Clinical Teaching Strategies in Nursing

Second Edition

Kathleen B. Gaberson & Marilyn H. Oermann

Teaching of Nursing

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This book is dedicated to all teachers of nurse educators.

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Preface

Teaching in clinical settings presents nurse educators with challenges that are different from those encountered in the classroom. In nursing education, the classroom and clinical environments are linked because students must apply in clinical practice what they have learned in the classroom. However, clinical settings require different approaches to teaching. The clinical environment is complex and rapidly changing, and a transformed health care delivery system has produced a variety of new settings and roles in which nurses must be prepared to practice.

The second edition of *Clinical Teaching Strategies in Nursing* examines concepts of clinical teaching and provides a comprehensive framework for planning, guiding, and evaluating learning activities for undergraduate and graduate nursing students and health care providers in clinical settings. While the focus of the book is clinical teaching in nursing education, the content is applicable to teaching students in other health care fields in which students will interact with patients or clients. The book describes a range of effective and practical clinical teaching strategies that are useful for courses in which the teacher is on-site with students, in courses using preceptors and similar models, in simulation laboratories, and in distance education environments. It also examines innovative uses of nontraditional sites for clinical teaching.

The book begins with three chapters that provide a background for clinical teaching and guide the teacher's planning for clinical learning activities. Chapter 1 presents a philosophy of clinical teaching that provides a framework for planning, guiding, and evaluating clinical learning activities. This philosophy forms the basis for the authors' recommendations for effective clinical teaching strategies. Chapter 2 discusses the intended and unintended results of clinical teaching; it emphasizes the importance of cognitive, psychomotor, and affective outcomes that guide clinical teaching and evaluation. In Chapter 3, strategies for preparing faculty, staff, and students for clinical learning are discussed. This chapter includes suggestions for selecting clinical teaching settings and for orienting faculty and students to clinical agencies.

The next three chapters explore the process of clinical teaching. Chapter 4 discusses various clinical teaching models, including traditional, preceptor, and partnership forms. This chapter also addresses important qualities of clinical teachers as identified in research on clinical teaching effectiveness and the stressfulness of clinical teaching and learning. Chapter 5 describes the process of clinical teaching, including identifying learning outcomes, assessing learning needs, planning learning activities, guiding students, and evaluating performance. Chapter 6 addresses ethical and legal issues inherent in clinical teaching, including the use of a service setting for learning activities and the effects of academic dishonesty.

The next part of the book focuses on effective clinical teaching strategies. One of the most important responsibilities of clinical teachers is the selection of appropriate learning assignments. Chapter 7 discusses a variety of clinical learning assignments in addition to traditional patient care activities and suggests criteria for selecting appropriate assignments. This chapter includes new content on service-learning activities. Chapter 8 focuses on self-directed learning activities; it reviews various approaches to meeting the individual needs of learners through the use of multimedia and computer-assisted instruction as well as more traditional print resources. In Chapter 9, the use of clinical simulation to supplement actual clinical learning activities is discussed, including suggestions for designing simulation scenarios and running them effectively. Chapter 10 describes one graduate nursing program's approach to clinical teaching in a distance learning program. The suggested strategies are applicable to a wide variety of graduate and undergraduate nursing education programs. Chapter 11 discusses the use of case method, case study, and grand rounds as clinical teaching strategies to guide the development of problem solving, decision making, and critical thinking skills. In Chapter 12, the role of conferences and discussions in clinical learning is explored. Effective ways to plan and conduct clinical conferences, questioning to encourage exchange of ideas and higher-level thinking, and the roles of the teacher and learners in discussions and conferences are presented.

Chapter 13 focuses on written assignments of various types, including short written assignments for critical thinking, journals, concept maps, and portfolios, among others. Suggestions are made for selecting and evaluating a variety of assignments related to important clinical outcomes. Chapter 14 describes effective strategies for using preceptors in clinical teaching. The selection, preparation, and evaluation of preceptors are discussed, and the advantages and disadvantages of using preceptors are explored. This chapter also discusses the use of learning contracts as a strategy for planning and implementing preceptorships. Chapter 15 presents examples of effective ways to use diverse settings such as community-based, international, and underused traditional patient care sites for clinical learning activities.

