confidence is that it enables the teacher to be genuinely enthusiastic about teaching. Elbe (1988) emphasises the strong force of the teacher's personality. "Denying the place of personality in teaching exposes us to a contrary danger of forgetting that human learning is the aim of teaching (Eble, 1988, p.16).

In an early study of teacher behaviours which facilitate or interfere with learning in the clinical setting, O'Shea and Parsons (1979) found that friendly, supportive, understanding, and enthusiastic behaviour of the teacher promoted learning. In more recent studies characteristics of the teacher perceived as important in clinical teaching include demonstrating self-confidence, being enthusiastic, being open minded and non judgmental, displaying a sense of humour, admitting mistakes and limitations, being co-operative and patient, and being flexible when the occasion calls for it (Bergman and Gaitskill, 1990; Knox and Mogan, 1987; Nehring, 1989).

The personal qualities of the teacher are important in engaging the student in the learning process and motivating them to learn. Teaching is a dynamic endeavour that "builds bridges between the teacher's understanding and student's learning", (Boyer, 1990, p.23).

❸.4.4 *Clinical teaching methods*

The traditional method of teaching which was purely teacher oriented where the teacher played the role of the expert and held the key to all information, does not apply to such a discipline as nursing which deals with human lives and a behavioural holistic perspective of a person. Such approach encourages student passivity and students are only expected to reproduce the knowledge presented thereby assuming that knowledge is cumulative and predetermined. Nurse educators are building upon descriptive and prescriptive theories of learning where in an synthetic approach may be utilised. Nevertheless, whatever approach was used, a congruence between the teaching and learning process is considered a central factor. As Diekelmann (1992, p.75) stated "what matters in teaching and learning are the practices that we create as teachers and how these practices are experienced by the students".

Greaves (1979) discussed different teaching methods which might be considered during clinical teaching process. Below is an outline of these methods:

(a) *Patient centred approaches*

Patient centred teaching is the use of methods which are directly concerned with the care of the patient, who can often take part in the learning experiences the teacher creates for the students. Patient centred nursing care is a different concept which relates to the individualised care of the patient and is unlike the ritualistic, task orientated approach to nursing care which is 'procedure inspired'. If patient centred teaching is to work, procedures, skills and tasks must be seen in terms of their effects on the individual patient through the giving of personalised care. Some useful teaching methods to help learners grasp the fundamentals of patient centred care clinical nursing

conferences, clinical nursing rounds and ward report sessions. This approach contrasts with one where clinical situations are used mainly a vehicles for demonstrating nursing theory.

(b) *Clinical nursing conference*

The idea of clinical nursing conference is to exchange information and opinion concerning the nursing care of an individual patient. It involves reviewing the patient's physical state, response to nursing care and attitude towards his illness. The conference may include students and trained staff caring for the patient. (Greaves, 1979).

The objectives of the conference are to:

(1) Stimulate all staff concerned to provide better quality of nursing care for the patient.

(2) To provide the opportunity to evaluate the nursing care of a patient and to discuss possible solutions to problems.

(3) To increase the level of communication between staff and the individual contribution to the patient's care.

(4) To help improve job satisfaction among the staff, stimulate interest, maintain morale and help the learning of the trainee nurses.

Student participation should be actively encouraged through discussion, exchange of information and expression of attitude and opinion. The patient may be present for part of the time and should be prepared for his part in discussion. When the patient's participation is not appropriate because of the nature or stage of his illness the nursing notes and medical notes on him are used for analysis and evaluation.

Learning during a clinical nursing conference is largely dependent on discussing the following:

(1) The total nursing care of the patient.

(2) specific technical nursing care.

(3) The observations on the patient and the records and implications of them.

(4) The patient's reactions, progress, response to care provided.

(5) Medical and surgical treatment, with particular emphasis on how they influence the type of nursing care to be given.

Evaluation and modification of nursing care are key factors for students and include the solving of patient care problems.

Student preparation is important and students should be given sufficient notice of the conference, so they can read the patient's medical notes and material on the medical teaching and nursing practices. Students themselves will have been involved with the planning and giving of care to the patient concerned.

(c) *Clinical nursing rounds*

Greaves (1979) claimed that one of the best ways to teach nursing assessment, diagnosis, planning and evaluation is the teaching round, on the lines of medical teaching rounds. However, it is not desirable to have the numbers and formality of the medical ensemble that follows the consultant, nor is it necessary to see all the patients. One or two learners can be taken by the clinical teacher on a round of a few carefully selected patients and the exercise used informally to develop improved communication with the patient, to seek information from him and to give information to him and to make the experience a learning exercise for the students.

To some extent, the learning exercise is an exercise that involves the process of problem solving. The condition and response of the patient to his illness and nursing care can be the central theme and by the use of questioning, the students can be tested on their knowledge and application of that knowledge to nursing care, treatments, the disease process, associated disordered physiology, and their ability to observe. Obviously a certain amount of ethical discretion is required.

The advantages of this method are that the student's grasp of patient problems and nursing care can be identified, knowledge tested and gaps filled, and the student can improve her communication skills by observing the clinical teacher as the role model in communication. The clinical and learning experience gained from the teaching round can later be further expanded and reinforced by discussion and reading.

(d) *Ward report sessions*

Greaves (1979) also discusses the verbal ward report given when a change in nursing shifts occur and the senior nurse reports to the nurses who are to take over, which should provide a small but important patient centred learning situation for students. Students of nursing have to be taught how to write reports and notes and how to give and take over from/for nurses. This requires instructions from the clinical teacher and ideally the ward sister, followed by practice. The clinical teacher has to develop students who are thoughtful, objective, accurate and perceptive in the way they write and speak. The use of jargon and stock phrases should be avoided and an accurate, detailed but concise account given of the patient's care, progress, responses and observations.

(e) *Individual procedures as learning events*

Greaves (1979) argued that procedure is only a method used to provide a particular aspect of nursing care; the teacher should not become obsessed with detail, at the risk of neglecting any special circumstances which relate to the patient's individual and immediate needs. From a teaching point of view, attention should be given to making the student aware of the reasons why a particular procedure is being used and what the consequences are for the patient in question. Considerable care must also be given to point out to the student the potential hazards.

Nursing procedures can and should be made meaningful to the student when they are taught within a patient centred context, with the technicalities kept flexible to meet the patients' needs. Students nurses should not be expected to carry out nursing procedures in robot fashion, otherwise the individual creativity in nursing is lost. Yet procedural principles and safety factors have to be maintained and a good degree of logic and sequence for adaptability for individual patients when demonstrating or teaching a nursing procedure to a learner the clinical teacher should use a patient centred approach. This means the central procedure (for example, giving an intra muscular injection) should be carried out within a complete delivery of care which involves meeting the patient's other needs, observing the patient, repositioning him, making him comfortable giving him to drink, helping him cough or whatever the circumstances of the moment prescribe. The procedure in question may be only one of a number of tasks required for the patient's total comfort, and the teacher must make the learner see the numerous aspects in any one caring situation and learning experience.

In addition to teaching the skills of the procedure itself, the teachers should consider the degree to which they can:

1) Help the student to see the whole of the nursing requirement which the patient needs.
2) Create a communication awareness in the student and help him/her develop the ability to express herself clearly in language the patient can understand.
3) Develop observational alertness in the student and the ability to act on the implications of observations made.
4) Help the student develop a caring attitude within the development of her procedure skills, by cultivating the personal qualities of gentleness, firmness and the correct manner which has a profound effect on the patient's willingness to co-operate.

(f) *Problem solving*

Reilly and Oermann (1992) argued that problem solving methods assist learners in analysing a clinical situation with the intent of defining problems to be solved, deciding on actions to be taken, applying knowledge to a clinical problem, and clarifying one's own beliefs and values.

Problem solving teaching methods appropriate for clinical practice may include:

(1) Problem-solving situation.
(2) Decision-making situation.

(1) *Problem - solving situation*

It represents a description of a clinical event for the purposes of defining problems to be solved as indicated in the situation, identifying relevant data significant to understanding the nature of the problem, proposing hypothesis,

identifying appropriate nursing actions to be taken in the situation and underlying theoretical bases for such actions, and applying theory to practice.

Problems - solving situations also can be used to address complex clinical practice problems and provide reflection - in - action experience in which new problem statements, methods of reasoning, and strategies of action are developed. Situations such as these assist students in dealing with the reality of practice concerns and realising that not all problems have one single answer nor are they all readily solved empirically. The ambiguous nature of many problems faced clinically and multiple solutions possible may be presented and taught through problem - solving situations, Reilly and Oermann (1992).

(2) *Decision - making situation*

A decision making situation is a form of problem solving in which a decision is required, learners examine the data presented, identify alternatives for action and consequences of each, establish priorities, and then make a decision (Reilly and Oermann, 1992). They describe another type of decision making situation in which the decision is stated and learners indicate agreement or disagreement with a supporting rational for the position chosen.

(g) *Format for creating problem orientated activities*

Greaves (1979) suggested the following points which clinical teachers might consider in order to facilitate using a problem solving approach. The teacher should:

(1) Give the student a solvable problem or ask the student to seek a problem that a patient has in the ward.

(2) Help the students to state and delimit the problems; this means reducing the problem through a written statement; questioning the student about her knowledge of the patient, has she identified a valid problem. Do both the student and patient agree that a problem exists?. This is important because problem defining involves both of them.

(3) Help the student find any required information, the student uses the patient as a primary source of information and secures knowledge by observing, talking to him and using his medical and nursing notes and recorded information from observational and treatment charts. The student then collates and organises the relevant information.

(4) Help the student to interpret and analyse the information by attempting a critical evaluation. The student assesses the patient's needs in the light of the information and the evidence she has collected. The teacher talks with students and carefully questions them to develop meaning and understanding.

(5) Provide opportunities for the students to implement and test their ideas. The student defines a course of action to deal with the patient's problem and from the assessment of the available evidence devises and sets nursing objectives on which subsequent care will be based. A nursing care plan is produced or an existing plan is modified so that the additional objectives can be achieved.

(6) The teacher and student discuss the care plan and the student implements the care. Both teacher and student carefully note how the planned care is developing in practice and through further observation anticipate further possible needs. The patient's responses to changes in care are re-evaluated.

(h) ***Nursing care study***

Nursing care studies provide excellent opportunity for learners to consider nursing care problems. When the choice of study is carefully made and where good clinical teacher guidance is evident, the student learns to meet nursing problems by critical and evaluative thinking and by making use of a wide range of information sources. the student learns to consider the patient as an individual and looks at the application of procedures and tasks with the patient the central point of interest in a total care.

The nursing care study is a way of collecting a sound data basis in the actual working situation which can be further developed as an in - depth nursing care study in the student's own study time.

The nursing care study is a short, concise but accurate synopsis of the care of a patient the student has actually been involved with. It involves collecting information directly related to on - going care: the student compiles, as a progressive developing record, the nursing care, treatment, patient progress and responses to care, which can be used as first hand learning material for further in - depth analysis. The clinical teacher supervising the student will need to confer daily with the student to advise, interpret difficult areas, suggest modified approaches and generally give guidance. This can be done quite effectively in a brief discussion and need not take a lot of time. The student may also need some guidance on reading references which can be used in her off duty time to help her with problematic areas. The student should be encouraged to consider physiological, pathological, pharmacological and behavioural aspects which relate to acquiring a better understanding of the patient, his disease and his physical and psychological responses.

All the above methods of teaching take place during routine clinical practice. However, none necessarily occur, just because clinical routines are

going on. For teaching to happen the teacher must at minimum be present with the student and interact with the student regarding both the clinical and the teaching objectives. This interaction may involve explaining and discussing things with the student, or simply serving as a role model (Bradshaw, 1989) whilst undertaking clinical tasks.

❸.4.5 *Instructional process*

Thinking more formally (Reilly and Oermann, 1992) viewed the instructional process in terms of five interrelated components: clinical objectives, assessment of learner, instruction, formative evaluation, and summative evaluation as depicted in Fig.(1).

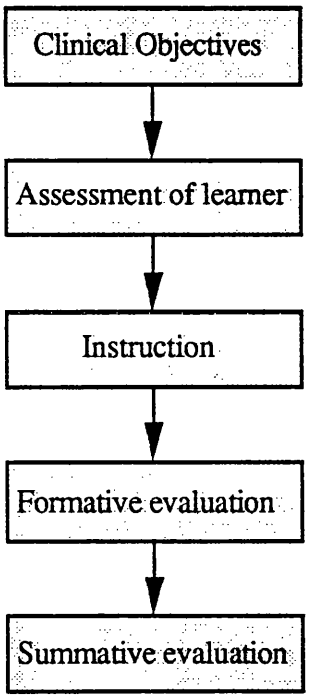


Fig.(3.1): Instructional process in the clinical field.

(a) *Clinical objectives*

Reilly and Oermann (1992) go on to say that the clinical objectives communicate to the learner the behaviour to be developed and, in turn, the focus of evaluation. These objectives indicate for the learner the competencies to be evaluated; the student can then direct learning toward them. The clinical objectives also direct the teacher as to the specific behaviours to be evaluated in the clinical setting, rather than allowing the teacher's personal desires and beliefs to become the focus of the evaluation. The clinical objectives represent a contract between learner and teacher, communicating to the student the outcomes to be judged and providing structure for the teacher so that these objectives will be addressed in the evaluation.

These objectives provide the basis for teaching in the clinical setting because they specify the outcomes to be attained there. The clinical objectives are part of the overall course objectives and represent those behaviours to be attained in practice. While the clinical objectives are developed by the teacher, students set individual goals for learning in clinical practice which are also representative, then, of this first component.

(b) *Assessment of learner*

Instruction begins at the level of the learner, so the second component necessarily deals with assessment in terms of (1) entry behaviours, the prerequisite knowledge and skills for learning a particular task, and (2) relevant characteristics of the learner. These prerequisites constitute the necessary link between the students and attaining the objectives. Given this view, the learner must possess or acquire the necessary entry behaviours to achieve the clinical objectives established for the practice experience.

Assessment might reveal differences in rates of learning cognitive style and cultural patterns among students relevant to planning the instruction. These differences might influence teaching methods, types of learning experiences, time allowed for learning and teacher behaviour. Learner assessment may be carried out by (1) questioning (2) observation of performance (3) written tests and (4) student self-evaluation.

(c) *Instruction*

It is the third component that pertains to the actual teaching process. This phase involves the selection of teaching methods and learning experiences for facilitating attainment of the objectives or initially assisting the student in acquiring any lacking prerequisite behaviours, development of the learning environment, and interaction with students and staff in the process of carrying out the instruction. These methods were discussed in the previous section.

(d) *Clinical evaluation*

The remaining two components of the instructional process refer to evaluation of the learner; formative and summative evaluation. Because evaluation is so important, it will be discussed in more detail.

Clinical evaluation is the process of obtaining information for making judgements about the learner's performance in the clinical field (CIDA project, 1992). Evaluation is not an end in itself, it is a process to achieve the end of the student having learned.

Evaluation is a dynamic, continuous process interwoven with the teaching -learning process. This view of evaluation emphasises its relationship

to growth of the learner, for the judgements made facilitate the learner's own further development of knowledge, skills, and potential, which are essential for professional practice. Evaluation carried out properly in an environment of trust and respect between teacher and learner aids both the teacher in the instructional process and the student in the learning process, (Reilly and Oermann, 1992).

Types of evaluation processes

There are two major types of evaluative processes, formative and summative. These are described bellow:

(1) *Formative evaluation*

Formative evaluation provides feedback to students regarding their progress in achieving the learning objectives. It occurs throughout the instructional process, it is diagnostic in nature, proving information to assist in correcting learning deficiencies and promoting demonstrated abilities. Formative evaluation enables the teacher and student to identify areas in which further learning is needed and plan relevant learning experiences. the focus of such evaluation is on assisting the student in meeting the clinical objectives. Both Reilly and Oermann (1992) and Ravin and Packer (1971) argued that deciding whether a student has attained a set of defined objectives and feeding this information back to the student is essential if the student is to correct his learning behaviour. However one might say that feedback is not a single act which takes place at the end of a course, rather, it is a continuous process that begins early in the course with the initial student - teacher contact. "Feedback begins with a clear understanding of what the course is all about, its purpose and detailed objectives" (Miller and George 1961). With its diagnostic focus,

data obtained through formative evaluation are not subjected to the grading process. Wilhite (1990) refers to formative evaluation as diagnostic evaluation in which the teacher provides learners with information on their strengths and weaknesses, (p.39).

(2) *Summative evaluation*

Summative evaluation may be defined as "end of instruction evaluation, provides information on the extent to which the learner has achieved the objectives", Reilly and Oermann (1992), p.381.

Such evaluation occurs at the end of a unit or course and is used to determine the grade for the entire experience. Summative evaluation is "final" stating what has been accomplished rather than what should be. It is concerned with how students have changed as a result of formative evaluation, while informing the teacher and student at the conclusion of an instructional period as to the degree of attainment of objectives, is not intended to identify learning deficiencies nor the appropriate experiences to assist in over coming them. Further, with summative evaluation, objectives not mastered are often identified too late in the instructional process for students to have an opportunity to meet them. On the other hand Ravin and Paker (1971) claimed that unless objectives are clearly and firmly fixed in the minds of both students and teachers, evaluations are at best misleading; at worst, they are irrelevant, unfair, or useless. Also, clearly defined objectives enable the students to organise their efforts into relevant activities and evaluate their own progress.

Formative versus summative evaluation

The distinction between formative and summative evaluation is important in teaching in the clinical setting for it is formative evaluation that, as an integral part of the teaching - learning process, provides information to the learner as to the knowledge and skills which have been attained and those for which further learning is needed; it also guides the teacher in planning relevant activities to assist the student in this process.

Summative evaluation, in contrast, is conducted at the conclusion of certain clinical experiences or the course to determine if the objectives have been achieved. In summative evaluation there is a concept of finality, stating "what is rather than what is and what can be" (Reilly and Oermann 1992. p.128). A commitment to formative evaluation requires that a systematic approach be developed and feedback to learners be given on a continuous basis, not for use in grading but for facilitating learner growth and development. Effective clinical evaluation also requires summative evaluation that is conducted periodically.

Nature of clinical evaluation process

Clinical evaluation is a judgmental process, reflecting the values and beliefs of the participants. Value is a part of the world and since values are personally chosen, there is a subjective involvement in all aspects of the process, (Reilly and Oermann, 1992). Evaluation is always subjective for it involves human beings with their own set of values that influence the process.

This value component of evaluation makes it critical for teachers to examine their values, attitudes, beliefs, biases, and prejudices about the process itself and the matter being evaluated, for these influence the

judgements made about students. Values affect the teacher's observations and interpretations of their meaning; the learner's values influence his or her own perception of performance in clinical practice and interpretation of the evaluation statements made by teachers about his or her performance. The evaluation process can "enhance the student's personal development and learning or destroy the incentive to learn" (Reilly and Oermann 1992, p.p.127-128). The way in which it is used depends on the teacher's beliefs about the process and role of evaluation in the clinical setting.

Furthermore Reilly and Oermann (1992) argued around the issue regarding the quality of fairness in the clinical evaluation. Whereas clinical evaluation cannot be objective, it can be fair; this quality of fairness in the evaluative process should be the goal of the clinical teacher. Fairness has two requisites: (1) clarity of the objectives identified for the clinical experience and (2) a supportive climate within which the evaluation takes place. In Bergman and Gaitskill's (1990) research on clinical teaching effectiveness in nursing, students and faculty emphasised the importance of fairness in evaluating students in the clinical setting.

Psycho-social climate of clinical evaluation

The climate within which the evaluation takes place is a critical determinant of the way the learner perceives the evaluation process. A supportive climate denoting trust and respect between teacher and student is essential if evaluation is to be viewed by the learner as a learning experience, (Reilly and Oermann, 1992). A trusting relationship between teacher and learner will enable students to value feedback and seek from the teacher evaluation of performance as the learning process occurs. Hedin (1989) emphasises the importance of teachers sharing themselves as human beings in

the clinical teaching process and demonstrating a deep respect for the learner. "Concern and caring are earmarks of this relationship", (Hedin, 1989, p.76). There is a special quality of caring in the teacher student relationship which places evaluation within the context of promoting growth and further development of the learner. Evaluation treated as a means for control of the learner does not promote a climate in which evaluation is perceived by students as an integral part of the learning process. Instead, learners are forced to direct energies to surviving in the system rather than using the teacher as a resource for learning.

A humanistic approach to clinical evaluation (Reilly and Oermann, 1992) considers evaluation as a process for growth and development of the learner. In this context, clinical evaluation is viewed as a diagnostic process providing information to learners for further development. Learning in the clinical setting is a difficult process for it places students in a vulnerable position. Learning, especially that which requires a demonstrated performance, occurs as a public event in front of the teacher, clients, and sometimes even staff and peers, often resulting in the student experiencing feelings of anxiety and stress. Clinical evaluation takes place under similar circumstances, and this vulnerability of the student must be acknowledged by clinical teachers.

Much of the data obtained for clinical education is through observation of the learner. The act of being observed during performance is in itself stressful. A climate based on trust, respect and caring between teacher and learner serves to minimise some of the anxieties inherent in evaluation in the clinical setting, Reilly and Oermann (1992).

Kleehammer, Hart, and Keck (1990) examined aspects of nursing student's clinical experiences which were anxiety producing. Both junior and senior nursing students participated in the study. Areas creating stress for

students in the clinical setting included communication and procedural aspects of care, interpersonal relationships with other health care providers, and interactions with faculty. When students were asked to identify the most anxiety producing aspect of clinical training, they reported, among other situations, that evaluation and observation by faculty were both stressful. Kleehammer (1990) emphasise that these processes "should be done in a supportive, non threatening manner and be used for formative guidance", (p.186).

Meiesenhelder (1982) emphasised the need to remain positive and supportive in the clinical evaluation process. Learners who feel threatened by the teacher will not seek feedback nor value what is given. Placed in this situation they are deterred from their pursuit of knowledge. This comment can also be applied to every stage of the instruction process.

❸.4.6 *Clinical practice setting*

(a) *A learning environment*

"The clinical setting is a non predictable multi-purpose environment where learning experiences are selected from a large reservoir of options", Reilly and Oermann (1992, p.109). The psycho-social climate in which the teaching and learning take place is a major contributing factor to the learning responses of students and ability of the teacher to carry out the educational responsibilities. The climate for learning may support these individuals, impede them, or limit options for learning. The continuing distractions inherent in a busy patient care environment place added stress on the learners as they practice their designated tasks. Nevertheless it is in practice setting where the student develops knowledge and learns how to use it in service for others. These purposes of clinical practice might be achieved in any setting

where the student is involved in the practice of nursing. Time allocated to learning tasks in this environment cannot be assured because of the pressure of other activities in the area which may impede the student's ability to focus directly on the learning tasks to be accomplished.

(b) *Faculty Responsibilities*

According to Reilly and Oermann (1992), development of a climate for learning requires a teacher who is knowledgeable, clinically competent, skilful as a teacher, and committed to clinical teaching. It is important for faculty to examine their own beliefs and values about teaching and learning, their role in promoting learning, and the role of the student, for these influence how the instructional process is carried out and also the quality of the climate for learning. In a supportive learning environment, the teacher encourages independence with learning and self-reliance rather than fostering dependence and reliance on the teacher for sanctions information needed for practice, solutions to problems, and evaluation of learning. With this independence the student learns how to learn.

In the clinical setting, students need freedom to explore, question, and dissent because without this, critical thinking is inhibited. Teachers may not be sure enough of themselves to encourage such experimentation and thus may stifle the innovative potential of students. Teachers as advocates of students often must intervene with staff to facilitate students opportunities for trying out the 'new'. Fear of making an error limits student development and willingness to experiment with care. Teachers, fearful themselves of student mistakes, often place unrealistic demands on learners for perfect practice. The climate for learning needs to be one in which teacher and student together examine failures and learn from them. For the student to admit error, seek guidance from faculty, and value the feedback given, the relationship between teacher and

student is characterised by trust and mutual respect.

In a supportive learning environment, the teacher accepts differences among students in their approaches to solving clinical problems and in the way they analyse situations.

In an environment which fosters independent learning, experimentation and risk - taking behaviour, students are still held accountable for their actions and for fulfilling commitments relative to practice.

The teacher is accountable for providing students with the clinical learning experiences needed to prepare them for practice. Lessner (1990) suggests three areas of legal concern to nurse educators: (a) issues related to student - university relationship, (b) tort liability, and (c) due process, (p.29). Both teachers and students should be familiar with documents which describe the academic appeals process, ineligibility of a student to continue in the clinical setting, types of grades allowed for clinical practice, and other policies related to student experience in the clinical setting.

Lessner (1990) also emphasises the need for an adequate data base when grading students in the clinical area, reflecting the requirements of the course and grading criteria, (p.30). This is important in justifying each student's grade so that no one is treated arbitrarily. The clinical objectives, requirements associated with the clinical experience, method of evaluation, and grading criteria should be written and distributed to students.

Lessner (1990) recommends that educators keep anecdotal notes "which address the course requirements and the grading criteria" for each student in the clinical group, (p.30). Evaluation data and the progress of each student toward achieving the clinical objectives should be shared with the learner on a regular basis.

The second issue identified by Lessher (1990) relates to tort liability including negligence and malpractice. An important principle in this area is that both faculty and students are held to the standard of care that a reasonable person would use in similar circumstances. Walker (1989) describes this standard of care as that which "a reasonably prudent person with the same education and experience practising in the same community would exercise under the same or similar circumstances", (p.181).

According to Lessner (1990), "a nursing instructor would not be considered vicariously liable for the negligent acts of or her students", (p.30). The teacher, however, would be responsible if she or he was negligent in supervising the student or assigned the student a task, procedure, or activity the teacher knew, or should have known, the learner was unable to perform (Lessner, 1990).

Walker (1989) explains that "only an employer may be held liable for the negligent act of an employer", (p.182); staff nurses, supervisors and nurse educators are not employers. They are responsible, and subject to liability, for their own negligent acts, such as inadequate supervision of a student in the clinical setting. The teacher is responsible for facilitating students' learning in the clinical setting and adequately supervising their experience; students, in turn, have a responsibility for seeking guidance when unsure of nursing care.

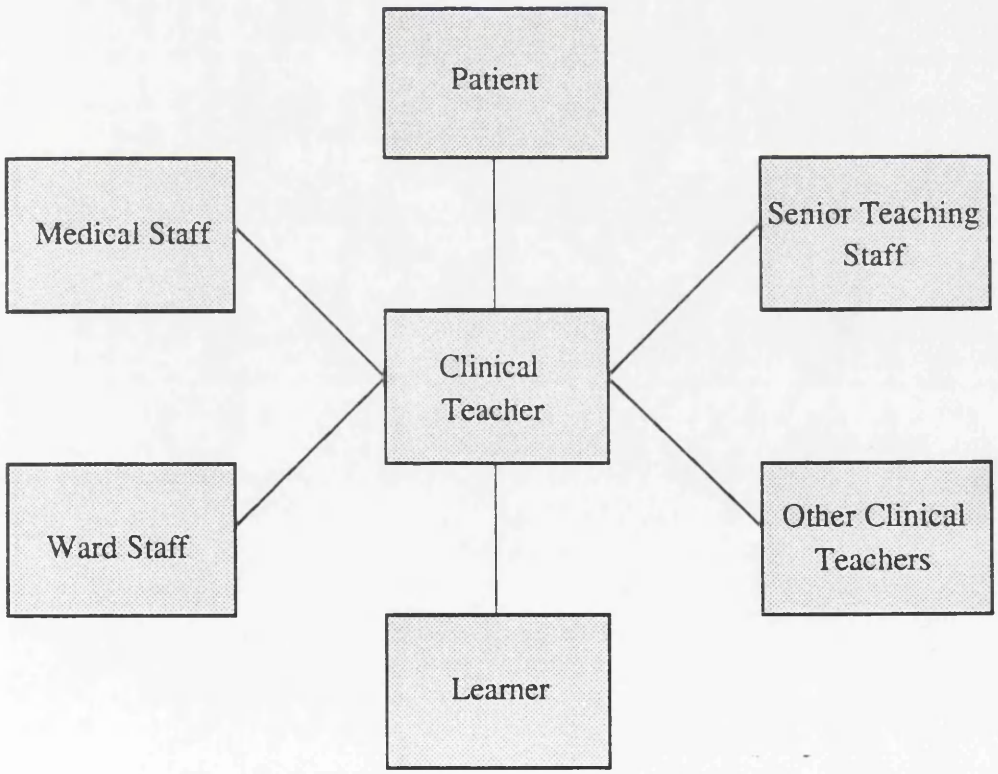
The third area of importance to faculty teaching in the clinical setting is assuming that students have due process in disciplinary actions. This means that procedural requirement should be followed in situations such as ones involving academic appeal, lack of accountability and unacceptable behaviour in the clinical setting, and plagiarism on clinical setting, and plagiarism on clinical assignments. Lessner (1990) emphasises that faculty should understand "which student issues require procedural due process action and

what the appropriate action should be" (p.31). The teacher in the clinical setting should be aware of the legal implications of statements in the university bulletin and school of nursing documents relevant to the teacher - student relationship, policies in the student handbook and other programme documents related to clinical teaching, and the specific procedures to be followed in assuring due process for students.

Relationship with agency personal

The clinical teacher who is responsible directly about facilitating of students learning in the clinical setting faces a set of conflicting demands or expectations and the experience of such discord is usually referred to as 'role conflict' or 'role strain' in the clinical setting, Burn, (1980).

The clinical teacher's role within a group of health workers might be illustrated using Merton's (1957) "role set".



Role-Set (After Merton, 1957)

House and Sims (1976) further emphasised the difficulties that clinical teacher experienced on the ward - "They may well not be seen as professional colleagues by ward sister, but instead a hindrance and not even a useful pair of hands. They may be seen as interfering and certainly not as making any contribution to improved standards of patient care. It may be that they are thought to 'take away' students from the ward rather than adding to it themselves".

Nevertheless the clinical setting for practice needs assessment in relation to the goal of the practice. Whereas, earlier periods of nursing education emphasised psychomotor skill development and used the clinical area for such practice, to day the clinical field is established on the basis of care of the patient. Psychomotor skill development should occur without the learner being concerned about the other care activities germane to environment. Thus it is not the setting that determines what the learner will experience, but rather, the needed experience will determine the practice setting.

The development of a supportive climate for learning depends upon the relationships established between the teacher and agency personnel and between student and staff. These relationships influence the practice experience in terms of learning and the satisfaction of students, faculty, and staff with the experience. Development of collaborative relationships between faculty and agency personnel is essential for a supportive learning environment.

Collaboration is an on going interaction which occurs between professionals in which each person contributes from their own professional knowledge base to problem solving. "collaboration expresses the value that patient needs are multi-dimensional and should remain the focus for concern for all care givers. Mutual respect among colleagues and open communication

are the corner stones of collaborative practice", Dumont & Kiziolek, 1991, p.331).

Northouse (1991) suggests that collaboration "is a distribution of control or a give - and - take of control rather than a fixed dominance of one professional over another", (p.190).

Working relationships between faculty and agency staff are important in creating a positive environment for learning and taking advantage of the many opportunities available for student learning in the setting. Conflicts and misunderstanding among professional interfere with positive working relationships.

Northouse (1991) identifies three factors which promote effective inter professional relationships:

(1) Clarifying roles in order for each professional to have an understanding of one another's role.
(2) Sharing control in which faculty and agency personnel collaborate in planning student assignments and other experiences in setting.
(3) Maintaining contact through clear and continuous interactions between faculty and staff in the setting.

Knowledge of the objectives of clinical practice enables staff to assist faculty in identifying experiences available in the setting which might be appropriate. The teacher, in turn, is sensitive to requests of staff in relation to client care and other kinds of learning experiences. In many practice settings, staff has contact with students from various types of programmes, including nursing and other health professions, who are at different levels of development, who have varying objectives to be achieved, and who engage in

a wide range of learning experiences. It is no surprise that, at times, service personnel become very weary regarding student experiences. Faculty should be sensitive to the purposes and priorities of the clinical setting and cognisant of the adaptations by staff necessary for implementing student experiences there. Agency personnel, in turn, need to recognise that because of varying clinical objectives and levels of students, the responsibilities of students and types of experiences in which they engage will differ.

Regardless of the organisational relationship of faculty with the practice setting, the teacher is responsible for assisting students in working with staff. This requires clarifying the role and expectations of staff in relation to student learning and supervision in the clinical setting and establishing lines of communication among faculty, students, and agency personnel. Preceptors, for instance, assume a different role with students than do staff nurses in a setting where the teacher provides on-site supervision.

Development of working relationships with agency personnel begins with the initial contacts made with the clinical setting and planning with agency staff for the practice experience, overall objectives to be achieved, and faculty role and responsibilities and provide opportunity for agency personnel to present requirements of the clinical setting and the agency's expectations of faculty and students. These meetings provide the basis for establishing a contract or formal agreement between the clinical setting and nursing programme, usually negotiated by administrative personnel of both settings.

Subsequent planning conferences, involving the teacher and staff with whom the students will interact, are necessary to complete the arrangements and deal with the specifics of the experience. Orientation of staff to the objectives, student role and responsibilities level of the learner, times in clinical setting and in contact with clients, faculty role, expectations of staff,

and other details is accomplished in these planning meetings. The roles and responsibilities of the involved parties and specifics of the experience need to be mutually agreed upon and not dictated by either faculty or staff.

Again, in order to manage teaching effectively in terms of relationships with other staff and students, the personal qualities of the teachers are probably important.

❸.4.7 *Qualities of effective and ineffective clinical teaching and teachers*

In theory, it can be seen from the previous sections that clinical teaching is critically dependent upon the qualities of the teacher. From the students' perspective, it is not possible to distinguish those qualities which are personal traits of the particular teacher and those which are products of the constraints of the teaching situation in which the teacher finds herself. For this reason, the empirical literature cannot usually distinguish qualities of the teacher from qualities of the teaching. Indeed, it is particularly difficult to evaluate clinical teaching because it occurs enmeshed with general clinical activities and is laborious to observe directly. Diverse methods have been used in empirical studies, but most have relied on student ratings or opinions of teaching/ teacher effectiveness. Other methods, such as self-evaluation by teachers, formal peer evaluation or direct observation of practice have been used less often. Two recent through reviews of clinical nursing teaching effectiveness exist (Oermann, 1995; Nahas, 1995). With the exception of Nahas (1995) there have been no previous studies of clinical nursing teaching in Jordan, or any similar culture. The work of Nahas (1995) occurred simultaneously to the research conducted here. Nahas (1995) compared the definitions of caring behaviour by clinical nursing students in Jordan and Australia, which is

peripheral to the issue of evaluating clinical teaching effectiveness.

The review here does not attempt to be comprehensive, but will focus on studies which used the critical incident technique, referring to other studies as relevant for comparison. By and large the central focus of critical incident studies has been clinical teacher/ teaching characteristics, rather than the characteristics of the curriculum or the clinical teaching situation. Oermann (1995) reviewed research on teaching in the clinical setting 1965-1994 and identified five areas of research.

(a) teacher behaviours in the clinical setting
(b) role of the clinical teacher
(c) clinical teaching methods
(d) student variables
(e) the clinical experience in general

Most relevant to the problems tentatively identified in Jordan (see Chapter 2) are (a) teacher behaviours. "Clinical practice creates stress for students. Often they are in a totally new environment; their success of the past may not guarantee success in this unfamiliar setting. They fear making mistakes, being put down by an instructor, or being made to look foolish in front of patient and peers", (Karns and Schwab, 1982).

How can the clinical teacher cope with the issues mentioned?. What are the characteristics of effective and ineffective clinical teaching as perceived by provider (faculty), consumer (student) and product (graduate) of nursing education?.

In one of the first studies, Barham (1965) conducted a descriptive study to identify the behaviour that differentiates between effective and ineffective nursing instruction in the junior-community colleges of California. The data

were collected from 178 respondents, 12 directors, 64 instructors, 52 first year students and 50 second year students. The participants were asked two weeks before the commencement of the study about the method they would like to be used to achieve the purpose of this study. Overall, they replied that they would like to be asked to describe two incidents, one describing effective and one describing ineffective teaching behaviour. Consequently this was the method chosen for this study. Barham argues that the advantage of this technique lies on its ability to allow almost complete freedom of responses.

After collecting the incidents, they were submitted to and received the approval of a Jury of qualified educators. Each one reviewed the cards separately. Their judgements did fit the 19 teaching behaviour categories that had been established. Examples of these categories were accepting students as individuals, being available when appropriate, stimulating and involving students. In this study nothing was mentioned about the procedures for selecting the subjects whether it was randomly done or non probability purposive sample. The percentage of return is not given and there are no details of the gender of the respondents. The behaviours identified were simply listed without being thematised. Barham's (1965) specific behaviours induces that teachers:

(1) recognise their limitations
(2) are able to stimulate the student to want to learn.
(3) do not let anxiety influence situations
(4) are available when students cannot handle situations
(5) provide understandable explanations.

In fact the first two of these categories are not "specific behaviours" at all but rather goals of behaviour.

Jacobson (1966) also conducted a descriptive study to identify the effective and ineffective behaviour of teachers of nursing as described by undergraduate students in five of the eight university schools of nursing offering graduate programme in the teaching in the USA. The population sample included 85.57% (961) of the undergraduate nursing students. Participation was voluntary. The method was a modified form of the critical incident technique in group interviews. The participants were asked to write their responses on a form design for this purpose and to describe as many recent effective and ineffective incidents as possible in a 50 minute time.

Jacobson categorised all the critical incidents collected into six major behavioural categories for effective teaching of nursing. They were as follows:

1. Availability to students (corresponds to Barhan's fourth category).
2. Apparent general knowledge and professional competence.
3. Interpersonal relations with students and others.
4. Teaching practices in class room and clinical areas.
5. Personal characteristics.
6. Evaluation practice.

When comparing Jacobson's findings to Barhan's, it should be noted that Barham identified a limited number of specific behaviours without attempting to place them in any categorical framework. Jacobson, however, did attempt to conceptualise behavioural categories and to list specific items for each of the categories. It will be seen that Jacobson's (1966) categories have remained useful.

Armington (1972) conducted a descriptive study to investigate which factors used by students to evaluate an instructor and a course appear to be most important; and to identify some characteristics of teachers whom students' rate above average. A total of 984 used the questionnaire to rate their

32 teachers. The questionnaire was developed by the University of Wisconsin - Milwaukee student government. It consisted of a list describing specific behaviour of clinical instructors. The nursing students used Likert scales, rating the behaviours they considered the most important for effective instruction. The following four specific behaviours were identified as most important:

Effective instructors

- exhibit enthusiasm about their work (5)
- impress students as being expert in their field (2)
- encourage students to think and (3)
- are easily accessible to them (1).

Each of Armington's specific behaviours coincides with one of Jacobson's behavioural categories. Armington did not identify any specific behaviours that would relate to two of six behavioural categories of Jacobson, teaching practices in class room, clinical areas and evaluation practices. However he also found that of faculty members who had published at least one book and one to five articles in state or national Journals, the majority were rated above the median

- in the organisation of principles and concepts,
- in conveying an excitement and enthusiasm for this particular subject,
- in outstanding encouragement of student thinking and
- in outstanding and imaginative approaches to course and subject.

Armington suggested that research ability to the degree that is reflected in books and periodical publication, has a significant bearing upon the students' concept of the good teacher.

Comparing these three studies, it can be argued that there is an element of consensual validation of the importance of three of Jacobson's categories.

Kiker (1972) designed an exploratory study to compare the characteristics of teaching effectiveness considered most essential by three groups of students. The sample consisted of 30 undergraduates education students, 37 undergraduate nursing students and 36 graduate nursing students. Participation was voluntary. A questionnaire consisted of 12 characteristics. These were grouped into three categories: professional competence, relationship with students and individual personal attributes. Kiker asked the three groups to rank their importance. It was found that all three groups of students valued professional competence as being more important than individual personal attributes. Two groups of undergraduate students ranked the behavioural category relationship with students higher than the graduates. This finding seemed logical because a graduate student would function more independently and therefore would not interact or relate with the instructor as frequently in the clinical area as an undergraduate student.

Kiker's three behavioural categories were also among those identified by Jacobson, except that there were some differences in categorising the specific behaviours under the behavioural categories. In addition, Kiker (1972) discusses the importance of being an effective role model and the need to demonstrate the skills, attitudes and values that students hoped to develop.

Stuebbe (1980) conducted a descriptive study to examine how nursing students viewed the role of nursing instructors and to compare this with how instructors vie their roles. A Clinical Instructor Characteristic Ranking Scale (CICRS), devised by Rauen (1974) was used. The scale includes 18 characteristics of clinical instructors with an equal number of teacher, person and nurse characteristics. The total number of subjects was 80, included 29

freshman, 21 juries, 18 senior nursing students and 12 instructors at Evanston Hospital School of Nursing.

It was found that students value the learning of observed nursing skills and theory most, while instructors valued teacher-students relations more. Stuebbe noted that "increased communication between instructors and students, as to what each of their objectives is and how they view each others' role, is mandatory in order facilitate increased understanding and working together to reach common goals".

One might say that Stuebbe supported Kiker by his conclusion that a large part of the nursing skill and behaviour learned by students is directly related to the behaviour they observe in their nursing instructors.

A small exploratory study was conducted by Wong (1978) to identify students' perception of teacher behaviours that either facilitate or hinder students' learning in the clinical field, and to determine if there is a difference in the perceptions of first and second year students. The sample was 8 out of 10 first year nursing students, 6 out of 10 second year students in the College of Applied Art and Technology in Ontario is basic nursing programme.

The method used for collecting data was a modified form of critical incident technique as used by Jacobson (1966). Participants were asked to describe in the form provided as many recent incidents (within a six month period) as possible (in 45 minutes) about their teachers' behaviours, either facilitating or hindering their learning. A description of their incidents was requested within 5 divisions: professional competency, relationship, personal attributes, teaching methods and evaluation practice. Wang reported the findings of the study as follows:

The teacher behaviours reported as helpful to students' learning, as identified by the students, were:

(1) Demonstrating willingness to answer questions and offer explanations.

(2) Being interested in students and respectful to them.

(3) Giving students encouragement and due praise.

(4) Informing students of their progress.

(5) Displaying an appropriate sense of humour.

(6) Having a pleasant voice.

(7) Being available to students when needed.

(8) Giving an appropriate amount of supervision.

(9) Displaying confidence in themselves and in the students.

About the teacher behaviours that hindered students' learning as identified by the students were:

(1) Posing a threat.

(2) Being sarcastic.

(3) Acting in a superior manner.

(4) Belittling students.

(5) Correcting students in the presence of others.

(6) Supervising students too closely.

(7) Laying emphasis only on correcting the students' mistakes or pointing out their weakness.

In this study the sample was small, and it was not mentioned when the study was conducted, at the end of the semester or in other time. Divisions for the incidents to be mentioned were imposed by the researcher that might force the participants just to report their answers within the divisions given. The findings were not presented within the categories.

However, when comparing Wong's (1978) findings with Barham's (1972), it should be noted that both identified similar specific behavioural statements that had been recognised as helpful to student learning. For example, these behaviours:

(1) being available when appropriate.

(2) Avoiding humiliating students in front of others.

(3) Counselling without humiliating.

(4) Explaining for understanding.

(5) Giving students feeling of importance.

(6) Recognising individual needs and stimulating and involving students.

Also Wong's (1978) findings supported those of Kiker (1972) in relation to the undergraduate students regarding their sensitivity how the teachers make them feel. In other words it be argued that this issue comes under the behavioural category as Kiker (1972) suggested. In addition graduate students in both studies ranked professional competency as more important than personal attributes. It would also probably be possible to fit Wong's categories in Jacobson's (1966) general scheme.

A descriptive study was conducted by Flagler (1988) to determine baccalaureate nursing students' perceptions of clinical teaching behaviours that helped or hindered the students' self confidence as a nurse. The questionnaire devised for this study consisted of two parts. the first part consisted of 16 items which were derived from previous studies; (Bliney, 1980; Brown, 1981; O'Shea,1979) and from the authors' experience with clinical supervision, respondents were asked to rate on a five-point scale the degree to which each behaviour helped or hindered the students' self confidence as a nurse.

The second part of the questionnaire consisted of two open-ended questions in which the respondents were requested to identify additional

clinical instructor behaviours or attributes that helped or hindered his or her self-confidence as a nurse.

A total of 139 (89%) students out of 155 participated in the study in the Pacific North West.

Factor analysis of the instructor behaviours from the first part of the questionnaire revealed five factors that were responsible for 59% of the total variance. When the individual items that contribute to each factor are examined, a picture of the different dimensions of clinical instruction emerges. Five aspects of clinical instruction are evident: instructor as resource (Factor I); instructor as evaluator (Factor II); instructor as encourager (Factor III); instructor as promoter of patient care (Factor IV); and instructor as benevolent presence (Factor V).

