

Kathleen B. Gaberson  
Marilyn H. Oermann

Clinical Teaching  
Strategies in

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NURSING

# Clinical Teaching Strategies in Nursing

**THIRD EDITION**

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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, online, and through other experiences. However, clinical settings require different approaches to teaching. The clinical environment is complex and rapidly changing, with a variety of new settings and roles in which nurses must be prepared to practice.

The third 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. It is a comprehensive source of information for full- and part-time faculty members whose responsibilities largely center on clinical teaching. Although the focus of the book is clinical teaching in nursing education, the content is applicable to teaching students in other health care fields.

The book describes clinical teaching strategies that are effective and practical in a rapidly changing health care environment. It presents a range of teaching strategies 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. The book also examines innovative uses of virtual reality and nontraditional sites for clinical teaching.

A new feature of the third edition is an exhibit in each chapter that highlights sections of the Clinical Nurse Educator (CNE<sup>CM</sup>) Examination Detailed Test Blueprint that relate to the chapter content; the entire test blueprint is reprinted as an appendix with permission of the National League for Nursing. An instructor's manual with learning activities for each chapter, suggestions for teaching this content, and PowerPoint

presentations for each chapter are available to faculty members who adopt this textbook. To obtain an electronic copy, contact Springer Publishing Company (textbook@springerpub.com).

The book is organized into four sections. The first section, “Foundations of Clinical Teaching,” comprises five chapters that provide a background for clinical teaching and guide the teacher’s planning for clinical learning activities. Chapter 1 discusses various elements of the context for clinical teaching and presents a philosophy of clinical teaching that provides a framework for planning, guiding, and evaluating clinical learning activities. 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. Student use of personal digital assistants in preparation for clinical learning activities is a new addition to this chapter. Chapter 4 discusses the process of clinical teaching, including identifying learning outcomes, assessing learning needs, planning learning activities, guiding students, and evaluating performance. Various clinical teaching models are described. This chapter also addresses important qualities of clinical teachers as identified in research on clinical teaching effectiveness and the stressful nature of clinical teaching and learning. Chapter 5 addresses ethical and legal issues inherent in clinical teaching, including the use of a service setting for learning activities, the effects of academic dishonesty in clinical learning, and the appropriate accommodations for students with disabilities.

The second section of the book focuses on effective clinical teaching strategies. One important responsibility of clinical teachers is the selection of appropriate learning assignments. Chapter 6 discusses a variety of clinical learning assignments in addition to traditional patient care activities and suggests criteria for selecting appropriate assignments. Chapter 7 focuses on self-directed learning activities to achieve desired cognitive and affective learning outcomes. 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 8, the use of clinical simulation to complement actual clinical learning activities is discussed, including suggestions for designing simulation scenarios and running them effectively. Chapter 9 is a new addition to the book; its focus is on the use of

virtual reality and game-based learning in clinical education. The chapter includes theoretical bases for the use of these technologies and the value of virtual reality and game-based learning in helping students to develop understanding and skills related to culture and diversity that they can transfer to future clinical practice. Chapter 10 discusses the use of case method, case study, and grand rounds as clinical teaching methods to guide the development of problem-solving and clinical judgment skills. In chapter 11, the role of discussions in clinical learning and clinical conferences 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.

The third section includes chapters that discuss appropriate clinical teaching techniques for special circumstances and settings. Chapter 12 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 13 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 14 presents effective ways to use diverse settings for clinical learning activities. A number of examples of such settings are given, such as community-based, international, and underused traditional patient care sites.

The final section contains two chapters that focus on clinical evaluation and grading. Chapter 15 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 16 is a succinct summary of three chapters in Oermann and Gaberson's *Evaluation and Testing in Nursing Education*, third edition (Springer, 2009). For a more extensive discussion of that topic, readers are referred to this companion book.

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. We also acknowledge Margaret Zuccarini, our editor at Springer, for her patience, encouragement, and creative approach to this edition.

*Kathleen B. Gaberson*  
*Marilyn H. Oermann*

# Foundations of Clinical Teaching

## SECTION I

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# 1

## Contextual Factors Affecting Clinical Teaching

A major determinant of the effectiveness of clinical teaching is the context in which it occurs. Clinical teaching is performed by a faculty within a curriculum that is planned and offered in response to professional, societal, and educational expectations and demands, using available human, intellectual, physical, and financial resources—the context of the curriculum. Because the context is different for each nursing education program, each curriculum is somewhat unique (Iwasiw, Goldenberg, & Andrusyszyn, 2009, p. xi). Therefore, the practice of clinical teaching differs somewhat from program to program. It is not possible to recommend a set of clinical teaching strategies that will be equally effective in every nursing education program. Rather, the faculty must make decisions about clinical teaching that are congruent with the planned curriculum and relevant to its context (Iwasiw et al., pp. 8–9).