Chapter 16, the final chapter, is new to this edition and focuses on the critical issue of clinical evaluation and grading. It is a succinct summary of three chapters in the authors' text, *Evaluation and Testing in Nursing Education,* 2nd edition (Oermann & Gaberson, 2006, Springer Publishing Company), and readers are referred to this companion book for a more extensive discussion of that topic. With the addition of this new chapter, *Clinical Teaching Strategies in Nursing* is a comprehensive source of information for full-time and part-time faculty members whose responsibilities largely center on clinical teaching.

Our thinking about and practice of clinical teaching has been shaped over many years by a number of teachers, mentors, and colleagues as well as through our own clinical teaching experience. It is impossible to acknowledge the specific contributions of each, but we hope that by the publication of this book they will know how much they have influenced us as teachers. Although we now cannot identify the sources of many ideas that we have gradually formed into our own framework for clinical teaching, we wish to acknowledge the origin of two ideas discussed in this book. The concept of essential and enrichment curricula came from G. Bradley Seager, Jr. The notion that every clinical teacher has a philosophy of clinical teaching, whether or not the teacher knows it, was adapted from Elizabeth Whalen's philosophy of editing, whether or not she knows it.

We thank Sally Barhydt for her patience and encouragement.

Kathleen B. Gaberson
Marilyn H. Oermann

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Chapter 1

A Philosophy of Clinical Teaching

Every clinical teacher has a philosophy of clinical teaching, whether or not the teacher realizes it. That philosophy determines the teacher's understanding of his or her role, approaches to clinical teaching, selection of teaching and learning activities, use of evaluation processes, and relationships with learners and others in the clinical environment.

This book provides a framework for planning, guiding, and evaluating the clinical learning activities of nursing students and health care providers based on the authors' philosophy of clinical teaching. That philosophy of clinical teaching is discussed in this chapter. Readers may not agree with every element of the philosophy, but they should be able to see congruence between what the authors believe about clinical teaching and the recommendations they make to guide effective clinical teaching. Readers are encouraged to articulate their personal philosophies of nursing education in general and clinical teaching in particular to guide their own clinical teaching practice.

WHAT IS A PHILOSOPHY OF CLINICAL TEACHING?

In the sense that it is used most frequently in education, a *philosophy* is a system of shared beliefs and values held by members of an academic or practice discipline. Philosophy as a comprehensive scientific discipline focuses on more than beliefs, but beliefs determine the direction of science and thus form a basis for examining knowledge in any science. In the modern sciences, it is taken for granted that every scientist has and needs a philosophy (Uys & Smit, 1994).

Philosophical statements serve as a guide for examining issues and determining the priorities of a discipline (Butcher, 2004; Iwasiw, Goldenburg, & Andrusyszyn, 2005). Although a philosophy does not prescribe specific actions, it

gives meaning and direction to practice, and it provides a basis for decision making and for determining whether one's behavior is consistent with one's beliefs. Without a philosophy to guide choices, a person is overly vulnerable to tradition, custom, and fad (Fitzpatrick, 2005; Tanner & Tanner, 2006).

An educational philosophy includes statements of belief about the goals of education, the nature of teaching and learning, and the roles of learners and teachers (Iwasiw et al., 2005). It provides a framework for making curricular and instructional choices and decisions from among options. The values and beliefs included in an educational philosophy provide structure and coherence for a curriculum, but statements of philosophy are meaningless if they are contradicted by actual educational practice (Dillard, Sitkberg, & Laidig, 2005; Tanner & Tanner, 2006). In nursing education, a philosophy directs the curriculum development process by providing a basis for selecting, sequencing, and using content and learning activities (Iwasiw et al., 2005).

The development and periodic examination of a shared philosophy of nursing education can guide professional development and lay the foundation for a common sense of identity among the faculty (Iwasiw et al., 2005; Uys & Smit, 1994). Each individual nurse educator has an educational philosophy that contextualizes, frames, and focuses his or her teaching activity, whether or not the nurse educator is aware of it (O'Mara, Carpio, Mallette, Down, & Brown, 2000; Petress, 2003). An educational philosophy comprises the "assumptions, goals, choices, attitudes, and values" that determine how the educator perceives the task of teaching and the means by which he or she carries it out (Iwasiw et al., 2005, p. 128).