The students' ratings of the degree each behaviour helped or hindered their self-confidence reveal that the behaviours contributing to the resource (I) encourager III, promoter, (IV), and benevolent presence (V) Factors were rated as helpful by more than 70% of the sample. Conversely, the majority of the behaviours that contribute to the evaluator Factor (II) were rated by the students as hindering self-confidence as a nurse.

Concerning the open-ended question about instructor behaviours relating to enhancing the students' self-confidence as a nurse: The major categories of responses were, giving positive reinforcement, showing confidence in student, encouraging and accepting questions, providing support and giving specific feedback.

Regarding the instructor behaviours that hindered the students' self-confidence, students stated the following: no feedback or negative feedback only, intimidation, and distress about students lacks of knowledge or

performance.

One might say that Flagler's findings also supported the previous studies of Jacobson (1966), Kiker (1972) and Barham (1972) concerning the role of positive feedback, reinforcement, accepting students' questions in facilitating students learning.

Brown (1981) conducted a descriptive study to identify characteristics of effective clinical teacher believed to be important by students and faculty and to compare between the two groups' perceptions. A total of 82 senior nursing students and 42 faculty members from East Carolina University, School of Nursing participated in the study.

A questionnaire was developed by the author in two parts. The first part identified 20 characteristics of clinical teachers. These characteristics were rated using Likert-type scales with a stated rating code, ranging from 'of most importance' to 'of no importance'. The second part of the questionnaire required the participants to select the five characteristics from the list of 20 that they considered most important for a clinical teacher. Only content validity was established before conducting the main study.

It was found that both groups ranked the following two items among the top five as most important:

- Provide useful feedback on students' progress.
- Objective and fair in the evaluation of the student.

It can be said that mutual acknowledgement of the importance of these characteristics signifies their impressiveness in the teaching-learning environment.

Over 60% of the students marked the following items as being the most important:

- Shows genuine interest in patients and their care.
- Conveys confidence in and respect for the student.
- Is well informed and able to communicate knowledge to students.
- Encourage the students to feel free to ask questions or to ask for help.
- Objective and fair in the evaluation of the students.

As can be seen that the other top three characteristics' rankers by students reflected the importance students regarding interpersonal relationship. It seems that the teacher must display confidence in the students' work and demonstrate respect for the student as an individual.

Around 50% of the faculty chose the following items as most important:

- Relate underlying theory to nursing practice.
- Is well informed and able to communicate knowledge to student.
- Provide useful feedback on student progress.
- Is objective and fair in the evaluation of the student.

As can be seen that the characteristics ranked most important by the faculty group related to professional competence. It is the educator's responsibility to keep abreast of current knowledge and practices in nursing and education.

After data collection the researcher categorised the items, but simply by surface appearance. Furthermore, the study was not piloted and nothing was mentioned about the reliability or validity of the instrument.

However, Bergman (1990) replicated Brown's study to determine whether previous findings remained valid and were transferable. In addition

Bergman wanted to identify which characteristics of the effective clinical teacher were deemed most important by nursing students and faculty and to investigate wither the perception of effective teaching behaviour shifted as students advanced towards graduation.

The author hypothesised that

(1) "BS nursing students and faculty would differ in their perceptions of the importance of selected characteristics".

(2) "Students would identify instructor-student relationship as most important".

(3) Instructors would identify professional competence as the primary characteristics".

(4) As the level of nursing education increased, student perceptions of the characteristics of effective clinical instructors would tend to become more similar to those of the faculty". (p.36).

The sample consisted of 134 students (11 sophomores, 77 juniors and 46 seniors) and 23 faculty members at a University College of Nursing in South Western Ohio. Access to students was gained during regularly scheduled class periods. Faculty questionnaire were completed during office hours. The "Brown" instrument was used. It was found that the following items considered were important by both groups:

(1) Shows genuine interest in patient and their care.

(2) Conveys confidence in and respect for student.

(3) Is well informed and able to communicate knowledge to students.

(4) Provides useful feedback on student progress.

(5) Is realistic in expectations of students.

(6) Is honest and direct with students.

(7) Encourage students to feel free to ask questions or to ask for help.

Two items were identified by the students as most important, that is the instructor is well informed and able to communicate knowledge to students and is objective and fair in the evaluation of the student.

The items most often identified by faculty members as important were shows genuine interest in patients and their care, conveys confidence in and respect for students and is honest and direct with students.

Therefore, the first hypothesis must be to a large degree, rejected. There was a relatively high level of congruence between student and teacher perceptions. The second hypothesis was supported. Students do identify instructor-student relationships as most important. The third hypothesis was rejected in this study as instructors identified relationships with student as more important than professional competence. The fourth hypothesis was only partially upheld. Although there was no broad-based convergence between the views of students as they mature and those of faculty, the trend was identified in responses concerning certain characteristics, including the characteristic of showing genuine interest in patients and their care.

Brown (1981) had suggested that the 20 characteristics could be classified into three categories: Those dealing with professional competence, relationships with students and personal attributes. The same thing was done by Bergman (1990). Both students and faculty members ranked the three categories in the following order:

(1) Relationships with students.

(2) Professional competence.

(3) Personal attributes.

These results differ from Brown's findings. Brown (1981) found that faculty members ranked professional competence above relationships with students.

In conclusion one can say that the results of with students (Brown, 1981; Bergman, 1990) show congruity in content but not in the ranking of items. congruity appears to cut across the faculty-student line and geographic and time differences suggesting that the findings are transferable, but that the relative importance of qualities are not.

O'Shea and Parsons (1979) conducted a study to identify and compare effective and ineffective clinical teaching behaviours as described by students and faculty in one baccalaureate school of nursing.

The sample consisted of 205 students (104 junior and 101 senior) and 24 faculty. A simple two-question written questionnaire was developed by the author. It consisted of a card with the heading, "facilitated" on one side of the card and the heading, "interfered" on the opposite side of the card. In responding to the questionnaire, students were asked to list three to five teacher behaviours that facilitated their learning in the clinical setting and three to five behaviours that interfered with it. Faculty were asked to complete identical cards and to list those behaviours they believed facilitated or interfered with student learning in the clinical setting.

The responses were sorted into three broad categories of teacher behaviours designated as evaluative behaviour, Instructive/Assistive behaviours and personal characteristics. It was found that regarding evaluative behaviours that the data indicated a degree of agreement between students and faculty. Regarding the relationship of feedback to learning, 37% of juniors, 79% of seniors and 59% of faculty agreed that feedback facilitates learning. Similarly 16% of juniors, 57% of seniors and 51% of faculty agreed that giving only negative feedback or none at all interferes with learning.

It is interesting to note that while 45% of faculty listed the fact that clearly defined objectives are provided as a facilitative behaviours, only 18%

of senior and 5% of junior did so. On the other hand, 28% of seniors and 11% of juniors felt that a lack of defined objectives interfered with learning. Students apparently did not perceive clearly defined objectives as important facilitators unless their absence resulted in negative evaluation by the instructor.

In terms of instructive/assistive behaviour, faculty availability was the behaviour noted by all groups to be most facilitative of learning. This relates to Jacobson's (1966) and Barham (1965) categories.

The most marked difference of opinion in the entire study was in respect to role modelling. Faculty indicated role modelling as a facilitative behaviour five times as often as students did. Faculty also identified the following as interfering with student learning: having unrealistic expectations, meeting their own needs first and "taking over" assignments from the students. In the broad category of personal characteristics, the facilitative behaviours listed indicated a general awareness that friendly, understanding, supportive behaviours facilitate learning. Even so, there was a marked difference between senior students responses and those of faculty and junior students. The senior students responses indicated however that they need clinical faculty to exhibit supportive behaviours if they are to learn in the clinical setting. Again, these qualities relate to earlier categories.

Regarding the opinions of faculty towards the teacher as role model, it seems that role modelling is currently a well-accepted term among educators and others interested in learning, but students may not find this abstract concept meaningful.

Mogan and Knox (1987) also conducted a descriptive study in order to identify and compare characteristics attributed to the 'best' and 'worst' clinical

teachers by students and faculty; to provide clinical teachers with a list of characteristics to be developed or strengthened and behaviours to be reduced or avoided. The participants were 28 clinical teachers, 173 undergraduate students from seven universities schools of nursing located in Western Canada and the USA.

The instrument was the Nursing Clinical Teacher Effectiveness Inventory - NCTEI, which is a 48 item checklist which describes discrete teacher characteristics clustered into five sub-scales or categories: teaching ability, nursing competence, personality traits, interpersonal relationship and evaluation.

Raters judged how descriptive a specific characteristics of a particular teacher on a seven-point Likert Scale. Category scores were obtained by summing scores of all items within a category. Summing all five category scores provided a total score for the teacher. Higher scores implied more positive teacher characteristics.

The instrument was found to be internally consistent ($\alpha = 0.79 - 0.92$), was stable over time (test-retest correlations after four weeks ranged from ($r = 0.79 - 0.93$) and was considered to have content and face validity. The questionnaire was distributed to volunteer students and clinical teachers. Each participant was asked to think of the 'best' clinical teacher and rate him or her using the NCTEI. Participants were then directed to think of the 'worst' clinical teacher and to rate him or her as well.

It was found that faculty and students perceived 'best' clinical teachers as good role models who enjoyed nursing and teaching, were well prepared for teaching and seen as self confident, skilled clinicians who took responsibility for their own actions, were approachable and fostered mutual respect.

Three characteristics were not shared by the two groups. While students perceived the 'best' clinical teachers as demonstrating enthusiasm, promoting student independence and correcting students without belittling them, faculty perceived them as teachers who demonstrated breadth of nursing knowledge, who explained clearly and who stimulated student's interest.

Regarding the 'worst' clinical teacher characteristics there was less agreement between the two groups on characteristics of the worst teacher. Faculty perception dealt with a lack of enjoyment of nursing, deficient communication skills, inability to objectively identify students strengths and weaknesses and an inability to help students organise their thoughts concerning patient problems. Students perceived the 'worst' clinical teachers as poor role models, judgmental and not open minded. Finally the worst clinical teachers were perceived as not having provided support and encouragement to students and to having failed to create an atmosphere of mutual respect.

The above results show a difference of perception between the two groups in regard to the characteristics of the 'best' clinical teacher. Student perceptions showed that they prefer to be active not passive learners. The teachers thought that the characteristics of the 'best' clinical teacher were the one who demonstrate breadth of knowledge but student ask for principle of learning rather than learning itself.

Regarding the perception of the students to the characteristics of the 'worst' clinical instructor, the one who is judgmental and not create good atmosphere for learning. That means it is crucial for the teacher to be objective and fair, to respect the learner, to create atmosphere that motivate them to learn, that is principle of adult learning. In terms of faculty perception of the characteristics of the 'worst' clinical teacher, one might agree with them but it

can be argued that not all students are able to perceive the dimensions of teaching-learning process the way teachers do.

Nehring (1990) replicated Mogan and Knox's study with their permission in order to determine the characteristics of 'best' and 'worst' clinical teacher as perceived by baccalaureate nursing faculty and students in Ohio, USA. The sample consisted of 63 teachers, 121 students (76 senior students and 46 registered nurses being in the senior level. The data was collected from eleven collegiate schools of nursing. The faculty and the students were asked to think of the 'best' clinical teacher and rate that teacher using the NCTEI. Respondents then ask to think of their 'worst' clinical teacher and rate it too. It was found that both groups similarly ranked the top four of the characteristics of 'best' clinical teacher those who are good role models, enjoy nursing, enjoy teaching and take responsibility for their own actions. Both groups also included encouraging mutual respect and providing support and encouragement in the top ten ranks. However, there were some differences in the top ratings. Students perceive the 'best' clinical instructors as those who were prepared, had clinical skills and judgement, were approachable and were self confident. Faculty perceived the 'best' clinical teacher as those who were characterised as demonstrating communication skills, listening attentively and promoting student independence.

Although there was a high degree of mutual agreement on the characteristics of the best instructors, as with Morgan and Knox (1987), there was less agreement between the two groups on the characteristics of 'worst' teacher. Students and faculty perceived several behaviours as rarely performed by the 'worst' faculty. These behaviours included: being good role model, encouraging mutual respect, demonstrating empathy, providing support and encouragement, and using self-criticism.

From the above findings it is clear that there are many commonalties between Knox and Mogan's (1987) findings and those of Nehring's (1990) findings. In both studies the characteristics seen as descriptive of the 'best' clinical instructors included being good role model, enjoyed nursing, enjoyed teaching, accepted responsibility for own actions, and demonstrated clinical skills and judgement. In both studies the 'worst' instructor was perceived as only rarely being characterised as a good role model, using self-criticism constructively, encouraging mutual respect or providing support and encouragement. Such similar findings confirm the tool's reliability over time and with different samples. The Nursing Clinical Teaching Effectiveness Inventory has therefore been further validated as a useful tool for faculty self-development or as a clinical teacher evaluation tool and the questionnaire used here drew many items from it.

Broadly, the effective and ineffective behaviours given in these two questionnaire studies fit into Jacobson's (1966) and Barham (1965) classification.

Ramsborg and Holloway (1987) conducted a descriptive study to identify characteristics of specific positive and negative learning experience as perceived by nursing students and teachers. The authors hypothesised that for all areas of clinical teaching, positive experiences would be rated significantly higher than negative ones.

The study was conducted with students and teachers from 22 schools of nurse anaesthesia which were randomly chosen from the "list of recognised educational programs" as published by the Council on Accreditation of Nurse Anaesthesia Educational Programs School. A total of 272 questionnaires were used of which 163 were usable. Included in the sample were 27 clinical instructors, 13 student nurse anaesthesia graduated from the Minneapolis

School of Anaesthesia, and 123 current students in schools across the USA. The instrument was a 26-item questionnaire, covering
(1) establishing goals and expectation, (2) motivation, (3) memory stimulation, (4) attention, (5) communications, (6) practice and (7) evaluation.

Each item was scored on a four point scale assessing wither a behaviour was extremely well done, fairly well done or not done. Respondents were asked to recall a specific instance of a negative or positive learning experience that related to the items mentioned. Analysis of variance was performed using 2×3 factorial design (two levels of learning experience, positive or negative $\times$ three levels of respondent type: clinical instructor, student or student/graduate) to determine if differences in perceptions existed between the instructors and students on positive and negative experiences.

Reliability was estimated (Cronbach's alpha) for the seven scales for each of the three populations and for the total. The authors concluded that the scales achieved an acceptable level of reliability to allow continuation with further analysis. of the 163 questionnaires returned, 85 related positive teaching/learning experience and 78 related a negative teaching/learning experience.

It was found that clinical instructors most often noted that positive teaching experiences resulted when the student was motivated and exhibited an enthusiasm for learning, and possessed the ability to correlate and apply didactic material in the clinical environment. Students and student/graduates most often noted that mastering a new skill or technique, having an instructor who projected confidence into the situation and winning a degree of independence in practice made for positive clinical learning experiences. Regarding negative experiences, clinical instructors stated that conflict between members of the anaesthesia care team and dislike for instructing students

created negative clinical teaching experiences. Students and student/graduates repeatedly expressed frustration at not being able to use techniques or anaesthetic plans they suggested. Additionally, several students noted that instructors who did not offer support when problem occurred and berated a student's judgement created negative learning experiences. Negative instructional experiences identified by clinical instructors were most often caused by students with a "know it all" attitude, argumentative students and students who were unable to meet expectations. Negative instructional experience from a student and student/graduate included condescending comments by instructors in the presence of others, frustration with the instructional technique utilised by the clinical instructor, lack of positive feedback and insensitivity to the student's personal needs. Clinical instructors noted that their most positive instructional experiences came from watching student mature and grow, as they moved through the program, changing from beginning students requiring extremely close supervision to safe, competent graduate practitioners.

Students and student/graduates indicated that managing a case with minimal supervisions using problem-solving skills resulted in positive learning experiences from an instructional perspective. Students responded positively to open communication and dialogue regarding case management, constructive feedback and reinforcement.

These results suggested that there is nearly complete congruence among faculty, students, and graduates regarding positive and negative learning experiences. Furthermore, results suggested that this instrument can differentiate between positive and negative learning experiences. The statistical analysis used and the reliability test was very concise and clearly helped the authors to derive reliable responses. It is not clear why each respondent was asked to expand answer on just one issue, either positive or negative, rather

than both.

Both students and teachers rated the lack of co-operation of the nurses in the clinical setting as a negative experience. The role of hospitals nurses contributed to the effectiveness of clinical teaching, which raises the issue of the importance of having a collaborative relationship between the academic and the clinical staff. In this study and in all the previous studies mentioned students highlighted their needs for self respect and positive, constructive feedback more than professional competency of the clinical teacher. Once again, these issues were covered by Jacobson's (1965) original scheme.

Dawson (1986) conducted a descriptive study to determine the relationship between hours of contact with a teacher and clinical teaching effectiveness and classroom teaching effectiveness as perceived by Baccalaureate students in a nursing course with a clinical component. The author hypothesised that there is a positive relationship between nursing students' ratings of an instructor's clinical teaching effectiveness and classroom teaching effectiveness. The second hypothesis was that the increased hours of contact with a teacher in the clinical setting will result in higher student rating of that teachers classroom teaching effectiveness. The participants were 341 nursing students. The teachers who were evaluated were involved in both classroom teaching and clinical teaching. Each of them teaches an equal block of 12 hours on content to all students enrolled in the course, in addition to that they are responsible for the clinical supervision of an average of eight of the students enrolled in the course and spend seven hours/day or a minimum of 45 hours/semester. The instrument was developed by the author. It consisted of six items measuring teaching ability and these were: encourages independent thinking and learning, makes students feel free to ask questions or ask for help, explains important material clearly, encourages student participation in class or clinical conference, presents

material in an interesting and stimulating manner, evaluates the student objectively and fairly. All students were asked to rate on a five-point Likert-type Scales, all teachers, one for classroom teaching and the other for the clinical teaching, on each of the six times. A rating of five corresponds to "excellent, one of the most effective teachers I know", and a rating of one to "poor, one of the least effective teachers I know". Reliability of the form was established using the test-retest method. Data were collected on the ratings of five course teachers over a period of 2.5 academic years. Of a total of N=357 evaluation forms received over this time period, N=341 were used for data analysis. The 16 excluded from the study evaluated only clinical teaching and omitted an evaluation of classroom lecturers.

The result of the study indicated that the hypothesis "The increased hours of contact with a teacher in the clinical setting will result in higher student ratings of that teacher's classroom teaching effectiveness" was highly supported. The increase number of hours contact with the teacher in the clinical setting reflected positively on rating their effectiveness in clinical and classroom teaching.

There were significant, moderately strong to strong positive correlations between students' evaluations of their clinical instructor's clinical teaching effectiveness and the same students' evaluations of their clinical instructor's lecture effectiveness. The impressions or feelings students developed about the teacher in the clinical setting appear to carry over into the classroom.

The ratings a clinical instructor receives from her clinical group are good predictors of how that group will rate her as a classroom teacher. This author showed in his study that the rating effectiveness in the clinical teaching can be good prediction for rating effectiveness in the class room. But this does not mean at all that effective classroom teaching can be good predictor for effective

clinical teaching; not every effective classroom teacher has the skill to break the wall between theory and practice in an effective way. The most important point is perhaps that the qualities of effective teachers may transfer between teaching settings.

Conclusions

The student-teacher relationship is important and in that relationship the attributes of good teachers have received most study. Jacobson's (1965) suggested classification of attributes has received some empirical support from both critical incident and questionnaire research. Parts of Jacobson's (1966) classification have been given further detail, notably by Barham (1965), Armington (1972) and Oermann (1995). Krichbaum (1991) concluded that "In nursing, descriptions of effective clinical teaching have generally attained the six categories of behaviour identified as Jacobson (1966)". The following characteristics seem most important.

1. Availability of the teacher to students.
2. Teacher's general knowledge and nursing competence.
3. Teacher's interpersonal relationships with
    a. Students
    b. Clinic staff
    c. Patients
4. Teacher's teaching practices
    a. Explanations
    b. Stimulating
    c. Encourages student problem-solving
    d. Creates non-threatening learning environment

5. Personal characteristics

   a. Professionalism - looks and behaves "like a nurse"

   b. General - is pleasant interpersonally.

6. Evaluation is fair and accountable

   a. Formative evaluation

   b. Summative evaluation

It should, however, be emphasised that these characteristics have not been derived empirically, rather they have been used to organise empirical findings. Although many of them have some degree of empirical support, they remain a schema imposed on teacher behaviour and may be neither all-inclusive, nor fully-appropriate for the Jordanian situation. Nonetheless, they provide a useful working framework for the research to be conducted.

Chapter ❹

Methodology

(Qualitative and Quantitative Evaluation)

❹.1 *Introduction*

This is a descriptive, exploratory study aiming to identify factors contributing to clinical teaching effectiveness in nursing as perceived by senior nursing students and nursing faculties at Jordanian Universities. The aims of the study were as follows:

First, to identify the clinical teaching activities in nursing as perceived by senior nursing students and nursing faculties at Jordanian Universities. The second aim was to describe the interaction process of the clinical teaching as observed by the researcher. The third aim was to identify behaviours of clinical teaching effectiveness and ineffectiveness as described by senior nursing students.

In order to achieve the aims mentioned above, a number of research methods were employed. The opting for a combination of methods was considered appropriate to meet the different aims of the study. Below is an outline of the methods used. More detailed description is given later on.

Three independent instruments were employed. Questionnaire design was used to achieve the first aim of the study; to identify the clinical teaching activities in nursing as perceived by senior nursing students and nursing faculties at Jordanian Universities.

The data collection instrument was constructed by the researcher, content validity was tested by jurors, the instrument was piloted and then data were collected from the subjects of the main study.

The second aim of the study was to describe the interaction process of clinical teaching. An observational method was employed. The purpose of using an observational method in this study was to describe accurately the experience of the phenomena under study and not to generate theories or models nor to develop general explanation. In other words it was used to describe the interaction process and the actual behaviours of the clinical teachers that occur in the clinical setting. A non participant and unstructured method was used.

The third aim of this study was to identify behaviours of clinical teaching effectiveness and ineffectiveness as described by senior nursing students. The critical incident technique was used to achieve this aim. Students were interviewed and asked to describe incidents of behaviours performed by their clinical teachers while they were teaching them nursing practice in the clinical setting, which students considered to be effective or ineffective. Then by analysing, categorising and coding these incidents, effective or ineffective clinical teaching behaviours would be identified.

In conclusion, questionnaire design was used to provide an overview of the activities of clinical teaching, observational method to describe the interaction process of clinical teaching and critical incident technique was used to identify effective and ineffective clinical teaching behaviour as described by senior nursing students (consumers). The three approaches offer different perspectives of the issue under investigation to overcome any limitations of a single approach.

In the following section a diagram of the conceptual framework of the methodological design is presented and described. The model incorporates the three methods selected and how they were was implemented.

❹.2 *Conceptual framework*

In order to presents the methods used to identify factors contributing to clinical teaching effectiveness, the model shown in Figure (4.1) was developed. The purpose of this model is to permit simplification and clarification of the relationship between these methods.

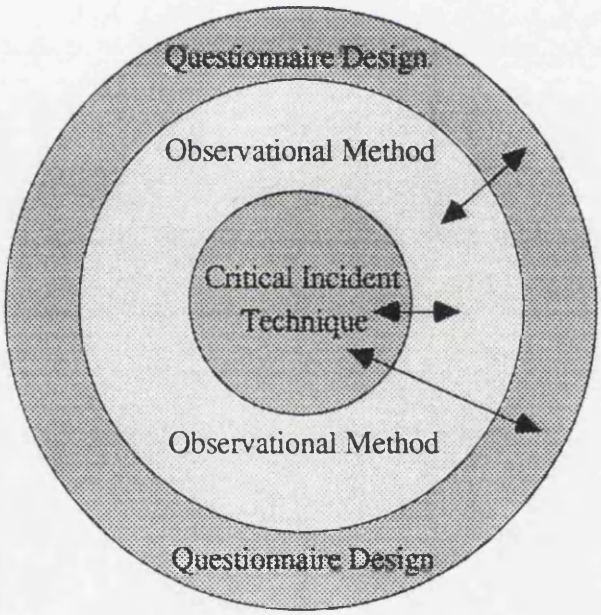


Figure (4.1): Methodical design.

As can be seen in Figure (4.1), the sequence in using these methods is presented in three circles with arrows showing the directions of each; the outer circle presented the questionnaire design which consisted of a list of activities of clinical teaching in addition to the open-ended question. For

further detail see method chapter (questionnaire design section).

Followed the data collection via questionnaire observational method was used which is presented in the next circle of the model. As previously mentioned in the method chapter (observational method section) the idea of using this method was to describe the interaction process of clinical teaching, at the same time to describe the actual behaviours of the clinical teacher with nursing students at selected period of time.

Finally, the last circle (the inner one which is considered the core of this research) was the C.I.T which provided the researcher with effective and ineffective clinical teaching behaviours.

In conclusion, one might say that this model showed that the process of data collection was proceeded from general (questionnaire) to specific observation method, and then to more specific (critical incident technique).

❹.3 *Questionnaire design*

❹.3.1 *Introduction*

The first aim of this study was to present an overview of the activities of clinical teaching effectiveness in nursing at Jordanian Universities.
A questionnaire may be defined as a scientific instrument for measurement and for collection of particular kind of data (p.21 Oppenhaim 1992). The purpose of using this method was to let it act as a preliminary step in order to identify clinical teaching effectiveness at school of nursing at Jordanian University. Furthermore to help in some way in evaluating the current status of clinical teaching in nursing over there.

❹.3.2 *Advantage of the questionnaire*

As previously mentioned the subjects of this study were from two different groups: students and teachers. The design of the questionnaire in using closed and open questions, allowed the perceptions of the two groups to be compared in both quantitative and qualitative ways.

The advantage of using questionnaire in the first phase of the study was that it is easy to administer, to analyse; can facilitate the development of quantifiable information, does not need much time, is not expensive and is a very efficient method of obtaining a high response rate over a very short period of time.

❹.3.3 *Disadvantage of the questionnaire*

Applying mathematics to social science data does not guarantee objectivity. Forcing the subjects to respond to the closed questions might not reflect the subject's thought or opinions. By using Likert scales one might be not able to discriminate between levels of importance of clinical teaching activities. Furthermore closed questions force the subjects to answer the questions provided and this might not reflected the subject thoughts or opinions. Therefore one open ended question was added to the questionnaire which was to ask the subjects implicitly about the crucial issues from their point of view. Open ended questions afford the opportunity for participants to express their opinions freely and to obtain additional data unlimited by the instrument. However, some open ended questions make analysis more difficult, plus respondents may not wish to write lengthy or difficult answers.

❹.3.4 *Self administered questionnaire:*

Self-administration of the questionnaire to the participants guarantees that the questions are answered by the subjects themselves and not answered by others. It is also gives the researcher the opportunity to answer queries which may arise and therefore misunderstandings are avoided, bearing in mind the need to avoid presenting information that results in variation in interpretation by respondents. Postal questionnaires were considered unnecessary in this situation since the participants are easily accessible.

❹.3.5 *Construction of the data collection instrument*

In the nursing literature there are many evaluation tools developed for the evaluation of clinical teaching effectiveness in nursing (Bergman 1990, Zimmerman 1988, Dawson 1986, Knox 1985, Brown 1981, Stuebbe 1980, and Wong 1980). All were developed in the United Kingdom or the United States. However, the researcher was not certain that a tool imported from abroad would be appropriate and acceptable in Jordan due to different cultural, health care and educational systems. Therefore, it was thought to create an evaluation tool building upon previous tools and validated by nursing experts in Jordan. The need for locally prepared tools were supported by the American Association of University Professors (1975); "There is no one questionnaire or method suitable to every department or institution".

Furthermore, a validated instrument for evaluation of clinical teaching would unify role perception, job expectations and job evaluation. It is also argued that in the future an evaluation instrument developed in Jordan might prove suitable and attractive for adoption there or similar cultural areas in the Middle East. This study was thought to be a preliminary step in development of a fully validated instrument in the future.

The questionnaire was developed to fulfil two purposes:

(1) To identify activities of clinical teaching effectiveness as perceived by nurse educators and senior nursing students.

(2) To identify the level of applicability of the activities of clinical teaching effectiveness as rated by nurse educators and senior nursing students.

The questionnaires were developed by the researcher for this study. The first questionnaire was directed to students (Appendix 1), and the second was directed to clinical nursing educators (Appendix 2).

The two questionnaires were similar in content but separate versions were written for students and teachers. Nevertheless, both questionnaires consisted of the following elements:

a) Covering letter.

b) Orientation to the questionnaire parts.

c) Demographic data

d) Directions to respondents about how to complete the questionnaire.

e) Research questions.

a) *The covering letter*

The covering letter (Appendix 1) invited participation in the study and gave its purpose. In the letter, it was written that responses were to be used for research purposes only. Confidentiality was assured. Participants were told to return forms without signing their names.

b) *Orientation to the questionnaire parts*

This section informed the participants that the questionnaire consisted of three parts, as follows:

1) Demographic data.

2) Scale of identifying activities of clinical teaching effectiveness.

3) Open-ended questions related to clinical teaching.

c) *The demographic data*

Although the literature suggests ending rather than beginning the questionnaire with demographic questions because they tend to be routine and dull (Polit and Hungler, 1989, Treece and Treece 1982), the researcher chose to start with them. It was thought that it would be easier for the respondents to answer and therefore they would be encouraged to carry on with the rest of the questionnaire. The following are the demographic variables that were considered with respect to students and nurse educators.

(i) *Student demographic variables*

The student demographic section started with directions to guide students to complete the first three questions by circling the appropriate answer. The first three questions included the variables of gender, overall grade point average for the student's university studies, and high school national exam score.

1) Gender was included because although nursing is predominately studied and practised by females, there are many male nursing students and nurses in Jordan. It was believed that the perception of males might differ from the perception of females in regard to clinical teaching.

2) Overall grade point average for the student's university studies was included because it reflects the student's level of achievement in previous studies and because it was believed that the perception of students with high achievement might differ from those with low achievement.

3) The score from the high school national exam (Tawjihi) was included because students with high scores have a better opportunity of being accepted into a wide range of university faculties, such as medicine or engineering. However, students with lower scores may have no other

choice except nursing. As noted earlier, nursing has had a poor image in Jordan, and that has contributed to students not wanting to select nursing as a professional field of study. To remedy the nursing shortage in Jordan, the government has undertaken recruitment measures, such as scholarships, low tuition fees, and acceptance of modest Tawjihi scores for nursing school programmes.

4) Next, in the fourth question, students were asked to respond 'Yes' or 'No' to each of four specific reasons for the respondent's choice of nursing as a future career. The data gathered were used to characterise the student sample.

(ii) *Demographic nursing educator variables*

1) Gender was included because a female nursing teacher's perception of clinical teaching may differ from that of a male nursing teacher.
2) Marital status data were gathered to characterise the teacher sample.
3) Highest academic degree attained was requested because those with different degrees may hold different views.
4) Years of experience before and since start of teaching was requested because those with more experience might rate differently on a scale of clinical teaching effectiveness than those with less experience.
5) Area of clinical speciality was requested in order to characterise the sample.

d) *Directions for completing the questionnaire*

The researcher believed that clear and simple directions would guide the respondents in answering questions without any further explanation or interpretation beyond the written words at the time of data collection. The

directions told respondents that the scale to measure effective clinical teaching had three groups of items:

1. Items of orientation to clinical practice.
2. Items of on-site activities.
3. Items of outcome results.

The directions presented the respondents with an example that indicated to them that each question has four alternative responses and that they were required to choose the most appropriate and accurate one.

e) *The research questions*

The questionnaire format was adopted from Wong and Wong's (1980), clinical teaching self-evaluation model. Their model consists of three sections: a pre-active step, an inter-active step and a post-active step. The names used for the questionnaire in this study section were derived from the activities inherent in each of the steps.

Questionnaire items from the three sections described below were derived from multiple sources: previous effective clinical teaching tools (Zimmerman and Westfall, 1988, Brown, 1981, Wong and Wong, 1980), literature reviews of articles on effective clinical teachers (Coleman and Thompson, 1987, Wotruba and Wright, 1975, Bailey, 1956), personal experience as a clinical instructor and as a clinical supervisor, the faculty evaluation form used at the faculty of nursing, University of Jordan, and discussions with experienced nurse educators in senior positions at Jordanian Universities nursing schools faculties.

In the first section, 'orientation to clinical practice', there were nine items which were concerned with the preparation required before the clinical

experience starts. This section included items such as 'distribution of course syllabus at the beginning of clinical practice', and 'discussion of hospital policies'.

The second section consisted of 24 items. These items were concerned with 'performance activities' such as "provides guidance in new activities" and "performs nursing procedures in front of the students". Also included in the second section was another question that asked respondents to choose the five most important on-site activities from the items mentioned and to place them in order of importance.

The third section, 'outcome results' consisted of five items. It was directed toward the evaluation method and included items such as 'provides the students with a second chance if he was not able to pass the first'.

The questionnaire ended by asking the respondents if there were additional items concerning effective clinical teaching. Space was provided for stating additional behaviours which they felt had been omitted.

A four-point Likert scale ranging from 'strongly agree' to 'strongly disagree' was utilised to rate responses in relation to the first purpose; face validity. A second four-point Likert scale ranging from always applicable to never applicable was utilised to rate the responses in relation to the second purpose; to rate the subject responses. The two rating scales were used with items of orientation, on-site, and outcome criteria sections.

Three other questions were added to the questionnaire, the first question was directed towards the evaluation of the overall current status of clinical teaching at Jordanian Universities. Four answers ranging from poor to excellent were available to respondents.

The second question asked the respondents to specify in their opinion the appropriate ratio of students to each clinical teacher. The third question provided respondents with an opportunity to state facilitating versus hindering factors to effective clinical teaching.

The last question allowed respondents to elaborate their views on the kind of change needed to bring about enhanced clinical teaching in nursing.

❹.3.6 *Content validity*

Initially, it was planned that the questionnaire would have two versions with the same items but different purposes. The first version was to ascertain whether the items listed reflected activities of clinical teaching effectiveness. The second version was to determine to what extent the items were applicable to the Jordanian clinical setting. Additionally, wording of directions for the two versions were composed as appropriate for either students or teachers. Wording of questionnaires was identical for the two groups.

The plan for validation of the questionnaire was discussed with a research designer at the Faculty of Education, University of Jordan. The validation of the first version of the questionnaire would fulfil the second purpose by changing the four-point Likert scale ranging from strongly agrees to strongly disagree to always applicable and rarely applied. In other words, the second version would be deleted except for its open-ended questions, which would be added to the first version of the questionnaire.

In regard to the validation of the questionnaire, face validity would be tested through submitting the questionnaire to examination by those most familiar with the possible content needed. Those given that task are called jurors. The jurors were comprised of the most experienced university nurse

educators and a random sample of senior nursing students. Teachers would validate the teacher's version, and students would validate the student's version of the questionnaire. The jurors would be then excluded from the pilot study because their opinion would have been given previously. However, they could participate in the main study, because evaluating the form for validity should not affect their use of the form for rating the level of applicability of the activities of clinical teaching effectiveness in Jordan, and also their participation would maximise the sample size for the main study.

Testing content validity

A meeting was held with the Dean of the Faculty of Nursing at Jordan University after receiving her written permission to collect data. The purpose of the meeting was to plan for jurors' evaluation of the tool and for access to conduct the main study.

Jury selection

jurors consisted of 25% of the total number of faculty of nursing academic staff (Jury A) and 10% of the fourth-year nursing students (Jury B). Juries were drawn from University of Jordan alone because its degree program had been established longer and had more highly experienced teaching staff.

Jury A

The Dean of the Faculty of Nursing identified the most highly experienced staff representing each degree level from a total of 40 staff members (10 Ph.D. holders, 19 master degree graduates, and 11 teaching and

research assistants). The group selected for Jury A included: three Ph.D. holders who were department heads within the Faculty on Nursing and who were also actively involved with academic and clinical teaching, two master degree prepared faculty members and five baccalaureate degree prepared clinical instructors.

Selected faculty members were approached individually by the researcher to introduce them to the purpose of the study and the manner of their selection. Each faculty member was given a questionnaire and asked to complete and return it to the Faculty of Nursing Administration Office. However, the Faculty were highly co-operative because previously the President of the University had asked for a similar form to be composed and the faculty had even made a rough draft of a teaching evaluation tool. Also, the Dean was supportive and urged her faculty to co-operate in this research.

Jury B

A list of 120 fourth-year nursing students was obtained from the Faculty of Nursing Administration Office. Their names were on slips of paper and put in a box. Twelve names,10%, were randomly selected.

Participation by the students in the Jury was arranged by the Faculty's nursing student association which arranged for a meeting between the researcher and selected students. The purpose of the study and their invitation to participate in it was explained to all. After verbal consent was given by each student, the Jury questionnaire was distributed and completed in the presence of the researcher.

Evaluation of the Juries' comments

In regard to the open ended questions which was added by the researcher for the purpose of identifying any additional clinical training activities, or any comments or suggestions the Juries wished to add it in order to improve the appropriateness of the questionnaire, the researcher studied all these issues carefully and took the decision whether to include them or not. Arising out of the Juries' comments and suggestions, many changes were made to the questionnaire. The following table presents a summary of the number of items added, deleted or modified in each section of the questionnaire.

Table (4-1): Summary of Juries' responses regarding questionnaire items.

#	Items	# of items added	# of items deleted	# of items modified	# of items before Juries	# of items after Juries
1	Domain (1) Items of (orientation to clinical practice)	3	2	1	9	10
2	Domain (2) Items of (on-site activities)	10	5	5	24	29
3	Domain (3) Items of (out-site criteria) results	1	2	2	5	4

Table (4-2): Changes in questionnaire items before & after Juries responses.

Group (1)

Items of orientation to the clinical setting

#	Before Juries	#	After Juries
1	Distributes to the students a course outline at the beginning of the clinical practice	1	Discusses with the students the main objectives of the clinical practice course.
2	Distributes the students all forms (i.e., nursing care plan, evaluation form)	2	Discusses with the students the use of each form as related to the requirements of each semester course.
3	Discusses with the students the main objectives of the clinical practice course.	3	Discusses with the students the kind of procedures he/she is allowed to perform in the clinical setting.
4	Discusses with the students the use of each form as related to the requirements of each semester course.	4	Introduce to the students the main administrative personnel of the clinical setting (hospital director, nursing director)
5	Discusses with the students the kind of procedures he/she is allowed to perform in the clinical setting.	5	Orientates the students to the hospital's nursing policy, rules and regulations of nursing practice.
6	Introduces the students to the main administrative personnel of the clinical setting, (hospital director, nursing director).	6	Discusses with the students the evaluation form items.
7	Orientates the students to the hospital's nursing policy, rules and regulations of nursing practice.	7	Accompanies the students on a tour of the clinical setting at the beginning of the semester.
8	Discusses with the students the criteria for clinical evaluation.	8	Discusses with the students human rights as related to the patient-nurse relationship.
9	Accompanies the students on a tour of the clinical setting.	9	Lists all procedures with a format that allows measurable behaviour
		10	Discusses with the students the principles of professional ethics.

Table (4-2)....continued

Group 2
Items of on-site activities

#	Before Juries	#	After Juries
1	Prepares all teaching cases from a previous day.	1	Prepare all teaching cases before assigning them to the students.
2	Is available to the student most of the time	2	Be available in the clinical area at the time of students' arrival.
3	Performs nursing procedures in front of the students as appropriate.	3	Conducts with the students daily nursing rounds.
4	Acts as a resource person to the student (being knowledgeable)	4	Performs nursing procedures in front of the students.
5	Has a pleasant voice.	5	Acts as a resource person to you (being competent).
6	Has a sense of humour.	6	Directs the students in writing the nursing care plan for patients.
7	Is very formal with the students.	7	Supervises the students in implementation of the nursing care plan to patients.
8	Has a professional appearance (i.e., nursing gowns).	8	Reviews the nursing care plan with the patients.
9	Encourages mutual interaction between the student and hospital staff.	9	Available to the students most of the time.
10	Is flexible (open minded) with the students and with the hospital staff.	10	Has a professional appearance (i.e. nursing uniform, short nails).
11	Co-operates with other health team members in the provision of care to the patients.	11	Is familiar with the clinical setting.
12	Respects the students in front of the patients and avoids embarrassing them.	12	Keeps notes about the students positive and negative attitudes in the clinical course.
13	Helps the students in writing nursing care plans for patients.	13	Co-operates with other health team members to facilitate students' learning.
14	Supervises the students' implementation of the nursing care plan.	14	Respects the students' as individuals and avoids embarrassing them.

Table (4-2)....continued

#	Before Juries	#	After Juries
15	Provide the students with continuous feedback about his progress in the clinical practice.	15	Flexible (open minded) with the students.
16	Cares about students' feedback with regard to the convenience of all learning activities.	16	Provides the students with periodic feedback about his progress.
17	Guide the students in new and/or difficult situations.	17	Asks the students for feedback in order to improve clinical teaching.
18	Is acceptable to the patients.	18	Guides the students in new and or difficult situations.
19	Is acceptable to the hospital staff.	19	Returns the students' written assignments corrected within week.
20	Is reasonable in solving any problems between the students and the hospital staff.	20	Discusses with the students comments as shown in the corrected assignment.
21	Acts as a health educator to patients and their families by teaching them about needed information.	21	Considers students' individual learning needs.
22	Helps the students recognise and his/her errors.	22	Be realistic in her expectation from a student as a learner.
23	Reinforces the students' positive attitude.	23	Is able to troubleshoot if problems raised in the clinical area.
24	Conducts frequent seminars about teaching cases.	24	Directs the students while doing health education to the patients.
		25	Reinforces the students' positive attitude.
		26	help students to correct their own mistakes.
		27	Conducts with the students case presentations as scheduled.
		28	Acts as an advocate for the student.
		29	applies theory to practice.
		30	Recommends for the students reading books and/or articles.

Table (4-2)....continued

Group 3

Outcome criteria (results)

#	Before Juries	#	After Juries
1	Evaluates the students objectivity.	1	Provides the students with self-evaluation opportunities.
2	Permits freedom of discussion.	2	Avoids his/her personal relation influence the student's evaluation (evaluate the student objectivity).
3	Provide the students with a second chance if he/she was not able to pass the first.	3	Allows freedom of discussion of the evaluation items after students' evaluation.
4	Involves the hospital staff in students evaluation.	4	Involves hospital staff in students' evaluation.
5	Clearly defines outcome expectations.		

Comments on items

Students:

Notable uniformity was found among students on addition and deletion of items in domain II (on-site activities) and domain III (out come activities). Of the 11 items recommended for addition or deletion, 9 items were identified similarly by all or nearly all the students and 3 by most students. Nearly all (10, 11, or 12) students wanted 'Nursing rounds', 'clinical site familiarity', 'less than one week return of paper', 'individualised learning', 'application of theory', 'recommendation of references', 'student self-evaluation' and rejected need for teacher to have pleasant voice and formal behaviours'. Most of the students (7-9) wanted anecdotal notes having both positives and

negatives, advocacy of students and rejected the need for 'teachers to have sense of humour'.

Teachers:

All (10) or nearly all (9) of the teachers wanted deletion of the need for 'students to have a second chance' and for teachers to have 'pleasant voice', 'sense of humour' and for distribution of course outlines and forms because these are routinely given when introducing the course and its objectives. Most (7-8) wanted added items for individualised learning and wanted deleted the need for teachers to be 'formal and define out come expectations'.

The results of Juries' responses to open-end questions were as follows:

1) Most (80%) of the teachers said that rereading the questionnaire for selecting of the five most important items would be boring to students and predicted that students would not co-operate, same conclusion was derived from the students responses regarding the same question; "question 2.B which was 'Among the previously mentioned items (domain 2 on-site activities) please choose the five most important and then place them in order of importance by numbering them as follows' (Numbered spaces were left for five answers)".

2) Regarding question No. 3A/B: ' In your setting and during your previous clinical teaching (learning) experience, write five points which are facilitating and five points which are hindering the process of your teaching (learning) in the clinical practice'.

   Almost all (90%) of the teachers Juries indicated that question No.3A/ was difficult to answer. They believed that facilitating and hindering factors are beyond the subject of inquiry. While (80%) of the students

Juries said that they prefer to list only hindering points. Therefore, the question was replaced by the following question based upon their suggestions:

'If you had the power to change three things in order to improve the teaching of clinical nursing in your setting, what changes would you bring about?'.