### **THE CURRICULUM PHILOSOPHY**

In the sense that it is used most frequently in education, a philosophy is a system of enduring 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.

Philosophical statements serve as a guide for examining issues and determining the priorities of a discipline (Haynes, Boese, & Butcher, 2004, p. 77; Iwasiw et al., 2009, p. 172). 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).

A curriculum 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., 2009, p. 172). It provides a framework for making curricular and instructional choices and decisions from among options. The values and beliefs included in a curriculum 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 curriculum philosophy directs the curriculum development process by providing a basis for selecting, sequencing, and using content and learning activities. Moreover, the curriculum philosophy of the nursing education program should be congruent with that of the academic institution of which it is a part (Iwasiw et al., 2009, pp. 172–173).

Although traditional views of curriculum development hold that a philosophy is essential as the foundation for building a curriculum, some nursing education leaders have suggested that a set of assumptions or one or more theories could be used instead (Bevis, 2000; Iwasiw et al., 2009, p. 174). When used as a curriculum foundation, learning theories such as behaviorism, cognitive theories, and interpretive pedagogies reflect a faculty's beliefs about learning, teaching, student characteristics, and the educational environment. Nursing theories such as Rogers's Unitary Person Model, Newman's Model of Health, and Watson's Theory of Human Caring may also serve as both theoretical and philosophical contexts for a curriculum (Iwasiw et al., pp. 173–174).

Contemporary nursing curriculum philosophies often are a blend of philosophy, nursing theory, and learning theory. Among others, these blended philosophical approaches include:

- Apprenticeship or cognitive apprenticeship
- Collaborative inquiry

- Constructivism
- Critical social theory
- Feminism
- Humanism
- Interpretive inquiry
- Phenomenology
- Pragmatism (Iwasiw et al., 2009, pp. 175–178)

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' philosophical approach to clinical teaching. That philosophical context for clinical teaching will be discussed in the remainder of this chapter.

## **A PHILOSOPHICAL CONTEXT FOR CLINICAL TEACHING**

Every clinical teacher has a philosophical approach to clinical teaching, whether or not the teacher realizes it. That philosophical context 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. 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 may evoke anxiety about exposing one-self and one's practice to scrutiny, but this self-reflection is a meaningful basis for continued professional development as a nurse educator (O'Mara, Carpio, Mallette, Down, & Brown, 2000).

Readers may not agree with every element of the philosophical context discussed here, 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 own philosophies of nursing education in general and clinical teaching in particular to guide their clinical teaching practice.

## **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 this philosophical approach to clinical teaching.

*Clinical.* This word is an adjective, derived from the noun *clinic*. *Clinical* means involving direct observation of the patient. Like any 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, not 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 allows 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 the 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 an 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 PHILOSOPHICAL CONTEXT FOR CLINICAL TEACHING**

The philosophical context 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 serves as 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, 2009). 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, 2009; 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, 2009).

## **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, 2009). Some learners who perform well in the classroom cannot apply their knowledge successfully in the clinical area.

If clinical instruction is so important, why doesn't all nursing education take place in the clinical area? Clinical teaching is the most expensive element of any nursing curriculum. Lower student-to-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 and through independent learning activities that they later apply and test, first in the simulation laboratory and then 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 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.

### **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 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 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 students 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. This takes time and energy, and sometimes faculty members 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 it 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. 233).

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 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, 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. These beliefs may explain why a group of nursing faculty members who teach medical-surgical nursing would suggest that a behavioral health clinical practice session should be cancelled so that all students may hear a guest speaker’s presentation on arterial blood gases or why many nursing faculty members advise students to practice for a year or two after graduation in a medical-surgical setting before transferring to the clinical setting that students initially express an interest in, such as behavioral health, community health, or perioperative settings.

This 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 (the “paper curriculum”), is what individuals say that they believe and do. Espoused theory is used to explain and justify action. The other level, theory-in-use (the “practice curriculum”), 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 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 fact, one of the competencies included on the National League for Nursing (NLN) Certified Nurse Educator (CNE) Examination Detailed Test Blueprint is “Respond effectively to unexpected events that affect clinical . . . instruction” (NLN, 2005, p. 2). In other words, every teacher must interpret the espoused curriculum in view of circumstances and resources in the specific clinical setting and the individual needs of students and patients at the time. 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 curriculum philosophy 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 (Saunders, 1999). 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 (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 philosophical context for clinical teaching articulated here will be applied to discussions of the role of the clinical teacher and the process of clinical teaching. Differences in philosophical approach can profoundly affect how individuals enact the role of clinical teacher. Every decision about teaching strategy, setting, outcome, and 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 the continual improvement of clinical teaching.