In nursing and other health care professions, one important type of educational philosophy is a philosophy of *clinical* teaching, a set of beliefs about the purposes of clinical education and the responsibilities of teachers and learners in clinical settings. To become more effective clinical teachers, nurse educators first must reflect on their fundamental beliefs and assumptions about the value of clinical education, the roles and relationships of teachers and learners, and how desired outcomes are best achieved. These beliefs serve as a guide to action, and they profoundly affect how clinical teachers practice, how students learn, and how learning outcomes are evaluated. Reflecting on the philosophical basis for one's clinical teaching can evoke anxiety about exposing oneself and one's practice to scrutiny, but this self-reflection is a meaningful basis for continued professional development as a nurse educator (O'Mara, et al., 2000).

A LEXICON OF CLINICAL TEACHING

Language has power to shape thinking, and the choice and use of words can affect the way a teacher thinks about and performs the role of clinical teacher. The

following terms are defined so that the authors and readers will share a common frame of reference for the essential concepts in the philosophy of clinical teaching.

Clinical

An adjective, the word *clinical* is derived from the noun "clinic," and it means involving direct observation of the patient. Like any good adjective, the word *clinical* must modify a noun. Nursing faculty members often are heard to say, "My students are in clinical today" or "I am not in clinical this week." Examples of correct use include "clinical practice," "clinical instruction," and "clinical evaluation."

Clinical Teaching or Clinical Instruction

The central activity of the teacher in the clinical setting is *clinical instruction* or *clinical teaching*. The teacher does not supervise students. Supervision implies administrative functions such as overseeing, directing, and managing the work of others. Supervision is a function that is more appropriate for professional practice situations than for the learning environment.

The appropriate role of the teacher in the clinical setting is competent guidance. The teacher guides, supports, stimulates, and facilitates learning. The teacher facilitates learning by designing appropriate activities in appropriate settings and allowing the student to experience that learning.

Clinical Experience

Learning is an active, personal process. The student is the one who experiences the learning. Teachers cannot provide a clinical experience; they can provide only the opportunity for the experience. The teacher's role is to plan and provide appropriate activities that will facilitate learning. However, each student will experience a clinical learning activity in a different way. For example, a teacher can provide a guided observation of a surgical procedure for a group of students. Although all students may be present in the operating room at the same time and all are observing the same procedure, each student will experience something slightly different. One of the reasons teachers require students to do written assignments or to participate in clinical conferences is to allow the teacher a glimpse of what students have derived from the learning activities.

ELEMENTS OF A PHILOSOPHY OF CLINICAL TEACHING

The philosophy of clinical teaching that provides the framework for this book includes beliefs about the nature of professional practice, the importance of clinical teaching, the role of the student as a learner, the need for learning time before evaluation, the climate for learning, the essential versus enrichment curricula, the espoused curriculum versus curriculum-in-use, and the importance of quality over quantity of clinical activities. Each of these elements of the philosophy is a guide to action for clinical teachers in nursing.

Clinical Education Should Reflect the Nature of Professional Practice

Nursing is a professional discipline. A *professional* is an individual who possesses expert knowledge and skill in a specific domain, acquired through formal education in institutions of higher learning and through experience, and who uses that knowledge and skill on behalf of society by serving specified clients. Professional disciplines are differentiated from academic disciplines by their practice component.

Clinical practice requires critical thinking and problem-solving abilities, specialized psychomotor and technological skills, and a professional value system. Practice in clinical settings exposes students to realities of professional practice that cannot be conveyed by a textbook or a simulation (Oermann & Gaberson, 2006). Schön (1987) represented professional practice as high, hard ground overlooking a swamp. On the high ground, practice problems can be solved by applying research-based theory and technique. The swampy lowland contains problems that are messy and confusing, that cannot easily be solved by technical skill. Nurses and nursing students must learn to solve both types of problems, but the problems that lie in the swampy lowlands tend to be those of greatest importance to society. Most professional practice situations are characterized by complexity, instability, uncertainty, uniqueness, and the presence of value conflicts. These are the problems that resist solution by the knowledge and skills of traditional expertise (Schön, 1983).