❹.3.7 *Pilot study*

(a) *Introduction*

Prior to the pilot study, many changes were made in the questionnaire instrument based upon Juries' comments and research consultant advice. Juries' comments resulted in questionnaire item additions, deletions, and modifications, as explained in detail in Tables (4-1) and (4-2). Also open-ended questions were deleted (No.2B) or replaced (No. 3A/B). Research designer advice resulted in modification the Likert scale points. The four points of the scale were changed from 'strongly agree' to 'strongly disagree to range from' always applicable to never applicable.

This section provides the rationale for the use of a pilot study before actual data collection and suggests appropriate pilot study procedures. Mistakes in a major evaluative study can be costly and difficult to correct. It is therefore economical to ensure that the instruments to be used in evaluation are as effective as possible. Researchers usually do this by conducting a pilot study (Treece and Treece, 1986; Oppenheim, 1992). A pilot study has been defined as 'a small-scale version, or trial run, done in preparation for a major study (Polit and Hungler, 1989, p.399). According to Treece and Treece (1986), It is necessary for a pilot sample to be as similar as possible to that of

the main study group, and 10% of the anticipated main study sample size is considered the most convenient size of the pilot sample.

The reason for preliminary testing on a small scale is to alert the researcher to any problems which the major study might encounter. Problems may be discovered with testing a questionnaire, for example, that its questions are ambiguous, not clearly worded, leading, misleading, or overly long. Correction of problems in the pilot stage leads to greater trust in results of the major study (Oppenheim, 1992; Treece and Treece,, 1986).

Some typical questions to be addressed in the pilot study are:

- Does the question ask what is intended?.
- Do the questions flow in an appropriate sequence?.
- Do the respondents understand the instructions?.
- Are the answers appropriate to the question?.
- Is the numbering system clear? (Oppenheim, 1992).

Thought not an exclusive list of questions to be considered, they illustrate the point that every detail of the instrument and of the planned research process is tried and tested during the pilot study. The very nature of a pilot study is that will throw up unanticipated effects, bearing in mind the warning from Oppenheim (1992, p.64) that 'pilot work can produce some nasty surprises, but it is never dull'.

(b) *Objectives of the pilot study*

The objectives of this pilot study were:

1. To establish the period of time respondents would require to complete the questionnaire.
2. To test the appropriateness of the instructions.

3. To test the design of the questionnaire; i.e.,
   (i). Adequacy of spaces for responses to open-ended questions.
   (ii). Correctness of box positions beside item pool questions.
4. To minimise unforeseen problems in the main study.
5. To test the method of accessing the samples.

(c) *Sampling*

The pilot study involved two groups of participants, nursing students and faculty members at a Jordanian University. Due to the nature of the main study sample, i.e. non-probability purposive, it was seen to be important not to risk losing excessive participants from the main study through pilot work. at the same time, as previously mentioned, it was necessary to have a pilot sample as similar as possible to that in the main study. Thus, it was decided to pilot only with 10% of the total number of participants from each group, excluding Juries. Participants of the pilot study were to be excluded from the main study sample.

(d) *Conduct of the pilot study*

To achieve a random sample for the pilot study, names from a list obtained from the Faculty of Nursing office were put in a box - 120 names of students in one box, 40 names of teachers in the other box - then were drawn blindly, retrieving 12 student names and 4 faculty names. None of the names drawn were of one of the Juries. It had been planned to discard draws of Juries' names.

Through the nursing student association, the nursing student pilot group was gathered together. They were informed of the purpose of the research and

the conduct of the pilot study. They were reassured of anonymity and confidentiality of responses. Each student gave verbal agreement to participate in the study. The researcher administered the questionnaires and remained in the classroom until all questionnaires were completed and collected.

Faculty members selected for the pilot sample were met individually during lunch in the cafeteria because it was difficult to meet with all at one particular time. The purpose of the pilot study was explained and reassurance of confidentiality of information was given to each one individually. After consent was obtained for study participation, each was told to complete the form anonymously and return it to the Faculty of Nursing Administration Office.

(e) *Findings*

One of the main objectives of the pilot study was to establish the approximate length of time required. It was found that the maximum time needed was 45 minutes. This issue was important because data collection had to be scheduled during a 60-minute lecture period.

The second objective was to test the appropriateness of the instructions. The respondents did not indicate any complaints concerning the instructions. It was observed that participants read the instructions quickly and without apparent difficulty.

The third objective was related to the design of the questionnaire; that is the adequacy of spaces for responses to open-ended questions and convenience of response box positions next to question times. The majority of respondents answered the open-ended questions in the space provided, although some students used the back page to complete their answers. Box positioning was convenient to respondents, as shown by correct completion.

The last objective was to minimise unforeseen problems in the main study. It was anticipated that some questions might be difficult to understand and that an explanation would need to be provided. However, respondents appeared to have good understanding of the questionnaire and instructions, as few asked for meanings of words, for example, tour which was changed to visit and shoot troubles was changed to solve problems. These words were changed after piloting.

(f) *Conclusion*

In conclusion one might say that questionnaire passed three main steps before submitting it to the subjects and conducting the main study. First step was that questionnaire was constructed by the researcher and then submitted to the selected Juries for validations; (content validity) and then submitted to the pilot sample for piloting. All these steps led to a lot of changes which improved the shape, structure and content of the questionnaire before submitting it to the main study sample.

❹.4 *Observational method*

❹.4.1 *Introduction*

The second aim of the study was to describe the interaction process of clinical teaching. Observation was the second choice of the method of data collection to achieve this aim.

Observation as defined by Backer (in Cormack, 1992, p.228) is "the systematic use of the researcher's sensory mechanism, within a rigorous framework,... seeking to define, clarify, redefine and measure objectively the

events which occurred.'.

The purpose of using the observational method in this study was to orientate the researcher about the social circumstances of clinical teaching, as well as the actual behaviour of the clinical teacher that occurs in the clinical setting. This might be considered as the ground where the effective and ineffective incidents occurred which will further helps to understand and to justify data that might be collected by other method, i.e. critical incident technique.

The following section is a review of the observational method.

❹.4.2 *Advantage of the observational method with this study*

Observation has the advantage of providing depth and variety to data and capturing a record of actual events. Thus the dynamic of clinical environment and complex teacher - student interactions may be more closely reflected by observational method (Wong and Blumberg, 1983).

Description by the trained observer is enhanced by the human ability to sense fine differences and fathom complex situations, so that hidden factors and relationships are possibly uncovered that would be missed in questionnaire or interview (Polit and Hungler, 1989).

❹.4.3 *Problems affecting the observational method*

It is time consuming compared to other methods, such as a questionnaire. Unstructured observation can be affected by data over load because of the large amount of unorganised data, much of which may be irrelevant.

Unstructured observations have the problem that the form of the data cannot be determined in advance, making analysis complex. However, they allow the observation of events without the potential bias of structured methods (Miles and Huberman, 1984). The latter can focus attention on what is expected to be important, missing what really is important in the clinical setting. Therefore it was decided not to restrict the research by imposing certain categories or check lists.

Another source of bias to be considered is the setting of the study, since the observer was familiar with the setting and would therefore have difficulty in seeing it objectively, (Morse, 1991). However, for this study since there are only two areas in Jordan where it is possible to conduct this study and since the researcher is very familiar with one of them, she has no choice but to use the setting in which she is known by the participants.

However as the researcher had been away from Jordan for over three years prior to this study and had intimated to participants that she will return to Jordan, so she was functioning as an outside observer rather than as someone with a day - to day role in the setting.

❹.4.4 *Dichotomies of the observational method*

Discussion of observational method have different dichotomies: deductive versus inductive approach, inclusive versus exclusive data collection, structured versus unstructured method, participant versus non participant method.

Researchers using observation vary in their ideas in how to achieve a faithful picture of reality. Miles and Huberman (1984) divided them into two groups, deductionists and inductivists. The social anthropologists who first

develop observational methods are described as inductivists. They undertook long, extensive observational studies and accumulated massive amount of unstructured data. They believed that from the raw data reality would emerge as the most important actors, relationships and events would become obvious.

In order to get a clear picture about the interaction of clinical teaching, the phenomenological approach was use. The observer went to the School of Nursing and observed the way students were getting access to the clinical setting. Furthermore, the time table was arranged to observe the actual behaviour in the clinical setting of each of the clinical teacher from the group selected for observation. Observation was done twice for each teacher, each time for two hours.

Observation of teaching, according to Wong (1983) and Good (1991) is better made by a neutral party. The teachers' direct involvement and responsibilities may make it difficult to see the whole situation and their role in it, whereas the observer can form a detached perspective, put primary attention on the task of observing and may be more objective than the teacher.

❹.4.5 *Choice of an unstructured observational method*

Following consideration of all alternatives in use of observational methods, it was determined that a non participant observer and unstructured approach would be most appropriate, called a "narrative system" by Evertson and Green (1986, pp. 176-177), and unfiltered record of events, context, conversation and non - verbal behaviour is taken for later analysis.

❹.5 *Critical Incident Technique (C.I.T)*

❹.5.1 *Introduction*

The third aim of this research was to identify effective and ineffective clinical teaching as described by senior nursing students. This aim is considered the crucial issue under investigation in this study. In deciding which data collection method would yield the quantity and quality of data to best meet the main objective of this study, besides the previous two methods, it was proposed that a description of effective and ineffective clinical teaching behaviour would be obtained by using the critical incident technique.

Critical incident technique may be defined as "a procedure for gathering certain important facts concerning behaviour in defined situation" (Flanagan 1954, p.335). In other word any observable human activity that is sufficiently complete in itself to permit inferences and predictions to be made about the person performing the act.

In nursing, Clamp (1980) described critical incidents as being "snapshot views of the daily work of the nurse. The advantages of this technique are that they provide a sharply focused description in which opinions, generalisation and personal judgement are reduced to minimum", (p.1756).

The purpose of using this technique is to collect critical incidents that were occurred through clinical teaching process wither it was reflected positively or negatively on the learning experience of senior nursing students. Therefore, for this study, this selective approach serves a number of functions such as: identifying those elements of clinical teaching activities that were perceived by the students (consumers) to be central to the general aim of the clinical teaching process.

Furthermore, the use of the retrospective method of reporting, as opposed to reporting on current events has a distinct advantage in this type of study. This approach enables informers to describe incidents that occurred in the recent or less recent past that are perceived as examples of effective or ineffective clinical teaching behaviour. In addition, the use of retrospective reporting avoids the possibility of clinical teaching activity being manipulated to provide more realistic or plausible outcome. The idea of collecting both the effective and ineffective incidents because it was noticed that some aspects of clinical teaching activities might be more easily notices or indeed only noticed, when performed ineffectively. Thus the exclusion of ineffective incidents might have resulted in only a partial description of what is actually happened in the real situations.

❹.5.2 *Validity of critical incident technique*

Regarding the validity of C.I.T. there is no statistical procedure to be done to assess the validity of the incidents. However, there are specific criteria for determining critical requirements and for increasing the validity of the results, such as:

(1) Actual behaviour must be observed by the observer reporting the incidents.

(2) The observer must have knowledge of the aim and goals of the individual with respect to the activity observed.

(3) The specific judgement to be made by the observer in applying the criteria for determining especially effective and ineffective behaviour with respect to important aspect of the activities reported on must be clearly defined.

(4) The observer must be qualified to make judgements regarding successful and unsuccessful behaviour in the activity observed.

(5) The conditions of reporting must be such as to insure a reasonable degree of accuracy, (Baily, 1956).

In this study all the above mentioned criteria were met. This will be seen in the following pages where selection of students as subjects for this method in this study will be justified. The first criterion that "actual behaviour must be observed by the respondent" was met and supported by Morton (1987), "Students are the only consistent observers of the instructor throughout study.". The fourth criteria which was "the observer must be qualified to make judgements regarding successful and unsuccessful behaviour in the activity observed" and the third criteria which was "the specific judgement to be made by the observer in applying the criteria for determining especially effective and ineffective behaviour with respect to important aspect of the activities reported on must be clearly defined, was supported by Knox (1985) and Yonka (1979). Both of them emphasised that students can be considered one of the main sources that provide criteria for effective clinical teaching "every consumer has the right to judge what he buys", (Knox, 1985, p.132).

❹.5.3 *Application of the C.I.T.*

After the decision was made that C.I.T. is the most suited method to collect data for this study, then the following steps were considered:

(a) Decide who should provide the critical incidents:

Senior nursing students at schools of nursing at Jordanian Universities were identified as the group of people who are able to give an informed description of the effective and/or ineffective critical incidents.

The selection of students only to participate in this method of data collection was supported by Morton (1987), "students are the only consistent observers of the instructor throughout the course of study. They are likely to know teacher's strengths and weaknesses better than a peer or administrator who makes an occasional visit to the classroom or practicum setting", p.42.

In addition Yonka (1979) and Knox (1985) emphasised that students can be considered one of the main sources that provide criteria for effective clinical teaching. Both of them agreed upon that students' assessment of clinical teaching provide a perspective from the consumer's point of view "every consumer has the right to judge what he buys", Knox (1985), p.132.

(b) Consider the number of critical incidents required

There was no way of knowing in advance how many incidents needed to be collected to answer the question being researched. However, two issues were taken into consideration. The first issue was that there was no previous studies done in Jordan to support or to guide the researcher to predict the kind of incidents expected, or the number of incidents needed. In order to deal with this issue a decision was made to conduct this method supported by previous studies in other fields in nursing which were used this method for different purposes. Cormak (1984) used C.I.T. to identify characteristics of professional psychiatric nursing. Bairly (1956) used this method to identify behavioural criteria of professional nursing effectiveness.

The second issue to be mentioned was that there are two schools of nursing at Jordanian Universities. In other word, the number of senior nursing students was limited to between three hundred to four hundred. Although this might be considered as a shortcoming, this issue was supported by Cormak (1991). He argued that as a general guide, the less complex the

subject being researched, the smaller in the number of incidents required. Conversely, the more complex the subject, the greater the number of incidents required. Therefore, a decision was made to follow the general rule as recommended by Cormak (1991) and it was as follows:

As a general rule, begin by collecting critical incidents without having any specific number in mind and collect the minimum number that will provide an answer to the question being asked. This can be achieved by continuing to collect and analyse critical incidents until the last 100 incidents fail to provide new information about the work of the nurse. Only then can the researcher be reasonably sure that the collection of further incidents would add nothing new, and that the incidents already collected contain a reasonably comprehensive description of the subject being researched (Cormack, 1991).

Coverage of all or nearly all the various critical behaviours is not the only criterion as to whether or not enough critical incidents have been collected. If a relatively precise definition of each critical behaviour category is required. It may be necessary to get at least three or four examples of each critical behaviour, (Flanigon 1954).

In summary, although there is no simple formula for determining the number of critical incidents that will be required, this is a very important consideration in the plan of the study. Checks should be made both on the first 100 or 50 incidents and again after approximately half of the number of incidents believed to be required have been obtained to make it possible to revise the preliminary estimates, if necessary with a minimum loss of effort and time.

(c) Decide where to collect critical incidents

The decision was made from the beginning that this study was to be conducted in Jordan. As it was mentioned in the introduction of this research, that one of the main reasons behind this study was that the researcher was going to be a Dean for a school of nursing in a new university in Jordan that is Applied Science University. The major philosophy of this university is addressed in its name (Applied Science). Therefore it was the intention of the researcher to focus this thesis on the applied part of the nursing curriculum and to be conducted in Jordan.

(d) Decide how to collect critical incidents

A decision was made that a structured interview is one of the best method to collect data for this section of the study. The crucial issue in this method is to find ways of making the question mean the same for each respondent.

In the case of critical incidents there was only one kind of data needed: informants were asked to describe effective or ineffective incidents that they already experienced it with their teachers. By interviewing the informants, one might guarantee high response rate in comparison with postal questionnaire. In the other hand one might give a prepared explanation of the purpose of the study more convincingly than a covering letter can, offer a standardised explanations to certain questions which might arise; prevent many misunderstandings, and maintain control over the order or sequence in which the questions are answered, (Oppenhaim, 1992).

However, although this technique was costly to the researcher in term of money, time, very tiring physically and mentally, specially because the researcher (the interviewer) must remain consistent with all interviewees, calm

pleasant and friendly, try to sustain good rapport and never show in her expression or behaviour what her own values are, regardless the way the subjects might respond. The researcher collected the data by interviewing the subjects herself and believed strongly that the advantages of this technique considerably out weigh the disadvantages.

(e) *Analyse critical incidents*

Prior to the development of the classification system to the incidents collected, the following conditions must be satisfied:

(1) The system would have to be comprehensive description of the work of the clinical teacher as described in the critical incidents.

(2) Categories in the system would have to be mutually exclusive.

(3) The system would have to be meaningful to those familiar with clinical teaching.

(4) The classification system would require to have a significant level of reliability.

Chapter ❺

Study (1): Clinical Activities (Questionnaire)

❺.1 *Target population*

The population of interest were Jordanian Nursing students and teachers at Schools of Nursing at Jordanian Universities.

Sampling criteria for inclusion in the study were:

(a) Fourth years (Baccalaureate) nursing students, enrolled at either the School of Nursing of the University of Jordan (UOJ) and or University of Science and Technology (UOST).

(b) Teachers who have direct contact with the students in the clinical setting or works at either the School of Nursing at the UOJ or UOST.

Students are seen as representing the consumers' point of view and are the most convenient subjects to identify factors contributing to clinical teaching effectiveness, while teachers are seen as representing the producer point of view. (Knox, 1985).

❺.2 *Sampling procedure*

A non probability purposive sample was employed in this study due to the limited number of Schools of Nursing in Jordan. All faculty members including teaching and research assistants was included in the sample. Fifty five faculty members out of a total population of sixty seven participated.

In regard to the students' sample, 195 fourth year Nursing students out of a total number of 229 were purposely selected. Fourth year nursing students had been exposed to different but comparable clinical teaching opportunities and should be able to identify effective and/or ineffective clinical teaching behaviour in their setting. In addition many researchers previously used the same kind of sampling technique with the same subjects such as (Heather 1992, Jairth 1991, Theis 1988, Knox and Magon 1985, and Brown 1981), thus allowing comparisons between students to be made.

❺.3 *The data collection process*

Following permission to access students, the questionnaire was administered by the researcher to the fourth year nursing students at University of Jordan during 45 minutes of three regularly scheduled class periods. Before the questionnaire was administered, the researcher gave a brief description of the study; the purpose of the questionnaire, the importance of their participation and how they had been selected. In addition students were told that participation was optional and those who choose to participate were not required to write their names in a given questionnaire in order to keep their identify anonymous. After the questionnaire had been distributed the researcher stayed in the class to ensure there was no conferring.

During the data collection, the subjects show their willingness to complete the questionnaire and a number of students commented that "they were waiting for this kind of research for a long time and it was very interesting area to discuss".

A total of 195 senior nursing students participated in this study, 120 students (83%) out of 144 students from Jordan University and 75 students

(88%) out of 85 students from Science and Technology University participated in this study.

In regard to the teacher subjects, a total of 55 teachers participated in this study, 36 teachers (85%) out of 42 teachers from Jordan University and 19 teachers (76%) out of 25 teachers from Science and Technology University.

⑤.4 *Data analysis process*

A computer entry sheet was used to make the data collected more presentable for quantification before doing any statistical analysis. The responses of each respondent for each question was included, starting from the demographic data to the end of the questionnaire except for the last question which was an open-end question. In this case each question was given a specific number in the entry sheet. Same numbers expected to be in the print out of the computer. The Statistical Package for the Social Sciences (SPSS) was used to compute the findings.

⑤.4.1 *Statistical analysis*

As previously mentioned, the questionnaire consists of three sections. The first section focuses on biographical data. The second section focuses in the possible clinical teaching activities expected to be while training the students. This section consists of 44 items. The third section consists of two closed questions and one open-ended question.

Before conducting any statistical analysis to section 2 (as shown in the questionnaire, Appendix II) the possible activities of the clinical teacher were

divided into three Domains:

Domain (1) (Items about the orientation to clinical practice).

Domain (2) (Items about on site activities).

Domain (3) (Items about assessment).

Therefore it became possible to calculate the responses of each subject by calculating the responses for each item in each Domain. Parametric statistical tests were used. (Also parametric statistics was used with demographic data and other closed questions in the questionnaire) frequencies based on categorical data i.e. Gender, marital status, educational background and summary tables of the frequencies were calculated. Means and standard deviation values of each item, (1-44) Likert scale and for each Domain was calculated and ranked in descending order for group of participants.

The correlation coefficient between each item and the Domain's sub scores was calculated to provide another clue to the validity of the questionnaire; construct validity. Cronbach coefficients were calculated for each Domain and for the questionnaire as a whole as an indicator of the reliability of the questionnaire.

The open ended question was a directive question and asked the subjects to recommend three suggestions in order to improve clinical teaching in their setting. Each of these suggestions which was made by the subjects was transcribed on a separate card and then those who reflects same meaning were collected together and then categories and sub categories were made accordingly.

⑤.5 *Presentation of findings*

⑤.5.1 *Validity*

As can be seen in (Appendix V), items from 1 to 10 have higher correlations in relation to the first Domain in comparison with other Domains (Domain 2 and 3). For example the score of item no.3 with Domain 1 was 0.72 while its correlations with Domain 2 was 0.56 and with Domain 3 was 0.37 while with the total it was 0.61.

Furthermore, the items from no. 11 up to 40 have higher correlations with Domain no.2 and with the total in comparison to with Domains one and three. It is also clear for the rest of the items (from 41-44) that the high correlations of the items are with Domain no. (3) and the total while they were less with Domains (1) and (2). These findings demonstrate construct validity; that is the items had strong relations with their Domain and with the total score, but less so with other domains.

⑤.5.2 *Reliability*

Coronbach alpha coefficients were calculated for each Domain and the questionnaire as a whole, as an indication of the reliability of the questionnaire. (α) was high for each Domain and for the total as well.

$\alpha 1$ Domain (1) = 0.84

$\alpha 2$ Domain (2) = 0.97

$\alpha 3$ Domain (3) = 0.69

$\alpha 4$ Domain (4) = 0.97

❺.5.3 *Socio - Demographic*

(a) *Students*

(1) Gender of respondents

Table (5-1): Frequency of Gender of student respondents.

Gender	Frequency	%
Male	93	47.7
Female	102	52.3
Total	195	100.0

Table (5-1) presents the distribution of the Gender of student respondents.

(2) High school national exam (Tawjihi)

Table (5-2): Frequency of (Tawjihi) score of student respondents

Tawjihi score	Frequency	%
60-67	0	0
68-75	9	4.6
76-83	72	37.1
84-100	113	58.2
Missing	1	-

Table (5-2) presents the percentage distribution of Tawjihi score of respondents. The highest percentage (58.2%) was for the highest score while the lowest percentage (0%) was for the lowest score. No students with merely a satisfactory grade (60-67) are accepted in the Schools of Nursing at Jordanian Universities.

(3) Cumulative grade point average (GPA)

Table (5-3): Frequency of cumulative grade point average of student respondents

Cumulative grade point average	Frequency	%
60-67	27	14.0
68-75	86	44.6
76-83	66	34.2
84-100	14	7.3
Missing	2	

Table (5-3) presents the distribution of (GPA) of student respondents. The highest percentage (44.6%) of students had a good average (68-75) while the lowest percentage (7.3%) had an excellent average (84-100).

(4) Reasons for studying nursing

Table (5-4): Frequency of reasons for studying nursing of student respondents

	Statements of reasons for studying nursing	Frequency	%	Frequency	%	No. of missing cases
1	You want to be a nurse and work with patients.	112	58.3	80	41.7	3
2	You want to teach nursing only.	59	31.7	127	68.3	9
3	You had no other choices due to your average in high school.	65	35.5	118	64.5	12
4	You want to ensure job after graduation.	139	73.9	49	26.1	7

Table (5-4) presents the responses of students in term of agreement and/or disagreement to the reasons listed for their selection to study nursing. As can be seen from this table, that the majority of students (73.3%) responded positively to the last statement "you want to ensure a job after graduation", while the majority of students (68.3% and 64.5%) responded negatively to the statement "you want to teach nursing only" and to the statement "you had no other choices due to your average in high school. Subjects are also asked to list any other reason which led them to study nursing. Only two students replied; one stated it was a family wish, while the other said that he was outside the country at the time of University registration, and the only faculty which would accept him as a late applicant was the Nursing Faculty.

(5) Ranking in order of preference the reasons behind students selection to study nursing:

Table (5-5): Distribution of student responds ranking in order from (1-2) of reasons for studying Nursing.

	Statements of reasons	Important (1) Frequency	%	Important 2 Frequency	%
1	You want to be a nurse and work with patients.	57	37.5	30	20.7
2	You want to teach nursing only.	15	9.9	30	20.7
3	You had no other choices due to your average in high school.	28	18.4	24	16.6
4	You want to insure a job after graduation.	52	34.2	61	42.1
5	Missing.	43	N/A	50	N/A

Table (5-5) presents the student ranking in order of preference of reasons behind their selection for studying nursing. As can be seen in this table that the first statement "you want to be a nurse and work with patients" as a most important reasons had the highest percentage, 57 students (37.5%). The fourth statement "you want to ensure a job after graduation" was the next highest percentage, 52 students (34.2%). While the fourth statement "you want to ensure a job after graduation" had the highest percentage, 61 students (42.1%) ranked as the next most important.

(b) *Teachers*

(1) Gender of respondents

Table (5-6) : Frequency of Gender of teacher respondents.

Gender	Frequency	%
Male	10	18.2
Female	45	81.8
Total	55	100.0

Table (5-6) presents the distribution of gender of teacher respondents. It can be seen that, compared to the students there were proportionally more female teachers.

(2) Marital status of respondents:

Table (5-7): Frequency of marital status of teacher respondents.

Marital status	Frequency	%
Single.	17	30.9
Married.	36	65.5
Others.	2	3.6

Table (5-7) presents the marital status of teacher respondents.

(3) Educational degree of respondents:

Table (5-8): Frequency of educational degree of teacher respondents.

Educational degree	Frequency	%
Bachelor degree	26	47.3
Master degree.	21	38.2
Ph.D.	8	14.5

Table (5-8) presents the distribution of educational degree of teacher respondents. As can be seen, the highest number 26 (47.3%) of teachers hold a BSc degree and the lowest hold a Ph.D. degree 8 (14.5%)

(4) Years of experience (in teaching) of teacher respondents:

Table (5-9): Frequency of years of experience of teacher respondents.

No of years of experience	Frequency No.	%
Less than 2 years	12	21.8
2-6 years.	21	38.2
More than 6 years	22	40.0

Table (5-9) presents the distribution of the years of experience of teacher respondents. Those who had more than 6 years experience had the highest percentage 22 (40%).

(5) Years of experience in clinical before teaching:

Table (5-10): Frequency of years of experience in clinical before teaching.

Years of clinical experience	Frequency	%
Less than 2 years.	37	67.3
2-6 years.	14	25.5
More than 6 years.	4	7.3

Table (5-10) presents the distribution of clinical experience before teaching of teachers respondents. The highest number of Nursing teachers, 37 (67.3%) had no or less than 2 years of clinical experience before teaching.

(6) Area of speciality of teachers:

Table (5-11): Frequency of area of speciality of teachers.

Speciality area	Frequency No.	%
Medical-Surgical.	25	45.5
Psychiatry.	4	7.3
Maternity.	6	10.9
Pediatrics	10	18.2
Community.	6	10.9
Adminstration	4	7.3

Table (5-11) presents the area of speciality of teacher respondents. It can be seen that the highest number 25 (45.5%) were in the Medical-Surgical area.

❺.5.4 *Main Results*

(a) *Likert Scales Rating*

Although the individual scales had high realiability, scrutiny of the responses indicated that there was a large response bias, with both students and staff tending to respond in a positive manner to all items, although students seemed somewhat less positive than teachers. Thus the 'reliability' of the scales might have been due merely to this bias.

To examine further the response bias, responses to all questions were correlated with each other. Additionally, a principal components factor analysis was conducted on all questions in order to reduce the number of comparisons which needed to be made between students and teachers.

Responses to virtually all questions were significantly correlated with each other and in the factor analysis the first factor explained 43% of the variance. The next largest factor (8 being extracted with eigenvalues >1) explained less than 4% of the variance. This confirmed that individuals tended to respond more-or-less positively to all items.

To correct for this response bias, each respondent's mean rating across all items was computed and individual item's ratings were corrected by subtracting the mean rating from them.

After eliminating individual response bias in this fashion, the items where there were the largest differences between students and staff were sought: T-tests were conducted for each question. Table (12) shows the questions where there were differences at the $p < 0.05$ confidence level. Because of mutiple comparisons, some of these differences will be due to chance alone and this analysis is exploratory, rather than hypothesis-testing. In fact, the absolute differences between staff and students were generally modest and there was no discernable pattern to the differences. In particular, it was not the case that students' adjusted ratings were consistently less positive that staff ratings. The main conclusions from the quantitative sections of the questionnaire survey are as follows:

- Respondents tended to rate every thing positively, which raises a question concerning the validity of assessing teaching in Jordan by self-rated questionnaire. This issue will be addressed further by the qualitative analysis below, where it will be seen that students were more critical when asked open-ended questions about the teaching.

- Insofar as it was possible meaningfully to compare staff and student responses, students were less positive about some aspects of the teaching than were staff.

(b) *Differences on adjusted scores*

Table (5-12a): Questions where students and teachers differed on their adjusted scores (Student > teacher).

Item No.	Statement of the items **Student > teacher**	Mean	
		student	teacher
4	Introduce the students to the main adminstrative personnel of clinical setting.	2.5	2.2
16	Direct the students in writing the nursing care plan to the patient.	2.0	1.8
18	Review the nursing care plan with students.	2.4	2.0
24	Respect students as an individuals (avoid embarresing them)	1.9	1.7
25	Are flexible open minded with students.	2.0	1.9
26	Provide the students with periodic feedback about their progress in the clinical practice.	2.2	1.9
27	Ask the students for a feedback in order to improve the clinical teaching.	2.2	2.0
28	Guide the students in new and/or difficult situation.	2.0	1.8
29	Return the students written assignments corrected within a week.	2.6	2.3
30	Discuss with the students her/his comments as shown in corrected written assignment.	2.4	2.0
31	Consider the students individual learning needs.	2.2	2.0
36	Reinforce students positive attitude.	2.0	1.8
38	Act as an advocate for the students.	2.2	1.8
39	Apply theory to practice.	2.2	1.9
42	Avoid her personal relation influence her evaluation (evaluate the student objectively).	2.2	1.8
43	Allow freedom of discussion of the evaluation items after student evaluation.	2.3	2.0

Table (5-12b): Questions where students and teachers differed on their adjusted scores (Teacher > student).

Item No.	Statement of the items **Teacher > student**	Mean	
		student	teacher
1	Discuss with the students the main objectives of clinical practice course.	1.8	1.5
7	Accompany the students through a visit to the clinical area at the begining of the semester.	2.0	1.6
9	Lists all procedures with a format that allows measurable evaluation.	2.2	2.0
11	Are available in the clinical area at the begining of the shift.	2.2	1.6
12	Prepare all teaching cases before assigning them to the students.	2.3	2.1
15	Are able to answer your questions.	1.9	1.7
21	Are familiar with the clinical setting.	1.9	1.4
22	Keep a note about students positive and negative performance in the clinical setting.	1.8	1.6
34	Direct the students while doing health education to the patients.	2.0	1.8
37	Conduct the students case presentation as schaduled.	2.0	1.6
41	Provide the students with self evaluation apportunity.	2.4	2.0
44	Involve the hospital staff in her evaluation to the students.	2.9	2.2

❺.5.5 *Results of closed and open ended questions*

(A) *Results of closed questions*

(i) Rating of current status of clinical teaching

Table (5-13): Frequency of status of clinical teaching practices of student and teacher respondents.

Status of clinical teaching	Students		Teachers	
	Frequency	%	Frequency	%
Poor.	76	40.6	3	5.5
Satisfactory.	60	32.1	17	30.9
Good.	48	25.1	26	47.3
Excellent.	3	1.6	9	16.4
Missing.	8	-	-	-

Table (5-13) presents the percentage distribution of status of clinical teaching as graded by student and teacher respondents. The highest number of students 76 (40.6%), and the lowest number of teacher 3 (5.5%) classified the current status of clinical teaching as poor. While the highest number of teachers 26 (47.3%) classified the current status of clinical teaching as good and the lowest number of students 3 (1.6%) classified the current status as excellent.

(ii) Preferred teacher : student ratio

Table (5-14): frequency of preferred teacher : student ratio of student and teacher respondents.

Ratio of students with each teacher	Students		Teacher	
	Frequency	%	Frequency	%
From 3-5	76	40.6	25	45.5
6-8	60	32.1	23	41.8
9-11	48	25.7	6	10.9
12-14	3	1.6	1	1.8
Missing.	8	-	-	-

Table (5-14) presents the preference ratio of students per teacher in the clinical setting. As can be seen in this table, the highest percentage of students 76 (40.6%) and teachers 25 (45.5) prefered between (3-5) students per clinical teacher, only 3 (1.6%) of students and 1 (1.8%) of teachers stated that more than 12 students per teacher would be satisfactory.

(B) *Results of the open ended question*

In regard to the responses of the subjects to the question "If you had the power to make three changes in order to improve clinical teaching in your setting what kind of change would you like to bring about?", many issues were raised by students. Some of these focused on teachers attitudes, others on teacher's appearence, others on evaluation issues. Furthermore, some issues concerned course adminstration.

For the teachers responses, some of their comments were similar to the students comments, and others were not. The following tables show first those similar comments of students and teachers and then other comments.

Only if at least 60/195 students wrote a comment, or 20/55 teachers, were comments tabulated.

(i) *Suggestions of students and teachers to improve clinical teaching.*

Table (5-15): Suggestions of students & teachers to improve clinical teaching.

	Statement of suggestions
1	Resources and equipment needed for clinical training should be available.
2	Teacher-student ratio must not exceed 1:5.
3	Increase number of clinical days up to 3 days/week.
4	Minimise the number of students by decreasing the number of entrants yearly.
5	Increase the number of practice hours by using the summer holiday only for practice in the hospital for the students.
6	Evaluation method: A) Establish criteria for daily evaluation of students in the clinical setting. B) Change the evaluation tools.
7	Carry out continuing in service education programme for clinical instructors to: A) Bridge the gap between theory and practice. B) To train the teaching staff regardless the degree they hold.
8	Get Ph.D. holders involved in clinical practice.
9	Choose those who have good experience in the clinical areas to work with nursing faculty.

Table (5-15) presents a number of distinctive issues where both groups had similar points of view. Some issues are purely adminstrative: There were felt needs to increase the time of practice; minimise the number of students accepted yearly; make more resources and equipment for clinical training available. Furthermore, there were two major issues which were not listed in the closed questions, section; "Establish criteria for daily evaluation of students in the clinical setting", "Change the evaluation tools". There were also suggestion that teachers should all, regardless of academic qualification, be experienced clinically and trained to teach.

(ii) *Tables of suggestions of student respondents*

The following tables show comments made by students, but not by teachers.

(a) Attitudes of teachers towards the students:

Table (5-16): Comments regarding attitudes of teachers towards students as reported by student respondents.

	Statement of suggestion
1	Respect the learner.
2	Consider his individual learning needs.
3	Accept his criticism.
4	Reinforce his positive attitude, not only punishing him.
5	Focus more on practice than theory in her/his discussion with the student in the hospital.
6	Do not concentrate on paper work in the hospital.
7	More attention, observation and guidence to students in the clinical area; the time the teacher spends with students should be longer.
8	Increase students opportunity to be involve in nursing care.

Table (5-16) presents the suggestions which were reported by students in regard to the attitudes of teachers towards the students in the clinical setting. As can be seen from this table that there were only three main suggestions which were not listed in the closed questions; that the teacher should accept students' critisism; focus more on practice than theory in her/his discussion with students in the clinical setting, and the teacher should not concentrate on paper work in the hospital. However, all the rest of categories was listed previously in the closed question section of the questionnaire, although not particularly rated as problematic there.

(b) Appearance of clinical teachers

Table (5-17): The teacher's appearance.

The teacher should:

	Statement of suggestions
1	Dress in nursing uniform and not doctor's coat.
2	Remove nail polish and jewels likes students.
3	Keep her hair tidy.

(c) Students' evaluation by clinical teachers

Table (5-18): In evaluation the teacher should:

	Statement of suggestion
1	Be objective and avoid her/his personal relationship affecting her/his evaluation to students.
2	Provide the students with an opportunity for self evaluation.
3	Give feedback to students periodically.
4	Discuss her/his evaluation to students with the students individually.

Table (5-18) presents the suggestions in regard the evaluation process as mentioned by students. All suggestions mentioned were previously mentioned in the closed question section.

(d) Suggestions to nursing adminstrators.

Table (5-19): Suggestions of student respondents regarding teachers' performance and other administrative issues.

	Statement of suggestion
1	Increase number of MSc clinical instuctors.
2	Orientate the clinical teacher that 'priority in the clinical setting is for practice not for theory'.
3	Keep an eye (supervision) on the the clinical teachers.
4	Conduct periodic meetings with nursing students to discuss their needs and problems in the clinical setting.
5	Leave the last semester before graduation for clinical training in the hospital only.
6	Develop specialities in nursing practice.
7	Try to improve the image of nursing in Jordanian society.

Table (5-19) presents suggestion by students to nursing adminstrators to improve the quality and performance of clinical teachers; orientate the clinical teachers that "priority in the clinical setting is for oractice not for theory". Also students recommended that clinical teachers should have a degree qualification.

Regarding the adminstrative issues as raised by students. As can be seen that students want to keep in touch with the nursing adminstrators in order to solve their problems; "conduct periodic meetings with nursing students to discuss their needs and problems in the clinical setting". On the other hand it seems that image of nursing in the society is considered as an important issue.

(iii) *Suggestions of teacher respondents not made by students*

Table (5-20): Suggestions of teacher respondents not made by students.

	Statement of suggestions
1	Provide enough clinical space for students.
2	Develop standards of care that should be followed in the hospital.
3	Coordination between hospital policy and school of nursing policy in regard to clinical practice of students.
4	Orientate the medical and nursing staff about the role of the clinical teacher and nursing student in the clinical setting.
5	Improve the relationship between the university and hospital staff.
6	Attitudes of medical doctors towards nursing students and nursing practice should be change.

Table (5-20) presents the issues which were raised by teachers. It can be seen that most of these issues related to the clinical setting itself and to the personnel in the hospital; nurses and doctors in regard to their relation with teachers and students. In other words it seems that issues mentioned in the table might interfere in clinical teaching process.

❺.6 *Discussion of the Questionnaire Study*

❺.6.1 *Closed questions*

The Likert-rated questions mainly showed a positive response bias, although many of the issues covered were raised by students and teachers in the open-ended responses. This suggests that while the content of the questions was appropriate, Likert style questions were inappropriate as a method for use with Jordanian students and staff. There was some tendency for students to rate clinical teaching less positively than staff. This was particularly obvious in the answers shown in Table 13, where only a minority

of students, but the majority of teachers, rated clinical teaching as "good" or "excellent." Otherwise the data do not support more specific claims about differences between student and teacher ratings.

Before turning to the open-ended question, there are some other matters of relevance. One is that the majority of both teachers and students felt that the student: teacher ratio should be 8:1 or less (Table 14) and this concern will recur in subsequent chapters. Another is that while about half the students were male, less than 20% of the teachers were male. As will be seen, this may be one factor which affected teacher-student communication within Jordanian culture.

❺.6.2 *Open-ended question*

By comparison with the closed questions, the open-ended question asking students and teachers to suggest three changes to the clinical teaching produced much richer data. As will be seen from the observational and critical incident studies, the suggestions made for improvement generally supported the findings from both other qualitative methods. Both students and teachers felt that more teaching resources should be made available, in terms of material resources, time and smaller staff-student ratios (see Wong and Sharly, 1978). Both also felt that teachers should be trained to teach and be experienced in clinical work as well as academically, (see Nehring, 1990). Finally, both felt that the current evaluation methods were unclear.

The teachers also made a number of suggestions not made by students. These were mainly to do with the relationship between clinical teaching and general clinical work in the hospital. The suggestions imply that this relationship was often difficult or unclear. For example, as will be seen in subsequent chapters, the expected contributions of both students and clinical

teachers to the provision of nursing care to patients was often uncertain and sometimes the subject of conflict between clinical staff, teachers and students. As mentioned in Chapter 2., in the Jordanian system clinical teachers are attached to the nursing schools but do not usually have joint appointments in the units where teaching occurs. Thus, both teachers and students usually arrived from "outside" to conduct teaching, may have been unfamiliar with the unit's routines and practices, and may have been seen as outsiders by unit staff, (see Kramer, 1974).

The students also made a number of suggestions not made by the teachers, perhaps because many of the student suggestions were critical of teachers. It is worth pointing out that when students suggested, for example, that teachers should "respect the learner", this implies that respect for the learner did not currently occur. For presentation, the student suggestions were divided into suggestions about teacher attitudes, about teacher appearance, about teacher's evaluation of students and about course administration.

❺.6.3 *Teacher attitudes*

Students apparently felt that teachers often failed to respect them, to consider their learning needs, or to allow students to criticise them. They also felt that they were often punished for being wrong, but not praised for being correct, (see Kiker, 1972. Also, that teachers sometimes did not spend enough time with students and did not involve them sufficiently in nursing care. Instead, they felt that teachers focused too much on paper work and theoretical knowledge, at the expense of clinical skills, (see Flagger, 1988).

❺.6.4 *Teacher appearance*

In essence, students suggested that teachers should dress like nurses, without adornment, as they themselves were expected to. Again, the implication was that teachers often failed to dress appropriately. It will also be seen in the critical incident study that inappropriately dressed teachers sometimes criticised students for inappropriate dress.

❺.6.5 *Evaluation of students*

Students felt that their evaluations could be more objective, less coloured by personal issues and that they should receive better feedback and discussion about the evaluations from clinical teachers, (see Reilly and Oermann, 1992). Again, this will be seen also in material from the other studies.

❺.6.6 *Administrative issues*

Finally, students made a number of suggestions for improving the administration of clinical teachers. These suggested improved monitoring of clinical teaching, by supervising teachers and meeting with students and better training for teachers, as well as some suggestions about changes to nursing, rather than to clinical teaching in particular.

❺.7 *Conclusions*

Closed questions were not very informative but the open question provided a lot of material, which is supported further in the other studies to be discussed below. It is difficult to neatly summarise the issues raised, but perhaps many of the problems identified stemmed from a lack of clarity about the role of the clinical teacher and the objectives of clinical teaching. This will be discussed further below, after considering the results of the other two studies.

Chapter ❻

Observation of teacher - student interaction

❻.1 *Introduction*

Prior to the data collection process and conducting the observational study, the following issues were discussed:
who should be watched? where, when, how long and how often should they be watched?. All these questions need to be answered by the researcher before starting the data collection process and conducting the observational method.

The population of interest were clinical teachers who have direct contact with the students in the clinical setting.

Regarding the number of clinical teachers who actually taught clinical nursing during the semester, when observations were made, a decision was made to select 10 names out of the 20 teachers. Jordan University hospital was selected for the observations. It is the biggest teaching hospital in Jordan and clinical teachers from major universities and colleges usually come to train students there.

In regard to the time scheduled for conducting the observations, it is worth mentioning the timetable of clinical teaching during the semester as identified by the school of nursing:

From	18 September	-	1 October	-	Orientation.
	2 October	-	12 November	-	First Rotation.
	13 November	-	24 December	-	Second Rotation.
	25 December	-	31 December	-	Final Exam (Clinical)

Usually, clinical teaching is conducted four days a week. It was planned to start the observation on 13 November when the first rotation started up and continue to the end of the second rotation on 24 December.

The decision was made to observe each clinical teacher two times a week, each time two hours. The total number of observational hours was 40 hours.

The time selected was from 7:30 - 9:30 am., because it was thought that it is the time of providing morning care to the patients, attending rounds, doing dressings and so on. In other word the work of the nurses is more intensive in morning hours than in the afternoon.

Following permission which was confirmed by the research committee in the University of Jordan, the researcher met the Dean of the School of Nursing at Jordan University. It was explained to the Dean the intention of collecting data via the observational method and also about the plans of approaching the subjects. The Dean showed her willingness to co-operate and she suggested that "The researcher tell the clinical teachers that my area of speciality in my Ph.D. in clinical teaching and I am lacking the experience in this field. Therefore I am interested to know how it appears in the real situation in Jordan in order to have some background for practice of it after graduation". Also the Dean suggested to tell the clinical teachers that the idea is to see whether the observational method can be used to collect data for research purposes or not. She reassured the researcher that they will not mind since the researcher is not going to work with them later.

After that the researcher met with each clinical teacher of those who were selected in the random sample in her office and introduced herself to him/her and briefed her about the researcher's background.

The researcher was to be a non participant observer and not interfere. She was to record data about the interaction process of clinical teaching. Fortunately, the researcher did not face any objections from the subjects and she arranged a time table with all of them.