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 philosophical approach to clinical education thus will serve as a guide to more effective practice and a means of ongoing professional development (Petress, 2003).

## SUMMARY

The context in which clinical teaching occurs is a major determinant of its effectiveness. The context of the curriculum comprises internal and external influences, expectations, and demands that ground the curriculum and make it unique. The internal contextual factors include the faculty's shared beliefs about the goals of education, the nature of teaching and learning, and the roles of learners and teachers—the philosophical context of the curriculum.

A philosophical context for 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 philosophical approach to 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.

The philosophical context of clinical teaching advocated in this book contains the following beliefs. Clinical education should reflect the nature of professional practice. Practice in clinical settings exposes students to realities of professional practice that cannot be conveyed by a textbook or a simulation. Most professional practice situations are complex, unstable, and unique. Therefore, clinical learning activities should expose students to problems that cannot be solved easily with existing knowledge and technical skills.

Another element of the philosophy of clinical teaching concerns the importance of clinical teaching. Because nursing is a professional practice discipline, the clinical practice of nurses and nursing students is more important than what they can demonstrate in a classroom. Clinical education provides opportunities for real-life experiences and transfer of knowledge to practical situations.

In the clinical setting, nursing students come in contact with patients for the purpose of applying knowledge, testing theories, and learning skills. Although typical activities of nursing students center on patient care, learning does not necessarily take place during caregiving. The central activity of the student in clinical education should be learning, not doing.

Sufficient learning time should be provided before performance is evaluated. Students need to engage in learning activities and practice skills before their performance is evaluated summatively. Skill acquisition is a complex process that involves making errors and learning how to correct and then prevent them. Teachers should allow plentiful learning time with ample opportunity for feedback before evaluating performance.

Another element of this philosophy of clinical teaching is the importance of a climate of mutual trust and respect that supports learning and student growth. Teachers and learners share the responsibility for maintaining this climate, but teachers ultimately are accountable for establishing expectations that faculty and students will be partners in achieving success.

Clinical teaching and learning should focus on essential knowledge, skills, and attitudes. Because every nursing education program has limited time for clinical teaching, this time is used to maximum advantage by focusing on the most common practice problems that learners are likely to face. Educators need to identify the knowledge, skills, and attitudes that are most essential for students to learn. Learners need to spend most of their time in this *essential curriculum*.

In clinical settings, the espoused curriculum may not be the curriculum-in-use. Although most faculty members would argue that there is one curriculum for a nursing education program, in reality, the espoused curriculum is interpreted somewhat differently by each clinical teacher. Consequently, every student experiences this curriculum-in-use differently. A faculty cannot prescribe every detail of what teachers will teach and what learners will learn in clinical settings. Instead, it is usually more effective to specify broader outcomes and allow teachers and learners to meet them in a variety of ways. Individual faculty members are cautioned not to take individualizing the curriculum as a license to ignore the shared philosophy that guides curriculum development and implementation.

Finally, the distinction between quality and quantity of clinical learning is important. The quality of a learner's experience is more important than the amount of time spent in clinical activities. Both the activity and the amount of time should be individualized.

## Exhibit 1.1

### **CNE EXAMINATION TEST BLUEPRINT CORE COMPETENCIES**

#### **1. Facilitate Learning**

- A. Implement a variety of teaching strategies appropriate to
  - 1. content and setting
  - 2. learner needs
  - 4. desired learner outcomes
- B. Use teaching strategies based on
  - 1. educational theory
- J. Create a positive learning environment that fosters a free exchange of ideas

#### **2. Facilitate Learner Development and Socialization**

- D. Create learning environments that facilitate learners' self-reflection, personal goal setting, and socialization to the role of the nurse

#### **4. Participate in Curriculum Design and Evaluation of Program Outcomes**

- B. Actively participate in the design of the curriculum to reflect
  - 1. institutional philosophy and mission
  - 2. current nursing and health care trends
  - 3. community and societal needs
  - 4. educational principles, theory, and research

*(continued)*

F. Update courses to reflect the philosophical and theoretical framework of the curriculum

*Note.* This exhibit and CNE Core Competency exhibits in subsequent chapters identify selected competencies that relate to content in each chapter. The lettering and numbering of competencies correspond to the structure of the Certified Nurse Educator (CNE<sup>CM</sup>) Examination Detailed Test Blueprint.

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