Because professional practice occurs within the context of society, it must respond to social and scientific demands and expectations. Therefore, the knowledge base and skill repertoire of a professional nurse cannot be static. Professional education must go beyond current knowledge and skills to prepare for practice in the future. Thus, clinical teaching must include skills such as identifying knowledge gaps, finding and utilizing new information, and initiating or managing change. Additionally, because health care professionals usually practice in interdisciplinary settings, nursing students must learn teamwork and collaboration skills (Oermann & Gaberson, 2006; Speziale & Jacobson, 2005).

Thus, if clinical learning activities are to prepare nursing students for professional practice, they should reflect the realities of that practice. Clinical education should allow students to encounter real practice problems in the swampy lowland. Rather than focus exclusively on teacher-defined, well-structured problems for which answers are easily found in theory and research, clinical educators should expose students to ill-structured problems for which there are insufficient or conflicting data or multiple solutions (Oermann & Gaberson, 2006).

Clinical Teaching Is More Important Than Classroom Teaching

Because nursing is a professional practice discipline, what nurses and nursing students do in clinical practice is more important than what they can demonstrate in a classroom. Clinical learning activities provide real-life experiences and opportunities for transfer of knowledge to practical situations (Oermann & Gaberson, 2006). Some learners who perform well in the classroom cannot apply their knowledge successfully in the clinical area.

If clinical instruction is so important, why does not all nursing education take place in the clinical area? Clinical teaching is the most expensive element of any nursing curriculum. Lower student–teacher ratios in clinical settings usually require a larger number of clinical teachers than classroom teachers. Students and teachers spend numerous hours in the clinical laboratory; those contact hours typically exceed the number of credit hours for which students pay tuition. Even if the tuition structure compensates for that intensive use of resources, clinical instruction remains an expensive enterprise. Therefore, classroom instruction is used to prepare students for their clinical activities. Students learn prerequisite knowledge in the classroom that they later apply and test in clinical practice.

The Nursing Student in the Clinical Setting Is a Learner, Not a Nurse

In preparation for professional practice, the clinical setting is the place where the student comes in contact with the patient or consumer for the purpose of testing theories and learning skills. In nursing education, clinical learning activities historically have been confused with caring for patients. In a classic study on the use of the clinical laboratory in nursing education, Infante (1985) observed that the typical activities of nursing students center on patient care. Learning is assumed to take place while caring. However, the central focus in clinical education should be on learning, not doing, as the student's role. Thus, the role of the student in nursing education should be primarily that of learner, not nurse. For this

reason, the term *nursing student* rather than *student nurse* is preferred, because in the former term the noun *student* describes the role better than does its use as an adjective modifying the noun *nurse* in the latter term.

Sufficient Learning Time Should Be Provided Before Performance Is Evaluated

If students enter the clinical area to learn, then it follows that students need to engage in activities that promote learning and to practice the skills that they are learning before their performance is evaluated to determine a grade. Many nursing students perceive that the main role of the clinical teacher is to evaluate, and many nursing faculty members perceive that they spend more time on evaluation activities than on teaching activities. Nursing faculty members seem to expect students to perform skills competently the first time they attempt them, and they often keep detailed records of students' failures and shortcomings, which are later consulted when determining their grades.

However, skill acquisition is a complex process that involves making mistakes and learning how to correct and then prevent those mistakes. Because the clinical setting is a place where students can test theory as they apply it to practice, some of those tests will be more successful than others. Faculty members should expect students to make mistakes and not hold perfection as the standard. Therefore, faculty members should allow plentiful learning time with ample opportunity for feedback before evaluating student performance summatively.

Clinical Teaching Is Supported by a Climate of Mutual Trust and Respect

Another element of this philosophy of clinical teaching is the importance of creating and maintaining a climate of mutual trust and respect that supports learning and student growth. Faculty members must respect students as learners and trust their motivation and commitment to the profession they seek to enter. Students must respect the faculty's commitment to both nursing education and society and trust that faculty members will treat them with fairness and, to the extent that it is possible, not allow students to make mistakes that would harm patients.