❻.2 *Prior to the process of writing field notes*

The researcher would like to draw the attention to the fact that the ultimate goal of conducting the observation is to capture the lived experience of the subjects during the clinical teaching process and to describe the community of which they are a part. This might involve at the same time describing the physical appearance, dress, mannerism or style of talking of the clinical teacher. At the date and time of observation sessions, the researcher used to attend 10 minutes earlier (7:20 am.), and wait for the clinical teacher and students to gather to start their clinical day.

❻.3 *The process of writing a field note*

Data were gathered by mobile positioning, which involved following the teachers throughout a given period of time (Polite and Hungler 1987). This provided the best opportunity to observe interactions. As observation focused on the clinical teacher, the researcher "shadowed" the clinical teacher throughout the period limited for observation (2 hours/session). As previously mentioned it is unstructured, non participant observation, therefore the researcher acted like a sponge, absorbed all the information, made notes on every thing she heard, saw, experienced even if it did not appear useful and relevant at that time. It is worth mentioning that the native language of the researcher and the subjects is the same. As Morse (1984) mentioned "The

more familiar the observer is with the language of the participants the greater the accuracy of the interpretation.

⑥.4 *Description of the findings*

As previously mentioned the aim of using observational method was to describe the interaction process during clinical teaching as it occurs in the clinical setting. It was noticed that there was three kinds of clinical teachers:

(1) teachers who have joint appointments and mainly work in the hospital setting, while also acting as clinical teachers.
(2) teachers who work only in the school of nursing. Some of them teach students in one unit at a time and others teach in different units at the same time.
(3) teachers who came from a remote school with their students - it can take them 1.5-2 hours to reach the hospital.

Also it was noticed that the number of students with each teacher was between 8-12.

Although the main objective of this method is to describe the interaction in clinical teaching, the situation of the teacher and other circumstances will also be mentioned where relevant.

The description of the interaction will be organised according to the types of clinical teachers mentioned above, because it was noticed that there is a relationship between the kind of interaction and the kind of the teacher.

This seemed to make more sense of the observations than any more abstract classification scheme. Rather than attempt to abstract qualities from a

small number of teachers, one teacher of each type will be described in depth. Examples of full observation notes are in Appendix (x), showing the best and worst teachers.

❻.4.1 *A jointly appointed teacher*

The teacher was hospital employee acting as a nursing supervisor for the paediatric unit at the same time she was acting as a clinical teacher for the student nurses in paediatric and adminstration. The teacher was constantly approached by many staff members, doctors, ward clark, nurses as well as patients, in addition to the students. The teacher was familiar with her unit, familiar with the hospital role, regulations, ways of getting things to cover the need of the patients and the staff of the unit. As can be seen in Appendix (x), the notes of the observation session, the teacher was approachable cheerful, relaxed and dealt informally with the students and the staff.

She delegated many teaching responsibility to her staff; oncology nurses discussed with the students how to do proper nursing care plans with oncology patients; kidney dialysis nurses discuss with the students the care of dialysis patients and so on. She delegated and involved all unit staff in teaching because she is their supervisor and has their support. With staff co-operation she ensured that both student learning needs and care needs were met by, for example, explicitly arranging contacts between students and staff where routine care and teaching tasks were both to be undertaken.

She utilised teachable moments; even a simple phone call from a family wanting information was an opportunity for instruction. She tried to pass on the ability of how to become integrated in the hospital system. She recognised individual students needs and helped them fulfil their objectives. Students were relaxed, hard working with all patients, looked happy. The teacher

maintained a positive attitude about all and equal respect was given to all. She did not like embarrassing any body and did not bother about students' appearance, did not dictate to the students while explaining to them about patients' conditions. She never talked book language, although she was master's degree. She answered students' questions and accepted their opinions easily.

The teacher was busy all the time. Her means of transmitting knowledge was highly practical. Knowledge was integrated into practice but practical experience was given greatest emphasis. The other two jointly appointed staff behaved similarly in terms of coordinating clinical care and teaching and in having a positive attitude to students. They differed in not being supervisors, thus they were unable to involve other staff in teaching to the same extent.

⑥.4.2 *A teacher who teaches in different units at the same time*

All the units were quite different and located on different floors. The teacher was going to the coronary care unit (CCU) in 6th floor, the Emergency Room (ER) (ground floor), then going to the Intensive Care Unit (ICU) and the Operating Room (OR) (second floor) for which she must wash and dress in a gown to enter.

Two students were on each unit. Her students were all males who were enroled in a Maternity course, but who were not permitted to take their clinical training in a maternity hospital. So they were placed in other units for clinical experience. Students were not assigned to single patients. Instead they were floating in the unit, free to observe or become involved in patient care as supervised by staff. It was the first day of their clinical rotation.

The clinical teacher started her round by visiting the Emergency Room, She met with the two students there and checked their presence. No patients were in Emergency. Then she left them. The Emergency Room was filled with the equipment and medication. The students were not familiar with the unit, nor was the teacher. The teacher did not make an orientation for the students although it was the first day of their clinical rotation. She did not discuss with the students about the unit itself or about the nature of the patients. The only thing done by her was that she asked the unit supervisor to take care of the students. The time spent with the students did not exceed 5 minutes. A similar pattern was reported in all other units. However, in one unit she told a student to put on his name tag. In one of the units the teacher did not find the students and she searched for them. She found them in an other unit where they had gone to visit their friends. Students did not pay any attention to the teacher and continued to drink tea.

Within the two hour clinic, the teacher then continued to rotate from unit to unit, checking students' presence but not interacting much with them and not becoming involved in the clinical activities of the unit. Because of the time it took to move between floors, the teacher had little time for more involvement. Furthermore, her lack of clinical involvement in the units would have hindered her if she had attempted practical teaching.

It would be difficult for any teacher to cope with having 12 students spread out in twos to 6 units on different floors. The spread-out teaching assignment was though to have the following effects upon teaching and learning.

1. Lack of time for individual students.
2. Lack of control over students due to unavailability of teacher. Students did not have adequate maturity to cope with independence, as noted by complaints that the teacher was not present to tell them what to do and

non-purposeful activities such as leaving unit and sitting drinking tea. The teacher did try to delegate responsibility for students to unit supervisors but it is apparent this was no guarantee of control over students.

3. Verbal statements of the teacher were largely superficial, such as greeting, encouraging remarks, and intention to see later, rather than substantial information given, evaluation or planning.Sometimes she chose inappropriate topics, as when emphasising privacy for an unconscious patient while taking pulse.

Assignment of a report was used to make students accountable. The teacher did not demand to see real accomplishments; although she did try to help a students enter into interviewing patients. The teacher's own limited teaching skills were also a factor, as evidenced by not making a pre-conference for all students for orientation. She also treated students as equals by negotiating return to units, when actually the teacher should have been authortarian.

4- The teacher was personally stressed by the wide-spread assignments as shown by her complaints, talking to herself, anxious expression, superficial statements, avoidance of conflict and avoidance of interaction. Avoidance of conflict was noted by tolerance of rude and irresponsible behaviour of students.

Reduced interaction was shown by lack of touching patients or students, even equipment, standing with arms closed at a distance, and quickly entering and leaving situations without actual interaction.

Overall, it was noticed that these situations showed low task orientation, poor student attention and motivation, learning was not assured. Information given was at a low level and no skill acquisition was obvious. The teacher had a difficult situation with the widespread placement of her students. She could

not afford to get involved in one area out of fear of neglecting students in another area, perhaps if she had pre-conferences with the students, they would have felt more secure in the learning situation requiring independence.of the two other teachers observed in this situation, one taught in multiple units on the same floor, which might have made things easier. However, she was nine months pregnant and if anything, interacted even less than the teacher described above. The other teacher rotated across different floors, with similar problems, and was also inexperienced, being a Masters degree student, teaching part-time. Again interaction was minimal.

⓫.4.3 *Teachers with university appointment only teaching in one unit*

The two teachers in this category were quite different and will be described separately. The first teacher was not a hospital employee. She was not caught up in the stresses of the floor, she moved slowly without spontaneity. Her focus was the preparation of nursing education objectives, papers, note books, charts and on the procedures associated with patient care, but not in patient care itself. She integrated to some degree theory into practice, but in a manner more appropriate to a classroom. Her students took notes while she spoke and she showed her concern about that as she told one student: "Did you have enough time to take that down?", she also blamed the students who were not writing while she was talking to them. The content of her discussion was mainly about the pathophysiology of the disease and not about the nursing care plan of the patients. No consideration was given to the social context of the patients.

She integrated nursing education little into the hospital nursing ward. An example, is the taking of vital signs by the staff, then the teacher and students took the apical pulse. She made no contribution to the work load. Each student

was located in one room. The hospital staff did not share in the nursing education. The teacher even seemed to be separate from the patients as well because her focus was the procedure and the equipment which were systematically approached step by step.

Overall, it was noticed that although the teacher was available all the time and working only in one unit, the teacher and the students failed to be involved in the work of the ward. The ward looked very busy with all the nurses kept running, while the students were standing in their rooms holding their note book in their hands and waiting for their teacher to come and dictate to them.

The other teacher from university assigned to a single ward was much more involved. He was male but dealt with both male and female students. It was noticed that the teacher arrived to the unit and took over with the nurses before the students arrival. He arranged the cases to the students while he was waiting them. The teacher was familiar with the unit and interacting freely with the nurses. The teacher was approachable, relaxed and respecting of students in front of others. For example one of the students laughed loudly in the unit, he just took her away and drew her attention in a polite way. The student accepted his comment and apologised to him. Because he had a good relationship with the nurses in the unit, the nurses were co-operative with him. With staff co-operation he ensured that both student learning needs and care needs were met. In other words he considered the student as a worker but as a learner in the first place. He utilized teachable moments. He recognised individual learning needs and helped to fulfil students objectives. Students were busy and anxious to learn. He was seen demonstrating many nursing procedures in front of the students, for example, insertion of a nasogastric tube, putting intravenous line into the patients, giving medication and so on. He acted as a role model in front of the students, doing things in front of them and then asking them to do it.

The teacher maintained a positive attitude about all the students. He did not like embarrassing anybody and did not bother much about students' appearance, when he saw one student without name tag, he whispered in his ear to remember to put it next time. The teacher was discussing with the students nursing procedures and nursing care plan to patients and was talking about the theory part of it while he was performing the skill. He did not dictate the students or ask them to take notes while he was discussing procedures to them. The teacher was busy all the time. Knowledge was integrated into practice but practical experience was given greatest emphasis.

⑥.4.4 *Two teachers who travelled from remote schools to the hospital*

The two teachers were seen together with 15 students arriving at the hospital at 9:30 am, and immediately going to the cafeteria to take a break from their long journey (one and a half hours). The students were distributed to the units by themselves and were seen asking about the location of their units. Then the two teachers started their rounds together. The way the teachers interacted with the students was minimal, like the teachers with students on different units, but with more emphasis on talking with the students about the theoretical aspects of the patients conditions.

The students arrived on the floor after the busy period was over, (Morning care was already done to most of the patients). Teachers were not seen teaching any student or doing any nursing procedures with the students. Overall interaction process was minimal, and students only learned by observing the nurses work in the unit.

6.5 *Conclusions*

The main problem observed was a basic lack of interaction between teacher and student. This appeared to be caused in large part by teachers being assigned to teach in several units at once, with which they were not familiar. Working across several units also restricted the teaching time available for patient contact or demonstration of procedures.

This contrasts with the situation when the teacher also worked in a specific unit. Then, teaching could be integrated into clinical practice, interactions between staff, teacher, students and patients were much more common and students (as well as teachers) appeared happier and more involved.

The non-jointly appointed teachers teaching in single units fell between these extremes. It is probably harder to integrate teaching and practice as an "outsider", but possible if the teacher makes the effort to orient to the unit and integrate with staff. This was exemplified by the male teacher observed.

The difficulties of clinical teaching, from the teacher's perspective, was described by Stuebbe (1980) in another observational study:

> *"In observing the actual role of an instructor, I worked with an instructor at the Evanston hospital school of nursing. This instructor stated that she tries to be patient and let students learn on their own, at the same time being available to students on the clinical floor, and she also sees herself as a resource person and facilitator. She sees this as a method to encourage students to work more independently and accept the responsibility for seeking out resources as needed. In acting as a facilitator, when answering questions she encouraged students to think through*

related concepts and frequently students could then think through and answer their own questions. This instructor stated that she felt it important for herself to establish and maintain good relationships with staff in the patient care units because how she gets along with staff ultimately affects how effectively staff and students will interact.", (p.5).

Of the ten teachers directly observed in Jordan, only three, the two joint appointments and the male university-only appointment, approached this standard.

Chapter ❼

Study (3): Clinical teaching behaviour (Critical Incident Technique "C.I.T")

Data Collection Process

❼.1 *Introduction to the main study*

As previously mentioned in the method chapter, the data collection method for this section was the critical incident technique via structured interview. Permission to interview the subjects was obtained from the administrations of the universities involved, and then from the nursing administrators at schools of nursing there.

The population of interest were all senior nursing students at Jordanian universities; Jordan university and Jordan University of science and technology.

The interviews were tape recorded upon the agreement of the subjects. Transcriptions of the tapes was done by the researcher. The following chapter presented the data collection process; the pilot study and the main study as well.

❼.2 *Pilot study*

Prior to interviewing the students, the assistant deans of the schools of nursing were approached, each was given a verbal outline of the intended research and the method of the data collection. Both showed their willingness to co-operate and to offer help when it is needed. The intention of the researcher was just to inform those leaders about the interview approach to collect the data and not to ask them to make any arrangement for the researcher to meet the subjects. The decision was made to give the subjects themselves the freedom to select the best way, best time, best place, to be interviewed, and not to impose a plan arranged by the administration.

❼.2.1 *Pilot sample*

Although this study involved two groups of senior nursing students, a group from Jordan University and a group from Jordan University of Science and Technology, it was decided to pilot with one group rather than the two groups. Due to the nature of the main study sample i.e. non probability purposive, it was seem to be important not to risk losing excessive participants from the main study through pilot work. At the same time, as previously mentioned in the questionnaire section, it was necessary to have a pilot sample as similar as possible to that in the main study. Participants of the pilot study were to be excluded from the main study sample.

A total number of 20 female students were interviewed in 4 groups of five. The used of the group interview technique seemed justified by Wagners (1948). He reported that the data obtained from the group interview were comparable in quality to the data obtained by the individual interview and required only about one fourth as much of the interview's time.

❼.2.2 *Aims of the pilot study*

(1) To identify whether the students agreed to be interviewed.

(2) To identify whether the questions asked produced the type of data expected.

(3) To identify relatively how many incidents can be given by each informant.

(4) To specify the method the informants prefer to respond; writing or talking.

(5) To test the students' acceptance of their interviews being tape recorded.

(6) To examine the quality of the tape-recordings to ensure tapes could be transcribed without difficulty.

(7) To seek advice from the pilot sample about the best way, best time and best place to conduct the interviews with their colleagues.

❼.2.3 *Conduct of the pilot study*

The researcher met with each of the selected group separately in the female mosque at the school of nursing at Jordan university. The researcher introduced herself to the informants and tried to establish rapport with them. The purpose and the procedure first explained carefully to the participant.

It was pointed out that a critical incident should be:
"an accurate report of the behaviour of the clinical teacher in a specific situation rather than interpretation of the clinical teachers". They were asked to recall incidents of clinical teaching effectiveness by describing what the clinical teacher did, which might cause them to feel happy and satisfied of what they have been learned from the clinical teacher or to feel that they would like to have this clinical teacher teach them again. At the same time to recall

incidents of ineffective clinical teaching, which might be the kind of behaviour exhibited by clinical teacher which cause then to be unhappy or to complain that teacher. During the interview, notes were made in respect of the pilot's aims.

The following section is describing the findings of the pilot study.

❼.2.4 *Findings of the pilot study*

One of the main objectives of the pilot study was to identify the level of acceptance of students to be interviewed since this was the first time of this approach to be used there. The students were very concerned about the confidentiality of their responses. They were reassured about that and also it was emphasised at that point that neither their names nor their teachers names were requested. Then the students showed their willingness to be interviewed and to respond fully to the research inquiry.

The second objective was to identify whether the question which was asked produced the type of data expected. It is worth mentioning that Arabic language was used to explain the purpose of the study and to clarify exactly what was needed. It was observed that the majority of the informants understood what was needed from them clearly and were able to give different kinds of effective and ineffective incidents. However, it was noticed that in one group two students out of five need to be stimulated, by trying for example to remind them to correlate the incidents with the name of the clinical courses. Also in an other group, it was noticed that some students need some time to remember and to recall the incidents, so the researcher had to be patient. This made the idea of interviewing the students seem more convenient, rather than asking them to write in a class. Furthermore, it was noticed that some students were encouraged more to speak by the presence of their colleagues (they felt shy to speak alone). However, it was preferred not

to make the groups larger than five; in order to keep replies relatively control. Also in one group of four the students misunderstood the question asked to them and they tried to be judgmental by saying: while I was in maternity course the clinical teacher was very bad, very tough and so on. The researcher then focused the information and reminded her to mention the incident exactly as it had happened. In this case the interviewer emphasised the issue of evaluation and not judging.

In regard to the number of incidents which might be given by each informant, it was noticed that a minimum of two incidents from each informant might be given. However, this was not a fixed number. Some informants gave four incidents.

In regard to the method the informants preferred to respond either in writing or talking. It was found that 3 students out of 20 asked the interviewer to write their thoughts. This meant that it might be some students who preferred to write although the majority prefer to speak their thoughts. More than one student said to the interviewer: *"To say something is much easier and quicker than to write it."*.

In regard to the agreement of the informants to tape record their incidents, it was noticed in the first group which was interviewed that it seemed unusual to the students to tape record their voices and some of them became sensitive to this issue. This gave the researcher the clue to explain to them that there would be no harm to them and nobody would listen to the tapes except the researcher. Then the students accepted it and acquired more courage to speak loudly. Therefore for the rest of the groups, at the beginning of the interview the researcher kept the recorder hidden in her hand bag and after establishing a rapport students said at least one incident, then the researcher apologised and asked if they did not mind her recording what they said. In this case the researcher guaranteed the agreement of the informants to

record their interviews. However, not all the subjects showed that much resistance or objection to the recording of their thoughts.

In regard to the examination of the quality of the tape recording and to ensure that the tapes could be transcribed, after finishing the first interview with the first group, it was noticed that there was no problem in regard to the length of the interview, and it was possible and easy to change the cassette without making any interruption to the interview. Furthermore, the cassettes were transcribed by the researcher and all their contents were written on papers. It was noticed that all the content was easy to be caught but it needed editing.

In regard to the objective which was about seeking advice from the pilot sample about the best way, best time and best place to conduct the interview with their colleagues, the majority of them said: *"your research is very interesting and we expect that all our colleagues will co-operate, it will be better not to ask them in a class to write to you the incidents; they might ignore it".*

In regard to the best time to conduct the interview, immediately they replied that Saturdays and Sundays after 1pm usually, all fourth year students are present in the school campus, and Monday and Tuesday, the third year students are present as well. These days are the clinical days and usually after finishing the clinical practice every body will be back to the school.

About the best place for interview, they replied:

- Changing room for female.
- Mosque for female.
- Student counsel room for male.
- Cafeteria.
- School gardens, under the trees, on benches.

In conclusion, the researcher came up with the following points which were taken into consideration while conducting the main study:

(1) To ask the subjects to speak their own language.

(2) During nice sunny days, while the students were sitting and relaxing under the trees might be better for interviews.

(3) Avoid interviewing students before or after an exam.

(4) Students were not asked to mention their names or teachers names, just the sex of the teacher.

(5) It had to be emphasised that student views were really important as consumers of clinical teaching.

(6) Accepting request from any student who wanted to write the incident rather than speak about it.

(7) Establish rapport prior to tape recording.

Finally one might say that by interviewing the subjects one can guarantee to avoid the problem of misunderstanding the handwriting of the subjects and it avoids irrelevant information being written.

❼.3 *Main study (data collection)*

Following permission to access students and conduct the pilot study, interviews were held with fourth and third year nursing students at school of nursing at both universities.

A decision was made to go daily to the school of nursing and interview the students in different places, schools, gardens female mosque, changing room, cafeteria,...etc. Sunny days were selected to meet the highest number of the students in the school's gardens, setting under the trees in the break

time. Also changing room for females was a very good place. Incidents taken from the students who were there were recent as they experienced them during their clinical days.

The language of communication between the interviewer and the informants was Arabic, the native language of the subjects and the researcher. Also a decision was made to interview the student without any previous arrangements from the administration. It was believed best not to prepare the students previously or to force them to be interviewed in particular time but to let them feel free to participate and to be relax, while they are in break time. Practically this approach was efficient enough to collect the data needed. However, the following points were taken into consideration:

The researcher introduced herself to the subjects. The purpose and the procedure were first explained carefully to them. It was pointed out that a critical incident should be an accurate report of the behaviours of clinical teacher in a specific situation rather than trait names or an interpretation of the clinical teacher behaviour. Students were asked to recall incidents of clinical teaching effectiveness or ineffectiveness describing what the teacher did to them to commend that teacher or to feel that they would like to have this teacher to teach them again on not to teach them at all. Students were told how they had been selected and about the importance of their participation at the same time, they were told that their participation was optional, and those who may chose to participate are not required to mention their names or the teachers' names but just to mention the sex of the teachers.

During the interview the interviewer, the researcher acted as a neutral person. She had nothing to defend, she was not judge, she showed her willingness to let the interviewee take the responsibility for carrying the interview. The interviewer makes sure that the subjects understood what was wanted and then directed her efforts at encouraging detailed responses to her

inquiry. At the same time the subjects showed their willingness to participate, for example some students were very co-operative and helped the researcher by informing and gathering their colleagues to make them more accessible to the researcher.

It is worth mentioning that as planned the students were interviewed in groups which did not exceed five. Interviews were conducted randomly with fourth and third year nursing students. In order to be sure that all or nearly all the students were interviewed, the researcher met with all the students during 30 minutes of four regularly scheduled class period, introduced herself again and mentioned that the purpose of meeting them again was to be sure that all the students had the chance to participate in this study, as well as identifying those who had not yet been interviewed by the researcher and did not mind participating. They were asked to raise their hands. At that time fewer than 35 students from all the senior nursing students in each university had not participated yet, they showed their willingness to participate. Then the purpose of the study was explained to them and the procedure as well. They were asked to write effective and ineffective incidents on papers.

It is worth mentioning that some students from those who were interviewed previously asked permission to write other incidents which they had not thought of at the time of their interviews. Permission was given to them and many incidents were written by them at that time.

❼.3.1 *Analysis of the critical incident data*

As indicated earlier data were recorded in two forms namely in writing and on tape. The data contained on the tape were transferred to cards under the following headings:

identification numbers, sex, and type of the incident. Where a respondent

gave more than one incident additional cards were used.

Data collected from students, who were asked to write down at least two effective and/or ineffective incidents, also included descriptions of the teachers' behaviours in the clinical setting and their attitudes without filling them in an incident format.

The data collected were analyzed using three headings:

(1) Critical incidents recorded on tapes.

(2) Critical incidents recorded on paper.

(3) Other data recorded on paper.

The following chapter discusses how the researcher dealt with the data from 1,2 and 3.

(A) *Incident recorded on tapes*

The content of the 25 tapes (90 minutes on each tape) were transcribed on to cards. The number of incidents on each tape ranged from 55 to 65. Three independent judges were used to check the accuracy of the transcriptions. They examined a randomly selected number of incidents. The judges were a senior student nurse, a senior law student and a solicitor. They were selected because of their skills in understanding incidents and their familiarity with the subject matter. Exclusion of clinical teachers from the judges was for two reasons. First because the researcher was very concerned about the students confidentiality; the teachers might recognise the voice of the student. Second because a teacher from nursing faculty might be subjective or defensive in his/her point of view.

This independent scrutiny from different judges with different background provides a validity check of the first stage of analysis.

Therefore since the incidents were accurately and comprehensively summarized the content of the interviews one might ensure and guaranteed that further classifications and analysis to the content would be established from an accurate base.

In regard to the judge's comments on the accuracy of transcribing process, there was general agreement between them that the transcribing process was well done. For example the nursing student said that the transcriber was very meticulous and obsessional, while the issue raised by the lawyer was that the translation process should be at the level of the transcribing process in term of its typicality and accuracy. In other word he stated that translation from language to language some times affected the meaning of the content.

(B) *Incidents recorded on paper*

Student's written material contained two types of data

(1) Incidents that were clearly demarcated as either effective or ineffective teaching.

(2) Descriptions that failed to fall into either category, for example one student wrote: *"I had four months training in psychiatric hospital and I used to see my teacher only in the morning coming with us in the bus to the hospital and just at the time of learning collecting us to be back".*

Deciding the category in which to Place such statements presents some difficulties even when using Flanagon's (1954) criteria to determine what descriptions could be included as incidents. This was not a problem for the incidents collected by interview, but in some of the notes written in the classroom, incidents were not clearly demarcated.

Some researchers exclude what may be termed (unverified) incidents from their analysis on the grounds that they do not meet Flanagon's criteria and therefore of questionable validity. and other researchers like Bairely (1956) include such three incidents without acknowledging that they did not meet Flanagan criteria.

In this research a decision was made to treat these incidents like other incidents which were well demarcated scenes, because since these incidents seems valid and comprehensive and might contribute a valuable data to the research. Therefore a decision was made not to apply Flanagon's criteria as if it is a rigid mathematical formula which can't be modified or flexible in certain situations taking into consideration that verification for the incidents might be seen clearly in other methods of this study. For example in the questionnaire method the students listed in the open ended questions many suggestions which were similar to critical incidents given by them. Also, in the observational method, the researcher saw incidents similar to those given by students.

Finally and before starting the categorization process all the data was reviewed and classified in four types:

(1) Incidents which contain effective events.
(2) Incidents which contain ineffective events.
(3) Incidents which were not clearly demarcated.
(4) Incidents which might have more than one meaning i.e. might be classified in more than one category.

(C) *Samples of the study*

From the 350 scheduled interviews; (tape recorded interviews) 1500 incidents were abstracted, and from the students written responses 500

incidents were collected. The distribution of the incidents obtained from the informants were shown in Table (7-1):

Table (7-1): The distribution of the incidents obtained from the informants.

Sex of the informant	No	%	No of incidents	%	Average of incident/informant
Male	180	45	770	38.5	4.3
Female	220	55	1230	61.5	5.7
Total	400	[illegible]	2000	100.0	

As can be seen in Table (7-1) that the number of female students exceeded the number of male students by 40(10%) and the number of incidents produced by the females exceeded the number of incidents produced by males by 23%.

(D) *Organising and classifying the incidents*

As can be seen in the initial treatment of the interview data, the quantitative analysis dealt with the number of incidents and the respondents providing them.

In the next stage qualitative techniques are used to separate the students comments or notes from the incidents and to separate all incidents which might have more than one meaning in each of them.

The qualitative analysis was applied using the process known as category formulation.

Category formulation

This procedure has been described in detail by Flanagan (1949). Category formulation consists of the following four steps:

(1) **Studying the behaviours intensively in accordance with the purpose of the research:**

In this study, the data were reviewed many times; tape recorded interviews were transcribed and validated by judges; incidents written by students were studied closely. Incidents that were clearly demarcated scenes, incidents that were considered to convey more than one meaning or themes, all these kind of incidents were identified separately.

(2) **Formulation of a rough classification system to encompass the major areas of the behaviour:**

Formulation of the major area was done inductively i.e. any incidents related to feedback whether the teacher did feedback, did not, did it in a bad way, or a good way, all these incidents were grouped together with an appropriate title such as "area of evaluation" or "feedback", and same procedure was done to the rest of the incidents.

(3) **Reclassifying the behaviours within the major area formulated:**

In this stage the incidents within each area were reclassified, and categories were formulated within each area according to the meaning of the incidents which was grouped within that area. For example in the area of "feedback", all kinds of incidents which conclude that positive feedback were made to students were grouped together, and the same process was applied to those with negative feedback and to the rest of the incidents. In this stage. one might say that the primary classification for all the categories was made.

(4) Studying the behaviours within the major areas and related categories, and writing specific descriptive statements to cover similarities of the incidents:

This process was carried out and repeated until all the specific descriptive statements for each area were made.

It is worth mentioning that in this research it was noticed that many students before they talk or write the incidents, they put them in a context or in other words they already helped in the categorization process. For example one of the student said:

"I feel very sorry that my teacher was not consider the students feeling when he exposed to a new situation for the first time", and then the student continued and said the incident *"It was my first day in the hospital and it was the first time for me to see dead body. I was very paniced even to look to the dead body while my teacher forced me to do complete death care to him and she does not care for my tears and my feeling"*.

In this case to establish the category was very directive and clear.

It is worth pointing out that the different numbers of the incidents within the categories was not considered as if it reflects the importance of that category. In other word, for example, if the number of incidents in category (x) was 100 and in category (y) was 30, this does not mean that the issue discussed in category (x) was more important than the issue discussed in category (y), bearing in mind that this is a qualitative study not quantitative one and the students were not responded to an items at a time. On the other hand, the subject of this study was one group only, i.e. senior nursing students at Jordanian Universities. The mathematical formula was used in previous researches only when their subjects include more than one group. For example Cormack (1983) in his study "An investigation of the role of psychiatric nurse using C.I.T.", and Bairly in her study "The critical incident

technique in identifying behavioural criteria of professional nursing effectiveness". The participants in the studies of both of the above researchers include many groups. For example, in Bairly's study, the participants were interns, residents, staff, physicians, patients, head nurses and clinical instructors from three general hospitals. In this case it seems convenient for both of them to utilise a statistical formula to identify the significant results as indicated by different groups. However, for this research, if no statistics was considered, it might be OK.

In summary, the classification process consisted of reading each incident, assigning it first to one of the major areas, then to specific category within that area involved. Descriptive statements were written for each area.

(E) *Reliability of the Data analysis process*

Flanagon (1954) stated that the induction of categories from the basic data in the form of incidents is a task requiring insight, experience, and judgment and the quality and usability of the final product are largely dependent on the skill and sophistication of the formulator. The only thing to be done is to submit the tentative categories to others for review. Although there is no guarantee that results agreed on by several workers will be more useful than there obtained from a single worker, the confirmation of judgments by a number of persons is usually reassuring.

Another way of checking reliability is by examining of consistency of data emerging from the three different sources of data collection. After an intensive study of the behaviours and several revisions of the major areas, a relationship between the categories emerging from the incidents and those which had emerged in the open ended questions in the questionnaire section.

Thus an Internal Consistency between the results emerged from the two methods. For example, in their responses, students wrote that the teacher should respect the learner while in the interview they described incidents where the teacher did not respect the learner.

With regard to the data which emerged from the observational method, many observations reported by the researcher were similar to critical incidents described. For example, one of the teachers who was observed was responsible for about 12 students placed in 6 different areas in the hospital, i.e. CCU, ICU, ER, BU, OR and Recovery Room. It was observed that the teacher spent with each student 2.5 minutes during the two hours of observation and her role towards the students did not exceed checking for absenteeism and a hello and a good bye. Many incidents collected from the interviews raised the issue that teachers are not available most of the time.

In order to deal with the incidents which could be classified in more than one category, three jurors were consulted. The following presented a discussion regarding the action made by these jurors.

(i) *The jury*

Because most of the incidents which might be classified in more than one category were related to the conflict between what the clinical teachers asked students to do and the students' religious or cultural values. Three jurors were selected from the educational psychology department at Jordanian university. They were selected because of the relevance of their background to culture of the students under investigation.

(ii) *Objectives of judging process*

The jury was asked to

(1) Sort the incidents which might be classified in more than one category into the identified categories.

(2) Test the suitability of the place of the categories within the identified area.

(3) Identify whether the categories formulated, reflected in the meaning of the incidents described.

(4) Select two out of four incidents from these which were selected the researcher to be considered as examples for the subcategories within the identified area.

(iii) *Findings from the jury*

Arising from the jury's comments and suggestions, changes were made in the categories. There was a high level of agreement among the three jurors' decisions.

With regard to the first objective which asked the jury to sort the incidents which might be classified in more than one category into identified categories, the jurors in their views prioritizing the issue of human rights before any other issue related to teachers behaviour during teaching - learning process e.g. a student mentioned that the teacher came and questioned him in an appropriate time and then started shouting him and criticising him in front of the patient. As it is known that respect is considered as a student's right during the teaching - learning process therefore in this case the incident was classified under the categories related to the area "interpersonal relationship; namely lack of respect for the students in front of the patient", and not under

the category: "teacher question students in an appropriate time".

The following example may clarify the issues raised:

Student said:

"during my clinical rotation in surgical nursing at 8:30 a.m. the teacher came and asked loudly: 'what did you do for your patient?', I told her: 'I did bed making'. She said: 'that is all?', and she shook her head and brought another teacher and she starting shouting on me in front of the patient and being sarscastic to me too. When the course finished I got a poor evaluation. In the next semester I was doing very well and I didn't have any problems with any one. One day my teacher said: 'are you the one who had a clashes with teacher x?', I said: 'yes'. Consequently the teacher ignored me and changed all her attitudes towards me and this was repeated from the beginning of the second year till the end of the fourth year and I feel that really I was not treated in a fair manner".

It can be seen that the student raised many issues namely, questioned at an inappropriate time; the teacher shouted at the student and being sarcastic in front of the patient; told other teachers about the students performance; the attitude of other teachers with her though she was not mistaken (not fair).

Although there were a number of issues raised in these incidents, the priority for categorizing the incident was for the student's right to be respected and was considered by the jurors to be the most important one.

In regard to the second objective, to test the suitability of the location of the categories within the identified areas three categories were transferred from their areas as located by the researcher and relocated in other areas as a result of the jury's decisions; eg. the category "imposing threat, using evaluation to threaten the students" was transferred from the area (A') "Teachers do not effectively communicate with students; interpersonal

relationship" to area (B) "Evaluation".

The category "Orientate the student to the clinical setting" was transferred from the area (D) "Professional competence" to area (E) "Teacher act as a motivator, encourager", the similar but opposite category i.e. "Teachers do not provide orientation to the students at the beginning of the course" were moved from area (D') to area (E') "Teachers discourage or inhibit".

Furthermore from the area (D') the category "Concentrate in paper work in the clinical setting more than technical skills" was placed under the area (E') "Teachers discourage".

The third objective identified whether the title of the categories identified were meaningful. A number of categories were also modified, others deleted or added e.g. in area (B) "Evaluation" the category "Teachers did not offer opportunity to practice before evaluating the student in clinical areas" was retitled "Teachers do not evaluate the student at an appropriate time". In area (E) "Teachers motivate", two categories were combined. The category "Help the student to be an independent learner" and the category "Gives students the freedom to try to do it on their own", became one category; "Gives the student the freedom to try to do it their own; helps him to be independent learner".

In the area (E') the categories "Supervising students too closely" and "Do not help student to be an independent learner" became "Does not help student to be independent learner; supervises student too closely".

Furthermore the jury suggested breaking the category "Does not support human dignity or understand values and beliefs of others" to become two categories in the same area (A) i.e.

- Does not support human dignity.
- Does not consider religious beliefs or understand values of students.

The same action was done to another category in the same area i.e. does not respect the confidentiality of students relationships...etc becomes

- Does not respect the confidentiality of student relationships;
- Teachers themselves take impressions about students before knowing them
- Teachers talk about students achievement in front of his colleagues.

Furthermore the jury reworded some of the categories statements eg. area (A) category (6): "Teachers do not give special consideration for handicapped students" Became "Teachers do not consider individual limited abilities".

Furthermore in area (B) the jury commented that the examples of the incidents under the category "Clinical evaluation is not built in to students experience in the clinical setting" should be titled with a category "Evaluate the students mainly on nursing and medical theory more than practice".

The same action was made to category (13) in area (E') it was "major punishment for minor mistakes" became "concentrate on students appearance".

Finally in regard to the objectives to select two out of four incidents from those which were selected by the researcher to be considered as examples for the subcategories within the identified areas.

To start with the jury agreed with the researcher to represent each category with two examples of incidents. This might be more helpful to enable the reader to understand what was really meant by the content of the category. Finally the jury selected the two incidents which they considered as an examples under each category. In this case the objectivity and the clarity of the selected incidents was decided by the jury, rather than the researcher.

❼.3.2 *Findings of the critical incidents*

(i) *Introduction*

The categorization and classification process led to the development of a performance record consisting of (10) behaviour areas. There are categories of effective and ineffective behaviours set up for each of the (10) areas.

To optimise clarity when using the classification system, the following conventions will be used:
Areas will be labelled thus:

"Area A, B, C, ...etc" and will be written as follows, "clinical teacher considers interpersonal relationship
Subareas (categories) will be labelled thus;

"category 1, 2, 3, 4,....etc" this will followed by the statementof the two incidents selected to be considered as an examples of that category. The same process will be done for effective and ineffective behaviours.

In the following pages, the list of the categories in each area will be presented and after that, the areas, its categories and the examples of the incidents selected for each category as well.

(ii) *Categorized critical incidents (N=2000)*

Area (A) "Interpersonal relationship"

(effective behaviours)

	Statements of the categories (1-6)
1	Respect students' opinion and is tolerant to students' disagreement.
2	Tactful in dealing with students in front of patients.
3	Shows concern and sympathy for the students' problems.
4	Improves student standing in eyes of the patients and their families.
5	Is flexible when the occasion calls for that.
6	Shows confidence in students' abilities, help them to be independent learners.

Area (A') "Interpersonal relationship"

(Ineffective behaviours)

	Statements of the categories (1-8)
1	Does not respect the confidentiality of students' relationships i.e. A) teachers themselves form impressions about students before knowing them. B) talk about student's performance in front of his colleagues.
2	Does not take in to consideration religious beliefs or understand values of students.
3	Does not deal with female and male students in the same pattern; male teacher with female students or female teacher with male students.
4	Does not help students to be honest while engaging in writing nursing care plan for their patients.
5	Interfere in personal matter.
6	Humiliate the students.
7	Does not build up a trust relationship with the students.
8	Does not respect students' opinions and is not tolerant to their disagreement.
9	Does not show respect for students in front of patients and others.
10	Is not flexible when the occasion calls for that.
11	Makes students feel worthless if they know little but never encourages them to be competent.
12	Belittling students.
13	Being judgemental.
14	Being sarcastic.
15	Does not consider human dignity.

Area (B) "Summative Evaluation"

(Ineffective behaviours)

	Statements of the categories (1-7)
1	Do not evaluate the students using a clear cut criteria.
2	Evaluate the students mainly on nursing and medical theory more than practice.
3	Do not evaluate the students at appropriate points during the course.
4	Do not discuss their evaluation of students with the students individually.
5	look for students' mistakes.
6	Impose threat, using evaluation to threaten the students' future.
7	Discriminate between students in their evaluation (not objective).

Area (C) "Formative Evaluation" (Feedback)

(Effective behaviours)

	Statement of the categories
1	Teachers provide helpful and timely feed back during and after performance of the procedure by the students; A) Explain why response/action is right. B) Explains why response/action is wrong. C) Identify area of improvement.

Area (C') "Formative Evaluation" (Feedback)

(Ineffective behaviours)

	Statement of the categories
1	No feed back provided from clinical teachers after procedure whether positive or negative.
2	Always pointed out students mistakes without showing them how to correct their mistakes.
3	Give false feed back.
4	No feed back provided from clinical teachers on students written assignment.

Area (D) "Professional competence"

(Effective behaviours)

	Statement of the categories
1	Demonstrate and teach technical skills in nursing activities were required, shows, shows and explains, give rational.
2	Make students aware of their professional responsibilities in the clinical setting.
3	Give the students the freedom to do it on their own, help them to be independent learner.
4	Shows genuine interest in patients and their care i.e. act as a role model in this aspect.

Area (D') "Professional competence"

(ineffective behaviours)

	Statement of the categories
1	Do not answer students' questions, instead make the question as an assignment to them.
2	Gives incorrect information, gives unclear clues.
3	Gives needless or wrong direction, question and explanation to the students while they are engaged in performing tasks.
4	Interrupt students while they are doing nursing procedure to their patients.
5	Question students at an inappropriate time.
6	Lack experience in performing many nursing skills.
7	Concentrate in theory more than practice in their discussion with the students.
8	Misses teachable moments.
9	Non verbal expression of agitation and frustration with any performance of procedure or explanation of medication.
10	Do not help student to be independent learner i.e. supervise student too closely.

Area (E) "Motivator (Encourager)"

(Effective behaviours)

	Statement of the categories
1	Orientate the students to the clinical setting and to the objectives of the clinical rotations.
2	Create a relaxed atmosphere making learning enjoyable.
3	Available to work with students as situation arises i.e. takes immediate and appropriate action in case of emergency.
4	Praise students, expressing confidence on them.
5	Act as an advocate to students.
6	Support students learning (Act as a facilitator).
7	Is tolerant to students' mistakes.
8	Shows understanding and recognition of the individuality of the students.

Area (E') "Discourager (Inhibitor)"

(Ineffective behaviours)

	Statement of the categories
1	Is not familiar with the clinical setting; -Do not make orientation to the students at the beginning of the course. -Do not orientate the hospital staff to the role of the students.
2	Not available most of the time.
3	Unable to handle difficult situation.
4	Do not consider that sometimes students might be exposed to certain clinical experiences before having any theoretical background especially at the beginning of the semester.
5	Restrict the students in one room with one patient all the day in the clinical setting.
6	Concentrate on students appearance.
7	Do not have professional appearance.
8	Do not consider students' feeling when exposed to new situation.
9	Do not consider individual learning needs.
10	Do not consider individual limited abilities.
11	Give contradictory information to the students in writing-nursing care plan.

❼.3.3 *Description of the classified incidents*

The purpose of this section is to describe the content of each part of the classification system and the numbers of incidents in each, effective or ineffective. To aid description of the content of the classification system abstracts of selected incidents will be presented taken into consideration to retain as much of the original context and flavour as possible, (Jacobson, 1973).

Four incidents from each category are submitted to the three judges who selected two that are considered to best reflect that category. The presentation of data will commence with the title of the area and its definition; followed by the statement of the category and then followed by a two statements of the incidents and finally a brief comment will be made on the content of the area and the categories as well.

Area (A) "INTERPERSONAL RELATIONSHIP"

General description of the area:

The teacher respects student opinions, is tactful and sympathetic, improves student's standing in eyes of the patients. The teacher is flexible and confident in student abilities. The teacher does not violate student confidentiality, consider religious beliefs and other values, which include the difficulties in Jordan of nursing patients of the opposite sex. The teacher does not humiliate or belittle the student, or make him or her feel undignified.

"A description of the effective behaviours as supplied by students"

Area (A) Category (1)

"Teacher respects student, opinion and is tolerant to students disagreement.".

Abstract (1)

Student said:

"While the clinical teacher was discussing with us about the medication of one patient she made a mistake, Immediately I interrupt her and told her about the mistakes made by her, She accepted that and she thanked me.".

Abstract (2)

Student said:

"While the teacher was trying to fix the patients dressing on his knee, by using a plaster, I suggested to her to use the crip bandage. She was very happy with me and said: 'you are an excellent student'.".

Area (A) Category (2)

"Tactful in dealing with students in front of patients.".

Abstract (1)

Female student said:

"During my rotation on psychiatric nursing one day I came to the hospital while my hair was spread up on my back and my shoulder, and while I was talking to my patient, the clinical teacher came and saw me immediately he apologise from the patient that he wants me just for 5 minutes, then

privately he asked me to tie my hair. I will never forget that teacher's attitude with me; although my patient was mentally sick but my teacher was very concern to be tactful with me in front of him.".

Abstract (2)

Student said:

"While I was doing dressing for my patient my teacher told the patient that we as students have intensive training in the school and tried to be very gentle with me, he helped into positioning the patient to help me in doing suctioning to the patient and also he said to me: take care don't spoil your gown and continued in like manner".

Area (A) Category (3)

"Shows concern and sympathy for the students problems".

Abstract (1)

Student said:

"While I was working with my patient, suddenly I fainted. Immediately my teacher took me to emergency and stayed with me tell I became o.k. Then she told me: 'you can go home now and do not worry about tomorrow. If you do not feeling well don't come in'.".

Abstract (2)

Student said:

"I came one day to the clinical and I had a family problem. I had divorced my fiancee, I was very upset and I was having exam in the clinical. I

explained my situation to my teacher. Immediately she took me to a private place and brought me tea and helped me to release my stress and at the end she told me: 'you can go home, you can repeat the exam any day you want, just now go'.".

Area (A) Category (4)

"Improve students standing in eyes of patients and his family".

