DILEMMAS OF CLINICAL TEACHING

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INTRODUCTION

Although clinical teaching is seen as an important part of nursing education, it receives amazingly little attention from nurse-educators. It is seldom given the same attention in the education of nurse-tutors as classroom teaching, and most tutors therefore have not had any real supervision of their skills in this area. Furthermore, the essential characteristics of this type of teaching are not easy to grasp.

It is easy enough to define clinical teaching in nursing as that teaching which goes on "at the bedside" or rather at the "patient-side" as Mellish (1982) calls it in this era of comprehensive training but this simple definition clarifies very little about this kind of teaching.

What is the difference between classroom teaching and clinical teaching? Does the difference lie in where the teaching takes place, in the methods used or in the content of teaching? Are there things that can be taught in the classroom as well as the clinical setting and other things that can only be taught in the clinical setting? How can learning in this setting be facilitated?

In order to answer these and other questions, we need a much closer look at nursing and the teaching of nursing.

THE DILEMMA OF WHAT IS TO BE TAUGHT.

Again, an easy answer is immediately available. The theory of nursing is taught in the classroom, and the application of that theory is taught in the clinical area but this over-simplification does not solve the problem.

Nursing is often defined as a science and an art (Mellish, 1982). The science part of nursing has to do with theory, or those generalizations that scientists have made over many years about patients, their conditions and the nursing interventions indicated in such situations. These generalizations, or statements that have a high probability of being true in a given situation, are the content that is taught in the classroom. It is also the part of nursing that is best suited to the problem-solving approach to nursing.

But the art part of nursing is much more than learning general rules. It refers to the intuitive, personal part of nursing in which a specific nurse with her personality and background, cares for a specific patient, with all the typical and atypical features the patient might display with his/her own personality and background. The art of nursing involves using yourself in caring for the patient as a unique person. Lindeman (1989) says that artistry is an exercise of intelligence, a kind of knowing that includes not only empirical knowledge, but also ethical, personal and aesthetic knowledge. It does not only use knowledge, but creates knowledge through intuition and improvisation.

The art part of nursing also includes the psychomotor skills that are needed for effective care. Skilful nursing with the nurse implementing procedures smoothly, effectively and in a reasonable time, is essential to the aesthetic component.

Now, this cannot be taught in the classroom; just as you cannot teach a person to become a concert pianist by sitting in a classroom at a desk, you cannot teach the art of nursing in a classroom. It is essentially only taught in the real situation; the student pianist sits in front of the piano for hours, practising. He/she listens to the sounds, get the feel of it in the fingers, listens to recordings of other artists playing the piece, listens to the feedback of the piano teacher, and learns to be a pianist. In the same way the student nurse "practises" nursing, looks/listens/feels herself doing it, gets feedback from others about her performance, compares her performance with others and learns to do it better.

When talking about the art of nursing, we therefore mean that the nurse produces work that is skilful, innovative, personalized and a joy to see and experience.

Nursing has both content and process components. It does not only consist of specific information but involves specific processes in which the information has to be used. The two most common ways in which the process of nursing is conceptualized, are as a PROBLEM SOLVING PROCESS and as a INTERPERSONAL PROCESS.

The problem solving process has been conceptualized in different ways by different authors. Engel (McMaster University, 1989-90) defines it as an intellectual approach to making decisions in the face of a situation in which the nature and interplay of components are not immediately obvious or fully identified.

Other authors have identified the steps in this process thus:-

Kelly (in Tanner, 1987)	*Huckabay (1980)*
Decide about the kind of observations to be made in the client situation	Presentation of the problem
Evaluate the data and derive meaning - arrive at a diagnosis	Definition of the problem: identifying essential features of the problem situation
Decide which nursing actions should be taken.	Formulation of hypothesis: This may be possible solution to the problem
	Verification of the hypothesis: Various hypotheses are tested until the problem is solved.

It is clear from both of these descriptions that the problem-solving process is the essential means by which the nurse applies theory to practice.

Callin and Ciliska (1983) have identified the following cognitive activities essential for successful problem-solving:

- selective attention : the ability to concentrate on certain classes of stimuli;
- sustained analysis : the capacity to probe a complex situation until its components are identified;
- analogizing : the capacity to identify and test resemblances between new and previously known situations;
- suspension of closure : the willingness to assign priorities to factors in a situation before considering possible solutions;
- autocensorship: the ability to test a solution covertly before applying it overtly;
- openness : being constantly alert and receptive to new information;

- confidence : having enough faith in your own judgement to act on it;
- living with ambiguity : the willingness to proceed based on a conclusion knowing that it is provisional.

When considering this very complex process, the question is "Where is the nursing student taught to problem-solve?" To some extent it can be taught in the classroom if this is the format of most class presentations and class tests. But the complexity, time constraints and attention diffusion that are essential parts of problem solving in the clinical situation cannot be simulated easily. In the clinical situation the nurse usually deals with a whole group of patients at the same time; in the classroom she is usually given one patient situation at a time. In the clinical situation the nurse has to make many decisions in a limited time, often without having all the information necessary; in the classroom situation she usually has enough time and all the relevant information is given. In the clinical situation, the nurse's attention is often not drawn to the problem by anybody; her attention is diffused over a broad spectrum of relevant and irrelevant stimuli. In the classroom situation, the student is given a situation in which she knows that a problem exists.