The responsibilities for maintaining this climate of trust and respect are mutual, but teachers have the ultimate responsibility to establish these expectations in the nursing program. In most cases, students enter a nursing education program with 12 or more years of school experiences in which teachers may have been

viewed as enemies, out to "get" students and eager to see them fail. Nurse educators need to state clearly, early, and often that they see nursing education as a shared enterprise, that they sincerely desire student success, and that they will be partners with students in achieving success. Before expecting students to trust them, teachers need to demonstrate their respect for students; faculty must first trust students and invite students to enter into a trusting relationship with the faculty. Setting up a climate of mutual trust and respect takes time and energy, and sometimes faculty will be disappointed when trust is betrayed. But in the long run, clinical teaching is more effective when it takes place in a climate of mutual trust and respect, so establishing such a climate is worth the time and effort.

Clinical Teaching and Learning Should Focus on Essential Knowledge, Skills, and Attitudes

Most nurse educators believe that each nursing education program has a single curriculum. In fact, every nursing curriculum can be separated into knowledge, skills, and attitudes that are deemed to be essential to safe, competent practice and those that would be nice to have, but are not critical. In other words, there is an *essential* curriculum and an *enrichment* curriculum. No nursing education program has the luxury of unlimited time for clinical teaching. Therefore, teaching and learning time is used to maximum advantage by focusing most of the time and effort on the most common practice problems that graduates and staff members are likely to face.

As health care and nursing knowledge grow, nursing curricula tend to change additively. That is, new content and skills are added to nursing curricula frequently, but faculty members are reluctant to delete anything. Neither students nor teachers are well served by this approach. Teachers may feel like they are drowning in content and unable to fit everything in; students resort to memorization and superficial, temporary learning, unable to discriminate between critical information and less important material. "Since it is impossible for faculty to teach everything that future nurses will encounter, nurse educators must be skillful in deciding what information is essential and how to teach it" (Speziale & Jacobson, 2005, p. 133).

Every nurse educator should be able to take a list of 10 clinical objectives and reduce it to 5 essential objectives by focusing on what is needed to produce safe, competent practitioners. To shorten the length of an orientation program for new staff members, the nurse educators in a hospital staff development department would first identify the knowledge, skills, and attitudes that were most essential for new employees in that environment to learn. If faculty members of a nursing

education program wanted to design an accelerated program, they would have to decide what content to retain and what could be omitted without affecting the ability of their graduates to pass the licensure or certification examination and to practice safely. Making decisions like these is difficult, but what often is more difficult is getting a group of nurse educators to agree on the distinction between essential and enrichment content. Not surprisingly, in nursing education programs these decisions often are made according to the clinical specialty backgrounds of the faculty: The specialties that are represented by the largest number of faculty members usually are deemed to hold the most essential content.

This observation is not to suggest that the curriculum should consist solely of essential content. The enrichment curriculum is used to enhance learning, individualize activities, and motivate students. Students who meet essential clinical objectives quickly can select additional learning activities from the enrichment curriculum to satisfy needs for more depth and greater variety. Learners need to spend most of their time in the essential curriculum, but all students should have opportunities to participate in the enrichment curriculum as well.

The Espoused Curriculum May Not Be the Curriculum-In-Use

In a landmark guide to the reform of professional education, Argyris and Schön (1974) proposed that human behavior is guided by operational theories of action that operate at two levels. The first level, *espoused theory*, is what individuals say that they believe and do. Espoused theory is used to explain and justify action. The other level, *theory-in-use*, guides what individuals actually do in spontaneous behavior with others. Individuals usually are unable to describe their theories-in-use, but when they reflect on their behavior they often discover that it is incongruent with the espoused theory of action. Incongruity between espoused theory and theory-in-use can result in ineffective individual practice as well as discord within a faculty group.

Similarly, a nursing curriculum operates on two levels. The espoused curriculum is the one that is described on paper, in the self-study for accreditation or state approval and in course syllabi and clinical evaluation tools. This is the curriculum that is the subject of endless debate at faculty meetings. But the curriculum-in-use is what actually happens. A faculty can agree to include or exclude certain learning activities, goals, or evaluation methods in the curriculum, but when clinical teachers are in their own clinical settings, often they do what seems right to them at the time, in the context of changing circumstances and resources. In other words, every teacher interprets the espoused curriculum differently, in view of the specific clinical setting, the individual needs of students, or the teacher's skills and

preferences. In reality, a faculty cannot prescribe to the last detail what teachers will teach (and when and how) and what learners will learn (and when and how) in clinical settings. Consequently, every student experiences the curriculum differently, hence the distinction between learning *activity* and learning *experience*.