Abstract (1)

Student said:

"When I was in the maternity child health centre and it was my turn to give a baby a vaccine, the mother of the baby refused and said: 'she is a student and she is still learning and I don't think she can give my baby the injection safely'. My teacher replied: 'This student is better than me and she is excellent you will see'. I gave the baby the injection in the appropriate way, although it was the first time for me to do it. Since that time I like to give the injection to any patient.".

Abstract (2)

Student said:

"My teacher was with me when I was giving Nasogastic tube feeding to my patient, while I was doing that she kept saying to the patient: 'as you can see how much our student is skilful in feeding you, see she did not let the air come to your stomach. She let the food coming in by gravity not by pushing it..see..see..', and at the end she thanked me in front of him and said you are excellent.".

Area (A) Category (5)

"Is flexible when the occasion calls for that"

Abstract (1)

Student said:

"In the surgical unit while we were doing nursing round with the clinical teacher, we saw a doctor who was doing c.v.p. line to a patient, immediately our teacher stop the nursing round and told us: 'let us see the procedure and then we will combine'."

Abstract (2)

Student said:

"During my surgical rotation my patient was a complicated case and I was busy with doing nursing care with her all the day, I was very worried about the nursing care plan which I must write for my teacher. When my teacher came and so me very busy with the patient, she said: 'do not worry about the nursing care plan, no need to write it today'".

Area (A) Category (6)

"Shows confidence in students' abilities, help him to be independent learner".

Abstract (1)

Student said:

"During my rotation in surgical nursing I had a patient with colostomy, and she was in need for colostomy care, my clinical teacher told me: 'you have to try to do the colostomy care for your patient', and she explain to me

the steps and she said: 'do not worry, I am sure you can do it. It is very easy procedure, I will be with you if you need any thing. I will help but please try to do it as much as you can by yourself'. I did it in a very good way with very little help from my teacher, and I did not expect from myself that I can do it.".

Abstract (2)

Student said:

"It was the first day of clinical for me in Emergency room, and one mass accident came at the time of my arrival. One of the doctor there shouted me and said: 'Please run and put I.V. canula to the patient'. I was in a state of panic and scared not knowing how I can do this. My teacher saw the doctor and said: 'yes run as he told you and get it', and then I was encouraged and I searched about things and I found it. My teacher said: 'see why you thought that you could not cope. Here in Emergency you must depend in yourself and do not worry. If you need any thing you can ask nurses, doctors or me if I am here and here it is your opportunity to learn many nursing procedures'.".

Area (A') "INTERPERSONAL RELATIONSHIP"

"A description of the ineffective behaviours as supplied by the students"

Area (A') Category (1)

"Do not respect the confidentiality of student relationship":

- Teachers themselves form impression about students before knowing them.
- Talk about students performance in front of their colleagues.

Abstract (1)

Student said:

"It was my first day in my surgical nursing rotation. The clinical teacher was just trying to know each student. When she read my name she immediately said: 'oh you are (x) student Take care I have full history about you Be cautious, you are the one who did so and so with (y) teacher'. I can't describe how much her words with me affected me, and I wished that I did not study nursing.".

Abstract (2)

- Teachers tells about the poor performance of the student in front of his colleagues.

Student said:

"During my paediatric rotation I failed to prepare the medication in an appropriate way for my patient, the clinical teacher who was giving us a theory part of paediatric course, explained in detail about my weak performance in front of all the students, I felt very sorry that my teacher did not respect my confidentiality. I think it is a private matter and she doesn't have the right to tell others about me.".

Area (A') Category (2)

"Do not take into consideration religious beliefs or understand values of students"

Abstract (1)

Female student said:

"I am a Muslim student and dress in a Muslim uniform; all my body covered and my face except my eyes (Hijab). During my first day in my

surgical nursing rotation, the teacher started criticising my (Hijab) and She said: 'the patient will be paniced when they see you and I don't think that you can practice nursing easily and I don't believe in your dress'. One of the students who was male said to the teacher: 'it is acceptable that you don't believe in her dress, but you must respect our religious values and believes and not to forget that we are living in a Muslim society and not in a European one'.".

Abstract (2)

Male student said:

"During my clinical rotation in paediatric nursing, the clinical teacher put me in a room where there was 6 babies with their mothers, and assigned one patient for me to do complete nursing care to him. I was told that I must stay all the shift inside the room and not allowed to move even to stand beside the door. After some time the mother wanted to breast feed her baby, she felt embarrassed by my presence. Consequently I left the room and waited outside until the mother had finished. Suddenly my teacher came and saw me and she started shouting at me why I left the room. I explained to her why I did that and it is our traditional values which make the mother and me embarrassed to be beside each other while she is lactating her baby. She replied: 'your traditional values is something related to you personally but here you are a student, and it is not the place to consider your values, medicine is medicine and nursing is nursing'.".

Area (A') Category (3)

"do not deal with female and male students in the same pattern; male teacher with female students or female teacher with male students".

Abstract (1)

Male student said:

"During my surgical rotation I was placed with a female student and our teacher was male. I do not remember he gave me any attention or try even to see what I was doing. One of the doctors came and ask me to prepare for my patient heparin. I went and searched about my teacher. I found him with the female student. I told him that I need his help to prepare for the patient. He said: 'you can go and tell the staff nurse to help you, I am sorry I am busy with your colleague'.".

Abstract (2)

Female student said:

"During our training in the lab, I was demonstrating in a model how to give a bath to a baby. My teacher said to me: 'this is junk..This is rubbish, I don't expect that you will be a good nurse in the hospital'. I finished the procedure and my eyes was fill with tears, and after that it was the turn of one male student, and every body observed how her tone change and she started encouraging him and help him tell the end without saying any bad word to him.".

Area (A') Category (4)

"Do not help student to be honest while engaging in writing nursing care plan for his patient".

Abstract (1)

Student said:

"I feel very sorry that my teacher encouraged me to deceive her. While I was giving my patient a bath much later than usual, my teacher came and asked me: 'did you write your nursing care plan.?'. I told her: 'not yet', she said: 'you will lose a lot if you did not finish it before the end of the day, this is the most important thing to do'. Consequently I finished with my patient very quickly and I opened the nursing text and I wrote many things from it which I did not do it really for my patient, and I submitted to my teacher before the end of the shift. When she saw it she said: 'oh that is great. This is the most important thing I wanted you to do it'."

Abstract (2)

Student said:

"During my rotation in surgical nursing one time I was allocated a patient from the previous day and in order not to make myself worry all the day I came to work at 6 a.m. before my duty started and I prepared a complete nursing care plan for my patient and it was an ideal one, I used three text books, and of course I made my teacher feel as if I did every thing for my patient, and then I continued all the day very relax and of course I did not do to my patient what I wrote. When my teacher saw the nursing care plan she made all the post conference about it and that I am an ideal student who can do every thing to her patient and at the same time document it in a perfect way".

Area (A') Category (5)

"Interfere in students personal matters"

Abstract (1)

Student said:

"One day I came to my daily training and I had my hair in a special design, but looked professional. My teacher said: 'this is not nice, do it another way'. I told her: 'sorry, am I doing it against the rules?'. She said: 'not at all but me personally I do not like the hair to be done this way'."

Abstract (2)

Student said:

"One day my clinical teacher saw me walking with one of my colleagues she called me and said: 'I don't like that student, she is silly. Do not walk with her.'"

Area (A') Category (6)

"Humiliate student"

Abstract (1)

Student said:

"One day a doctor in the unit ask us a question and he was very happy with our responses. When the teacher came, he told her: 'you have a very clever students', She replied: 'really, they know some thing?, strange, unbelievable!'."

Abstract (2)

Student said:

"My teacher was telling the other teacher who came to visit her, that I am a wonderful student who work very hard. The other teacher said: 'oh he was very weak last semester'."

Area (A') Category (7)

"Do not build up a trust relationship with the students"

Abstract (1)

Student said:

"One day during my clinical rotation in medical nursing. I was not feeling well at all I had severe colic with diarrhoea. I came to the hospital before my clinical day started and I went to ER. I had an injection there and the doctor gave me sick leave for one day, then I went to my teacher and I explained to her about my condition and I gave her the sick leave. She replied: 'if I were you every day I could go to ER and bring a sick note and be absent from clinical in an official way'. At that time I felt as if my teacher thought that I am telling a lie and that I was not really sick.".

Abstract (2)

Student said:

"One day I came at 7:20 a.m., five minutes later than the usual time i.e. 7:15. My teacher came to the changing room and she asked me: 'what time you came to the floor?', I said: '7:20 a.m.', Immediately she replied: 'you are a Muslim girl and you are telling lies? don't you feel embarrassed to tell lies?. This is the last time I will accept you. Next time I will send you home'. This

conversation was before my clinical day started. This episode made me very upset during the whole day.".

Area (A') Category (8)

"Do not respect student opinion and is not tolerant to his disagreement".

Abstract (1)

Student said:

"During my clinical rotation in paediatric nursing, the teacher asked me to prepare a solution with certain electrolyte for my patient; (if the solution is not available it is prepared by nurses in the floor). I calculated the amounts required and came up with the right concentration for the electrolyte. When I explained my way to the teacher she reacted aggressively and she criticized my method strongly and she insisted that I use hers. Furthermore she did not stop there but she went and gathered together my colleagues and was sarcastic about me in front of them and she tried to prove the accuracy of her method and how it is better than mine but she did not succeed in doing that. Then she asked to explain to them my method, and when I did that she noticed that my method is more convenient than hers, but she did not say any thing just she told the students to go back to their work.".

Abstract (2)

Student said:

"At the time of my clinical exam in surgical nursing the teacher asked me a question and I answered, She said: 'it is wrong', but I was sure that my answer was right. Then next day I brought for her three texts to show her that

my response was right. At the beginning she refused strongly to look to the text, but I insisted strongly that she look at it. She realised that she was wrong but did not acknowledge that and did not comment at all. What was funny in that situation that my friend advised me to answer her wrongly in a forthcoming examination in order to guarantee high evaluation and not to let her know that she was mistaken.".

Area (A') Category (9)

"Do not show respect for student in front of the patient and other health team members".

Abstract (1)

Student said:

"While I was doing bed making my teacher came and saw me and immediately she shouted: 'is this the way we taught you in the lab?. This is rubbish.', and then she left. After that I went to take the blood pressure of the patient, she said to me: 'if your teacher is not confident in your work for the bed making how do you expect me to have confidence in your measurement of my blood pressure, I am sorry I don't want you to take it for me'."

Abstract (2)

Student said:

"While I was regulating the intravenous drops for my patient my teacher shouted: 'this is wrong, your calculation is not right you must do...and do...are you really a nursing student?'. I could not believe it. I was surprised that she told me all these words in front of six patients in the room and three nurses. Then she took me out and continued in the same manner. At that time I hate the moment when I thought to study nursing, to see such a teacher.".

Area (A') Category (10)

"Is not flexible when the occasion call for that"

Abstract (1)

Student said:

"While I was assissing the doctor to do physical examination of my patient, suddenly the patient went in cardiac arrest. Of course I stayed with my patient and helped the blue team in doing the ressustation for the patient. At that time, the post conference had started immediately. After I finished I went to attend the post conference and I apologise from my teacher for my delay. She shocked me when she replied: 'Even if your patient is dying you must leave her and come the post conference. This is the last time I will accept your delay'.".

Abstract (2)

Student said:

"While I was preparing my patient for an operation, I offered psychological support for her as she was very depressed and crying badly. She asked me to take her to the theatre. I told her o.k., but let me tell my teacher. I went and told the teacher but unfortunately she refused to let me go with my patient and she said your care is only while the patient is inside the floor and it is the duty of the porter to take her. My patient was very angry and I was angry too, because my teacher did not consider the importance of psychological support to a pre operation patient.".

Area (A') **Category (11)**

"Make student feel worthless who knows little but never encourage to be competent".

Abstract (1)

Student said:

"During my clinical practice in medical nursing I took the blood pressure of my patient. My teacher was observing me. After I finished she called another student and asked her to take the blood pressure for the patient again and she said: 'I am not sure that you took the blood pressure correctly'. Fortunately when the other student measured it was the same like my measurement. I felt very sorry that my teacher did not have confidence in my abilities.".

Abstract (2)

Student said:

"During my paediatric rotation I had a clinical teacher who was very interested to let me believe that I know very little. One day my patient had diarrhoea, she asked me about the consistency and frequency of his motion. I told her exactly as I noticed my patient then the teacher asked me about the content of his motion. At that time I realised that my teacher really wanted to say that I do not have enough knowledge.".

Area (A') Category (12)

"Belittling students"

Abstract (1)

Student said:

"One day I came to my clinical day while my nails was not cut. When my teacher saw it she shouted and said: 'come here'. In front of the doctors and the patients she cut my nails.".

Abstract (2)

Student said:

"One day I came to the hospital and my hair was not tiding up in a good way. In front of the doctors and the patient my teacher brought a rubber band and said in an ordered: 'come here', and then she bound my hair with the rubber band, and after that she wagged her finger and said: 'next time I want to see your hair that way! O.K..? Go now!'.".

Area (A') Category (13)

"Being judgmental"

Abstract (1)

Student said:

"One day while I was interviewing a psychiatric patient I asked her a question: 'are you married?'. The patient refused to answer this question. Thus I told her: 'it is up to you'. Immediately my teacher looked at me and said: 'it seems

to me that you have personal psychological problem and you try to reflect it in your question to your patient because your personality is not allowing you to be frank with yourself'. Then I asked myself in which kind of teaching is the teacher allowed to analyse the student's personality and to be judgmental.".

Abstract (2)

Student said:

"I was very shocked when my teacher said to me after I finished doing dressing for appendectomy patient: 'you are unsafe in psychomotor skills'.".

Area (A') Category (14)

"Being sarcastic"

Abstract (1)

Student said:

"While I was submitting a clinical exam, my teacher commented on my response in front of the patient in a very sarcasting way. She said: 'oh really. you are the biggest scientist in the world. From which bible you found this information' and so on. When the teacher left me the patient said to me: 'you are very poor student, it seems to me all your study and degree did not deserve to put you in such this situation'.".

Abstract (2)

Student said:

"While I was presenting a seminar some times I can't speak every word in English. After I said something in Arabic, my teacher said: 'do not forget that I can speak Arabic but I can't understand Arabic'.".

Area (A') Category (15)

"Do not consider human dignity while engaging in a professional practice".

Abstract (1)

Student said:

"During our clinical rotation I never felt that I am an adult learner and nor my dignity is respected. For example, on the first day for us in the clinical setting, the clinical teacher put us in a room there and stood beside the door and said: 'I don't want to hear any voice, I don't want any one to move from his place, I don't want .... I don't want ....'. I felt as if I am a kid in a nursery school though I am older than this clinical teacher."

Abstract (2)

Student said:

"One day in the morning before our clinical day started the clinical teacher asked the staff nurses in each section in the floor: 'How many students do you need?' One said: 'two', other said: 'one', other said: 'three',.... In this case we felt as if we are just followers or helpers who came to help nurses without any consideration for our learning needs or regard for our dignity.".

Area (B) "SUMMATIVE EVALUATION"

General description of the area:

The teacher fails to evaluate using clear criteria, evaluates on theory rather than practice, evaluates without having feedback problems when they occurred, does not give individual feedback, seeks out mistakes, uses evaluation as a threat to control students and evaluates in a discriminatory way.

"A description of an ineffective behaviour as supplied by students".

Area (B) Category (1)

"Teachers do not evaluate the students in a clear criteria"

Abstract (1)

Student said:

"I received my evaluation in psychiatric nursing for two days and it was 6.5/10 and 8.3/10. I asked my teacher: 'in what criteria you establish your evaluation and what exactly I did when I had 6.5/10, and when I had 8.3/10'. She replied: 'Do not talk too much, I am your teacher and I can evaluate student sometimes only from one look'.".

Abstract (2)

Student said:

"I received my evaluation in maternity nursing and it was not expected at all, 5.5/10. I went immediately to my teacher and asked her, how she judged me. The only reply I got was: 'I am looking to your performance as a whole and not in pieces'.".

Area (B) Category (2)

"Evaluate the student mainly on nursing and medical theory more than practice"

Abstract (1)

Student said:

"I was very surprised at the time of my clinical examination in medical nursing, there were three clinical instructors. The first one asked me to identify the area of the blockage in the heart as the ECG strip showed it, while the other teacher asked me: 'did you ask how the doctors differentiate patients diagnosis when they considering whether it is acute penceriatitis or acute myocardiac infarction', and I answered both of them: 'I am not training to be a doctor, Do you think I must know all these things. is it my business?'."

Abstract (2)

Student said:

"When I had my clinical examination in clinical paediatric nursing, my teacher brought the patient file and started asking me about the ABG, blood gases values, about the findings from the blood film. I told her: 'when you gave me the objectives of this course, you mention the student should know the stages of growth and development of the baby but you did not mention about his ABG'.".

Area (B) Category (3)

"Teachers do not evaluate the student at appropriate points during the course".

Abstract (1)

Student said:

"Usually the teacher visits us to check our performance. Sometimes she comes to see us after we finished certain task, and we might be not working on any thing at that time. Then the teacher evaluates us very poorly. Vice versa the teacher might see me accidentally while I have been just started doing some thing although for the previous one hour I was doing nothing and she gives me a very high evaluation."

Abstract (2)

Student said:

"After spending a half an hour carrying out nursing care for my patient my teacher came and start asking me: 'did you do dressing?, did you give the patient bath?, did you check her file?'. I told her: 'sorry my teacher I have been with the patient only half an hour. How you want me to do all of this'."

Area (B) Category (4)

"Teachers do not discuss their evaluation to student with the student individually".

Abstract (1)

Student said:

"When I received my evaluation in clinical practice in paediatric, I could not imagine how my teacher evaluate me and I went to her and ask her to

reconsider my evaluation or to explain to me how she did it. She replied: 'I do not want to discuss your evaluation with you even if you will bring me the head of the university', and then of course just I left her.".

Abstract (2)

Student said:

"I received my evaluation in maternity practice and it was 14/20, When I asked my teacher, she did not say any thing except: 'that is it, No talk, Bye'.".

Area (B) Category (5)

"Teachers look for students mistakes"

Abstract (1)

Student said:

"One day my teacher was observing me while I was removing the stitches of my appendectomy patient and she kept writing her notes about me and after I finished she told me: 'come here, you made many mistakes', I told her: 'you are here to correct me or at least to tell me about good things I did?', she replied: 'I am here mainly to show you your mistakes and not to tell about good things'."

Abstract (2)

Student said:

"While I was demonstrating on a model in the lab how to do dressing under sterile technique I made a mistake, and the teacher was observing me, and suddenly the teacher shouted: 'this is wrong..this is

wrong..zero...zero..'.I told her: 'ok, put me zero but no need to shout at me'."

Area (B) Category (6)

"Impose threat, using evaluation to threaten the student future".

Abstract (1)

Student said:

"While I was doing health education for my patient who had renal failure, I was very happy with myself because the patient was very interested in talking to me. My teacher was standing and observing me. When I finished she said: 'four marks reduced because you forget to ask the patient what he wants to know about his disease, not just what you want him to know'. I replied: 'but you are here to help me, to correct me, and to draw my attention to my short comings, she said: 'Do not argue, one word more I will reduce your evaluation more, even the evaluation you took you do not deserve it'.".

Abstract (2)

Student said:

"It was the first time for me in my rotation in medical nursing, the teacher was very strict with me. For example she asked me to prepare the Lim medication for my patient and when I started doing that, she shouted: 'Is this what we taught you in the lab to do., miserable. Any way every thing will appear in the evaluation'. She kept reminding me of what will happen to my evaluation. Then I became very upset and when I went to give the patient the injection. As a result of the injection there was a leakage of a drop of blood at

the site of the injection. At that time the patient started shouting: 'my blood, my blood', and I became very scared, and my teacher started shouting at me very loudly in front of the patient, relative, students. Really I will never forget this incident in my life.".

Area (B) Category (7)

"Teachers discriminate between students in their evaluation (not objective)".

Abstract (1)

Student said:

"The clinical teacher assigned a patient for me and my friend to work together with her because it was a serious case. The teacher did not observe us while we were working with the patient, but at the end of the day she came and we told her about every thing were did to our patient. When it comes to evaluation, I was very shocking when she evaluate me 13/20 while my friend was 18/20. I asked the teacher in what basis you evaluated me and my friend, and in what things my friend is better than me?. She answered: 'just like that, and I do not want to argue, sorry', and she left me."

Abstract (2)

Student said:

"The incident started when the teacher was discussing with us about the treatment of one disease and I felt that she was mistaken. I apologised for questioning what she had said and corrected what she said. Although I was working very hard as it is known about me by the staff nurses, I received a very low evaluation at the end, it was 60/100. When I asked my teacher to justify to me her evaluation, she said: 'It is your level and that is all what you deserve'.".

Area (C) "FORMATIVE EVALUATION OR FEEDBACK"

General description of the area:

The teacher provides feedback, not only pointing out mistakes without correction, but explaining during and after procedures. The teacher does not praise falsely but explains why actions are right or wrong and suggests improvements.

"A description of an ineffective behaviour as supplied by students".

Area (C) Category (1)

"No feedback provided from clinical teacher after procedures wither positive or negative".

Abstract (1)

Student said:

"During my training in surgical nursing, my teacher failed to give me feedback: 'you are good in this, you are not safe in this, you must improve your performance in (x) procedure' and so on. However she kept all of this for herself, till I received my poor evaluation. At that time it was too late and time is over to correct myself. She simply showed me my weak points."

Abstract (2)

Student said:

"While I was doing dressing for my patient who had cholestectony, my teacher was standing beside me and observe every thing I did and when I finished, she left me without saying any word, though I am sure I did not do every thing perfect. Then I followed her and I asked her: 'please tell me am I

right, or wrong?'. Unfortunately she did not give me any attention and she left me."

Area (C) Category (2)

"Always pointed out students mistakes without showing them how to correct their mistakes".

Abstract (1)

Student said:

"While I was doing physical assessment for my patient the clinical teacher was observing me, She kept saying most of the time: 'this is wrong, this is wrong'. I told her: 'O.K., how could I do it right, or what is the right way to do iy?'. She said: 'it is not my business, it is your duty to know'. At that time I was very upset because it is not a knowledge to be searched for in rooms, it is the matter of demonstration.".

Abstract (2)

Student said:

"The teacher asked me to prepare a medication; antibiotic, the concentration of it was 50 mg in one ml and the teacher watched me to prepare 0.025 mg for a baby. I tried to do it. Then I told my teacher about what I did. She said: 'it is wrong..wrong..wrong.', and she took it from my hand and she threw it away and left me without telling me any thing."

Area (C) Category (3)

"Gives false feedback".

Abstract (1)

Student said:

"I had a complete course in medical nursing with the clinical teacher with me, rarely showing up through the day. If he saw me do any thing, 'oh this is excellent, this is fantastic'. Even if I am only carrying a syringe in my hand or standing beside the patient doing nothing, 'I admire you I think you will be the first in your class'. All these reassurance was just for nothing, no teaching, no learning and the outcome was very high evaluation for every body. We felt very sorry because we were cheated in two ways. First for having excellent evaluation which we did not deserve and second because we accepted that and did not complain about the teacher.".

Abstract (2)

Student said:

"While I was in maternity rotation, my teacher was either appraising me or just keep silent. She never said to me you did some thing wrong. When it comes to evaluation it was 55/100. I was very upset, how did it come without any warning or any feedback about my performance?"

Area (C) Category (4)

"No feedback provided from the teacher on student written assignment".

Abstract (1)

Student said:

"During my rotation in paediatric nursing my clinical teacher told me when she gave me the nursing care plan to write it: 'I am like you, this is the first time for me to see such this assignment, so try to write it in your own way'. I told her: 'so how you will correct it for me at the end and put a mark for me'. She said: 'By that time solution might come'."

Abstract (2)

Student said:

"While I was in surgical nursing rotation, three times I gave my teacher a written nursing care plan for my patient, She gave it back to me too late and with moderate to low evaluation without any clear written corrections on them.".

Area (C') "FORMATIVE EVALUATION"

"An effective behaviour supplied by students"

"Teachers provide helpful and timely feedback during and after performance of the procedure by the student".

Area (C') sub category (A)

"Teachers explain why response/action is right"

Abstract (1)

Student said:

"It was my first time when I gave my patient an I.M. injection. My teacher was very happy from me and said: 'this is very good', and then he took me out and told me: 'you know why I told you very good', I said 'no', he said 'because first you explain to the patient what you are going to do, second because you...third because... and keep on, well done!'.".

Abstract (2)

Student said:

"While I was in the Emergency room rotation, one patient was admitted who had a car accident, immediately I put the patient in bed and I took her vital signs. Then the patient started to vomit. Immediately I put up the side rails and I gave her kidney dish to vomit in it and then I prepare Valium. My teacher observed me till after the patient condition stabilised. She told me: 'I admire your work. You behaved very quickly but quietly and before you left the patient you put the side rails which mean that you anticipated that she might fall. What is more you prepare the Valium which means that you anticipate that the patient might have a fit after a while because she started to vomit. I really expect that you will be an excellent nurse in the future'.".

Area (C') Sub category (B)

"Explain why response/action is wrong".

Abstract (1)

Student said:

"While I was assisting the nurse in patient's delivery and usually the routine is to give the patient anticoagulant injection and immediately I prepared it and I gave it to the patient. I was very happy and I told my teacher about what I did. My teacher put her hand on my shoulder and explained to me that I was mistaken when I gave the patient the injection because the patient had varicose veins and it is contra indicated in this case. I will never forget this incident. Although I made a big mistake, my teacher drew my attention to my mistake in a very polite way.".

Abstract (2)

Student said:

"It was the first time for me to interview a psychiatric patient who has schizophrenia. I started asking him about his name, age, occupation and about his address. When it comes to question him about the address, he became very angry and then he became withdrawn. My teacher was beside me, he told me: 'you have to take care in that you cannot immediately ask a schizophrenic patient about his address before establishing a rapport with him because he might became suspicious of you'. It was very educational experience to me.".

Area (C') Sub category (C)

"Identify area of improvement".

Abstract (1)

Student said:

"While I was doing a dressing for a baby who had burns in his thigh. the teacher was observing me. After I finished, she told me: 'you did very well, but in this case it might be more helpful if you used two layers of fusidine gauze because the patient is very active, but don't forget that you did very well'.".

Abstract (2)

Student said:

"While I was talking to a mentally sick patient, suddenly he started to leave. Immediately I asked: 'where are you going?'. My teacher who was beside, told me: 'see, you are very good in communicating with this patient but take care when he left you. It is better if you told him: when you will be back, instead where are you going'."

Area (D) "PROFESSIONAL COMPETENCE"

General desrciption of the area

The teacher can and will demonstrate skills and activities and can explain them correctly, but also allows the student to try things out. The teacher makes the student aware of professional responsibilities and serves as a role model in caring for patients. The teacher does not conceal ignorance by setting student questions as assignments and gives correct information at appropriate times. The teacher does not interrupt or questions student in appropriately and does not just focus on theory. The teacher uses opportunities to teach nursing methods as they arise. The teacher gets and does not show imitation or impatience.

"A description of the effective behaviours as supplied by students".

Area (D) Category (1)

"Demonstrate and teach technical skills in nursing activity were required, shows, shows and explain, give rational".

Abstract (1)

Student said:

"While I was in medical nursing rotation my teacher assigned for me an unconscious patient who had a cerebrovascular accident. My patient was in bad need for intensive nursing care; continuous suctioning, bathing, feeding, ...etc. My teacher assessed me in doing every thing to the patient and told me in detail about the rational of each step and how to do it. For example, although the patient was unconscious she talked to her and told her about what we want to do for her and why and she told me: 'I am talking to an

unconscious patient, although the patient cannot reply but she may hear every thing and so on'. Actually I was happy, I learned a lot from this teacher."

Abstract (2)

Student said:

"In a surgical unit there was a Gastrojejonostomy patient when the teacher saw the patient he gathered all the students in the floor and he started telling us about the condition, the RX, the diagnosis and then exchanged questions and information with him. After that he demonstrate the complete care of the patient's wound and he told us why he put this solution, not that, and why he positioned the patient this way not that way, and so on. It was a very educational experience to all of us because he made us feel free to ask any questions."

Area (D) Category (2)

"Make student aware of his professional responsibility in the different area in the clinical setting".

Abstract (1)

Student said:

"It was the first day for me in medical nursing and my patient died. I was very shocked and I started crying. My teacher took me away and then after the patient was sent to the mortuary, he sat with me and explained to me about the nature of the cases in this unit, that most of them are terminally sick and... and .....and after that he explains to me about the role of nursing in such these cases and how the student nurse should behave. For example she

has to try to be empathetic not sympathetic and to give full nursing care to these patients as if they have very good prognosis and so on . It was very educational experience to me.".

Abstract (2)

Student said:

"It was the first day for me in Emergency and that day it was very crowded and busy. At the end of the shift, the clinical teacher sat with me and talked to me about Emergency nursing; that in this unit the primary role of nursing is saving life, and avoid further complication or deterioration of injured patient and not concerned with rehabilitation or secondary management and so on."

Area (D) Category (3)

"Give the students the freedom to try to do it on their own, help them to be independent learner"

Abstract (1)

Student said:

"During my rotation in neurosurgical unit I had a brain tumour patient who was unconscious. My teacher helped in preparing every thing to give the patient total care, and then she explained to me beside the patient all the steps she wants me to do to my patient in order to achieve a total care of him and then she said: 'I want you to depend in yourself to do things and if you need me you can ask, I will come and help you'."

Abstract (2)

Student said:

"My teacher wanted to teach me how to remove stitches from a patient, he said: 'I know it is the first time to you to do it but if you do not mind I want you to try by yourself and I am ready to help, just you try', and really although it was the first time but I did it."

Area (D) Category (4)

"Shows genuine interest in patient and their care (acts as a role model)".

Abstract (1)

Student said:

"One day there was an elderly obese female patient who had total hip replacement and the patient defecated on herself and the unit became very smelly. All the nurses there left the patient dirty and were very angry with her. When my teacher saw the situation, immediately she told four of us (the students who were there) to bring water and soap and then by herself she started cleaning the patient and we were just helping her and after she finished, she made the bed and she placed the patient in a very comfortable position. Then she called the cleaner to clean the room. Since that incident I became very willing to work with any kind of patient remembering what the attitude of my teacher was and imagining if the patient was my mother or me and the nurses behave like this, what my situation would be. I wish that I could see all the teachers behave like Miss (x).".

Abstract (2)

Student said:

"During my training in surgical nursing, there was a patient who had nephrectomy and she has two drainages in the kidney. My teacher told me: 'I will do to patient (x) what I want you to do for patient (y), just I need you to observe carefully how I do the dressing and how I deal with the drainage and calculate the discharge and so... and.. so... and please while I am doing do not hesitate to ask any questions'. Then he completed these tasks with patient (x) and after he finished, he went with me to patient (y) and let me do every thing to that patient, exactly what he did to the other patient. He guided me, helping me, encouraging me till I finish. Then he thanks me in front of the patient and said: 'you did an excellent job'. After that he took me away and give me very constructive feedback about each step I did. That was an unforgettable situation to me.".

Area (D') "PROFESSIONAL COMPETENCE"

"A description of an ineffective behaviour as supplied by student".

Area (D') Category (1)

"Do not answer students question, instead make the question as an assignment to them".

Abstract (1)

Student said:

"One day a mother of a cleft palete baby asked me to describe to her the difference between her baby and other normal baby. I ran to ask my teacher to help me, she said: 'why you don't know how to answer her?. This is an

assignment for you and tomorrow I will ask you about it'. 'But the baby is going to be discharged today and the mother wants to know this before leaving'. She told: 'O.K. tell her you do not know'".

Abstract (2)

Student said:

"One day a doctor was dressing an inflamed wound and he used brown sugar and put it on the wound. He asked me: 'do you know why I used brown sugar'. I said 'no'. Accidentally my teacher came there. Immediately I asked her what he asked me. She said: 'as you do not know this is an assignment to you'. When the doctor heard this, he said to her: 'no need if this is the case with you I will tell this poor student that I used the brown sugar to...so and so....'."

Area (D') Category (2)

"Teachers gives incorrect information, give unclear clues"

Abstract (1)

Student said:

"During my clinical rotation in medical nursing I asked my teacher about the complication of the disease of my patient, she told me many things. When I went home I opened the text, I found all that she said was not correct. I told myself it might happen to any body. Then the doctor asked me next day to prepare for my patient heparin in special concentration and to put it in a continuous process in heparin machine, I asked my teacher to help me but unfortunately she was at all not able to prepare the medicine and to put it in the pumping machine. At that time, I lost my confidence in that teacher, and I put in my mind not to ask her about anything."

Abstract (2)

Student said:

"During my rotation in surgical nursing the clinical teacher looked tense. In order to break the wall between me and him, I tried to find any thing to talk to him about. I told him about an operation which is done in the brain (craniosynectectomy), I asked him: 'what is this operation?'. Immediately he said: 'oh this is an operation which is usually done in the testicles if it has certain kind of abnormality'.".

Area (D') Category (3)

"Gives needless or wrong direction, question and explanation to the students while they are engaged in performing tasks".

Abstract (1)

Student said:

"After I inserted the I.V. canula for my patient I started cleaning a way the disposable material. I was carrying in my hand the needle of the canula, then the teacher shouted: 'what you are going to do with this canula?'. I said: 'I am going to cover it then I will put it in the rubbish'. He told: 'yes, why you have to cover it before throwing it. Tell the students (there was three students and one nurse and the ward clerk in the room)'. Then I look to him and felt sorry for his question, and I told him, just I would like to tell you that I am not a stupid student."

Abstract (2)

Student said:

"I had a patient with myocardial infarction and he was just in his first day of this attack. My teacher came to me and asked me to do physical assessment of his eyes and ears.".

Area (D') Category (4)

"Interrupt student while he/she is doing nursing procedure to the patients".

Abstract (1)

Student said:

"In community nursing, while I was giving my diabetic patient health education about his disease and how to take care of his eyes, food,... and so on. I was very annoyed by my teacher who kept interrupting me and repeating to the patient what I told him or telling him about things which I was about to tell him, She kept the patient looking to her and left me not knowing what to do."

Abstract (2)

Student said:

"While I was doing dressing to my patient my teacher would every now and then stop me and say about things which I was about to do by myself and does not need her to interfere. For example: when I wrapped the patient with antiseptic gauze, then she said: 'now throw out this dirty gauze, then use another one, put it here in the solution, and..and... and so on'.".

Area (D') Category (5)

"Question student at an inappropriate time"

Abstract (1)

Student said:

"After I finished doing dressing on my patient, my teacher was observing me, and in front of the patient and his relative she started giving me a very good lesson about my performance. Although the dressing was so

simple and I did not make any fatal or major mistakes but in front of the others she showed them how much her guidance and questions to me is very important. At that time, I hoped that my teacher would have delayed her instruction till after we left the patient and had told me privately about my mistakes."

Abstract (2)

Student said:

"After 40 minutes only from taking over about my patient, my teacher came and started asking me about the patient's history, RX, Dr order, ... and so on. I told her: 'I have just finish bed making and bed bathing for my patient. May I have another hour to know what you want me to know'. She came with the result that I am not at the level of a 3rd year student.".

Area (D') Category (6)

"Teachers lack experience in performing many nursing skills"

Abstract (1)

Student said:

"I was very surprised when my teacher was just telling me to follow the nurses while they are doing procedure to the patients, even my patient. The procedure was just to change the chest drain bottle and I wanted to do it. My teacher said: 'No, let the nurses do it'. I told her: 'why don't you do it for me. Let me learn', she said:'sorry, I don't know'.".

Abstract (2)

Student said:

"One doctor asked me to measure the c.v.p. line to a patient. It was the first time for me, so I went and asked my teacher. She said: 'sorry, I don't know'.".

Area (D') Category (7)

"Teachers concentrate on theory more than practice in their discussion with the students"

Abstract (1)

Student said:

"While I was in paediatric nursing rotation, I felt that the clinical teacher gave the classroom lectures beside the patients bed. For example the teacher gathered us beside a patient who had intestinal obstruction, and started to talk to us about the signs and symptoms, pathophysiology of the G.I. Tract and the treatment. At that time one nurse came to change the colostomy bag to the patient. The teacher continued talking to us about the case, while the nurse herself did the colostomy care of the patient.".

Abstract (2)

Student said:

"One day during my medical rotation, our teacher came beside a diabetic patient and started her lecture to us and the students took notes. At that time I was not writing. She looked to me and said: 'why you are not writing like your colleagues?'. I told her: There is plenty of time to write but here I want to do something practical for my patient'."

Area (D') Category (8)

"Misses teachable moment"

Abstract (1)

Student said:

"While I was in maternity nursing rotation I had the opportunity to learn how to do an ECG to a patient. I was very shocked, when my teacher said: 'this is a maternity course not a medical one. You must learn this procedure in second year of your study not now in your third year.', and really she did not allow me.".

Abstract (2)

Student said:

"While our clinical teacher was discussing with us about a case in surgery, suddenly patient had a cardiac arrest. Immediately the teacher stopped the discussion and told us to leave the room. I asked her to let me see how the patient will be resuscitated. She said: 'it is too early for you to know this now, just as I am telling you..you have to leave, means you have to leave.'.".

Area (D') Category (9)

"Non verbal expression of agitation and frustration with any performance of procedure or explanation of medication"

Abstract (1)

Student said:

"One day during my medical nursing rotation, I was not able to measure the blood pressure of my patient. My teacher was beside me. I told her that I can't take it, then immediately her facial expression changed and she open her eyes and her mouth and put her hand at the site of her waist, and said: 'that is unbelievable, incredible. You are in your 3rd yr and you can't take it.'. I told her: 'you want me to tell you a lie! Yes I can't take it, I can't take it'. Thus she tried to measure it by herself but she failed too. Then she called the doctor who found that the patient is started to have hypovolumic shock. Then the teacher felt embarrassed and she left the room.".

Abstract (2)

Student said:

"I think that doing dressing under sterile technique is the most difficult procedure in nursing. While my clinical teacher was teaching me in the lab how to do it, I made a mistake. She shouted very loudly on me though I was demonstrating on a model. Another teacher was passing by. She heard her when she was shouting. She told her: 'take it easy, slow down with the student.'. She replied: 'this...this student will give me heart failure'.".

Area (D)' Category (10)

"Do not help student to be independent learner, supervise student too closely."

Abstract (1)

Student said:

"It was the first time to me to prepare I.V. medication and I had just read the dose and the instruction. My teacher just took it from my hand and said: 'it seems I cannot depend in you to prepare this medicine and you are so slow'."

Abstract (2)

Student said:

"One time my teacher came and saw me removing stitches from a patient, She shouted: 'why you are doing it without having another nurse with you?. Why you did not wait for me?'. I told her: 'because I know how to remove themand I did it by myself twice'. Then she start looking to the movement of my hands while I removed the stitches as if I was so risky to do it and she was worried about my performance.".

Area (E) "TEACHER ACT AS A MOTIVATOR"

General description of the area

The teacher knows the clinical setting and orients students to it, as well as orienting clinical staff to students and defending students to staff. The teacher does not leave the students, creates a relaxed atmosphere, works completely with students when required, praise students, tolerates mistakes, facilitates learning and is not contradictory. The teacher understands students individually, is sensitive to their knowledge, limitations, their feelings in new stressful situations and individual needs. The teacher does not criticise student appearance excessively and maintains his or her own appearance to professional standards.

"A description of an effective behaviour as supplied by students"

Area (E) Category (1)

"Orientate the student to the clinical setting and to the objective of the clinical rotation"

Abstract (1)

Student said:

"While we were going by bus with our clinical teacher to a psychiatric hospital in our first day of clinical there, she kept orientating us all the way about what we might see there and how the patients might behave i.e. she said: 'you have to expect that psychiatric patient might escape from the hospital, might be cooperative, withdrawal, aggressive and might hit you so try not to turn your back.. and so on'. It was very helpful to us and was very encouraging."

Abstract (2)

Student said:

"At the first day from our rotation in the medical nursing, our clinical teacher gave an orientation to the unit and introduced us to the nurses there, and then after that she said: I would like you to know the following points in the first week and she said the names and then the next week I want you to start doing so and so and in the third week..and so on. Really this was very helpful to us and minimised the reality shock."

Area (E) Category (2)

"Create a relax atmosphere, making learning enjoyable"

Abstract (1)

Student said:

"While I was in my medical nursing rotation, in the unit there was a very aggressive, strict supervisor. When she saw us she started shouting and complaining about overcrowding of the unit and so on. However, our clinical teacher kept quiet till she finished, then she went beside the supervisor and talked to her in a very polite way and showed her how much she and all of us are ready to do any help for that supervisor, for the patient whatever, and really if she still does not need us that we will leave. Then all of us noticed that suddenly the facial? expression and tone of voice of that supervisor changed, and she apologise to the teacher for what she said and she allowed us to act freely in the unit."

Abstract (2)

Student said:

"At the time of my clinical exam the teacher told me: 'are you ready to do the exam. If you are not, I am ready to postpone it'. I said: 'no , I am ready', then he started asking me question as if he is simply talking to me and I did not feel when I started the exam and when I finished.".

Area (E) Category (3)

"Available to work with students as situation arises, takes immediate and appropriate action in case of Emergency"

Abstract (1)

Student said:

"While I was giving a patient in a private room an I.M injection, suddenly the patient shouted. I left the needle inside him and stop giving him the injection. Immediately my teacher came and continued giving him the injection and she removed the needle and reassure the patient. Then she told me: 'do not worry it looks like a fussy patient, but do not forget that next time do not leave the needle inside the patient's body even if he shouted, remove it at least'."

Abstract (2)

Student said:

"While I was trying to pull the placenta of a delivery patient, the umbilical cord broke and the placenta remained inside. Immediately my teacher took over from me and tried all her best with other sister and they helped the patient. Then she came to me and said: 'do not worry sometimes this might happen, but take care'."

Area (E) Category (4)

"Praise student, expressing confidence on him/her"

Abstract (1)

Student said:

"During my clinical rotation in paediatric nursing, one day, I was due to give health education to a mother for a baby who had congestive heart failure. Before I started talking to the mother, my teacher told the mother: 'I would like to tell you about my student, she is an excellent one and you can consider her as a resource person, I trust her that she will give you very useful information in regard to your baby's condition'. My teacher at that time made me a very happy learner and very confident, and very interested to study and work hard to fulfil the impression of my teacher about me."

Abstract (2)

Student said:

"It was the first time for me to put an NIG tube to a patient. My teacher said to me: 'see, you are a very good student and I am sure you can do it, and I want you to do it'. Then when I tried to do it I did it very nicely. She said: 'this is excellent. You are a wonderful student and so on'."

Area (E) Category (5)

"Act as an advocate to student"

Abstract (1)

Student said:

"While I was in medical nursing rotation, one day the supervisor there came and shouted at me and said: 'what are you doing here?, I want you to take the blood pressure for all the patients in the unit'. I went and I reported that supervisor to my teacher. Immediately my teacher went to the supervisor and talked to her in front of all the nurses and said: 'my student here is not only to help you, she is here to learn many other things. i.e. I want my student to learn how to do charting, how to prepare medication ..and so on, and if she has time she might help you'. Really I was happy because I felt my teacher supported me."

Abstract (2)

Student said:

"One day during my rotation in orthopaedic nursing I took the x ray of my patient to a medical student to explain to me about him. However I did not tell the nurses in the floor that the x ray is with me. Suddenly the consultant came to see the x ray and he waited a lot for the x ray and the nurses searched for it but did not find it. When my teacher heard about that she suspected that it is with me. She ran to me and she took it from me and said: 'do not let any body know that it was with you, I don't want them to be angry from you, do not worry I will manage'. She gave the x ray back to them and apologised saying that it is her mistakes because she did not tell the student not to take the x ray without permission."

Area (E) Category (6)

"Support student learning, act as a facilitator"

Abstract (1)

Student said:

"One day we were attending the medical round, the consultant asked me a question to which I didn't know the answer. My teacher, without letting any body see any thing stood behind me and whispered to me the answer to the question. I answered it correctly. The doctor was very happy and became motivated to explain to us about the case and when the consultant left, my teacher was very happy and she said: 'even if you do not know the answer, do not forget that you are still learning'."

Abstract (2)

Student said:

"One day I had a difficult case (heart failure, diabetes and had 2nd degree burn). When my teacher saw the patient, she brought another student to help me and she herself helped both of us till we completed nursing care of the patient".

Area (E) Category (7)

"Is tolerant to student mistakes"

Abstract (1)

Student said:

"One day during my rotation in medical nursing I was just sitting in my patient's room, reading a magazine and eating seeds. My teacher came and saw me, she said: 'excuse me, I need you for a while', and a way from the patient and any body else, she told me in a very polite way: 'I have a very big hope in you that the image of nursing will be much better through the eyes of others, as it will be reflected in your behaviour with your patients and other health team members'. Really that teacher made me feel embarrassed and I promise her that I will never repeat it."