The conclusion therefore is inevitable that this process can be learnt fully only in the clinical situation.

As far as the interpersonal process inherent in nursing is concerned, different authors again identify different essential components. Travelbee (1971) defines nursing as a interpersonal process based on the fact that nursing is always concerned with people. She then relies strongly on communication and the concept of person-to-person relationships to describe nursing further. Hockey (quoted by Alexander, 1983) identifies education for empathy as one of the five major aspects of nursing education.

It has been shown that interpersonal skills such as empathy can be taught in the classroom through role play, modelling and feedback. However, using these skills effectively in the clinical situation is an application of theory to practice which might need more intervention from the tutor. Bendall (1965) found that what students write in examinations does not predict what they do in practice.

Without interpersonal skills the nurse would find it difficult to obtain the information necessary for decision-making, and it would be difficult to involve the patient in problem-solving or implementation of plans.

In summary then, clinical teaching should be aimed at teaching students:

- the art of nursing, including skilled performance;
- the process of problem solving;
- the interpersonal process inherent in nursing.

THE DILEMMA OF HOW IT SHOULD BE TAUGHT

When I tried clinical teaching myself, I found it very difficult and I found the literature on this area of teaching not very helpful. It mostly dealt with "teachable moments" without explaining how the tutor can ensure that she is there when the teachable moments occur. Or they dealt with structured teaching such as demonstrations and lectures in the clinical area which interfere with the student's role as part of the work force in busy units.

Last year I did a small exploration of the clinical teaching done by tutors at different colleges. These tutors agreed to keep a record of the clinical teaching they did over one month. The data were analysed using content analysis.

Twenty-six tutors were involved, and they supplied a total of 247 incidents which were analysed. Each incident described one visit to a unit.

The area concerned was not mentioned in the majority of incidents, but where it was mentioned, midwifery, medical, surgical, ENT, orthopaedic, outpatient and theatre units were covered,

All kinds of students were involved in the incidents - pupil nurses, staff nurses, bridging course students, nursing assistants, student midwives and comprehensive course students from all four years. Many tutors did not stipulate which students were involved.

PLANNED VS UNPLANNED VISITS

Although many tutors did not stipulate whether the students were expecting them (a planned visit) or not (an unplanned visit), a classification of this aspect was made based on the information in the anecdote.

From this it would seem that tutors used the unplanned visit slightly more often than the planned visit.

It is difficult to evaluate the effectiveness of planning a visit as opposed to just arriving on a visit. Five tutors mentioned that they found a particular visit negative, and of those five, four were negative because they felt that they were interfering with ward work and one felt she was distracting the student from her work.

However, this might occur with a planned visit too, since three tutors described the ward as "busy" during a visit, and two said it was "very busy".

OBJECTIVE

In about 75% of the incidents the tutor did not stipulate her objectives for the visit. Again this was deduced from what happened in the incidents.

It was found that teaching was done in 100 incidents, evaluation in 48 incidents and just checking of progress in 60 incidents.

In supervising the clinical teaching practice of Nursing Education students I have found that students interpret the clinical visits of tutors as aimed at evaluation even when the educators themselves saw themselves as having taught. The 23% of incidents which dealt with evaluation might therefore be much higher in the eyes of the student. This may raise their anxiety about such clinical visits, so that they are not seen as supportive of learning or of the student.

"Just checking progress" might be part of being available to the student for support or teaching but it might be classed also as part of evaluation by the students - or it might represent activity on the part of the tutor which is unplanned and inefficient.

PROCESS

Of the 247 incidents, it was found that a specific procedure was the focus of the teaching in 145 (59%) of cases. In about 71 additional incidents there were some additions to simply teaching a procedure such as discussions. This means that 87% of the clinical teaching is concerned with teaching procedures.

Coming second, very far behind, were patient discussions, described in 17 incidents. In eight incidents workbook assignments were discussed with students, while discussions in which theory was applied was described in six incidents.

The enormous focus on procedures may indicate the following:

- that clinical nursing is perceived by tutors and students as primarily consisting of procedures strung together;
- that the summative evaluation is so procedure focused that it forces the teaching into this mode;
- that the tutors are not well-versed in alternative clinical teaching approaches, and therefore use the one with which they are most comfortable.

RESULTS

In eight incidents the tutors indicated that an evaluation decision was made based on the incident.

In 49 incidents the tutor identified the need for further learning/practice/supervision in the area covered. In most cases the student was given a written assignment or assigned to read something. In some cases the remedy for the identified need is not stipulated. Ward staff

were used as a back-up in these cases in only four incidents.

Unless clinical teaching is done in a systematic way follow-up of such visits may be problematic.

My conclusion based on this very limited study is that

- clinical teaching is seldom done in a systematic planned way;
- it is often focused on either evaluation or procedures, which compares unfavourably with the objectives of what should be taught.

The dilemma is how this unplanned, almost haphazard, procedure/evaluation focused activity can be shaped into the systematic modelling and reinforcement of the art and process of nursing which we need. This is the challenge we are facing in this conference and I hope that in the next two days we will find at least some solutions.

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