When the notion of individualizing the curriculum is taken to extremes, an individual faculty member can become an "academic cowboy" (Saunders, 1999), ignoring the curriculum framework developed through consensus of the faculty in favor of his or her own "creative ideas and unconventional approaches to learning" (p. 30). Because a philosophy of nursing education is designed to provide clear direction to the faculty for making decisions about teaching and learning, the integrity of the program of study may be compromised if the practice of an individual clinical teacher diverges widely from the collective values, beliefs, and ideals of the faculty. Academic freedom is universally valued in the educational community, but it is not a license to disregard the educational philosophy adopted by the faculty as a curriculum framework. Thus, the exploration of incongruities between espoused curriculum and curriculum-in-use should engage the faculty as a whole on an ongoing basis, while allowing enough freedom for individual faculty members to operationalize the curriculum in their own clinical teaching settings.

Quality Is More Important Than Quantity

Infante (1985) wrote, "The amount of time that students should spend in the clinical laboratory has been the subject of much debate among nurse educators" (p. 43). Infante proposed that when teachers schedule a certain amount of time (e.g., 4 or 8 hours) for clinical learning activities, it will be insufficient for some students and unnecessarily long for others to acquire a particular skill. The length of time spent in clinical activities is no guarantee of the amount or quality of learning that results. Both the activity and the amount of time need to be individualized.

Most nursing faculty members worry far too much about how many hours students spend in the clinical setting and too little about the quality of the learning that is taking place. A 2-hour activity that results in critical skill learning is far more valuable than an 8-hour activity that merely promotes repetition of skills and habit learning. Nurse educators often worry that there is not enough time to teach everything that should be taught, but, as noted in the previous section, a rapidly increasing knowledge base assures that there will never be enough time. There is no better reason to identify the critical outcomes of clinical teaching and focus most of the available teaching time on guiding student learning to achieve those outcomes.

USING A PHILOSOPHY OF CLINICAL TEACHING TO IMPROVE CLINICAL EDUCATION

In the following chapters, the philosophy of clinical teaching articulated here is applied to discussions of the role of the clinical teacher and the process of clinical teaching. Differences in philosophy can profoundly affect how individuals enact the role of clinical teacher. Every decision about teaching strategy, setting, outcome, or role behavior is grounded in the teacher's philosophical perspective.

The core values inherent in an educator's philosophy of clinical teaching can serve as the basis for useful discussions with colleagues and testing of new teaching strategies. Reflection on one's philosophy of clinical teaching may uncover the source of incongruities between an individual's espoused theory of clinical teaching and the theory-in-use. When the outcomes of such reflection are shared with other clinical teachers, they provide a basis for curricular improvement and for the continual development of a sense of community within a faculty (Uys & Smit, 1994).

Nurse educators are encouraged to continue to develop their philosophies of clinical teaching by reflecting on how they view the goals of clinical education and how they carry out teaching activities to meet those goals. A philosophy of clinical education thus will serve as a guide to more effective practice and an effective means of ongoing professional development (Petress, 2003).

SUMMARY

A philosophy of clinical teaching influences one's understanding of the role of the clinical teacher and the process of teaching in clinical settings. This philosophy includes fundamental beliefs about the value of clinical education, roles and relationships of teachers and learners, and how to achieve desired outcomes. This philosophy of clinical teaching is operationalized in the remaining chapters of this book.

Terms related to clinical teaching were defined to serve as a common frame of reference. The adjective *clinical* means involving direct observation of the patient; its proper use is to modify nouns such as *laboratory*, *instruction*, *practice*, or *evaluation*. The teacher's central activity is *clinical instruction* or *clinical teaching*, rather than supervision, which implies administrative activities such as overseeing, directing, and managing the work of others. Because learning is an active, personal process, the student is the one who experiences the learning. Therefore, teachers cannot provide *clinical experience*, but they can offer opportunities and activities that will facilitate learning. Each student will experience a learning activity in a different way.