Abstract (2)

Student said:

"During my clinical rotation in medical nursing one of the patient's relatives asked me about the diagnosis and prognosis of a patient, At that time I was very naive and thought that it is one of my role as assume to discuss this with the patient and his relative. Consequently I told that relative about the diagnosis and the case was cancer of the pancreas when the physician heard about that he became very angry and shouted at my teacher: 'why she did not tell me about this issue', but my teacher apologised to him highly. When I saw this I felt very sorry for what I caused for my teacher. However, my teacher was very polite with me and her main concern was just to deal with the situation and not to punish me although I had made the mistake."

Area (E) Category (8)

"Shows understanding and recognition of the individuality of the students"

Abstract (1)

Student said:

"During my clinical rotation in medical floor, my teacher admired my performance and said: 'I am very happy with you and I need to ask you to go to your friend (x) in the second room and to help him to do for his patient the things you did to your patient, without making him feel that I told you to help him'. At that time I felt very happy, that my teacher made me feel I am a recognised one and I went and helped my friend."

Abstract (2)

Student said:

"My clinical teacher was very interested to let me know the name of the enlarged lymphnode of my patient who had lymph adenopathy, and she named those lymphnodes for me twice and she asked me to repeat it but I was not able to do that. Then she wrote them on a paper and gave to me and said: 'When you have time try to look at it'."

Area (E') "TEACHERS ACT DISCOURAGER (INHIBITOR)"

"An ineffective behaviour as supplied by students"

Area (E') Category (1)

- **"Are not familiar with the clinical setting; do not make orientation to the student at the beginning of the course"**

Abstract (1)

Student said:

"It was the first day for us in King Hussain medical centre. Our teacher told us: 'I am like you, I don't know this area before', and then the nurses started asking us to do this, do that, bring this form and etc. At that time we were very shocked. We do not know the area. We do not know what exactly we can or can't do and so on."

Abstract (2)

Student said:

"One day a doctor ask our teacher to prepare for him a lumbar puncture set because he want to do lumper puncture to a patient. She answered: 'sorry I am a clinical teacher and I am not a nurse to know about the things in the floor and my students are also the same'."

- "Do not orientate the hospital staff to the role of the students"

Abstract (1)

Student said:

"While I was under training in a demonstration course, the nurses in the floor kept asking me to do many things which I am not supposed to do in a demonstration course. For example the nurses asking me to send the patient to the theatre, to bring a patient from x ray department and so on. Of course my teacher is not with me most of the time. When she came I told her about that. She said: 'tell the nurses that it is not your duty to do this or that'. I told her: 'why you did not tell them exactly about what I am supposed or supposed not to do'."

Abstract (2)

Student said:

"One day during my clinical rotation in surgical nursing, the supervisor asked me to spend all my day arranging the store, and in order to avoid further complications and because my teacher is not with me I obeyed her. When my teacher came she said: 'this is not your business'. I told her: 'I know it is not my business but the supervisor here does not know that'."

Area (E') Category (2)

"Teachers are not available most of the time"

Abstract (1)

Student said:

"I had a teacher in medical nursing rotation. She used to come to the unit at the beginning of the shift, and then all the day she disappeared and came back only at the time of the seminar."

Abstract (2)

Student said:

"In surgical nursing rotation, I did not used to see my teacher around me most of the time, and one day a doctor asked me to bring to him some thing, and I felt embarrassed him that I don't know what he wanted, I went and kept searching for my teacher to help me but unfortunately I could not find her, and all the day the nurses were using me just to help them to finish their work and not to help me to learn what I want to learn."

Area (E') **Category (3)**

"Unable to handle difficult situations"

Abstract (1)

Student said:

"One day a doctor came to the room where we were standing there with our teacher discussing a case, and he started doing a lumbar puncture on his patient. Immediately we went beside that patient to observe the procedure. He stopped and look to us and said: 'what is the matter! do you think that I have a school for you here..go out..'. Immediately our teacher took us out of the room. It was very frustrating to us to see even our teacher is not able to defend us as learners in the hospital who have the right to observe him.".

Abstract (2)

Student said:

"During my clinical rotation in orthopaedic unit patient came from E.R and mistakenly I put her in a wrong bed. The bed was for another patient. When that patient came and saw my mistake she started shouting at me and talked to me using very bad words, and she was going to hit me. The problem was that my teacher was standing in the room and she did not defend me and just she became scared and left the room."

Area (E') Category (4)

"Do not consider that sometimes at the beginning of the course students might be exposed to certain clinical experiences before having any theoretical background especially at the beginning of the semester"

Abstract (1)

Student said:

"During my clinical rotation in surgical nursing I had a patient who had cholestectomy with pregnancy. My teacher came and asked me whether I did assessment of the fetal heart sound. I told her: 'I did not take maternity care yet, it is still my second year'. She said: 'why you did not ask the nurses about it?', I told her: 'why you did not teach me how to do it?'.".

Abstract (2)

Student said:

"It was the first day for me in the medical unit and I had a patient who perceived peritinial dialysis. My teacher just put me in the room and asked me to do a complete nursing care plan and to give the report to her. I couldn't imagine how could I know to do it for I never heard about it or gave care to similar cases."

Area (E') Category (5)

"Restrict the student in one room with one patient all the day in the clinical setting"

Abstract (1)

Student said:

"It is a common practice to us that each student must be kept in one room with one patient only, and she is responsible about providing care only to that patient. One day the patient was very angry with me because he felt that I restrict his freedom. He shouted: 'where is your teacher?, how care she is keeping you with me all the day; I want to take my rest, I want to undress, I want to eat,...etc. I do not need you all the day. You are not learning any thing and you do nothing for me'."

Abstract (2)

Student said:

"One day my teacher put me in a room where there was nothing interesting for me to do and in the other room there was a cardiac arrest patient. My teacher was not in the floor to ask her permission to go and see the patient there, so I went without permission. Then the teacher came accidentally and saw me and started shouting: 'I told you do not leave your room it means do not leave your room. You want me to search about for you all the day?'."

Area (E') **Category (6)**

"Concentrate on student appearance"

Abstract (1)

Student said:

"One day I came to my clinical day and I was wearing shoes which were not black as they must be in the regulations, and my teacher started shouting and arguing the reasons why the university specify the colour of the gown and shoes and...etc, and I am not supposed to do that. Then I look to my teacher and said: 'I wish if just one time you discussed with me about the nursing care plan for any patient the way you showed your interest in my shoes'."

Abstract (2)

Student said:

"One day I came to duty and I forget my name tag at home. My teacher did not allow me to continue that day and considered me absent. Of course this will be associated with poor evaluation."

Area (E') Category (7)

"Does not have professional appearance"

Abstract (1)

Student said:

"I was really confused when my teacher started talking and talking that the ring on my finger was against the regulations, while she has three rings on her finger plus nail polish and high shoes. Both of us were in the same position of providing care to a patient."

Abstract (2)

Student said:

"One day the teacher criticise me for having my hair in a particular way saying that it should not be that way in the hospital, and although she had her hair in a way as she was going to a party. She took a rubber band and tided my hair."

Area (E') Category (8)

"Do not consider students' feelings when exposed to new situation for the first time"

Abstract (1)

Student said:

"It was the first day for me in the clinical practice in medical nursing. My patient had congestive heart failure. After half an hour from my arrival my patient died. I was very upset. This is the first time for me to see a dead

person and I was near to fainting. My teacher looked at the situation as if she was in the lab with a model, and she started to explain to me about caring for the dead patient. What is more she forced me to wrap the patient for the mortuary. After that I had one month of nightmares and it was very painful experience to me because that was the first time in my life to see a dead body."

Abstract (2)

Student said:

"During my rotation in psychiatric hospital my patient became very aggitated and wanted to hit me. I was very upset and I went to search about for my teacher and I told her about the patient. She shocked me when she said: 'you are mistaken, may be he did this to you because you were not able to communicate properly with him'."

Area (E') Category (9)

"Do not consider individual learning needs"

Abstract (1)

Student said:

"It was the first time of my clinical rotation in surgical nursing, my teacher assigned a patient who had cholecystectomy for me to do complete nursing care plan to her and she told me: 'now I will leave you and I will to come back may be after one hour and I want to see you did every thing for your patient, bed bath, bed making, NIG tube feeding, dressing and ....etc', and she left me alone there. How can she expect me to do every thing to her without any help on the first day. I was really confused and-I didn't know what to do or what not to do, and it was very painful experience to me."

Abstract (2)

Student said:

"It is my fourth year in nursing; I am a senior student, there was an I.M injection for my patient and I went to give it to the patient, then my teacher put her hand above my hand as if I am a baby and told me: 'Just give', I told her: 'sorry I don't want to give it to you. How come I am a senior student and I will be graduated after two weeks and you don't have confidence in me to give I.M. injection?'."

Area (E') **Category (10)**

"Do not consider individual limited abilities"

Abstract (1)

Student said:

"I am a student who is short sighted (Myopia) and sometimes I am not able to see certain objects easily. During my clinical rotation in the paediatric floor, my teacher asked me to draw up an antibiotic medication from the vial and I brought the needle and the syringe and I drew up the medicine. Then I told my teacher it is ready. The teacher looked at it and start laughing loudly and she gathered other students to show them that the vial was empty (actually the medicine was transparent (look like water)) and really was not easy to me to see it. It was very traumatic experience to me not because of my weak vision but because of the attitude of my teacher."

Abstract (2)

Student said:

"I am a female student, and I have one leg shorter than the other (limping). It was my first day in clinical practice, when my teacher saw me, she said: 'why you select to study nursing, no body told you that you are not fit for this profession.'. I replied: 'Could you please assign any job to do it first and then judge me whether I am fit or not fit'. At that moment I cried really because she insulted me in front of my colleagues."

Area (E') **Category (11)**

"Give contradictory information to the students in writing nursing care plan"

Abstract (1)

Student said:

"It was noticed by many students that the interpretation of the nursing care plan is different between the clinical teachers. For example, it happened with me when I was in paediatric rotation, I wrote one nursing care plan for a clinical teacher and I received very good feedback. The rotation finished with that teacher and another teacher came also to a paediatric course. I wrote a nursing care plan according to the same criteria and submitted to her. Her feedback was total different although both N.C.P. were very similar. I had a major correction, she said to me what you wrote in intervention section should be under nursing diagnosis.".

Abstract (2)

One student said:

"We were ten students in one floor (surgical), each five of us were with one clinical teacher, and we use to exchange ideas with each other in regard to writing the nursing care plan. All of us noticed that each teacher direct her students in a different way. What was right with (x) teacher might be unacceptable to (z) teacher and vice versa."

❼.3.4 *Summary of the findings*

One might say that the classification system ended up with certain number of areas and categories as it shown in Table (7-2).

Table (7-2): Summary of the findings.

Statement of the area	Number of categories of an effective behaviour	Number of categories of an ineffective behaviour
Interpersonal relationship	6	15
Summative Evaluation	-	7
Formative Evaluation	one category with three subcategories	4
Professional competence	4	10
Teacher act as a motivator (encourager or discourager)	8	11

As can be noticed, the total number of the categories of the ineffective behaviours in all areas exceeds the number of effective categories by 33 categories; in other word the number of the ineffective categories in each area was nearly three times in comparison with the number of effective categories.

No effective behaviour was found in the evaluation area which might led to question whether the students forget to mention it or it was really not applicable.

Also in most of the incidents the students mentioned that it had happened in the first day of their clinical experience, which make it more memorable. Maybe their sensitivity became less after some time or their background changed. Some of the examples selected were not clearly demarcated scene incidents, which strengthened the idea of considering those incidents along with those which fulfil the criteria of Flanagon (1954).

Indeed, some problems identified did not fit well into discrete incidents which occurred in one place at a specific time. One example would be teachers failing to spend enough time with students.

❼.3.5 *Discussion of the findings of the incidents*

(a) *Introduction*

The main data collection instrument was the critical incident technique which was used to identify incidents of effective and ineffective clinical teaching behaviour in nursing. From 400 student nurses at Jordanian Universities 2000 critical incidents related to effective and ineffective clinical teaching behaviours in nursing were obtained. Analysis of the incidents through a process known as category formulation indicated the following 5 major areas of clinical teaching effectiveness; (1) interpersonal relationship, (2) evaluation (formative) (3) evaluation (summative), (4) clinical competence, (5) motivation (encouragers and discouragers).

It is worth pointing out that there was overlap between the categories in these areas. In other words the classification system was not mutually exclusive, the area of motivation might have some categories which might be classified in the area of interpersonal relationship and vice versa. However, the decision was made to accept this phenomenon because the idea of classifying the incidents was a matter of simplifying the presentation of the findings. This process of making sense of qualitative material is standard in qualitative research. Furthermore, the scheme developed here was validated by the use of independent judges.

In their studies Brown (1981), Wong and Sharly (1979), Bergman (1990), Nehering (1991), Knox and Mogan (1987) did not attempt to classify the teaching characteristics under a classification system but simply presented the teaching behaviours in an item pool.

From the two thousand critical incidents collected a total of 73 categories were created. Twenty one referred to the effective clinical teaching behaviour and 52 reflected ineffective teacher behaviour.

(b) *Discussion of the area of interpersonal relationship*

Within the interpersonal relationship area. The categories of effective clinical teaching behaviours described by students were that the teacher:

(1) respects students opinion and is tolerant to students disagreement

(2) is tactful in dealing with students in front of patient

(3) shows concern and sympathy for the students problems

(4) improves student standing in eyes of the patients and his family

(5) is flexible when the occasion calls for that

(6) shows confidence in students' abilities, help them to be independent learner.

One might say that the categories in this area suggest a tendency for the effective clinical teacher to show her willingness to admit shortcomings. The extent to which an instructor can admit to error or lack of knowledge is considered by student nurses to be an important factors in effective teaching. This is based on its inclusion in many of the incidents described by the students. The ability to admit errors might be a reflection of self-confidence. This might lead to the students becoming less fearful of venturing a defence of ideas and attitudes incompatible with those held by their teachers. Furthermore, the teacher's interpersonal relations were in accordance with Rogers (1983). He identified certain qualities of this relationship that facilitate learning. These qualities include realness or genuineness, trust and respect for the learner and empathetic understanding. The teacher who exhibits realness or genuineness in a relationship is honest and open with students and willing to express his or her own feelings. Genuineness implies an ability to admit mistakes and acknowledge limitations.

Empathetic understanding is also a significant attribute of a strong teacher - student relationship. Empathy means the teacher can view a situation from the learner's perspective. The development of a helping relationship requires teacher responsiveness to the feelings of the students and an ability to communicate that understanding to them.

Rogers (1983) writes, "when the teacher has the ability to understand the student's reactions from the inside, has a sensitive awareness of the way the process of education and learning seems to the students, then again the likelihood of significant learning is increased", p.125.

Reilly and Oermann (1992) claimed that the interpersonal dimension of teaching cannot be underestimated; it is a critical variable in the way the instruction is designed and carried out with students and in the process of

learning and its outcomes. The teacher's relationship with learners influences to a great extent the psycho social climate for learning in the clinical setting.

Bergman and Gaitskill (1990) found that the characteristics of effective clinical teachers in nursing could be grouped into three categories: (1) relationship with students (2) professional competence and personal attributes. In their research, relationships with students were ranked as the most important characteristic. Other studies have confirmed the importance of the relationships established between teacher and students (Brown, 1981; Knox and Mogan, 1987; Nehring, 1990; Puph, 1988).

The ability to form effective learning relationships between teacher and student is seen as crucial to clinical teaching. Smith (1968) believes this relationship assumes the nature of a senior-junior partnership. Wong and Wong (1980) suggest many studies have shown that the highly developed inter-personal skills of the clinical teacher are essential to build up the teacher - learner relationship.

Whitehead (1964) stated "Among the optimum conditions for learning and teaching is an atmosphere of mutual respect between the learner and the teacher. The teacher's ability to respect students feeling and listen to students will help create a climate that is conductive to learning and development. Student should be treated with respect, understanding, and human dignity in the learning situation if it is desired to foster student - teacher relationship most favourable to progress", p.349-366.

Within the interpersonal relationship area, the category of the ineffective teaching behaviours described by students were that teachers

	Statements of the categories (1-8)
1	Do not respect the confidentiality of students' relationships i.e. A) teachers themselves form impression about students before knowing them. B) talk about student's performance in front of his colleagues.
2	Fail to take in to consideration religious beliefs or understand values of students.
3	Deal with female and male students in a different pattern; male teacher with female students or female teacher with male students.
4	Encourage students to be dishonest while engaging in writing nursing care plan for their patients.
5	Interfere in personal matter.
6	Humiliate the students.
7	Fails to build up a trust relationship with the students.
8	Shows disregard for students' opinions and is not tolerant to their disagreement.
9	Do not show respect for students in front of patients and others.
10	Is not flexible when the occasion call for that.
11	Make students feel worthless who knows little but never encourage to be competent.
12	Belittling students.
13	Being judgmental.
14	Being sarcastic.
15	Do not consider human dignity.

In the first five categories from the above list, five issues were raised by Jordanian students which were not mentioned in the literature before. In the first category, teachers do not respect the confidentiality of student relationships; they themselves form impressions about students before knowing them. That teachers judged the students based on another person's evaluation results in the acquisition of a negative reputation by students. Students expressed feelings of frustration because any effort to gain approval was seen as useless and frequently ignored. A student said: "I am one of the

students who was classified from the first clinical rotation as being a poor student, i.e. those who had problem with teacher X. This means that it is useless to do any good things because it will not be considered by other teachers as good". One might say that even this issue was not mentioned in the literature related to UK or USA However, in the UK or USA it is possible that while teachers talk to each other about students, they may not allow this information to overtly affect their relationships with students.

This may be related to a number of issues; specific culture within nurse education in Jordan, the immaturity of the teachers who may lack experience compared to elsewhere and were not much older than the students, or due to the general cultural differences between Jordan and other countries.

The other issue raised within the same category is confidentiality. Here the teacher talks about the student's performance in front of his colleagues adversely affecting his standing in eyes of others. This too may be due to teachers' inexperience and the other factors already discussed.

The second category was that Jordanian clinical teachers fail to take into consideration or agree with the religious beliefs and values held by students. An example is where a clinical teacher insists on pursuing Western practices such as assigning male student nurses to look after female patients and female students to look after male patients. Although the traditional practice of assigning males to males and female to female are now being overcome slowly in some part of Jordan, some students and patients still strongly believed that patients have the right to refuse being looked after by a student nurse of the opposite sex. One student wrote as a message to the teachers "Remember that we are living in a muslim society and the patients are muslim, please do not let them feel that being in the nursing profession might lead us to break the Islamic role."

The clinical teacher, according to the student's judgement, must be sensitive to the health care needs of the country and its capabilities of meeting such needs and strategies foreign to the culture. Because the clinical teachers lack clinical experience in working with Jordanian patients before teaching, it is likely to be difficult for them to understand or to appreciate the impact of this issue. If the teacher is from those who have joint appointment, working in the hospital and as well as being a clinical teacher, the possibility of incidents of this kind occurring is much less because of the familiarity of the teacher with the patients' society. This was noticed in the direct observations of clinical teaching.

The development of the theory of Cultural Care Diversity began in the mid 1950s when Leininger (1988d, 1991) started questioning the nature and science of nursing and how this differed from the practice of medicine while studying the role of a child psychiatric nurse who cared for children of different backgrounds. It became evident to Leininger that care and culture were linked together, and she studied anthropology in order to expand her knowledge of people, human conditions, and human cultures world wide. During her intense study, she regretted the fact that anthropology was not included in the basic nursing curriculum, as she argued that knowledge of anthropology was a large missing knowledge domain of nursing (Leininger, 1970).

Some of the assumptions of Leininger's theory (1991), pp.44-45, which deals with the issues raised by Jordanian students in this area were:

(1) Culture care is the broadest holistic means to know, explain, interpret, and predict nursing care phenomena to guide nursing care practices.

(2) Every human culture has generic (lay, folk, or indigenous care knowledge and practices and usually professional care knowledge and practices which vary transculturally.

(3) Culture care values, beliefs, and practices are influenced by and tend to be embedded in the world view, language, religious (or spiritual), kinship (social), political (legal), educational, economic, technological, ethno-historical and environmental context of a particular culture.

(4) Culturally congruent or beneficial nursing care can only occur when the individual, group, family, community or culture care values, expressions, or patterns are known and used appropriately and in a meaningful ways by the nurse in communicating with the people.

(5) Culture care differences and similarities between professional care giver(s) and client (generic) care receiver(s) exists in any human culture world wide.

(6) Clients who experience nursing care that fails to be reasonably congruent with clients beliefs, values and caring life ways will show signs of cultural conflicts, non compliance, stresses, and ethical or moral concern.

Also Leininger (1991) claimed that since one of the important goals of trans cultural nursing is to provide culturally congruent care, it is essential to know the student nurses' meaning of care within their cultural context. Only then will nurse teachers be able to provide care that fits with the students' meaning of care rather than impinging their own values upon the students. Leininger (1978) also argued that students and clients had a right to have their cultural values and beliefs understood in the same way that they have had rights to good physical and emotional nursing care practices. The tension between traditional nursing practices, expected by Jordanian patients, and some students, and western mixed-gender practices as expected by some teachers, was to some extent a failure to facilitate such good practices.

In regard to the issues raised in category (4), that the teacher encourages students to be dishonest while engaging in writing nursing care plans. One

possible reason why this issue was not raised in the previous literature is because the language used in writing plans outside Jordan is usually student's native language. Therefore, it might be easier for students to write it. In Jordan plans have to be written in English while the native language of the students is Arabic. The other reason might be that it is possible that clinical teacher may conceptualise theory as being separate from practice and is therefore concerned with the student being aware of prescribed care and not concerned with the student actual care. Putting a student in a situation to write things without having actually done them seems inappropriate.

In regard to category (5), the issue raised by the students was that clinical teacher interfered in their personal affairs. Jordanian students were concerned about the teachers' attitudes about this matter. The clinical teacher, according to students' judgement, must consider them as an adult learners and mature enough to deal with their personal affairs. In addition it was considered by them that this issue is outside the professional role of their teachers.

In this discussion regarding the categories which were not mentioned previously in the literature, each category was discussed alone. However, for the rest of the categories the discussion is made in general.

Examples of ineffective behaviours of the clinical teacher in terms of interpersonal relationships contained lack of respect for the student in front of the patient, belittling them, being judgmental, being sarcastic and making students feel worthless. This disrespectful behaviour by the clinical teachers may lead the students to question their ability to nurse or successfully complete the course. As students experienced the effect of teachers comments in term of degrading and belittling them they begin to lose confidence in themselves and in their abilities to do the right thing. As one of the student

said: "one day when the teacher was observing me while I was doing a dressing for a patient she said to me 'you are very dangerous student and I doubt that one day you can work in the hospital like other nurses'".

The categories in this area; the teacher belittling students, being judgmental, being sarcastic and so on have been considered in detail in the previous literature and were identified as the characteristics of the ineffective teacher; Wang (1978) conducted an exploratory study to identify students' perception of teacher behaviours that either facilitate or hinder students' learning in the clinical field. The teachers behaviours reported as hindering students' learning were:

(1) posing a threat

(2) being sarcastic

(3) belittling students

(4) correcting students in the presence of others.

Also many other studies had similar findings to this study (e.g., O'Sheo and Parason, 1979; Nehiering, 1990; Magon, and Knox, 1987; Halldordor Dottir's, 1990). Belittling and degrading were found to be the most extreme forms of ineffective behaviours. Furthermore, disregard for the student as a person is perceived as non humanistic and is against educational and nursing principles in which empowerment can be used as a teaching strategy through building, and increasing power through co-operation, sharing, and working together (Hawks, 1992; Hawks and Hromek, 1992).

The interaction between the teacher (empowering) and the student (empowered) is facilitated through active student participation in the learning process and is similar in this respect to the nurse/patient relationship. Unfortunately, some clinical teachers failed to empower students. Freedom to learn in an atmosphere of openness, respect, supportiveness, and authentic

concern by the clinical teacher enhances the development of empowerment. Such a climate has been supported in the research studies by Bush (1988), Miller (1990) and Smith (1977). The end result was seen as increasing responsibility and autonomous decision - making and a feeling of self - worth.

Whitehead (1964) and Raven and Paker (1971) claimed that among the optimum conditions for learning and teaching is an atmosphere of mutual respect between the learner and the teacher. The teachers' ability to respect students feelings and listen to students will help create a climate that is conductive to learning and development. According to Whitehead (1964), students should be treated with respect, understanding, and human dignity in the learning situation if it is desired to foster a student - teacher relationship most favourable to progress.

Ramsburg (1987) argues that open - two way communication between instructor and student allows each individual to discuss practical applications, strengths and weakness, personal feeling and values which ultimately influence important decisions with regard to patient care. This type of interactive process greatly improves the learning situation, and the practice in communication helps the student to solidify the knowledge, attitudes and or skills to be learned in each clinical situation.

Finally, one might conclude the discussion about this area by what Tornyoy (1988) said: "It is good to keep in mind that in order to make nursing an attractive academic field, not only must an existing curriculum to stimulate and challenge student be offered, but also the opportunity to be taught by faculty who treat students as respected individuals and who model nursing's caring philosophy in their (interpersonal actions). The ineffective behaviours described would probably hinder this process.

(c) *Discussion of the area of summative evaluation*

For summative evaluation, the second area of the classification system, no incidents of effective summative evaluation were given at all, which suggests that students were dissatisfied with the summative evaluation procedures that they had experienced. The categories of ineffective clinical teaching incidents were as follows. Teachers:

1. Did not evaluate the students using clear criteria.
2. Evaluated students mainly on nursing and medical theory, rather than on clinical practice.
3. Failed to evaluate students at appropriate points during the course.
4. Did not discuss their evaluations with the students on an individual basis.
5. Looked for students' mistakes.
6. Imposed threats by using evaluation to threaten students' futures.
7. Discriminated between students in their evaluations on a personal basis, rather than being objective.

Of these seven categories of incident, the first three have not been previously mentioned in the literature. The lack of clear criteria for evaluation was also an issue raised by both students and teachers in their answers to the open ended question from the questionnaire survey. Both groups suggested that clear criteria should be established in order to facilitate the process of evaluation. One might say that this problem was not due to deficits in the clinical teachers' behaviours, as much as to short-comings in the system used in the Nursing Faculties. Thus, this is a matter for consideration by the administration of the faculties; the Dean and his deputies. If teachers are not given clear guidelines for how they should evaluate students in clinical teaching, then it is not surprising that teachers were often seen to fail to evaluate fairly and objectively.

The issue of evaluating theoretical, rather than clinical expertise was also raised under the category of teachers' clinical competence and will discussed in the relevant section below.

The third category was that teachers failed to evaluate students at appropriate points during the course. Students complained strongly that clinical teachers sometimes appeared to consider student mistakes for the first time during summative evaluation, having failed to draw students' attention to the mistakes when they occurred. This was particularly resented when the mistake had occurred the first time that the student had attempted a nursing procedure. As Reilly and Oermann (1992) point out, formative evaluation is supposed to provide students with feedback, enabling them to improve prior to summative evaluation. Penalising students for every mistake, particularly without feedback at the time, is thus both unfair and an inappropriate evaluation method which confused formative and summative evaluation. Yet, this distinction is extremely important , as formative evaluation is a key mechanism of the teaching-learning process, providing information to the learner concerning the knowledge and skills which they have attained and concerning those for which further learning is needed. The distinction may be harder to establish clearly in the clinical setting, but this does not diminish its importance.

That the preceding problems have not been mentioned previously in the literature suggest that they are a product of the particular situation with clinical nurse teaching in Jordan. They are likely to be due to deficiencies in the organisation of the courses, rather than to deficiencies with particular teachers, such as would probably have been also observed elsewhere.

Turning to the categories also found elsewhere: Teachers' failure to discuss evaluations with students individually may have been-related to the absence of clear evaluative criteria, as well as the confusion between

formative and summative evaluation. Basically, if teachers are unclear about the basis for evaluation, then they will find it difficult to explain evaluations to the students. Also, some teachers may believe that students have no right to know the basis of their evaluations. Ravin and Parker (1971) suggested that "Unless objectives are clearly and firmly fixed in the minds of both students and teachers, evaluations are at best misleading, at worse, they are irrelevant, unfair, or useless." It would appear in Jordan that clear objectives which could be used to base evaluation are often absent. Furthermore, the clinical evaluation forms used may not be fully appropriate.

That teachers were felt to seek student mistakes, rather than providing both positive and negative feedback, may have been related to the lack of clear evaluation objectives. Seeking mistakes is likely to make formative evaluation seem unfair and decrease student trust in the teachers. In the terms described by Reilly and Oermann (1992), this is not good practice.

The same could be said of the next category, where students reported incidents when evaluation had been used as a threat against them. Not only is this poor practice, but both "mistake seeking" and using evaluations as threats to control student behaviour will lead to a poor psychosocial climate, where the students neither like nor trust their teachers. Evaluation is anxiety-provoking at the best of times (Kleehammer, Hart & Keck, 1990) and a punitive evaluation probably more so.

Reilly and Oermann (1992) argued that a positive psychosocial climate was a critical determinant of the way the learner perceived the evaluation process. In a negative climate, the student is unlikely to view evaluation as a learning experience, is unlikely to value it and may see evaluation as a punishment, hurdle or ordeal, rather than a useful and central part of clinical learning. Hedin (1989) suggested that effective evaluation requires a good student - teacher relationship which places evaluation within the context of

promoting growth and further development of the learner. Using evaluation as a means of control will prevent this occurring (Reilly and Oermann, 1992) and will hinder the students' growth and development.

The seventh and final category was also related to the basis for evaluation being unclear. Students reported incidents where teachers had apparently evaluated them on a subjective basis, considering matters other than their knowledge or performance of nursing tasks. Instead, teachers had apparently based evaluations in part on the student's values and beliefs, their personal dislike of the student, a preference for students of the opposite sex, or other personal factors, particularly if these did not conform to the teacher's expectations. The problem has been noted many times previously (Wong & Shirly, 1978; Kiker, 1966; Jacobson, 1973; Bergmann & Gaitskills, 1990). Once again, this problem is likely to harm the student - teacher relationship and therefore hinder the learning process.

Reilly and Oermann (1992) emphasised that evaluation is a value-laden process. Thus, while clinical evaluations cannot be entirely objective, they can at least be fair and fairness should be a major goal of clinical teachers. According Reilly and Oermann (1992), fairness has two requisites, clarity of evaluation objectives and a supportive climate for evaluation to occur within. It is clear from all the ineffective incidents described by students, that neither of these requisites was being consistently met in clinical nurse teaching in Jordan.

Returning, finally, to the absence of any incidents of effective evaluation behaviour. This might suggest that evaluation was never very well done. Alternatively, perhaps students were less likely to remember effective evaluation incidents because they were less striking than the ineffective incidents described above. Perhaps also they tended to forget them because a fair evaluation (that is an effective one) will often be accepted by the student

without great anxiety, upset or concern and thus may be seen merely a routine part of the learning process.

(d) *Discussion of area of formative evaluation (Feedback)*

The category of the ineffective clinical teaching behaviours in this area were:

(1) No feedback provided from clinical teachers after procedure wither positive or negative.

(2) Students mistakes pointed out without showing them how to correct their mistakes.

(3) False feedback given.

(4) No feedback provided from teachers on students written assignment.

As can be seen in the above categories, there were four kinds of ineffective teaching all of which in one way or another could adversely affect the students' learning process. If the teacher does not tell the student whether he did right or wrong, this might make the student uncertain and keep him questioning himself unnecessarily. Wether it was wrong or right this would reflect negatively on his motivation to learn. Furthermore if the teacher only pointed out the student's mistakes without showing him how to correct those mistakes, this might affect the student's self image and might keep him in an uncertain state, worrying that he is just doing things wrong.

Greaves (1979) argued that if the students are doing well, or not very well, the teacher should let them know. Students must have knowledge of the results of their learning and it is the duty of the teacher to provide that information to the student. Kathleen (1987) in her article "Adult learning

principles" argued that immediate, descriptive feedback is essential if adult learners are to modify their behaviour.

The issue that teachers giving false feedback was raised. In the incidents described, teachers gave positive feedback to the students when the students felt that it was not deserved. In this case one might say that this reflects the maturity of the students who recognised the false feedback and were not impressed that it was positive. Kathline (1987) argued that students are adult learners and they are able to recognise and evaluate the behaviours of their teachers. The giving of undeserved positive feedback reduces the credibility of the teacher and could be interpreted by students as patronising. Therefore the effect on the learning climate might be negative.

Regarding the lack of feedback on students' written assignments; the provision of feedback is particularly important because the language used in writing the care plan is not their native language, therefore there may be discrepancies between the intended and actual meanings. In addition, teachers were apparently inconsistent in their expectations of the nursing care plan, i.e. one teacher might recommend an issue to be written under 'nursing intervention' while other recommended the same issue to be written under 'nursing diagnosis'. When the teacher did not give the students feedback he will not be able to know what exactly he did or he must do.

In conclusion, regarding the ineffective behaviour of the clinical teacher in the area of formative evaluation: students expressed a strong desire to receive feedback from their clinical teachers, wither it is positive or negative. Students do not want to be left in dark. They want to know where they went wrong so that they could improve themselves and also want to know where they did well so that they will at least be assured that they are progressing in the right direction. Feedback can also give motivation to further study and prepare students for the examinations. For example one student wrote as a

message to the teachers "I really want to know whether you are satisfied or not satisfied with my performance - please do not leave me in the dark".

Turning to effective clinical teaching behaviours in the area of formative evaluation, or feedback, there was one main category and three sub-categories:

Teachers provided helpful and timely feedback during and after performance of procedures by the students;

i) Explain why response/action is right.

ii) Explain why response/action is wrong.

iii) Identify area of improvement.

The students considered that positive and negative feedback was very important to their learning and for example they mentioned that as they were happy to know when they did right and when they made mistakes. Furthermore some teachers went beyond just drawing the attention of the student to their right or wrong performance and told them how to improve their correct performance. One student wrote "Grades will not make me rich, but knowledge will make me rich." Another wrote "You say 'You don't understand.' OK I am ignorant, but I am here to learn from you."

Wilhite (1990) refers to formative evaluation as diagnostic evaluation in which the teacher provides learners with information on their strengths and weaknesses. Mogan (1994) found that providing positive feedback to the students was among the most effective teaching behaviour. Reilly and Oermann (1992) claimed that formative evaluation is important in teaching in the clinical setting and considered it as an integral part of the teaching-learning process, provides information to the learner as to knowledge and skills which have been attained and those for which further learning is needed. It also guides the teacher in planning relevant activities to assist the student in this process.

In conclusion, regarding evaluation in general, it is possible that there is a cause-effect relationship between the deficiencies found in the formative evaluation and those raised by students concerning summative evaluation. Students mentioned no incidents of effective summative evaluation at all, which suggests that, even if their final evaluations were often fair and justified, this was not perceived to be the case by students. This in turn suggests that by the stage of summative evaluation the students had often lost trust in the teachers' ability to evaluate fairly. This loss of trust may have been due to the deficiencies they mentioned in the formative evaluation process. If formative evaluation was often seen by students to be punitive - that is, used as a threat - insincere and with deficient or only negative feedback, then it is not surprising that students had lost faith with the evaluation system.

(e) *Discussion of area of professional competence*

With regard to the fourth area of the classification system, i.e. professional competence, the categories of the ineffective clinical teacher behaviours in this area were:

Teachers

(1) do not answer students' questions, instead turn the questions into assignments for them

(2) give incorrect information, gives unclear clues

(3) give needless or wrong directions, questions and explanations to the students while they are engaged in performing tasks

(4) interrupt students while they are doing nursing procedure to their patients

- do not help the student to be an independent learner, supervising students too closely

(5) question students at inappropriate times

(6) lack experience in performing many nursing tasks

(7) concentrates on theory rather than practice in their discussion with the students

(8) misses teachable moments

(9) show non verbal expressions of agitation and frustration with students.

Category (1)

The teacher does not answer student questions, instead make the question an assignment for them. Students claimed that in many situations the clinical teacher, instead of acknowledging her/his ignorance, used this strategy which students found unacceptable.

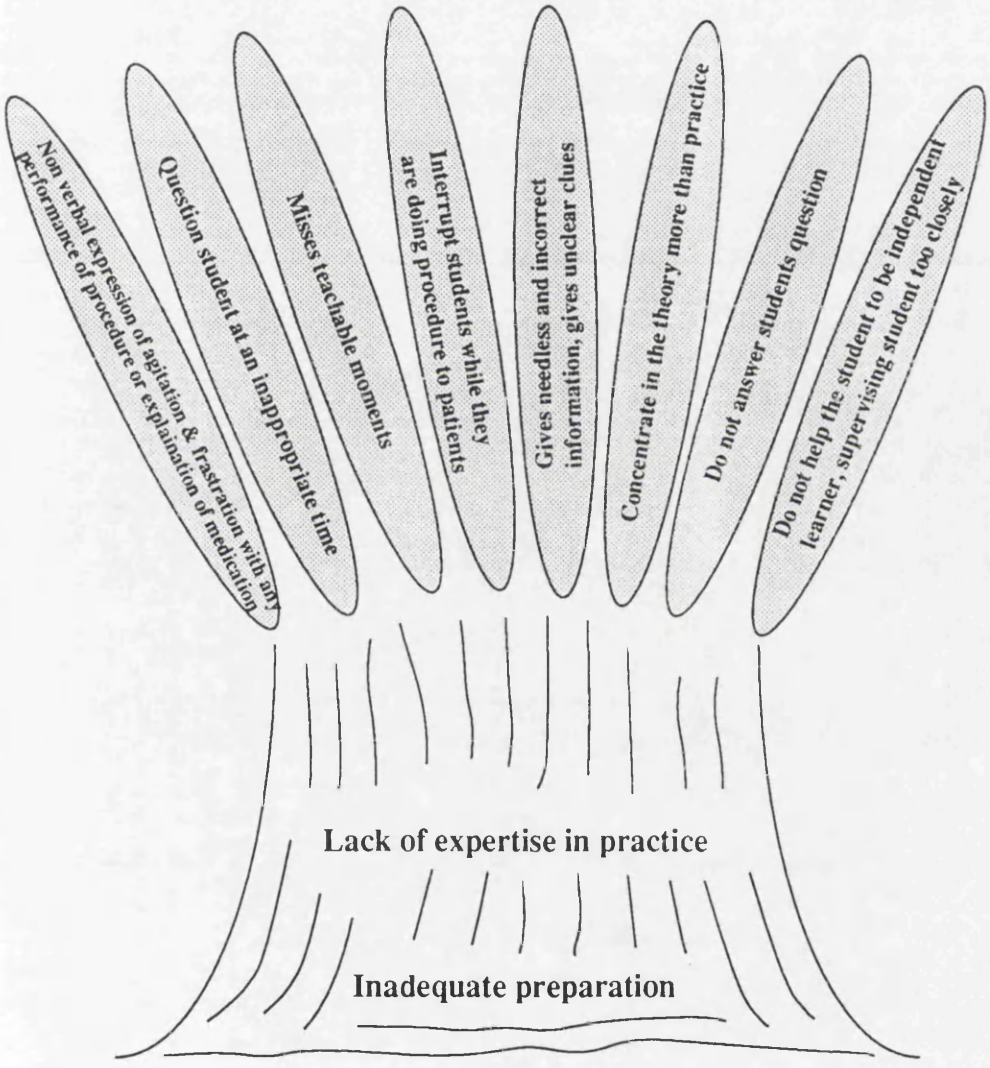
As can be seen in all the categories in this area, i.e. give incorrect, gives needless or wrong directions, interrupt student, concentrate in theory more than practice, till the end of the categories in this area, it is possible to say that there is a close relationship between all the teacher behaviours in this area, which might related to the background of the clinical teacher, i.e. in this study the students described their clinical teachers as recent graduates who were only the previous year their seniors in the school.

Again, some examples of messages written by students to their teachers during the written critical incidents will illustrate the problems. One wrote "Do not catch my hand when I am trying to give an injection and am already in fourth year." Another wrote "Please do not come after half an hour and ask me what I did to my patient, give me enough time." Another comment was "If you feel that my mistake while I am performing a procedure on a patient is not fatal or dangerous, I wish you could delay your criticism until after we leave the patient." Finally, another commented "Please remember not only to

evaluate me on what I did wrong, but on all I did to my patients."

General Discussion

A key problem would appear to be that some clinical teachers may not have had adequate clinical and teaching skills. The following diagram offers a visual representation of the extent of the teacher lack of expertise in performing many nursing skills.



Tree of Ignorance

In Bergman and Gaitskills' (1990) study of effective clinical teachers, both faculty and students identified knowledge as an important characteristic; also findings suggested that important dimensions of clinical teaching included ability to relate underlying theory to nursing practice, being well-informed and possessing the ability to communicate knowledge to students. Berman and Gaitskill (1990) recommend that "special attention should be given to developing a functional body of knowledge in the area of instruction and in communicating that knowledge to students", (p.14). Kramer (1974) questioned why nurse teachers leave nursing practice in the first place, and believed one important factor to be a "dislike of nursing practice" or because they "find it impossible to practice nursing the way they believe it should be practised". Kramer (1974) believes there is a need for clinical nurse teachers to both work and teach in the ward, and to be accepted as such in order to socialise, change the nurses of tomorrow.

Although based on American research, Kramer's study seems to have important parallels in Jordan. One quote from an American students in Kramer's (1974) research seems to illustrate the problem: "A number of our instructors could not function as nurses per se, so therefore went to graduate school and then into teaching. The problem is, students can see this - they know it is so, but they cannot do any thing about it. We can learn the facts out of the book, but it is how to get what we learn in good nursing care into practice - not just our own practice, but the practice of the others we work with...That, the faculty don't teach us because they cannot really nurse themselves. Some of our faculty do not know how to nurse at all, others can only take care of a single patient when they have lots of time." Kramer sees the need for "role models" who, to be effective

- plan care , give care
- teach
- keep up to date , research and
- communicate with all groups

She considers that in most cases, students do not relate to and hence learn from their teachers because of an inegalitarian system which puts them (the teachers) as "one of them" , "the higher - up". Thus they relate to and learn more from those more equal status - especially their fellow students.

Furthermore regarding correlating theory and practice, it has been suggested that a gap exists between the theory of nursing taught in the school and the practice in the wards. Bendall (1976) believes this lowers standards of patient care and creates profound dissatisfaction among educators, practitioner and students of nursing a like. Bendall suggests that the syllabus for nurses in training needs more research and believes that "patching-up" may not work, rather it may be necessary to re-define the whole process of nurse training. This may go so far as to "accept that ward nursing is job centred and should be taught as such". She identifies the need for greater support for the ward staff, and questions the current tendency of teachers in schools of nursing to teach principles of nursing, rather, she argues, details could be given first and the students learn to group them into principles themselves, she writes "in terms of application of theory to skilled practice, many teachers believe that principles should be taught early, so that they can be applied in different situations in different practice areas," (Bendall, 1976). She suggests that there is "another school of educational psychology with an alternative theory - that discrimination between things should (and must) be learnt before they are put into groups to which principles can be applied".

On the other hand, Lancaster (1972) surveyed the opinions of 225 tutors (85% of all practising tutors in Scotland). She felt that the difficulty in relating theory to practice in basic nursing programmes "seems to be accentuated by the distinction between classroom and clinical teacher represented respectively by two grades of nurse teachers". She further remarks that "if all teachers were involved in both classroom and ward

teaching they would be in a better position to assess the needs of nurses in training, and to select the practical experiences and theoretical background most appropriate to the nurses' future role in a rapidly changing environment".

Turning to the categories of the effective clinical teaching behaviour in the area of professional competence, these were that the teachers

(1) demonstrate and teach technical skills in nursing activities were required, shows and explain, give rational

(2) make student aware of his/her professional responsibilities in the clinical setting

(3) give the students the freedom to do it on their own, help them to be independent learners

(4) shows genuine interest in patients and their care, i.e. act as a role model in this aspect.

This area has only four categories while the ineffective categories in the same area has nine categories. Also it appeared that there is a relationship between the categories themselves. For example it is possible for the teacher who shows genuine interest in patients and their care, to make the student aware of his professional responsibilities at the same time to demonstrate and teach technical skills in nursing activities.

Reilly and Oermann (1992) argues that clinical experience serves a multi-purpose role in the education of professionals. It provides experience necessary for the learner to develop knowledge, skills, and values interest in the theories of action accepted by the profession and necessary for the individual to be self confident.

The teacher's theoretical and clinical knowledge used in the practice of nursing and attitude towards the profession influence teaching effectiveness. Nehring (1990) and Knox and Mogan (1987) referred to this theoretical and clinical knowledge as nursing competence. Findings of studies by them indicated that the best clinical teachers possess nursing competence and the worst lack such ability. The best clinical teachers were ones who enjoyed nursing, were good role models, demonstrated clinical skills and judgement, assumed responsibilities for their own actions, and demonstrated a breadth of knowledge in nursing. In Bergman and Gaitskill's (1990) study, findings suggested that important dimensions of clinical teaching included ability to relate underlying theory to nursing practice, being well-informed, and ability to communicate knowledge to students. Also Reilly and Oermann (1992) argued that maintenance of clinical competence is essential in assisting students in development of knowledge and skill and provide expert supervision in the clinical setting.

Nehring (1990) found similar to an earlier study by Knox and Mogan (1987), that the best teachers were ones who demonstrate the skills, attitudes, and values that are to be developed by the student in the clinical area and ability to stimulate the student to want to learn behaviours associated with professional competence. In an early study by Rauen (1974) of role characteristics of clinical nurse teachers, one of the highest ranking characteristics was the teacher's skill in demonstrating how to function in areal nursing situation. This skill is dependent upon maintaining clinical competence. Puph (1988) also reported that the teacher's ability to demonstrate nursing care in areal situation was an important behaviour in clinical teaching identified by students. The teacher serves as a role model for students in the clinical setting.

Some teachers were perceived as Role-Models. One student stated that when she saw her teacher caring for a patient who had been ignored by nurses because she was very smelly. She said: "I will never say no or refuse to do nursing care to any kind of patients after I saw my teacher doing care by her hands in front of me and I wish other clinical teachers behave like teacher X."

The importance of learning in the clinical area was emphasised by Wong and Wong (1986) who said: "The bed side care of the sick must be taught in the hospital, and it is here that the art of nursing must be acquired, it is also at the bed side that the true spirit of nursing is passed from the great teacher to the student no other kind of teaching and learning will take its place.

(f) *Discussion of the area of Motivation*

With regard to the last area in the classification system the teacher acts as (motivator or encourager). The categories of the effective clinical teaching behaviour were as follows: that the teachers

(1) orientate the students to the clinical setting and to the objectives of the clinical rotation

(2) create a relaxed atmosphere making learning enjoyable

(3) available to work with students as situation arise, i.e. take immediate and appropriate action in case of emergency

(4) praise students, expressing confidence in them act as an advocate for students

(6) support student learning (act as a facilitator)

(7) is tolerant of student mistakes

(8) shows understanding and recognition of the individuality of the students.

It is worth pointing out that there is a relationship between the categories in this area and the categories in the area of interpersonal relationship and there might be some kind of overlapping or these two areas. However, this was considered acceptable because the idea of the classification system was to simplify the presentation of the findings. The factors which affected student motivation have been discussed by other authors.

Busl (1981) in her article "The teacher as manager of the learning environment" summarizes all the issues raised by students in this area in one statement. She wrote "The teacher has a great influence on the learning environment. His attitude toward the students is extremely important; he will usually get the kind of behaviour from the students that he expects. The students need to know exactly what is expected from them. The teacher needs to encourage students to think and ask questions. A favourable atmosphere for learning will be present if the teacher makes himself available to student, is responsive to the students' learning needs, values and respects the learner, and minimises the inhibiting effects of emotions on learning", (p.43).

Kestin (1963) claimed that teaching is more than the transfer of knowledge or understanding from the brain of the teacher to the brain of the students. Somehow, the teacher must motivate the student to become an active participant in the learning process and to assume more responsibility for meeting his own learning needs. Furthermore, Messick (1976) claimed that the learning preference of the student is extremely important, so the teaching strategies should be adapted, whenever possible, to meet the learning style of the student learning styles can be influenced by many factors such as the age of the student and previous learning experiences. Some students are enriched by identifying their own plans and purposes and taking their own initiative to realise them while others have difficulty using their own ideas, values, and

attitudes as a starting point for increasing their involvement in the learning process.

Regarding reinforcement of students' learning, Greaves (1979) claimed that the clinical teacher should give praise for good performance and correct method, if the students are doing well, or not very well, let them know. They must have knowledge of the results of their learning and it is the duty of the teacher to provide that information to the student. Greer (1990) believes that honest praise generously given early in the semester "bolsters students' self-confidence", (p.38).

On the other hand Reilly and Oermann argued that the psycho-social climate in which the teaching and learning takes place in a major contributing factor to the learning responses of students and the ability of teachers to carry out their educational responsibilities. The climate for learning may support these individuals, impede them, or limit options for learning. A supportive learning environment is characterised by valuing learning; exhibiting a caring relationship for all concerned; providing for student freedom within structure for exploring, questioning, and trying out different approaches; accepting differences in others; and fostering the development of each individual. Regarding the teacher behaviour as an advocate for students, Reilly and Oermann (1992) claimed that teachers as advocates of students often must intervene with staff to facilitate student opportunities for trying out "the new".

In an early study of teacher behaviours which facilitate or interfere with learning in the clinical setting, O'Shea and Parsons (1979) found that friendly, supportive, understanding and enthusiastic behaviour of the teacher promoted learning. In more recent studies characteristics of the teacher perceived as important in clinical teaching include demonstrating self-confidence, being enthusiastic, being open-minded and non judgmental, displaying a sense of humour, admitting mistakes and limitations, being co-

operative and patient, and being flexible when the occasion call for it (Bergman and Gaitskill, 1990; Knox and Mogan, 1987; Nehring, 1989).

Carter (1979) argued that the clinical teacher is seen as having eight important functions, six of these functions relate to the findings in this study, for example, the clinical teacher should be

(1) establishing good working relationships with the ward sister
(2) orientating him/herself to the unit and staff
(3) building up a "knowledge of resources"
(4) maintaining "open channels of communication" between staff, teacher and learner
(5) collaborating with staff to bring about learner/patient assignment
(6) dealing with student problems in an open and constructive way, consulting (and being seen to consult by the student) the staff when nursing care problem arise.

However, House and Sims (1976) emphasised the difficulties that clinical teachers experienced on the ward. They may well not be seen as professional colleagues by ward sisters, but instead a hinderance and not even a useful pair of hands. They may be seen as interfering and certainly not as making any contribution to improved standards of patient care. It may be that they are thought to "take away" students from the ward rather than adding to it themselves. The role of the clinical teacher puts the teaching firmly in the ward setting and the ward as the appropriate learning area. This lack of appreciation of their role and inadequate orientation to ward teaching must seem particularly galling.

Ravin and Paker (1971) argued that clearly defined objectives better enable the student to organise his efforts into relevant activities and evaluate his own progress. Also Whitehead (1964) claimed that one secret of a

successful teacher is that he has formulated quite clearly in his mind what the pupil has got to know in precise fashion and McKeachie (1969) claimed that the teacher whose students make good progress towards educational goals is an effective teacher regardless of how he looks or what techniques he uses.

To sum up, students felt motivated by behaviours which enabled them to acquire and practice clinical skills in a safe, supportive environment with both positive and negative feedback about their performance. This required the teacher to be present with the student on the ward. One student wrote "The most important thing which motivates me is when you are around me in the unit. Believe me, without you I am nobody on the unit."

Regarding the ineffective behaviour in this area, when the teacher acted as discourager or inhibitor. The categories of the ineffective clinical teaching behaviours are as follows: that the teachers

(1) are not familiar with the clinical setting
   - do not make orientation to the students at the beginning of the course
   - do not orientate the hospital staff to the role of the students

(2) are not available most of the time

(3) are impersonal, showing irresponsibility or inability to handle situation in case of emergency

(4) do not consider that sometimes students exposed to certain clinical experiences before having any theoretical background especially at the beginning of the semester

(5) restrict the students in one room with one patient all the day in the clinical setting

(6) concentrate excessively on students' appearance

(7) do not have professional appearance themselves

(8) do not consider students' feelings when exposed to new situations

(9) do not consider individual learning needs

(10) do not consider individual limited ability

(11) give contradictory information to the students in writing nursing care plans.

One basic problem regarding the effects of teacher behaviour on student motivation was teachers not being available to students and not giving an orientation to the hospital staff about the role of the students. In addition to what was mentioned about the importance of this issue above, Bourne (1950) wrote that clinical teacher must be an effective practitioner, she should belong to the ward, that is she should work in it daily with the students, she should know the patients and nurses, should be really an fait with the details of patients' treatments and progress being present at the morning and evening reports whenever possible. He added, for effective clinical teaching the instructor must 'really know as much about the patients' condition as do the nurses, other-wise she will be at a serious disadvantage. However well trained she may be without a real working knowledge of the ward, of patients and students, she will have a very difficult and rather unpleased task.

Being unavailable might result in either positive or negative consequences. Some students reported that such behaviours resulted in being self-sufficient and independent. Other students, however, felt a little uncertainty about their own capabilities which was mostly evident in the early stages of their clinical experience. As one of the student said: "We like our teacher to let us to be independent learner but not to that extent and not at the beginning of our training at least at the beginning the clinical teacher should help us to put our feet a little bit in the unit and then she can leave us".

Furthermore, students strongly criticised the failure to orientate hospitals' staff to the students and failing to orientate the students themselves

to the clinical areas. One student commented "We wish that you would serve as a liason between us and the hospital staff."

Category (3)

The clinical teacher was impersonal, as well as showing irresponsibility or inability to handle emergency situations. There are three issues in this category first (impersonal) attitude, Jordanian students criticised strongly the teacher's attitude. Some of the doctors do not show any consideration for nursing students or teachers and many of the nursing teachers responded in a passive manner towards the doctors. For example one of the incidents given was about a doctor who wanted to do a lumber puncture for a patient when the students were in the same room having a discussion with their teacher about another patient. The doctor started the procedure and immediately they went to observe the procedure. When the doctor saw them he said: "what is the matter, am I having a school for you here? go out". The student said: "what shocked us was not the doctor attitude but our teacher attitude who just took us outside the room without saying any ward to the doctor.".

Another example of teacher's passivity was when a patient's relative was shouting at a student and said to her very bad words in front of other patients and her teachers, the teacher did nothing when she saw the situation. She simply left without saying any thing. Some of the reasons behind such behaviour could be that teachers tend to be non assertive lacking experience, relatively or lacking clear guidelines about their role as teacher in the clinical setting. This illustrates a relucatance to take responsibility for the students in the clinical situation.

The final issue was inapproprate behaviour in emergencies. In a similar example to the above, a patient assaulted a student and the teacher did not

intervene. There were also cases when rather than participate personally in resuscitating patients in distress, the teacher withdrew the student.

Reilly and Oermann (1992) argued that a clinical setting rich in learning experiences but lacking a supportive environment discourages learners in seeking experiences and results in the loss of many opportunities for growth. Like wise, a setting with potentially limited experiences but rich in a supportive environment may provide opportunity for students to examine new health care needs and ways of addressing them. Regardless of the setting for clinical practice, the climate for learning is a factor in determining student achievement and satisfaction with the learning experience. The teacher and agency personnel influence the nature of this climate and degree to which it supports learning.

Category (4)

Do not consider sometimes that students are exposed to certain clinical experiences before having any theoretical background specially at the beginning of the semester. One student wrote "Do not start questioning me before giving me any information."

Dodd (1973) suggested that ward and school can be kept separate, but Reilly and Oermann (1992) claimed that the theoretical basis for teaching psychomotor skills finds its roots in theories of learning. A key aspect of modern learning theory is the role of cognitive pressure in skill acquisition. The directions that theory development in psychomotor learning are taking have significant implication for nursing education. For example, in a field study, Gairy (1981) examined the effect of cognitive teaching during nursing students' learning of two skills: intramuscular injection and intravenous insertion. The experimental group received its teaching of the cognitive

component of the skill prior to the performance while the control group received its teaching of the cognitive component concurrent with the skill performance. The findings supported the hypothesis that those students who experienced teaching of the cognitive component prior to performing the skill carried out the skill with a significantly higher degree of precision.

Reilly and Oermann (1992) argued that psychomotor skill learning is a complex activity that requires knowledge of purpose, principles, and anticipated outcome in relation to both the cognitive and affective domains. The knowledge component is discussed in conferences either prior to the actual skill performance or following the performance, where the later is analyzed and evaluated.

Teachers failed to meet the Reilly and Oermann principle, first because they questioned students about issues they had not yet studied, second because they did not discuss new experiences with the students either beforehand or afterwards.

Category (5)

Restrict the students in one room with one patient all the day in the clinical setting.

In Jordan usually the patients are in rooms, not in large wards and the number of patients in each room ranges from 6-1 so if a patient is assigned to a student in one room, the student may not communicate or see any other patients in the unit. Therefore the students reported feeling frustrated by being all the shift dealing only with one patient. A student said: "We are not helping the patients and we are not learning and just kept waiting time to pass to leave the clinical area". Another student described this issue by saying "I consider keeping me only with one patient is a punishment not learning".

It is possible that the clinical teacher use this strategy to manage the placement of students on the floor. When the clinical teacher has 12 students in 6 units and she wants to do rounds on them it might be not easy to her to check all the patients' rooms in order to know where the student might be. Or, it may be because the clinical teacher is not familiar enough with the clinical setting, so it is not easy for her to move freely. Another possible reason is that the teacher believe that if she keep the student with one patient it might be easier for her to know what the students did or did not do.

Flagger : (1988) argued that clinical experiences have an important impact on nursing students. The clinical setting is not only a laboratory in which to learn but an interpersonal environment, where the students receive clues from patients and staff as well as the clinical instructor regarding their capabilities as nurses.These experiences influence not only the students acquisition of knowledge and skills, but their professional developments well therefore one might question, what kind of professional development the student nurses might achieve if they are spending all the shift doing nothing most of the time?. How can the student nurse feel the spirit of nursing and the flavour of the work in a multi disciplinary team if she is isolated in one room with one patient?.

Pohl (1973) argues that much learning takes place on an unstructured and informal level, where students learn from simple observation of the daily activities in the ward, often without being aware that they are 'learning' and 'being taught', or by following the example of peers and senior staff on the ward.

Restricting the students in one room with one patient all the day in the clinical setting might interfere with the process of students' learning. Monteiro (1964) notes that in her experience, beside nurses often "viewed teaching narrowly as formal instruction and that opportunities for informal teaching

were missed". Pohl (1965) found that the concept of teaching held by a large proportion of nurses was unclear. Many students seem to envisage teaching as formal lectures and periods of direct instruction, whereas much learning takes place outside these activities. Redman (1976) wonders if the basis for the suggested inadequacies in ward teaching is "wholly due to lack of clarity as to what teaching is". One student complained "It is too difficult to describe, even for the patient, how much he and I suffer from being all the day together. He does not feel free and I am not learning."

Category (6) and (7)

The teacher concentrate on students' appearance at the same time the teacher herself does not adhere to the same standards. Students criticised the teachers' attitude regarding their appearance. For example, one of the students said that one day the clinical teacher dismissed him from the floor because he forget to put his name tag. Another student said that while he was talking to his patient the clinical teacher interrupted him and took him away and ask him about his neck tie and had a big discussion with him warning him not to forget it again. At the same time, teachers sometimes broke the rules themselves, by wearing jewellery for example. Teachers are supposed to monitor students' appearance. It appeared that students resented this most when the teacher broke the dress code, or when there had been little other interaction between teacher and student. Comments about appearance may be appropriate within a full clinical teaching session where clinical issues are the main topic. Such comments were seen as inappropriate when the teacher failed to spend much time with the student or discuss clinical issues.

In regard to category (8), in this area the issue raised related to the teachers who do not consider students' feelings when exposed to new

situation for the first time. Actually this issue had two dimensions as described by Jordanian student nurses, first was regarding the students' reactions to tragidic situations in the clinical setting, for example when the student sees a dead patient for the first time. Teachers sometimes failed to help students cope with such situations.

Clinical practice is inherently stressful for students. The environment cannot be fully controlled, and the student is faced with unexpected occurrences and uncertainties. Results of research by Beck and Strivastava (1991) indicated that nursing students experienced high stress levels. Kleehammer, Hart, and Keck (1990) examined anxiety - producing situations in clinical setting. Students expressed the highest anxiety during the initial clinical experience on the unit and the fear of making mistakes. In addition, students' anxiety increased in the clinical setting with non supportive faculty. Often, the clinical setting, client population, teacher, and even peers are unfamiliar to the learner. Clinical practice places the student in a vulnerable position in that learning occurs as public event, in front of others - the teacher, clients, pears, agency staff, and sometimes even individuals from other disciplines.

The other dimension raised within this issue concerned when students were exposed to awkward or embarrassing situations for the first time. Actually this is closely related to the traditional values and believes in Jordanian society. For example, one of the male students described a traumatic experience which happened with him at the beginning of the course when his clinical teacher asked him with other female student to insert ureteric catheter for male patient. Another male student said that it was very difficult for him to observe a baby being delivered. As Crick (1982) discusses, this is an example of the impact of cultural factors on nursing and one would hope that teachers were sensitive to such problems.

There were also three other factors which tended to demotivate students. They have not been previously discussed in the literature, but they are obviously ineffective teaching practices. Failing to be appreciate what a student is capable of led to incidents where the students was prevented from undertaking a procedure she was capable of and to incidents where a student was left to attempt nursing procedures without adequate supervision. Students were also sometimes assigned duties on the basis of what the ward needed rather than what they needed to learn.

Another problem was when teachers criticised students with mild disabilities such as myopia or a limp, rather than helping them to compensate for the disability in nursing practice. It is not for the teacher to over-rule the university's decision to admit a student to nursing. One student wrote "My limp is not your responsibility, only my performance is your responsibility."

Another different problem was when different teachers gave contradicting information about nursing plans. This may have been partly a problem of expression in a second language (English).

(g) *Conclusion*

To conclude, the effective incidents were mainly examples of behaviours already identified in the literature as good teaching practice. However, the ineffective incidents included many not previously identified. Some of these may be specific to the current situation in Jordanian nurse teaching, or they may reflect the relative inexperience of some teachers and the lack of guidelines about what clinical teaching should involve.

Overall, there were many problems with the practice of clinical teaching in Jordanian nursing schools. While students could cite examples of good

practices, they also cited many problems to do with poor, sometimes virtually nonexistent, supervision, inappropriate teacher-student interactions and unclear evaluations. Many of these problems had been identified in the previous literature. One student wrote "It is a shame that effective behaviour is very limited, but ineffective behaviour was unlimited and too frequent." In the past literature (Nehring, 1990; Magon & Knox, 1987; Bairly, 1954; Cormack, 1980) effective teaching behaviours have tended to be more frequent than ineffective ones. Here, it was the other way around.

It is fitting to conclude with another student message: "I think that nursing practice in itself is very enjoyable and very useful, but in our university it is very boring and not useful. From the beginning of the day we start counting minutes for the end of the day to come."

Chapter 8

General Discussion

This chapter will compare findings from the three studies conducted and relate them to the previous literature reviewed in Chapter 3. Of the three methods used, the critical incident method produced the strongest results and findings from the questionnaire and observational studies will be used to support the critical incident study's findings.

8.1 *Quantitative and Qualitative Data*

First, the advantages and disadvantages of qualitiative and quantitative data must be discussed. The questionnaire did not generally produce useful results, except for the single open-ended question and the overall rating of the course. There were a number of problems with the Likert items. First, a strong response bias, with all subjects tending to rate everything positively. Second, it may have been inappropriate to make subjects complete a lengthy questionnaire not in their native language. Third, students said that they were tired of completing questionnaires for research purposes, without obtaining any feedback. If a questionnaire were to be used again to evaluate nurse teaching in Jordan, then it should probably be in Arabic, should be brief and students should receive feedback about the results.

However, students reported prefering the open-ended, qualitative approach used in the open-ended question and the elicitation of critical

incidents. They felt that this was an opportunity to talk about teaching with the researcher, rather than merely writing a questionnaire. Students (and teachers) were able to produce suggestions for improving teaching which highlighted the existing problems and to bring up incidents which illustrated both good and bad teaching practices. Such qualitative material was time-consuming to gather and analyse, but produced much richer information about clinical teaching. Any future evaluation of clinical teaching in Jordan should therefore ask open-ended questions as well as closed ones.

8.2 *Comparing the results from the three studies*

Because the critical incident study produced the richest information, the approach here will be to discuss the data from the questionnaire and the direct observation study as supporting evidence for the issues found in the critical incident study. According to the jury used to assess the critical incidents, incidents could be classified into the following categories:

A. Interpersonal relationships, which corresponded to Jacobson's (1966) first (availability) and third (interpersonal relationships) categories.

B. Summative evaluation, which corresponded to Jacobson's (1966) sixth category of evaluation.

C. Formative evaluation, which also corresponded to this sixth category, as well as to components of the fourth category "teaching practices".

D. Professional competence, which corresponded to half of Jacobson's (1966) fifth category.

E. Motivating behaviour, which corresponded to parts of the fourth (stimulating, encourages problem-solving, non-threatening environment) and fifth (interpersonally pleasant) categories.

The jury was not aware of the past literature on clinical teaching, thus unlike Jacobson's (1966) scheme, the current categories have some objective support and for this reason they, rather than Jacobson (1966), will be used to organise the discussion. There is considerable overlap between the two schemes and all the issues raised in the modification of Jacobson's (1966) scheme described at the end of Chapter 3 were also raised in the research conducted here.

Having elicited suggestions for improving clinical teaching, observed teaching in practice and elicited critical incidents of good and bad practice, it is possible to assess the extent to which findings from the three methods support each other. It will be seen that this triangulation is generally good, although not every detail is identical, the key issues were identified by all three, or at least two methods.

8.3 *Summary of findings*

The findings from the three studies will be related together in table form, showing all issues which were found by at least two methods. Some matters were only reported in critical incidents. The numbers shown represent the numbers in in the tables of Chapter 7, listing all categories of critical incidents. In several cases, mention will be made of 3/10 teachers who were observed to use good teaching practices.

❽.3.1 *Interpersonal relationship*

(a) *Effective Interpersonal relationship*

	Critical Incidents	Open-ended Suggestions/ Observed
1	Respect students' opinion and is tolerant of students' disagreement.	Suggest teachers should accept student criticisms.
2	Tactful in dealing with students in front of patients.	Suggest teachers should respect the student.
4	Improve students standing in eyes of the patients and their families.	Suggest teachers should respect the student.
6	Shows confidence in students' abilities, help them to be independent learners.	Suggest teachers should consider the student's individual learning needs.

(b) Ineffective Interpersonal relationship

	Critical Incidents	Open-ended Suggestions/ Observed
1	Do not respect the confidentiality of students' relationships	Observed teachers gossiping about students in judgemental ways.
2	Do not take in to consideration religious beliefs or understand values of students.	Observed students being made to nurse patients of the opposite sex.
3	Do not deal with female and male students in the same pattern.	Observed teachers' preference to work with students of the opposite sex.
4	Do not help students to be honest while engaging in writing nursing care plan for their patients.	Observed instructions to write care plan as a priority over giving care.
7	Do not build up a trust relationship with the students.	Observed lack of contact between some teachers and students.

It was not always possible to directly observe ineffective interpersonal interactions because the teachers were unlikely to behave in this way in front of the researcher and because often observed teachers barely interacted with students (see "Motivators" below). The key issue for effectiveness appears to be respect for the student and his or her opinions. There was no single ineffective activity, but rather a number of behaviours which appear somewhat inappropriate for a teacher, excepting the issue of cross-gender nursing, which is contentious in Jordan.

❽.3.2 *Summative Evaluation*

(a) *Ineffective Summative Evaluation*

(no effective bevaviours)

	Critical Incidents	Open-ended Suggestions/ Observed
1	Do not evaluate the students using a clear criteria.	Suggested need for clear criteria.
2	Evaluate the students mainly on nursing and medical theory more than practice.	Suggested changing evaluation tools to reflect practice.
4	Do not discuss their evaluation of students with the students individually.	Suggested individual feedback about evavluation.
7	Discriminate between students in their evaluation (not objective).	Suggested that teachers should be objective.

Summative evaluation was not observed directly as examinations were not taking place during the observation periods. Basically, it seemed to be felt that current summative evaluation procedures for clinical work were not clear or fair.

❽.3.3 *Formative Evaluation (Feedback)*

(a) *Effective Formative Evaluation*

	Critical Incidents	Open-ended Suggestions/ Observed
1	Teachers provide helpful and timely feed back during and after performance of the procedure by the students; A) Explain why response/action is right. B) Explains why response/action is wrong. C) Identify area of improvement.	3/10 teachers, including both joint appointments were observed to behave in this fashion. Suggested a need for feedback to be given periodically.

(b) *Ineffective Formative Evaluation*

	Critical Incidents	Open-ended Suggestions/ Observed
1	No feed back provided from clinical teachers after procedure whether positive or negative.	Observed a lack of feedback from most teachers. Suggested a need for feedback to be given.

The key problem with formative evaluation would appear to be that it was not always provided in any form, in part because of difficulties in teaching students distributed across different hospital floors and in part because of teachers' infrequent, sometimes inappropriate interactions with students.

❽.3.4 *Professional Competence*

(a) *Effective Professional Competence*

	Critical Incidents	Open-ended Suggestions/ Observed
1	Demonstrate and teach technical skills in nursing activities were required, shows and explains	Observed that some teachers did this, particularly those with joint appointments. Suggested more focus on practice rather than theory.
2	Make students aware of their professional responsibilities in the clinical setting.	Observed some teachers participating in clinical activities as role models, others not. Suggested that students be oriented to clinical duties
3	Give the students the freedom to do it on their own, help them to be independent learner.	Observed teachers discouraging independence, by restricting students to one room.
4	Shows genuine interest in patients and their care i.e. act as a role model in this aspect.	Some teachers got involved in patient care, most did not. Suggested using teachers with clinical experience.

(b) *Ineffective Professional Competence*

	Critical Incidents	Open-ended Suggestions/ Observed
1	Do not answer students' questions, instead make the question as an assignment to them.	Observed in one case.
2	Gives incorrect information, gives unclear clues.	Suggested need for inservice education to keep them informed. Suggested need for teaching qualification for staff.
6	Lack experience in performing many nursing skills.	Observed reluctance of teachers to become involved in clinical procedures. Suggested better training for teachers.
7	Concentrate in theory more than practice in their discussion with the students.	Suggested focus on practice, not theory.
8	Misses teachable moments.	Observed a general lack of interaction between teachers and students, and missing the busiest ward time entirely.

Problems in professional competence appeared to be attributed to teachers' inexperience. It was suggested that teachers should (a) have higher degrees, (b) be trained to teach, (c) be kept up to date on nursing by inservice training and (d) be involved in clinical nursing, as well as in university duties. These suggestions seem reasonable on the basis of the problems identified.

❽.3.5 *Motivation*

(a) *Effective (Encourages) Motivation*

	Critical Incidents	Open-ended Suggestions/ Observed
1	Orientate the students to the clinical setting and to the objectives of the clinical rotations.	Only 3/10 teachers were observed doing this, including both joint appointments.
2	Create a relaxed atmosphere making learning enjoyable.	This was observed notably for one particular jointly appointed teacher.
3	Available to work with students as situation arises i.e. takes immediate and appropriate action in case of emergency.	Most teachers were observed to be not available to students for sufficient time.
4	Praise students, expressing confidence on them.	The same 3/10 teachers were observed to use praise. Suggested that students be reinforced, not just criticised.
5	Act as an advocate to students.	Observed for one jointly-appointed teacher. Suggested that relationships between clinical staff, teachers and students be better coordinated.
6	Support students learning (act as a facilitator).	The same 3/10 students were observed to facilitate learning. Suggested that individual learning needs be considered.
7	Is tolerant to students' mistakes.	Suggested need for reinforcement, rather than just punishment for mistakes.
8	Shows understanding and recognition of the individuality of the students.	Suggested that individual learning needs be considered.

(b) *Ineffective (Discourages) Motivation*

	Critical Incidents	Open-ended Suggestions/ Observed
1	Is not familiar with the clinical setting; -Do not make orientation to the students at the beginning of the course. -Do not orientate the hospital staff to the role of the students.	These problems were observed for all but 3/10 teachers. Orientation of students to setting, and staff to students was suggested, as was that teachers should have worked in the setting.
2	Not available most of the time.	This was observed particularly for teachers whose students were distributed on different floors. Suggested more time should be spent with students.
3	Impersonal, showing irresponsibility or inability to handle situation in case of Emergency.	It was observed that some teachers appeared unwilling to undertake clinical tasks at all, even when available.
4	Do not consider that sometimes students exposed to certain clinical experiences before having any theoretical background specially at the beginning of the semester.	Suggested consider individual learning needs.
5	Restrict the students in one room with one patient all the day in the clinical setting.	This was observed for some teachers.
6	Concentrate on students appearance.	
7	Do not have professional appearance.	Suggested that teachers should dress according to code.
9	Do not consider individual learning needs.	Suggested that individual needs be considered.
10	Do not consider individual limited abilities.	Suggested that individual needs be considered.

Most of these motivational issues centre around teacher-student interaction. The fundamental problem was that some teachers interacted little with students, or indeed ward staff. In addition, for some the interactions which did occur were impersonal and not oriented towards undertaking clinical tasks.

❽.4 *Factors affecting clinical teaching effectiveness*

The main goal of the research was to document factors contributing to clinical teaching effectiveness. A key finding from the research was in fact that clinical teaching as observed and described by both students and teachers was often not very effective in Jordan. For this reason, the factors affecting effectiveness will be discussed in terms of the barriers which appeared to reduce effectiveness, before going on to describe the characteristics of effective teaching.

❽.4.1 *Organisational barriers*

(a) *Insufficient teacher - student contact*

The first requirement for clinical teaching to be effective on the basis of the past literature, and this research, would appear to be adequate teacher - student contact in the clinical setting. This was sometimes reduced in Jordan by a teacher's students being distributed about the hospital, rather than together on one unit. While about 12 students per teacher is not excessive, it appeared to be unmanagable and unsatisfactory for both students and teachers when the students were distributed. There is a need for at least one teacher per clinical unit, no matter how few students are placed in that unit. However, even when teachers were one per unit adequate contact was not necessarily maintained.

One of the suggestions made about improvements to clinical teaching was that the current clinical time was insufficient. If there were more time in the clinics, then it would also be possible for there to be more contact between teachers and students in the clinical setting, but current clinical time was not often used well for teaching.

(b) *Poor liason between clinical staff and teaching staff*

In the direct observations it was notable that the jointly-appointed staff appeared to teach effectively, as did one of the university-appointed teachers. There were many suggestions and incidents which highlighted a basic lack of liason between clinical staff and teaching staff, leading at times to lack of clarity about the role of students (and teachers) in the clinical setting, lack of cooperation of clinical staff in teaching, failure to involve students in clinical tasks and many other problems. Some teachers failed to orient students to the wards, or clinical staff to the students. This led to some teaching sessions where students basically stood about observing the activities of the ward, but did not become involved in the clinical activities themselves. Even when teachers were present with them, involvement did not always occur and not all clinical teachers would engage in clinical activities themselves. The past literature emphasises the importance of students becoming involved in and practicing clinical tasks. Additionally, the literature emphasises the importance of the teacher serving as a role model, which is impossible if the teacher avoids activities which the student could model.

(c) *Unclear role of the clinical teacher*

A related issue was that the role of the teacher appeared to be unclear. Some clinical teachers used a formal, classroom approach to teaching in the clinical setting, emphasising theory rather than practice and interacting with students only in terms of question and answer, as they might in a classroom.

(d) *Unclear criteria for clinical evaluation*

There were many incidents and comments from students about the lack of clarity about how they were being evaluated on their clinical placements. This problem was so severe that no incidents of effective summative evaluation were provided. It is known from personal knowledge about the system in Jordan that the evaluation forms in use at the time of the research were unsatisfactory and did not clearly specify the criteria to be used. These are currently being improved.

Another reason for poor evaluation methods may have been that many teachers were relatively inexperienced and had not been trained to teach, as shown by the suggestions for improved teacher training and monitoring. In combination, the lack of clear criteria and inexperienced teachers appears to have led some teachers to evaluate not merely poorly but inappropriately, using personal prejudice or gossip to judge students, using evaluation as a threat and being unwilling or unable to discuss evaluations with students.

Inadequate guidelines may also have explained the difficulties of formative evaluation, which was often virtually absent and was sometimes presented as if it were summative evaluation, for example when students were criticised and evaluated poorly for errors the first time they attempted a procedure.

To sum up there were two kinds of organisational barriers, inadequate liason between teachers/ the nursing schools and the hospital staff and system and inadequate guidelines for the conducting of clinical teaching, particularly for the evaluation of clinical teaching.

❽.4.2 *Teacher barriers*

It is difficult to separate stable characteristics of the teacher from their behaviour as dictated by the teaching situation in which they find themselves. Although it is useful to discuss some barriers in terms of teacher characteristics and behaviour, this is not to blame the teachers. Generally, as shown in the demographic data from the questionnaire, the clinical teachers were relatively inexperienced teachers, many had acquired postgraduate degrees outside Jordan and many had little clinical experience. The teachers also faced the organisational barriers described above. Nonetheless, some of their behaviours were problematic.

(a) *Lack of contact with students*

Even when teachers supervised students within a single unit, students described many incidents when teachers did not interact with students. This was not clearly observed in the direct observations, probably because of the presence of the researcher. If there is only limited teacher - student contact then teaching will also be limited and students' clinical experiences may be restricted, or haphazard.

(b) *Inadequate contact with students*

There were many incidents, observations and suggestions that contact was often restricted to "Hi and Bye" perhaps with the addition of some remarks about the students' personal appearance, or personal affairs. This was the extreme, but appeared not to be uncommon. Teachers sometimes left students to get on with it, sometimes restricted to one room of a ward, without

orienting them to the ward, orienting the staff to the students, without remaining available to the students and without setting any clear clinical or learning objectives.

(c) *Lack of orientation and involvement in the clinics*

Some teachers were essentially outsiders, who had not acquainted themselves with the clinics prior to teaching in them, who did not introduce students to staff, did not involve clinical staff in teaching and did not participate in clinical activities themselves. When they interacted with students at all, then this tended to be to discuss the theoretical aspects of a patient's condition, or, less often, to demonstrate a nursing procedure. These teaching activities were not integrated into the operation of the clinic and students complained that some teachers withdrew them if the clinical staff had to conduct procedures on patients, rather than seizing the opportunity for teaching about those procedures.

(d) *Lack of adequate formative feedback*

Given the low levels of teacher - student interaction, formative feedback often did not occur at all. When it did, students reported incidents and made suggestions which indicated that teachers sometimes emphasised mistakes, but did not praise the positive, were excessively critical the first time a student attempted a procedure, used formative evaluation punitively (as part of summative evaluation) rather than using it as a learning opportunity, or to assess students' individual learning needs and sometimes told students that they were wrong but did not explain the correct procedures. Students suggested that sometimes the teachers did not appear to know the correct

procedures themselves. At other times, the teachers appeared to be more concerned to demonstrate their own expertise than to allow the students to learn. For example, they would sometimes take over a procedure which the student already was competent to undertake. Teachers were sometimes unwilling to listen to student suggestions, even when these were correct.

(e) *Lack of respect for students*

Students reported via both the critical incidents and the suggestions for improvement two kinds of disrespectful behaviour from teachers. (1) General lack of respect, including belittling, being judgemental , making inappropriate personal remarks and operating a double standard where teachers did not adhere to the dress code demanded of students. (2) Cultural insensitivity, most often insisting on the application of Anglo-American nursing standards to the Jordanian situation, whether or not this was necessary or appropriate.

The general lack of respect may have been due to the teachers' inexperience, leading to defensiveness towards students and a concern to impose, rather than show, their authority. The problem of cultural insensitivity may have been due to the fact that most clinical teachers in Jordan have received postgraduate education abroad, few have worked in Jordanian hospitals themselves (except the jointly-appointed staff) and that the medium of nursing instruction is English, including the textbooks which are all written from a British or American perspective.

There is no simple way of summarising the teacher barriers, but they generally suggest that teachers often found themselves in teaching situations where they neither knew nor had been instructed how to behave.

❽.4.3 *Effective teaching*

As already noted, unlike previous critical incident studies, this research found far more ineffective than effective incidents. This suggests that effective teaching practices were rare. On the basis of this research the most effective clinical nurse teachers in Jordan would either have joint appointments, or would be university-appointed staff who had made efforts to orient and integrate themselves into the wards where they would be teaching. They would teach in only one ward at a time and would have clinical experience sufficient to enable them to be involved in and knowledgeable about the clinical activities of that ward.

Given that background effective clinical teaching, here and in the previous literature reviewed in Chapter 3, would involve the following:

(a) *Interpersonal relationships*

The teacher would interact with the students, respect their opinions and tolerate disagreement, be tactful and praising in front of patients, show sympathy, show confidence in student abilities and encourage independent learning.

(b) *Summative evaluation*

The teacher would be able to provide fair evaluations and be willing to discuss these with individual students. This would require clear criteria for evaluation, which are currently absent.

(c) *Formative evaluation*

The teacher would provide regular feedback to students, be able to explain why a nursing behaviour is right or wrong and identify areas in which students should seek to improve. Formative evaluation, particularly from early on in clinical training, would not be used against students in their summative evaluations.

(d) *Professional competence*

The teacher would be able to demonstrate technical skills and procedures and give their rationales. Also, make students aware of their responsibilities in the clinical setting, both as a role model and by explaining those responsibilities. The teacher would have the confidence and judgement to give students some autonomy and would become involved in patient care, again serving as a role model in this regard.

(e) *Motivating behaviour*

The teacher would motivate the students by providing an adequate orientation to the clinical setting and creating a relaxed, enjoyable learning environment. Also, by being available when required for advice or help with procedures, particularly in emergencies. The teacher would praise students and defend them to staff and patients. The teacher would encourage learning, tolerate mistakes and show understanding of students as individuals with individual learning needs.

It would appear that, as described by Rogers (1983) the students' view of the effective teacher is of an individual who has both knowledge and good

communication skills and who supports student learning, rather than imposing teaching or letting students learn without assistance. In the clinical setting "knowledge" means knowledge of relevant clinical procedures and of the particular ward where teaching is occurring.

❽.5 *The reasons for the study reconsidered*

It is also of interest to reconsider the problems with clinical nurse teaching identified informally in Chapter 1. It is likely that the observed deficiencies in the clinical skills of recent graduates were due to the poor teaching practices documented here. Some teachers also provided inappropriate role models for students, emphasising theoretical and writing skills rather than clinical practices. Also, clinical teaching time was not a positive experience for many students and this may have contributed to their reluctance to engage in clinical work. Although student unwillingness and lack of clinical time may also have caused problems (not documented here), it was clear that the available clinical teaching time was often being used ineffectively. The specific concerns about cultural insensitivity, particularly the use of textbooks and models of nursing developed in American and Britain, also appeared to cause some problems in that the needs of Jordanian, usually Muslim, patients can differ.

❽.6 *Conclusions*

There were three objectives of this research. The first was to overview what clinical teaching activities ought to be. The desired activities were very similar to those found in the previous literature, but were often defective or absent in Jordan. The second objective was to describe the social context and

setting of clinical teaching. This was found to be often poorly integrated with clinical practice, and to involve not enough teacher - student interaction. The third objective was to identify effective and ineffective behaviour of clinical teachers. These have been summarised above.

This initial research has served to identify several behaviours and factors important to clinical teaching in Jordan. The majority of these are very similar to the previous factors identified elsewhere. In addition, some problems with inappropriate interpersonal interactions and cultural insensitivities were identified. Being a first study, this work may have overlooked some issues and the questionnaire and critical incident data may both be biased by students towards an emphasis on the negative. Nevertheless this study has found sufficient information to form the basis of some practical recommendations for change, which will be described in the final chapter.

Chapter ⑨

Limitations and implications of the research

⑨.1 *Limitations*

A. This research has relied primarily on views of student nurses to describe effective and ineffective clinical teaching behaviour. One limitation of this approach is that it cannot guarantee the realism of the incidents they described or the improvements they suggested, although the direct observational data supported some of the students' descriptions and the teachers' also identified some of the same problems with clinical teaching in the open-ended question from the questionnaire. There is some concern in teaching evaluation that students may not be able to evaluate teaching accurately, or may be excessively negative (Dixon and Koerner, 1976)), although some have suggested that the student is the most appropriate evaluator of teaching (Morton, 1987). Even if the ineffective incidents reported were exaggerated, there was considerable consensus among students and between different study methods and any occurrence of some of the ineffective behaviours mentioned would be cause for concern.

B. For this population of students, eliciting critical incidents produced more useful information than having them complete a questionnaire. If there had been sufficient time, it would have been possible to also ask teachers and administrators to give critical incidents. Whether or not these would have resembled those offered by students is unknown. Taking one common problem - teachers not interacting with students - as an

example, it may be that the teachers had good reasons for leaving students unsupervised in the hospital wards, which the students failed to appreciate.

C. It is important to point out that the questionnaire was highly valid and reliable, unfortunately this consistency was due to a consistent response bias with all subjects, both students and teachers, tending to answer all items the same way, usually positively. After correcting for this response bias, the results were essentially meaningless, neither discriminating teachers from students nor highlighting clear issues or problems.

D. Another approach which could have been used to assess clinical teaching qualities was to seek opinions on hypothetical situations (Oppenheim, 1992). This approach can work well, but only if realistic hypothetical situations can be written. In the situation being studied here, it was not obvious initially what problems would be identified. A further difficulty with hypothetical situations is that subjects may not know how they would really respond and may give idealised or unrealistic answers. In contrast, in the critical incidents students knew how they had behaved and felt.

E. A further limitation of this research was that it was focussed on teaching behaviour, rather than the organisation, administration and physical environment of teaching. While the latter issues came up to some extent, the ineffective teaching behaviours identified should not be used to blame the teachers. To an unknown extent, their behaviour was constrained by the other factors. With hindsight, it would have been useful to ask the teachers to identify the problems with teaching from their perspective.

⑨.2 *Implications for the evaluation of clinical teaching*

The accounts of effective clinical teaching developed in the primarily American literature appeared to apply to Jordan. The classification scheme developed by the jury who assessed the critical incidents was broadly similar to that initially suggested by Jacobson (1965) and modified since.

However a number of problems with clinical teaching in Jordan had not been previously identified in the literature. Some of these related to religious and cultural issues, others reflected some fundamental problems in the practice of teaching, such as spending barely any time with the students.

The most useful method in the Jordanian setting appeared to be the critical incident method. It would be of interest to study clinical teaching practices with this method in other Arabic countries and with other types of student. The problems identified in Jordan may be unique to the nursing schools in that country, or they may reflect more general cultural differences between Arabic and Anglo-American culture.

The teaching/ learning process is a complex human transaction dependent on a multitude of variables, psychological, sociological and environmental . The complexity of this process is multiplied by the milieu in which clinical teaching takes place: Pain, suffering and the ever present threat of death; found in most clinical settings, create an atmosphere unsuitable for learning. Added to this highly charged atmosphere is the fear of possible grave consequences resulting from errors the learner might commit. The ability to transform this unsuitable milieu into one conducive to learning is a skill needed by an effective clinical teacher, a skill not often shared by teachers in other settings (Morgan, 1987).

Against this background, the problems identified in this research, although serious, are understandable and probably have remedies. It is appropriate to conclude this thesis with some suggestions for improvement.

⑨.3 *Recommendations for clinical teaching in nursing in Jordan*

On the basis of this reseach a number of problems have been identified. Here, some solutions to those problems are suggested. It should be pointed out that while the problems are grounded in the research findings, their solutions are merely suggestions. Further research would be required to discover if the suggested changes were feasible and successful.

A. Clinical teaching should be organised so that it is possible for teachers to be with students in a supervisory role.

B. Clear objectives for clinical teaching should be set. Teachers appeared to vary in what they thought the objectives to be. For some, the students were merely expected to be present at a patient's bedside, for others the students were left to wander around and observe a ward. Only a few provided the kinds of practical training in clinical skills and development of a professional attitude which the previous literature recommends.

C. Serious consideration should be given to the possibility of clinical nurse teachers working ward hours and being based in no more than one or two wards. Failing this, nursing school teaching staff should be encouraged to form the best possible relationships with ward staff prior to teaching sessions, and to orient ward staff to the roles of teachers and students during the clinical teaching sessions.

D. New clinical teachers require training in teaching methods, particularly in interpersonal skills and in the theory of clinical education, emphasising the importance of formative evaluation and the distinction between formative and summative evaluation.

E. New clinical teachers require clinical experience themselves and a mechanism should be developed for those who are appointed primarly on academic merit to obtain further clinical experience within the Jordanian health care system.

F. Islam and Jordanian cultural values both have implications for the provision of nursing care. Both students and new clinical teachers should be taught about these issues, to supplement the current nursing textbooks and other teaching material which is primarily of Anglo-American origin.

F. The criteria and forms for summative evaluation of clinical students need to be improved so that summative evaluation is seen by students to be fair and so that staff can explain the basis of their evaluation to students.

G. The methods of students routinely evaluating teachers should be improved. Ideally, using a brief questionnaire, in Arabic, with some open-ended questions.

H. A system should be developed for clinical teachers to self-evaluate their teaching.

I. There is a need to conduct research regarding teachers' job satisfaction and perceptions of clinical teaching problems. Teachers showed many ineffective behaviours, but to an unknown extent these may have been caused by problems with the organisation or administration of teaching, or with the clinical environment. For example, perhaps a relatively

young and inexperienced teacher should not be expected to go to a ward by themselves, establish good relationships with the staff then successfully teach without additional assistance from the nursing school. Teachers's opinions would suppliment the research conducted here.

J. After changes to clinical teaching the research should be repeated to monitor improvement.

⑨.4 *Conclusion*

The dimensions of effective and ineffective behaviour in clinical teaching which emerged from this study could serve as a basis for evaluating clinical teaching. An objective, or at least fair, measure of effectiveness would provide valuable information to both the individual instructor and the nursing school and would enable improved teaching practices.

There is no end point to learning in a complex arena of human behaviour, but it is hoped that this research will make a small contribution towards helping clinical teachers become more aware of thier own attitudes and behaviours so that the teaching given to students may always be effective, that is, thoughtful, sensitive and positive.

Appendices

APPENDIX (I)

General Figures of Chapter (2) {Jordan Chapter}

I.1 *General country data* *

			Year
1	Population Estimate (millions)	3.45	1991
2	Population Projections (millions)	4.75	2000
3	GDP per capita (US$)	1250.0	1991
4	Urban Population (% of total)	68.0	1990
5	Adult Male Literacy Rate (% of 12 + years of age)	85.0	1990
6	Adult Female Literacy Rate (% of 12 + years of age)	75.0	1990
7	Higher Education Enrollment Rate	24.0	1989
8	Population Density (per sqkm)	39.0	1990
9	Low Birth Weight Babies (%)	15.0	1985

I.2 *Population* *

				Year
1	Crude Birth Rate (per 1,000 population)		38.0	1990
2	Crude Death Rate (per 1,000 population)		6.20	1990
3	Annual Rate of Natural Increase (%)		3.20	1991
4	Total Fertility Rate		5.70	1990
5	Infant Mortality Rate (per 1,000)		38.0	1990
6	Life Expectancy at Birth (years)		67.0	1990
7	Population Age Structure (%)	0-4 years	18.4	1990
		5-14 years	27.0	1990
		15-64 years	51.8	1990
		65 + years	2.40	1990
8	Women in Childbearing age (15-49 years of age in 000's)		740.0	1990
9	Maternal Mortality Rate (per 100,000 live birth)		40.0	1990

* **Source:**
Document of the World Bank (1992). Health Management Project: Staff Appraisal Report. Amman: Ministry of Planning Library.

I.3 *Health sector resources* *

			Year
1	Population per physician	445	1990
2	Population per nurse	1,640	1990
3	Population per Hospital Bed	600	1990
4	MOH primary care centers	759	1990
	Primary care centers	274	1990
	MCH centers	161	1990
	Dental clinics	110	1990
	Village health clinics	214	1990
5	Comprehensive health centers	18	1991
6	Hospital beds	5,749	1990
	Ministry of Health	2,233	1990
	Royal Medical Services	1,503	1990
	Jordan University Hospital	507	1990
	Private sector	1,506	1990
7	Population per pharmacist	1,570	1991
8	Total Expenditure on Health as % of GDP	8.5	1991
9	Public sector expenditure as % of Government Budget	8.4	1991
10	MOH Budget as % of Total Governmental Budget	5.2	1991

I.4 *Hospital utilization* *

			Year
1	Admissioins per 1,000 population	93.00	1988
2	Total patient days per 1,000 population	335.0	1988
3	Average Occupancy Rate (%)	60.20	1988
4	Average Length of Stay (days)	3.600	1988

* **Source:**
Document of the World Bank (1992). Health Management Project: Staff Appraisal Report. Amman: Ministry of Planning Library.

I.5 *Definitions of health, and population* *

Adult Literacy Rate	The percentage of persons aged 12 and over who can read and write.
Contraceptive prevalence Rate	The percentage of married women of reproductive age who are using a modern method of contraception at any time.
Crude Birth Rate	Number of live births per year per 1,000 people.
Crude Death Rate	Number of deaths per year per 1,000 people.
Infant Mortality Rate	Annual deaths of infants under 1 year per 1,000 live births during the same year.
Life Expectancy at Birth	The number of years a newborn child would live if subject to the age-specific mortality rates prevaliing at time of birth.
Low Birth Weight (LBW)	Infant weight at birth less than 2,500 g. LBW may be associated with either per-term (less than 37 weeks gestation) or full-term but small-for-dates (38 weeks or more) of gestation.
Maternal Mortality Rate	Number of maternal deaths per 100,000 live births in a given year attributable to pregnancy, childbirth or post-partum.
Morbidity Rate	The frequency of disease or illness in a population.
Mortality Rate	The frequency of death in a population.
Rate of Natural Increase	Difference between crude birth and crude death rates; increase usually expressed as a percentage.

* **Source:**

Document of the World Bank (1992). Health Management Project: Staff Appraisal Report. Amman: Ministry of Planning Library.

I.6 *Establishment of Nursing Education Programs: A Historical Perspective*

I.6.1 *Non - University - Nursing Education* *

Year	Programme
1952	Midwifery/ Diploma/ MOH
1953	Basic General Nursing/ Diploma/ MOH
1962	Basic General Nursing/ Diploma/ RMS
1972	Practical Nursing/ MOH
1977	Post-basic Midwivery/ Diploma/ MOH
1987	Secondary School Nursing Education/ MOE
1984	Two Basic General Nursing Colleges established/ Diploma/ MOH
1989	Two General Nursing Colleges Conjoined on one college/ Diploma/ MOH.

I.6.2 *University - Nursing Education* *

Year	Programme
1972	BSN/ University of Jordan
1983	BSN/ Jordan University of Science and Technology
1983	Post Diploma-BSN/ University of Jordan
1986	Master of Science in nursing. Education/ University of Jordan
1992	BSN/ University of Applied Sciences/ Private
1993	BSN/ Al-Zaytona University/ Private

* **Source:**
Document of the World Bank (1992). Health Management Project: Staff Appraisal Report. Amman: Ministry of Planning Library.

APPENDIX (II)

Research Questionnaire

Dear Student,

Thank you for participating in this study. The study is designed to identify the characteristics of effective clinical teaching as perceived by senior nursing students, and nurse educators. And to evaluate the current status of clinical teaching at two settings : The Faculty of Nursing at the University of jordan and the Faculty of Nursing at the University of Science and Technology. The purpose of this study is to improve clinical teaching in nursing.

Your answers will be kept confidential, therefore, your name is not required, please fill out the questionnaire following the guideline as shown at the beginning of each section.

Thank you again for your time and cooperation.

The Researcher,
Ferial Hayajneh

Note :

The attached questionnaire consists of 3 sections as follows:

1 - The first section focuses on biographical data.

2 - The second section focuses on the evaluation of the current situation of clinical teaching at the faculties of nursing.

3 - The third section consists of open ended questions as related to the clinical practice.

student questionnaire:

For office use

☐☐☐
1 2 3

1 - biographical data :

please put (x) beside each of the following.

1 - Sex

A . male ☐
B . female ☐

☐ 4

2 - Cummulative grade point average.

☐ 5

A . 60 - 67 ☐
B . 68 - 75 ☐
C . 76 - 83 ☐
D . 84 - 100 ☐

3 - Your high School national exam score was.

☐ 6

A . 60 - 67 ☐
B . 68 - 75 ☐
C . 76 - 83 ☐
D . 84 - 100 ☐

Please, check yes or no by placing an (x) infront of each Statement as appropriate.

4 - You are studying nursing because :

No.	Statement	Yes	No	
a	You want to be a nurse and work with patient.			☐ 7
b	You want to teach nursing only.			☐ 8
c	You had no other choices due to you avarege in high school (tawjehi).			☐ 9
d	You want to insure a job after gradution.			☐ 10
e	Please list andy other reason.			☐ 11
5	Please choose the most important two statements from the above question (Q.5) and rank them in order of preference.			
	A - Most important ☐			☐ 12
	B - Next most important ☐			☐ 13

2 - Evalution of the current status of clinical teaching in nursing :

Direction :

listed below are three groups of possible activities of the clinical teacher :

A . Group **1** : (Items of orientation to clinical practice).
B . Group **2** : (Items of on - site activities).
C . Group **3** : (Items of outcome results).

You. as a senior nursing student. are asked to check one-column by placing an (x) beside each item indicating whether you believe that this item was applied or not applied in your setting during your clinical teaching.

EXAMPLE

Statement	Always applicable	Some times applicable	Rarely applicable	Never applicable
The number of clinical instructors exceeds the number of nursing students in your setting				X

II.A Group I : (Items of orientation to the clinical practice).

Direction :

Please: remember that you are required to place an (x) in the appropriate column beside each of the following items :

The clinical teacher :

No.	Statement	Always applicable	Some times applicable	Rarely applicable	Never applicable	For office use 1 2 3
1	discusses with you the main objectives of the clinical practice course.					☐ 14
2	discusses with you the use of each form as related to the requirement of each semester course.					☐ 15
3	discusses with you the kind of procedures you are allowed to perform in the clinical setting.					☐ 16
4	introduces you to the main adminstrative personnel of clinical setting: (Hospital director. Nursing director, etc ...)					☐ 17
5	orientates you to the hospital's nursing policy, Roles and Regulation of nursing practice.					☐ 18
6	discusses with you the evaluation form items.					☐ 19

No.	Statement	Always applicable	Some times applicable	Rarely applicable	Never applicable	For office use 1 2 3
7	Accompanies you "through a tour to the clinical area at the begining of the semester.					☐ 20
8	Discusses with you the human rights as related to the patient. nurse relationship.					☐ 21
9	lists all procedures with a format that allows measurable behaviour.					☐ 22
10	Discusses with you the principle of professional ethics.					☐ 23

Group 2 : (Items of on - site activities).

Direction : Please, remember to place an (x) in the appropriate column beside each of the following items :

The clinical teacher :

No.	Statement	Always applicable	Some times applicable	Rarely applicable	Never applicable	For office use 1 2 3
1	is available in the clinical area at the time of your arrival.					☐ 24
2	prepares all teaching cases before assigning them to you.					☐ 25
3	conducts with you a daily nursing round.					☐ 26
4	performs nursing procedures infront of you .					☐ 27
5	acts as a resourse person to you (being competent).					☐ 28
6	directs you in setting the nursing care plan to the patients.					☐ 29
7	supervises you while implementing the nursing care plan to patients.					☐ 30
8	review the nursing care plan with you.					☐ 31
9	is available for you most of the time.					☐ 32
10	has a professional appearance (i.e. Nursing uniform, short nails,).					☐ 33
11	is familiar with the clinical setting.					☐ 34

No.	Statement	Always applicable	Some times applicable	Rarely applicable	Never applicable	For office use ☐☐☐ 1 2 3
12	keeps a note about your positive and negative attitudes in the clinical course.					☐ 35
13	cooperates with other health team members to facilitate your learning.					☐ 36
14	respects you as an individuals. (avoids embarrassing you).					☐ 37
15	is flexible (open minded). with you.					☐ 38
16	provides you with periodic feedback about your progress in the clinical practice.					☐ 39
17	Asks you for a feedback inorder to improve the clinical teaching.					☐ 40
18	guides you in new/ and or difficult situation.					☐ 41
19	returns your written asignments corrected within a week.					☐ 42
20	ciscusses with you her comments as shown in corrected written assignments.					☐ 43
21	considers your individual learning needs.					☐ 44
22	is realistic in her expectations from you as a learner.					☐ 45

No.	Statement	Always applicable	Some times applicable	Rarely applicable	Never applicable	For office use 1 2 3
23	is able to shoot troubles if they arise in the clinical area.					☐ 46
24	directs you while doing health education to the patients.					☐ 47
25	helps you to correct your own mistakes.					☐ 48
26	reinforces your positive attitudes.					☐ 49
27	conducts with you case presentations as scheduled.					☐ 50
28	acts as an advocate for you.					☐ 51
29	apply theory to practice.					☐ 52
30	recommends to you reading texts and/ or articles before going to clinical practice.					☐ 53

2.C.1. Group 3 : (**Items of outcome criteria**).

Please remember to place an (x) in the appropriate column beside each of the following items :

The clinical teacher :

No.	Statement	Always applicable	Some times applicable	Rarely applicable	Never applicable	For office use 1 2 3
1	provides you with self evaluation opprotunities.					☐ 54
2	avoids her/his personal relation ship influence your evaluation. evaluate you objectively.					☐ 55
3	allow Freedom of discussion of the evaluation items after your evaluation.					☐ 56
4	involve the hospital staff in your evaluation.					☐ 57

1 - From your point of view as a senior nursing student, you rate the current status of clinical teaching in your setting as :

A - Poor ☐
B - Satisfactory ☐
C - Good ☐
D - Excellent ☐

☐ 58

2 - From your piont of view, as a senior nursing student, the number of students per each clinical - teacher should be :

Please put (x) bside the appropriate answer :

A - From 3 - 5 ☐
B - From 6 - 8 ☐
C - From 8 - 10 ☐
D - From 11 - 13 ☐

☐ 59

3 . C. As a senior nursing student, if you had the power to change three things in order to improve the teaching of clinical nursing in your setting, what changes would you bring about?.

1 - .....

.....

2 - _____

_____

3 - .....

.....

Thank you for your Cooperation

The Researcher

Ferial hayajneh

Dear Colleague

Thank you for participating in this study. The study is designed to identify the characteristics of effective clinical teaching as perceived by senior nursing students, and nurse educators. And to evaluate the current status of clinical teaching at two settings : The Faculty of Nursing at the University of jordan and the Faculty of Nursing at the University of Science and Technology. The purpose of this study is to improve clinical teaching in nursing.

Your answers will be kept confidential, therefore, your name is not required, please fill out the questionnaire following the guideline as shown at the beginning of each section.

Thank you again for your time and cooperation.

The Researcher,
Ferial Hayajneh

Note :

The attached questionnaire consists of 3 sections as follows:

1 - The first section focuses on biographical data.

2 - The second section focuses on the evaluation of the current situation of clinical teaching at the faculties of nursing.

3 - The third section consists of open ended questions as related to the clinical practice.

Faculty questionnaire:

For office use

☐☐☐
1 2 3

1 - biographical data :

please put (x) beside each of the following.

1 - Sex

A . male ☐
B . female ☐

☐ 4

2 - Marital Status:

A . single ☐
B . married ☐
C . others ☐

☐ 5

3 - Educational degree :

A . Bachelo'r degree ☐
B . master's degree ☐
C . PHD degree ☐

☐ 6

4 - Number of years of experience in teaching clinical and/ or class room).

A . less than 2 years ☐
B . 2 - 6 years ☐
C . more than 6 years ☐

☐ 7

5 - Number of years of clinical experience before teaching

A . less than 2 years ☐
B . 2 - 6 years ☐ ☐ 8
C . more than 6 years ☐

6 - your area of speciality is :

A . medical - surgical ☐
B . psychiatry ☐
C . Maternity ☐
D . pediatrics ☐ ☐ 9
E . community ☐
F . adminestration ☐

2 - Evalution of the current status of clinical teaching in nursing :

Direction :

listed below are three groups of possible activities of the clinical teacher :

A . Group **1** : (Items of orientation to clinical practice).
B . Group **2** : (Items of on - site activities).
C . Group **3** : (Items of outcome results).

You, as a nurse educator, are asked to check one column by placing an (x) beside each item indicating whether you believe that this item was applied or not applied in your setting during your clinical teaching.

EXAMPLE

Statement	Always applicable	Some times applicable	Rarely applicable	Never applicable
The number of clinical instructors exceeds the number of nursing students in your setting				X

II.A Group I : (**Items of orientation to the clinical practice**).

Direction :

Please; remember that you are required to place an (x) in the appropriate column beside each of the following items :

As a Nurse educator in the clinical area you :

No.	Statement	Always applicable	Some times applicable	Rarely applicable	Never applicable	For office use 1 2 3
1	discuss with the Students the main objectives of the clinical practice course.					☐ 10
2	discuss with the Students the use of each form as related to the requirement of each semester course.					☐ 11
3	discuss with the Students the kind of procedures they are allowed to perform in the clinical setting.					☐ 12
4	introduce the Students to the main adminstrative personnel of clinical setting; (Hospital director, Nursing director, etc ...).					☐ 13
5	orientate the Students to the hospital's nursing policy, Roles and Regulation of nursing practice.					☐ 14
6	discuss with the Students the evaluation form items.					☐ 15

No.	Statement	Always applicable	Some times applicable	Rarely applicable	Never applicable	For office use 1 2 3
7	accompany the Students "through a tour to the clinical area at the begining of the semester.					☐ 16
8	discuss with the students the human rights as related to the patient, nurse relationship.					☐ 17
9	lists all procedures with a format that allows measurable behaviour.					☐ 18
10	discuss with the students the principle of professional ethics.					☐ 19

Group 2 : **(Items of on - site activities).**

Direction : Please, remember to place an (x) in the appropriate column beside each of the following items :

As anurse educator, you :

No.	Statement	Always applicable	Some times applicable	Rarely applicable	Never applicable	For office use 1 2 3
1	are available in the clinical area at the time of students arrival.					☐ 20
2	prepare all teaching cases before assigning them to the students.					☐ 21
3	conduct with the students a daily nursing round.					☐ 22
4	perform nursing procedures infront of the Students.					☐ 23
5	act as a resourse person to the Students (being competent).					☐ 24
6	direct the students in setting the nursing care to the patients.					☐ 25
7	supervise the students while implementing the nursing care plan to patients.					☐ 26
8	review the nursing care plan with students.					☐ 27
9	are available for the students most of the time.					☐ 28
10	have a professional appearance (i.e. Nursing uniform, short nails,).					☐ 29
11	are familiar with the clinical setting.					☐ 30

No.	Statement	Always applicable	Some times applicable	Rarely applicable	Never applicable	For office use ☐☐☐ 1 2 3
12	keep a note about students positive and negative attitudes in the clinical course.					☐ 31
13	cooperate with other health team members to facilitate students learning.					☐ 32
14	respect sudents as an individuals. (avoids embarrassing them).					☐ 33
15	are flexible (open minded). with students.					☐ 34
16	provide the students with periodic feedback about their progress in the clinical practice.					☐ 35
17	ask the students for a feedback inorder to improve the clinical teaching.					☐ 36
18	guide the students in new/ and or difficult situation.					☐ 37
19	return the students written asignments corrected within a week.					☐ 38
20	discuss with the students your comments as shown in corrected written assignments.					☐ 39
21	consider the students individual learning needs.					☐ 40
22	are realistic in your expectations from the students as a learners.					☐ 41

No.	Statement	Always applicable	Some times applicable	Rarely applicable	Never applicable	For office use 1 2 3
23	are able to shoot troubles if they arise in the clinical area.					☐ 42
24	direct the students while doing health education to the patients.					☐ 43
25	help the students to correct their own mistakes.					☐ 44
26	reinforce sudents positive attitudes.					☐ 45
27	conduct with students case presentations as scheduled.					☐ 46
28	act as an advocate for the students.					☐ 47
29	apply theory to practice.					☐ 48
30	reccomend to the students reading texts and/ or articles before going to clinical practice.					☐ 49

2.C.1. Group 3 : (**Items of outcome criteria**).

Please remember to place an (x) in the appropriate column beside each of the following items :

As a nurse educator, you :

No.	Statement	Always applicable	Some times applicable	Rarely applicable	Never applicable	For office use ☐☐☐ 1 2 3
1	provide the students with self evaluation opprotunities.					☐ 50
2	avoid your personal relation ship influence your evaluation, evaluate students objectively.					☐ 51
3	allow Freedom of discussion of the evaluation items after students evaluation.					☐ 52
4	involve the hospital staff in your evaluation to the students					☐ 53

1 - From your point of view as a nurse educator you rate the current status of clinical teaching in your setting as :

A - Poor ..... ☐
B - Satisfactory ..... ☐
C - Good ..... ☐
D - Excellent ..... ☐

☐ 54

2 - From your piont of view, as a anurse educator, the number of students per each clinical - teacher should be :

Please put (x) bside the appropriate answer :

A - From 3 - 5 ..... ☐
B - From 6 - 8 ..... ☐
C - From 8 - 10 ..... ☐
D - From 11 - 13 ..... ☐

☐ 55

3 . C. As a anurse educator, if you had the power to change three things in order to improve the teaching of clinical nursing in your setting, what changes would you bring about?.

1 - .....

.....

2 - _____

_____

3 - .....

.....

Thank you for your Cooperation

The Researcher

Ferial hayajneh

APPENDIX (III)

Field Notes of Observational Method

III.1 *Session (1) of jointly appointed teacher*

(a)	*Gender of the teacher:*	*Female*
(b)	*Location of training:*	*J.U.H.*
(c)	*Area of speciality:*	*Administration, Paediatric*
(d)	*Date of observation:*	*1.12.1993*
(e)	*Duration of observation:*	*7.30 - 9.30*
(f)	*Number of students:*	*3 administration (4 yrs N. students)*
		11 Paediatric (third yr N. students).

Brief description of the situation

The teacher is hospital employee act as a nursing supervisor for the paediatric unit at the same time she is acting as a clinical teacher for nursing students in paediatric and administration courses; (preceptor). The teacher is constantly approach by many staff members, doctors, ward clerk, patients' relatives....in addition to the students.

There are three administration and 11 paediatric students. She welcomed them and looked at the objectives of each one. For example one student wanted to distribute medication and she looked at the student "When you see the medication nurse tell her that you want to help her to distribute medication and I will tell her to help you". Other students wanted to see colostomy, she

said " I will notify the staff member responsible and let you do it", and so on for other students objectives.

After she looked at all the students objectives she said: "I will not let you leave the floor until you achieve all your objectives" while she was smiling, she said "I want you to feel that this is your floor, your home, whatever you like to work just help the nurses while they are providing patient care, attending rounds, feeding babies whatever" and she looked at the students smiling and the students respond with smiles and moods then they quickly leave her to began their work on the floor.

After that she starts talking to the three administration students (it is their first day), she orientates them to the floor section, patients of each and facilities available. Some students interrupt the teacher and ask questions. She responded in an even tone as if it is part of her planned tasks.

Then she took the administration students on nursing round and showed them all sections, this took a half an hour, went back to nursing. The three students were in a circle around her.

After she finished the round she took the students to her office and let them feel as if they are all colleagues, she kept smiling all the time and look to them all then she said: "You are three senior students, I want each one to act as a team leader for one week for paediatric and administration students and I do expect from you to organise the work and do assignment for the students. However, the team leader has to come at 7 a.m. and to attend the nursing round with the floor nurses". Then, the students left the office and they went to the nurses station and there the teacher collected all the unit papers, schedules relevant forms. She demonstrated how to complete the forms and sent them to the nursing office. The students are watching very carefully nodding their heads and trying to be closest to the teacher.

Meanwhile the students asked questions about possible problems affecting scheduling, she said "Good point", she answered these questions in an even voice as if there were part of her planned table. Then she went into more detail about specifics on these papers. She starts to discuss other administrative tasks as supervisor, such as checking supplies, writing request for supplies.

Suddenly one doctor comes shouting because a solution was not available on the floor. She took the students with her to the patients room where the doctor was, she smiled and said "Do not worry we will solve it". She wrote an urgent request for the solution to central supply and sent someone to get it. The students were watching how she immediately solved the problem. She said while we are waiting: "let us look to see if any other solutions are missing". Then a student raised a question about where there are bringing things: solutions, syringes, etc. She stopped and answered in detail all the requests and supply departments. She was looking at the students and picked up each item in the supply and stated which department has it and which form is used to request it. Afterwards, she finished answering the students questions and checking.

Next she discussed how patients are charged for supplies used in order to maintain the hospital budget. She emphasised nursing responsibility and showed how to fill out form for one patient. Then she explained how she made other requests example for maintenance, milk, video tapes. Still the students were listening carefully, touching papers. She asked the students to fill out the papers on their own.

III.2 *Session (2) of jointly appointed teacher*

Students came to the floor at 7:30am. Teacher already present at the floor busy giving both for 2 year old baby with his mother. She welcomed them how are you. Sorry I'm busy now giving a bath. One of the students began to help with the bath. Teacher is playing with the child during bath. Child wants to climb into her lap. All (teacher, child mother, students) are laughing and happy. Teacher sits the child on the bed, dresses him.

She asked the students "who would like to feed this child". All respond enthusiastically me, me. One student, a female, was selected and put the child on her lap.

The teacher starts talking to the mother about the way and the kind of food suitable for the child due to his condition (intusseption) and at the same time she was looking to the students and explaining to them the importance of giving special food for the child.

One student raised a question, how this disease occurs ? the teacher reply "Oh that's a good question. This occurs so... and so... and can be diagnosed by simple kub and then continued". She kept looking at the students and smiling and before she finished she said "Is this clear ? are you satisfied" the student look to her and said: "Yes, thank you".

The teacher took the students to the nursing station. She stands next to a bulletin board, then points to assignment assignment sheets. She asks them: "What is assignment ? why make assignments ? what is the benefit of it ?". While her back was turned to the students as she pointed to different points of the assignment sheet, a students asked her a question. She turned completely around and looked straight at the student, smiled and responded: "Good point. I am glad you asked that question". She responded in a quite even manner "Yes we can do that". Meanwhile the nurses station was noisy and busy.

A patients family was speaking with the ward clerk on the telephone the ward asked the teacher to speak with them to discuss the health status of their child. Before going to the room, the teacher told the students: "Truly their is seriously ill, and I do not want to say any thing that will alarm them or mislead them. But still I want to give them hope so I say sometime non committal "In sha Allah (if it is Allah's will) he will get better". I will tell them ". Then she spoke briefly on the telephone (she used even a telephone call as an opportunity to teach the students).

She returned to the assignment sheet subject, she asked someone to get an empty assignment sheet and to fill it. She asked a student to call the paediatric course students for discussion of medication, administration in the unit. She took the students to the narcotic cupboard showed its contents and explained to them the rules and regulations of narcotic usage and administration. She told the students how these were applied in the ward. The students had many questions such as who keeps the keys ?, what do you do if a vial breaks, how do you get more on findings when the pharmacy is closed. She answered these questions in an even tone patiently. While talking to the students a doctor passed by and asked about the condition of one of the patients. She answered him in the same manner as she spoke to the student. Near the narcotic box was the medication cupboard, she took the students to it and oriented them to the contents, rules and regulations, how to obtain other medication, how organised, and how preparing for the patients. She also described the role of medication nurse. She gestured as she emphasised the need for exact dosages. The students asked many questions throughout her discussion. The teacher stopped immediately and said in a loud voce: "look darlings" and emphasised the possible mix up with look like or similar name drugs or excessive dosages - all potentially fatal to paediatric patients.

The students seemed started by the change in their teacher's voice and looked at her most intentionally (Throughout both sessions with this teacher it has been observed that there is always great interaction between students and teacher, whether in information giving and questioning, or by smiling)

Suddenly, one student said please teacher yesterday you promised me to explain DC shock. Promptly the teacher took the students to the DC shock next to the emergency trolley. She said to the students: "You must know everything on this floor. If I forget to tell you something, please remind me".

Then she showed them how to operate the Dc shock and its parts. She next discussed nursing process and nursing notes: How to write it and how to implemented and uses on the floor. Then she took a nursing process form and filled it with a newly admitted patient esophagialatrasia. First she welcomed the mother and asked her question about the history and expectations. The mother was sad. the teacher put her hand on the mother's arm and shoulder. Meanwhile a student sat down on the other side of the bed next to the child and also talk to the mother. Then she took them to the emergency trolley and discussed with the student how to check and organise it. The students still are paying attention to her by look at her and asking questions (This is despite the long information giving session of their teacher). Then she told the administration students to gather the nursing process forms and prepare to report to her. They were also to assess the progress of the paediatric students.

III.3 *Teacher worked in different units*

(1)	*Gender of the teacher:*	*Female*
(2)	*Location of training:*	*special units of J.U.H.*
(3)	*Area of speciality:*	*ICU, CCU, Recovery, OR, ER.*
(4)	*Duration of observation:*	*7:30 - 9:30 am.*
(5)	*Number of students:*	*10 (2 in each unit).*

Brief description of the situation

All units are quite different and on different floors. Teacher going to CCU (6th floor), ER (zero floor), then going to ICU and theatre operating room (2nd floor) for which she must watch and dress gown to enter.

Those students are all males who are enrolled in maternity, who are not permitted to take clinical in maternity hospital so are placed in other units for clinical experience students are not assigned to a single patients. Instead they are floating in the unit, free to observe or become involved in patient care as supervised by staff. It is the first day of their clinical rotation.

I met with the teacher in the ER. Two students were there. Teacher said "good morning, how are you ?". Students wondered why no patients in the emergency. Teacher went to supervisor of the floor and ask to take care of the students. ER is full with equipment and special things that need to be discussed. Then she looked at the students and said: "I will come back to see you later".

She went next to CCU 6th floor (there is 5 patients with CHF). She said to the students: "good morning, how are you ?". They were in the process of giving bed bath, teacher said: "oh, that is good. What else did you do ?".

Students said: "We clean the trolleys and attend the medical round".
Teacher said: "OK - have a nice time, I will see you later".

Then she went to the supervisor of the unit and ask her to report on them at the end of the shift and said: "sorry, I cannot stay for long, I have students in other units".

Then the teacher left sixth floor and went to the first floor to see two student in the ICU. there in ICU there were 5 cases - 3 car accidents, one liver serrocies and one postoperative coma. She went to the student and ask "could you please show me your specific objectives", then she read it loudly then asked: "how are you going to achieve these objectives ?".
Student said: "I hope this procedures will be done by a doctor today and I will be able to see it". The teacher said: "OK that is fine". Then the teacher said: "let us talk about the nursing observation sheet in this unit and how to record patients signs, did you ask any nurse how they are using it ?".
The student said: "yes".

Then the teacher look to the side there was unconscious patient, with CVP line, she took the student to that patient and drew the curtains and greatly and at length discussed need for privacy. The teacher put her hand on the patient's wrest and located the arterial pulse, and she asked the student: "what is the difference between the arterial and radial pulse ?". He gave some answer, she said: "any thing else", the student added more then she completed the answer.

Then the teacher went to another patient and began discussion about catheterization. She stood at the side of the bed, resting her knee on the bed and facing the student and ask: "if we want to insert a catheter with what kind of lubricant ? what can we do with removal of catheter if we want to have a sample for urine calture".

The student said: " We have to remove the water from the baloon ?".
The teacher said: "What else ?". The teacher did not respond, then said: "We have to send the tip of the catheter for calture. 1st we have steps of changing catheter (she was using fingers to count it) 1st tell the patient 2nd select the catheter, 3rd clean the area....etc.".
The teacher said: "is this okay with you ?".
Students said: "yes".

Then the teacher left that patient and went to another. This patient had multiple procedures: NG tube, endotracheal intubation, chest drain, catheter. She stood at the side of the bed with her arms crossed and said: "Why does he had this...", she looks over and nods, and this ... and this....and so on.

Then they went to the other two patients, one of the patient respiration machine was alarming the teacher was not able to maintain it. So a staff nurse was called and between the two they were able to maintain it. Then she told the student: "take this patient and write about it in a nursing care plan. Get involved in any other case if you want. I need to go now, see you later. Bye".

Now the teacher went to the recovery room where she has two students. But when she went there she did not find them. She asked the staff nurse. She said: "they went to look for her because they did not know what to do there".

Then she went to the theatre, and met with students in the minor room. The students were setting and drinking tea with technician there. The teacher said: "what are you doing ?". The student said: "There is nothing to be done. What do you want us to do ?". The teacher also found the students who were missed from the recovery. The teacher said: "why you came here ? you have to be in the recovery room.". The student said: "No body came to ask about us, we thought we had no teacher today. There were no patients there. So why stay ? ". The teacher said: "Why you did not wait me to come". The student

said: "We are used to seeing our teacher at 7:30 not at 9:30 a.m.". The teacher said: "Okay, go back to your place (recovery)". The students replied: "OK, we will, as soon as we finish our tea". The teacher whispered to staff member: "they are rude students. I won't argue with them", and then the teacher started her next round starting from Emergency Room in the first floor and ending in the CCU in the six floor.

III.4 *Teacher worked in different units in the same floor*

(1)	*Gender of teacher:*	*Female*
(2)	*Location of training:*	*J.U.H.*
(3)	*Area of speciality:*	*Maternity.*
(4)	*Date of observation:*	*23.12.1994*
(5)	*Duration of observation:*	*7.30 - 9.30 am.*
(6)	*Number of students:*	*11 students*

Brief description of the situation

The teacher is in the 9 month pregnancy. The students are distributed to four departments in the same floor:

Gynea unit	3 students
post partum unit	3 students
Delivery room	3 students
N. nursery	2 students

This is the first day for this group in these units.

The students came half an hour before the teacher and kept waiting for her in the visitors room till she came. When she arrived she, immediately she said: "Good morning" and she sat. She starts reading the names of the students, she looked at them and said: "I want to read your name for three reasons, 1st to check the absenteeism, 2nd to know you in person, and 3rd to distribute you to the different units. Excuse me". While she was looking at the students and smiling, she said: "I do not know about were each of you was in the first rotation, just tell me". Each student told her where she was and then they were distributed to the area where they did not get access previously.

After that she told them to go to the units according to their distribution and said: "I will follow you after some time". (The students went to the units without any previous orientation or without introducing them to the nurses in the floor).

Then the teacher went to the delivery room, she sat with a nurse there and she drunk coffee. After that she left to the postpartum department. She starts searching for the students. She found them, one was with caesarean section patient, the teacher looked at the student while she was standing beside the door of the room, and the student is beside the patient, the distance is around 3 meters. The teacher said: "What are you doing", the student replied: "I am trying to do morning care to this patient because she had SIC last night". The teacher respond: "OK, do bed bath, bed making , take observation, and write all what you do in a paper, OK. I will see you later". (The teacher did not reach the patient bed, did not make any communicating with the patient and not even reach her and she left the student).

She searched about the other student, she was in other room, the room is full with medical student (medical round), the teacher said: "Oh, it is very crowded, very noisy ", and she whispered in the student's ear: "I will see you later". (The teacher did not try to attend the medical round or try to see what exactly the student made).

After she left the room, while she was in away to leave the unit, she saw one student in other room sitting on a chair. She stopped and said loudly to her while she was pointing by her finger: "It is not allowed for you to sit in the patient room", then she left the unit.

Now she is in the Gynea unit, she found the students still waiting in the nursing station waiting her to assign them to certain patient. The time is around 9 am, (of course the morning care given to the patient) immediately the teacher

took the nursing process and stand beside the students, she looks at them and said: " OK, I will select for you the cases now". Now the teacher is looking to the nursing process of the patients and she is talking to herself: "Oh, good, this nice cases. You (student no. (1)) can go to room no. (3) and work there,....", and the same done to other students. Then the students went to their patients. (She did not discuss with the students the patients diagnosis or what is expected from them though it is the first time to them in this hospital).

Before she left she went to the students and stand beside the door while they are in their room and she look at them and said: "I am leaving you now and I will come after some time". One of the students looks and move her hand up and down and turned her face in a strange manner.

Now the teacher is in the delivery room, beside the door the two students are still waiting her to come and put them inside. Beside the door they waited more than 15 minutes to have a sterile gowns to be in (the role is to dress strile gown) then the teacher came in and said: "Good morning" to the supervisor and ask her about the cases in the delivery, the supervisor informed that there is CIS case. The teacher look at the students and told them: "OK you must prepare yourself to attend it", accidentally the teacher saw placenta in the minor room. The teacher said: "Oh, very good, let us go and examine". She look to one student and said: "Could you please go and call your colleagues from Gynea and postpartum unit and tell them that I want to explain to them about placenta". The students gathered, they look very happy to see the placenta. One student said: "Oh, since six weeks I am waiting to see placenta".

Now the teacher starts explaining about the placenta after she dressed gloves. She look at the students and said: "I would like to show you the parts of the placenta and to explain to you it is function, OK". She said: "Just I need your attention", the student were getting closer and closer to her and looking and listening very carefully while she was explaining and looking to them. She

was using her finger to clarify some points, and she manipulated to placenta in many direction to let the students see all its parts. One student raise a question (Is placenta same in all normal cases ?), the teacher respond: "Oh, good question, I think so...and so....". While she was looking to the students and left the placenta and starts using her hands while looking to the students and looking to all. Then, when she finished, she said: "Is this clear ?", the student said: "Yes, thank you". Then she finished her explanation about placenta and the students discard and left.

Met with the students in the postpartum at 7.30 am. It is the first day in this week for the students. Either the teacher or the students, they do not know any thing about the units, the teacher said to the student: "Good morning", and immediately she checked the absenteeism and after that she said: "It is your luck you might or might not find cases in the units, just we will see", (I think if the teacher came earlier she would know what cases were available and would not consider assignment to be a matter of luck but a matter of planning by the instructor).

She continued: "Any way for the three students who will go to Delivery Room, one has to take patient's history, the second has to do physical examination, and the third has to do observation and vital signs". She said that while she was pointing this by her fingers. The students and the teacher are still setting in the minor room.

Now about the group who wants to go to the postpartum, your role are, she opened her left hand and separated her fingers and she pointed by each finger:

1. to do bed side nursing
2. to attend the round
3. to behave professionally with the patients and others
4. do not gather

Then she stands and look at the students and said: "Since we are already in the postpartum, the students who are in the post, please come with me", and she went to the nursing station and she brought the nursing process and select certain patients to the students. While she was catching the pen in her hand she told the students: "Now you can go to your patients and do not forget to give me a nursing care plan for your patient". Then she returned back to the minor room. Of course the rest of students are still waiting her. She said: "It seems to me it is difficult to know about your previous experience, she nodded her hand up and down and she look at the students and said: "I think the best thing to do is to contact your teacher in the previous area and ask her about you individually". Then she stand and told the student: "Let us go to the delivery room and to the Gynea unit".

She knock the delivery room door and said good morning to the supervisor and told her: "I brought you a morning gift, two students, please take care of them. I will see you after I finish from the Gynea unit". Then she took the last two students to the Gynea unit and she said good morning to the staff in the nursing station, and then immediately she took the nursing process and started reading the cases from the nursing process. Then she selected two cases to the students and said to them: "I want you to assess the human needs, and to write the nursing care plan" and she added other instructions and was moving her hands left and right. One student told the teacher: "Could you please tell me about the meaning of my patient's diagnoses (Indometerioses)". The teacher answered the student: "OK, Endometerioses is.....", (The teacher did not go with students to their patients or admit them to them or touch ant patient). She is dressing high shoes with polished nails, pregnant dress gown above her clothes, not touched ant patient by her hand or just talk to him.

APPENDIX (IV)

Contents of interview of C.I.T.

Dear Student,

I am inviting you to participate in this study which aim to identify factors contributing to clinical teaching effectiveness as perceived by senior nursing students. As you are in Year 4 of your study you are especially well qualified to tell me about effective and ineffective clinical teaching behaviour as you experience it during your previous training in the clinical field. Your answers will be kept confidential. Your name is not required you are asked to describe on the form provided as many incidents as possible.

Thank you very much for your co-operation.

Ferial Hayajneh

From your own experience during your previous clinical period, please try to recall a time when your teacher in the clinical setting did some thing which you think should be encourages because it seemed to be effective.

(1) What were the events leading up to this activity ?

---

(2) What did the teacher do that seemed so effective ?

---

(3) Why was the activity so effective ?

---

(4) Sex of the teacher

Male ..... Female .....

(5) Background of the teacher

PhD.....

MSc.....

BSc.....

APPENDIX (V)

Construct validity of the questionnaire

Correlation coefficient between each item and the domains sub-scores has to be calculated to provide another clue of the validity of the questionnaire.

Construct validity (correlation analysis) - pearson

Domain / Item	1	2	3	Total
1	0.52	0.51	0.33	0.52
2	0.66	0.55	0.42	0.59
3	0.71	0.55	0.37	0.61
4	0.68	0.54	0.47	0.60
5	0.65	0.50	0.40	0.56
6	0.63	0.49	0.39	0.54
7	0.37	0.23	0.19	0.27
8	0.69	0.52	0.37	0.58
9	0.64	0.47	0.38	0.53
10	0.73	0.62	0.50	0.68
11	0.37	0.46	0.29	0.45
12	0.48	0.62	0.39	0.61
13	0.55	0.66	0.44	0.66
14	0.55	0.64	0.47	0.65
15	0.51	0.61	0.37	0.60
16	0.56	0.69	0.51	0.69
17	0.51	0.66	0.42	0.65

To be continued in the next page

Domain	1	2	3	Total
Item				
18	0.653	784	0.52	0.77
19	0.57	0.76	0.50	0.74
20	0.43	0.53	0.31	0.52
21	0.37	0.49	0.35	0.48
22	0.52	0.67	0.37	0.65
23	0.61	0.71	0.46	0.71
24	0.59	0.71	0.47	0.71
25	0.62	0.77	0.57	0.76
26	0.63	0.82	0.62	0.81
27	0.60	0.73	0.53	0.73
28	0.54	0.72	0.56	0.71
29	0.50	0.70	0.58	0.69
30	0.62	0.79	0.67	0.79
31	0.60	0.79	0.589	0.78
32	0.59	0.73	0.52	0.73
33	0.57	0.75	0.51	0.7
34	0.49	0.67	0.41	0.65
35	0.58	0.74	0.46	0.73
36	0.60	0.78	0.48	0.76
37	0.41	0.54	0.41	0.53
38	0.63	0.76	0.55	0.75
39	0.59	0.69	0.53	0.70
40	0.51	0.60	0.48	0.6
41	0.46	0.56	0.72	0.59
42	0.44	0.55	0.77	0.59
43	538	0.60	0.79	0.65
44	0.22	0.25	0.58	0.30

Reliability :

Cronbach alpha coefficient will be calculated for each domain and for the questionnaire as a whole as an indication of the reliability of the questionnaire.

$$\text{Internal Consistency Coefficient} = \alpha = \frac{K}{K-1}\left\{1-\frac{\sum \sigma_i^2}{\sigma^2}\right\}$$

Where:

K is the number of the items.

σ_i^2 is the variance of the i^{th} item.

σ^2 is the variance of the total score.

α_1 Domain (1) = 0.84

α_2 Domain (2) = 0.97

α_3 Domain (3) = 0.69

α Total = 0.97

APPENDIX (VI)

Letters of permission

Dean, Faculty of Nursing

University of Jordan

AMMAN - JORDAN

May 4, 1993

Letter of Permission

Dear Dean:

I am a Ph.D. student at the University of Glasgow. I recently came to Jordan to collect data for my research entitled 'Effective Clinical Teaching of Nursing Students at Jordanian Universities'. The purpose is to explore nursing educators' and nursing students' perception of effective clinical teaching and to evaluate the current status of clinical teaching of nursing at Jordanian Universities.

I am writing this letter to request your permission to collect data from staff members and fourth-year nursing students before their graduation because their perception may influence and shape decisions concerning strategies of clinical teaching of nursing.

The data will be collected through a self-administered questionnaire which may take sixty minutes to complete. Enclosed is a copy for you to look at.

The nature and rationale of the study will be explained to participants at the time of data collection. They will be informed that their participation is optional, and their responses will be kept strictly confidential. Upon completion of the study, the faculties of nursing at Jordanian universities involved in the study will be provided with a summary of findings.

Looking forward to hearing from you soon.

Sincerely,

Ferial A. Hayajneh

PO Box 509 Tariq

Amman - Jordan.

بسم الله الرحمن الرحيم

الجامعة الاردنية
THE UNIVERSITY OF JORDAN
AMMAN - JORDAN عمان - الاردن

كلية التمريض

Ref. 7 / 1 / 21 / 621

Miss Ferial Hayajneh
PO. Box 509 Tariq
Amman - Jordan

May 5, 1993

Dear Ferial

I received your letter dated may 4, 1993. You are welcome to collect data from fourth year nursing students and faculty members. Please, note that the students final exams will start May 19 till 27, 1993. We will arrange for you to collect data before May 19.

Concerning the Faculty of Nursing at the University of Science and Technology, I have called Dr. Roida Mai'ta the Dean of the Faculty of Nursing over the phone. She recommends to contact Mrs. Johara, a Faculty member, to help you in collecting data at their University.

Wishing you all the best.

Sincerely Yours"

Wafika A. Suliman
RN, Ph.D.
Dean of Faculty of Nursing
University of Jordan
Amman - Jordan.

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